By: Martinez Fischer H.B. No. 4351

A BILL TO BE ENTITLED

AN ACT

relating to utilization review of and health benefit plan coverage for emergency care.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle E, Title 8, Insurance Code, is amended by adding Chapter 1380 to read as follows:

CHAPTER 1380. COVERAGE FOR EMERGENCY CARE

Sec. 1380.0001. DEFINITIONS. In this chapter:

(1) "Emergency care" has the meaning assigned by Section 4201.002.

(2) "Enrollee" means an individual covered by a health benefit plan.

(3) "Health benefit plan" means a plan to which this chapter applies under Section 1380.0002.

(4) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state.

(5) "Utilization review" has the meaning assigned by Section 4201.002.

Sec. 1380.0002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance

agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843;

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(6) a stipulated premium company operating under Chapter 884;

(7) a fraternal benefit society operating under Chapter 885;

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) a managed care program under the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(10) a managed care program under the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code;

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code;

(13) county employee group health benefits provided under Chapter 157, Local Government Code; and

(14) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

Sec. 1380.0003. EMERGENCY CARE. (a) When prospective, concurrent, or retrospective utilization review is being conducted for a health benefit plan issuer or the issuer makes a benefit determination to determine the medical necessity and appropriateness of emergency care, the health benefit plan issuer and any utilization review agent acting on the issuer's behalf shall comply with this chapter.

(b) The issuer:

(1) shall provide coverage for emergency care necessary to screen and stabilize an enrollee, as determined by the health care provider providing the emergency care;

(2) may not require prior authorization of emergency care; and

(3) shall comply with other applicable provisions of this code, including Sections 843.252, 843.258, 1271.155, 1301.0053, 1301.155, 4201.304, and 4201.357, as applicable.

(c) Coverage of emergency care may be subject to applicable copayments, coinsurance, and deductibles under the health benefit plan.

(d) Before a health benefit plan issuer retrospectively denies coverage for emergency care based on the determination that it was not medically necessary or appropriate to provide the care as emergency care, the issuer or the utilization review agent acting on the issuer's behalf shall review the enrollee's medical record regarding the medical condition for which the emergency care was provided. If the issuer or agent requests a record relating to a retrospective review of emergency care, the health care provider who provided the emergency care shall submit the record of the emergency care to the issuer or agent in accordance with Section 4201.305.

(e) Notwithstanding Section 4201.152, a board-certified physician licensed in this state must complete a retrospective review of emergency care for a health benefit plan issuer.

(f) The process for an appeal of a determination subject to

this section must comply with Section 4201.357.

SECTION 2. Section 1380.0003, Insurance Code, as added by this Act, applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2020, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2019.