

By: Buckingham, et al.

S.B. No. 1186

A BILL TO BE ENTITLED

AN ACT

relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers.

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

SECTION 1. Section 843.348(b), Insurance Code, is amended to read as follows:

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the fifth ~~10th~~ business day after the date a request is made, a list of health care services that ~~do not~~ require preauthorization and information concerning the preauthorization process.

SECTION 2. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.3481, 843.3482, 843.3483, and 843.3484 to read as follows:

Sec. 843.3481. POSTING PREAUTHORIZATION REQUIREMENTS. (a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

1           (1) be conspicuously posted in a location on the  
2 Internet website that does not require the use of a log-in or other  
3 input of personal information to view the information;

4           (2) be written in plain language that is easily  
5 understandable by enrollees, physicians, providers, and the  
6 general public;

7           (3) include a detailed description of the  
8 preauthorization process and the applicable screening criteria  
9 using Current Procedural Terminology codes and International  
10 Classification of Diseases codes; and

11           (4) include statistics showing the health maintenance  
12 organization's preauthorization approvals and denials, including  
13 for each approval or denial the:

14                   (A) physician specialty;

15                   (B) medication, diagnostic test, or procedure;

16                   (C) indication offered; and

17                   (D) reason for denial.

18           Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

19           (a) Not later than the 60th day before the date a new or amended  
20 preauthorization requirement takes effect, a health maintenance  
21 organization that uses a preauthorization process for health care  
22 services shall provide each participating physician or provider  
23 written notice of the new or amended preauthorization requirement  
24 and disclose the new or amended requirement in the health  
25 maintenance organization's newsletter or network bulletin, if any.

26           (b) A health maintenance organization shall update its  
27 Internet website to disclose any change to the health maintenance

1 organization's preauthorization requirements or process and the  
2 date and time the change is effective. A new or amended  
3 preauthorization requirement may not take effect before the fifth  
4 day after the date the health maintenance organization's Internet  
5 website is updated as required by this subsection.

6 (c) A health maintenance organization is not required to  
7 comply with Subsection (a) or (b) for a change in a preauthorization  
8 requirement or process that removes a health care service from the  
9 list of services requiring preauthorization or amends a  
10 preauthorization requirement in a way that is less burdensome to  
11 enrollees and participating physicians and providers.

12 Sec. 843.3483. EXEMPTION FROM PREAUTHORIZATION  
13 REQUIREMENTS. A health maintenance organization that uses a  
14 preauthorization process for health care services may not require a  
15 physician or provider to obtain preauthorization for health care  
16 services if the physician or provider establishes in accordance  
17 with standards adopted by the commissioner by rule that the  
18 physician or provider routinely submitted claims to the health  
19 maintenance organization that were consistent with national  
20 evidence-based guidelines and that were preauthorized by the health  
21 maintenance organization.

22 Sec. 843.3484. REMEDY FOR NONCOMPLIANCE; AUTOMATIC  
23 PREAUTHORIZATION. A health maintenance organization that uses a  
24 preauthorization process for health care services that violates  
25 this subchapter with respect to a required publication, notice, or  
26 response regarding its preauthorization requirements, including by  
27 failing to comply with any applicable deadline for the publication,

1 notice, or response, waives the health maintenance organizations  
2 preauthorization requirements with respect to any health care  
3 service affected by the violation.

4 SECTION 3. Section 1301.135(a), Insurance Code, is amended  
5 to read as follows:

6 (a) An insurer that uses a preauthorization process for  
7 medical care or ~~and~~ health care services shall provide to each  
8 preferred provider, not later than the fifth ~~10th~~ business day  
9 after the date a request is made, a list of medical care and health  
10 care services that require preauthorization and information  
11 concerning the preauthorization process.

12 SECTION 4. Subchapter C-1, Chapter 1301, Insurance Code, is  
13 amended by adding Sections 1301.1351, 1301.1352, 1301.1353, and  
14 1301.1354 to read as follows:

15 Sec. 1301.1351. POSTING PREAUTHORIZATION REQUIREMENTS.

16 (a) An insurer that uses a preauthorization process for medical  
17 care or health care services shall make the requirements and  
18 information about the preauthorization process readily accessible  
19 to insureds, physicians, health care providers, and the general  
20 public by posting the requirements and information on the insurer's  
21 Internet website.

22 (b) The preauthorization requirements and information  
23 described by Subsection (a) must:

24 (1) be conspicuously posted in a location on the  
25 Internet website that does not require the use of a log-in or other  
26 input of personal information to view the information;

27 (2) be written in plain language that is easily

1 understandable by insureds, physicians, health care providers, and  
2 the general public;

3 (3) include a detailed description of the  
4 preauthorization process and the applicable screening criteria  
5 using Current Procedural Terminology codes and International  
6 Classification of Diseases codes; and

7 (4) include statistics showing the insurer's  
8 preauthorization approvals and denials, including for each  
9 approval or denial the:

10 (A) physician specialty;

11 (B) medication, diagnostic test, or procedure;

12 (C) indication offered; and

13 (D) reason for denial.

14 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

15 (a) Not later than the 60th day before the date a new or amended  
16 preauthorization requirement takes effect, an insurer that uses a  
17 preauthorization process for medical care or health care services  
18 shall provide to each preferred provider written notice of the new  
19 or amended preauthorization requirement and disclose the new or  
20 amended requirement in the insurer's newsletter or network  
21 bulletin, if any.

22 (b) An insurer shall update its Internet website to disclose  
23 any change to the insurer's preauthorization requirements or  
24 process and the date and time the change is effective. A new or  
25 amended preauthorization requirement may not take effect before the  
26 fifth day after the date the insurer's Internet website is updated  
27 as required by this subsection.

1       (c) An insurer is not required to comply with Subsection (a)  
2 or (b) for a change in a preauthorization requirement or process  
3 that removes a medical care or health care service from the list of  
4 services requiring preauthorization or amends a preauthorization  
5 requirement in a way that is less burdensome to insureds,  
6 physicians, and health care providers.

7       Sec. 1301.1353. EXEMPTION FROM PREAUTHORIZATION  
8 REQUIREMENTS. An insurer that uses a preauthorization process for  
9 medical care or health care services may not require a physician or  
10 health care provider to obtain preauthorization for medical care or  
11 health care services if the physician or health care provider  
12 establishes in accordance with standards adopted by the  
13 commissioner by rule that the physician or health care provider  
14 routinely submitted claims to the insurer that were consistent with  
15 national evidence-based guidelines and that were preauthorized by  
16 the insurer.

17       Sec. 1301.1354. REMEDY FOR NONCOMPLIANCE; AUTOMATIC  
18 PREAUTHORIZATION. An insurer that uses a preauthorization process  
19 for medical care or health care services that violates this  
20 subchapter with respect to a required publication, notice, or  
21 response regarding its preauthorization requirements, including by  
22 failing to comply with any applicable deadline for the publication,  
23 notice, or response, waives the insurer's preauthorization  
24 requirements with respect to any medical care or health care  
25 service affected by the violation.

26       SECTION 5. The change in law made by this Act applies only  
27 to a request for preauthorization of medical care or health care

1 services made on or after January 1, 2020. A request for  
2 preauthorization of medical care or health care services made  
3 before January 1, 2020, under a health benefit plan delivered,  
4 issued for delivery, or renewed before that date is governed by the  
5 law in effect immediately before the effective date of this Act, and  
6 that law is continued in effect for that purpose.

7 SECTION 6. This Act takes effect September 1, 2019.