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

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

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

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

(A) physician specialty;

(B) medication, diagnostic test, or procedure;

(C) indication offered; and

(D) reason for denial.

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider written notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any.

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

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

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

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

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

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

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

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

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

Sec. 1301.1351. POSTING PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

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

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

(2) be written in plain language that is easily

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

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

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

(A) physician specialty;

(B) medication, diagnostic test, or procedure;

(C) indication offered; and

(D) reason for denial.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide to each preferred provider written notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the insurer's newsletter or network bulletin, if any.

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

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

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

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

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

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

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