

AN ACT

relating to physician and health care provider directories, preauthorization, utilization review, independent review, and peer review for certain health benefit plans and workers' compensation coverage.

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

ARTICLE 1. HEALTH CARE PROVIDER DIRECTORIES

SECTION 1.01. Section 1451.501, Insurance Code, is amended by amending Subdivision (1) and adding Subdivisions (1-a) and (1-b) to read as follows:

(1) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.

(1-a) "Facility-based physician" means a radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(1-b) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist, pharmacy, hospital, nursing home, or other medical or

1 health-related service facility that provides care for the sick or
2 injured or other care. The term does not include a physician.

3 SECTION 1.02. Section [1451.504](#), Insurance Code, is amended
4 by amending Subsection (b) and adding Subsections (c) and (d) to
5 read as follows:

6 (b) The directory must include the name, street address,
7 specialty, if any, and telephone number of each physician and
8 health care provider described by Subsection (a) and indicate
9 whether the physician or provider is accepting new patients.

10 (c) For each health care provider that is a facility
11 included in the directory under this section, the directory must:

12 (1) list under the facility name separate headings for
13 radiologists, anesthesiologists, pathologists, emergency
14 department physicians, neonatologists, and assistant surgeons;

15 (2) list under each heading described by Subdivision
16 (1) each facility-based physician described by Subsection (a)
17 practicing in the specialty corresponding with that heading that is
18 a preferred provider, exclusive provider, or network physician;

19 (3) for the facility and each facility-based physician
20 described by Subdivision (2), clearly indicate each health benefit
21 plan issued by the issuer that may provide coverage for the services
22 provided by that facility or physician; and

23 (4) include the facility in a listing of all
24 facilities included in the directory indicating:

25 (A) the name of the facility;

26 (B) the municipality in which the facility is
27 located or county in which the facility is located if the facility

1 is in the unincorporated area of the county;

2 (C) for each specialty of facility-based
3 physician practicing at the facility, the name, street address, and
4 telephone number of any facility-based physician that is a
5 preferred provider, exclusive provider, or network physician or of
6 the physician group in which the facility-based physician
7 practices;

8 (D) each health benefit plan issued by the issuer
9 that may provide coverage for the services provided by the
10 facility; and

11 (E) each health benefit plan issued by the issuer
12 that may provide coverage for the services provided by each
13 facility-based physician group.

14 (d) The directory must list a facility-based physician
15 individually and, if the physician belongs to a physician group, as
16 part of the physician group.

17 SECTION 1.03. Section 1451.505(c), Insurance Code, is
18 amended to read as follows:

19 (c) The directory must be:

20 (1) electronically searchable by physician or health
21 care provider name, specialty, if any, facility, and location; and

22 (2) publicly accessible without necessity of
23 providing a password, a user name, or personally identifiable
24 information.

25 ARTICLE 2. PREAUTHORIZATION

26 SECTION 2.01. Section 843.348(b), Insurance Code, is
27 amended to read as follows:

1 (b) A health maintenance organization that uses a
2 preauthorization process for health care services shall provide
3 each participating physician or provider, not later than the fifth
4 [~~10th~~] business day after the date a request is made, a list of
5 health care services that [~~do not~~] require preauthorization and
6 information concerning the preauthorization process.

7 SECTION 2.02. Subchapter J, Chapter 843, Insurance Code, is
8 amended by adding Sections 843.3481, 843.3482, and 843.3483 to read
9 as follows:

10 Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

11 (a) A health maintenance organization that uses a
12 preauthorization process for health care services shall make the
13 requirements and information about the preauthorization process
14 readily accessible to enrollees, physicians, providers, and the
15 general public by posting the requirements and information on the
16 health maintenance organization's Internet website.

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

19 (1) be posted:

20 (A) except as provided by Subsection (c) or (d),
21 conspicuously in a location on the Internet website that does not
22 require the use of a log-in or other input of personal information
23 to view the information; and

24 (B) in a format that is easily searchable and
25 accessible;

26 (2) except for the screening criteria under
27 Subdivision (4)(C), be written in plain language that is easily

1 understandable by enrollees, physicians, providers, and the
2 general public;

3 (3) include a detailed description of the
4 preauthorization process and procedure; and

5 (4) include an accurate and current list of the health
6 care services for which the health maintenance organization
7 requires preauthorization that includes the following information
8 specific to each service:

9 (A) the effective date of the preauthorization
10 requirement;

11 (B) a list or description of any supporting
12 documentation that the health maintenance organization requires
13 from the physician or provider ordering or requesting the service
14 to approve a request for that service;

15 (C) the applicable screening criteria, which may
16 include Current Procedural Terminology codes and International
17 Classification of Diseases codes; and

18 (D) statistics regarding preauthorization
19 approval and denial rates for the service in the preceding calendar
20 year, including statistics in the following categories:

21 (i) physician or provider type and
22 specialty, if any;

23 (ii) indication offered;

24 (iii) reasons for request denial;

25 (iv) denials overturned on internal appeal;

26 (v) denials overturned by an independent
27 review organization; and

1 (vi) total annual preauthorization
2 requests, approvals, and denials for the service.

3 (c) This section may not be construed to require a health
4 maintenance organization to provide specific information that
5 would violate any applicable copyright law or licensing agreement.
6 To comply with a posting requirement described by Subsection (b), a
7 health maintenance organization may, instead of making that
8 information publicly available on the health maintenance
9 organization's Internet website, supply a summary of the withheld
10 information sufficient to allow a licensed physician or provider,
11 as applicable for the specific service, who has sufficient training
12 and experience related to the service to understand the basis for
13 the health maintenance organization's medical necessity or
14 appropriateness determinations.

15 (d) If a requirement or information described by Subsection
16 (a) is licensed, proprietary, or copyrighted material that the
17 health maintenance organization has received from a third party
18 with which the health maintenance organization has contracted, to
19 comply with a posting requirement described by Subsection (b), the
20 health maintenance organization may, instead of making that
21 information publicly available on the health maintenance
22 organization's Internet website, provide the material to a
23 physician or provider who submits a preauthorization request using
24 a nonpublic secured Internet website link or other protected,
25 nonpublic electronic means.

26 Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

27 (a) Except as provided by Subsection (b), not later than the 60th

1 day before the date a new or amended preauthorization requirement
2 takes effect, a health maintenance organization that uses a
3 preauthorization process for health care services shall provide
4 notice of the new or amended preauthorization requirement and
5 disclose the new or amended requirement in the health maintenance
6 organization's newsletter or network bulletin, if any, and on the
7 health maintenance organization's Internet website.

8 (b) For a change in a preauthorization requirement or
9 process that removes a service from the list of health care services
10 requiring preauthorization or amends a preauthorization
11 requirement in a way that is less burdensome to enrollees or
12 participating physicians or providers, a health maintenance
13 organization shall provide notice of the change in the
14 preauthorization requirement and disclose the change in the health
15 maintenance organization's newsletter or network bulletin, if any,
16 and on the health maintenance organization's Internet website not
17 later than the fifth day before the date the change takes effect.

18 (c) Not later than the fifth day before the date a new or
19 amended preauthorization requirement takes effect, a health
20 maintenance organization shall update its Internet website to
21 disclose the change to the health maintenance organization's
22 preauthorization requirements or process and the date and time the
23 change is effective.

24 Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to
25 any other penalty or remedy provided by law, a health maintenance
26 organization that uses a preauthorization process for health care
27 services that violates this subchapter with respect to a required

1 publication, notice, or response regarding its preauthorization
2 requirements, including by failing to comply with any applicable
3 deadline for the publication, notice, or response, must provide an
4 expedited appeal under Section 4201.357 for any health care service
5 affected by the violation.

6 SECTION 2.03. Section 1301.135(a), Insurance Code, is
7 amended to read as follows:

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

14 SECTION 2.04. Subchapter C-1, Chapter 1301, Insurance Code,
15 is amended by adding Sections 1301.1351, 1301.1352, and 1301.1353
16 to read as follows:

17 Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS.

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

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

26 (1) be posted:

27 (A) except as provided by Subsection (c) or (d),

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

4 (B) in a format that is easily searchable and
5 accessible;

6 (2) except for the screening criteria under
7 Subdivision (4)(C), be written in plain language that is easily
8 understandable by insureds, physicians, health care providers, and
9 the general public;

10 (3) include a detailed description of the
11 preauthorization process and procedure; and

12 (4) include an accurate and current list of medical
13 care and health care services for which the insurer requires
14 preauthorization that includes the following information specific
15 to each service:

16 (A) the effective date of the preauthorization
17 requirement;

18 (B) a list or description of any supporting
19 documentation that the insurer requires from the physician or
20 health care provider ordering or requesting the service to approve
21 a request for the service;

22 (C) the applicable screening criteria, which may
23 include Current Procedural Terminology codes and International
24 Classification of Diseases codes; and

25 (D) statistics regarding the insurer's
26 preauthorization approval and denial rates for the medical care or
27 health care service in the preceding calendar year, including

1 statistics in the following categories:

2 (i) physician or health care provider type
3 and specialty, if any;

4 (ii) indication offered;

5 (iii) reasons for request denial;

6 (iv) denials overturned on internal appeal;

7 (v) denials overturned by an independent
8 review organization; and

9 (vi) total annual preauthorization
10 requests, approvals, and denials for the service.

11 (c) This section may not be construed to require an insurer
12 to provide specific information that would violate any applicable
13 copyright law or licensing agreement. To comply with a posting
14 requirement described by Subsection (b), an insurer may, instead of
15 making that information publicly available on the insurer's
16 Internet website, supply a summary of the withheld information
17 sufficient to allow a licensed physician or other health care
18 provider, as applicable for the specific service, who has
19 sufficient training and experience related to the service to
20 understand the basis for the insurer's medical necessity or
21 appropriateness determinations.

22 (d) If a requirement or information described by Subsection
23 (a) is licensed, proprietary, or copyrighted material that the
24 insurer has received from a third party with which the insurer has
25 contracted, to comply with a posting requirement described by
26 Subsection (b), the insurer may, instead of making that information
27 publicly available on the insurer's Internet website, provide the

1 material to a physician or health care provider who submits a
2 preauthorization request using a nonpublic secured Internet
3 website link or other protected, nonpublic electronic means.

4 (e) The provisions of this section may not be waived,
5 voided, or nullified by contract.

6 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

7 (a) Except as provided by Subsection (b), not later than the 60th
8 day before the date a new or amended preauthorization requirement
9 takes effect, an insurer that uses a preauthorization process for
10 medical care or health care services shall provide notice of the new
11 or amended preauthorization requirement and disclose the new or
12 amended requirement in the insurer's newsletter or network
13 bulletin, if any, and on the insurer's Internet website.

14 (b) For a change in a preauthorization requirement or
15 process that removes a service from the list of medical care or
16 health care services requiring preauthorization or amends a
17 preauthorization requirement in a way that is less burdensome to
18 insureds, physicians, or health care providers, an insurer shall
19 provide notice of the change in the preauthorization requirement
20 and disclose the change in the insurer's newsletter or network
21 bulletin, if any, and on the insurer's Internet website not later
22 than the fifth day before the date the change takes effect.

23 (c) Not later than the fifth day before the date a new or
24 amended preauthorization requirement takes effect, an insurer
25 shall update its Internet website to disclose the change to the
26 insurer's preauthorization requirements or process and the date and
27 time the change is effective.

1 (d) The provisions of this section may not be waived,
2 voided, or nullified by contract.

3 Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition
4 to any other penalty or remedy provided by law, an insurer that uses
5 a preauthorization process for medical care or health care services
6 that violates this subchapter with respect to a required
7 publication, notice, or response regarding its preauthorization
8 requirements, including by failing to comply with any applicable
9 deadline for the publication, notice, or response, must provide an
10 expedited appeal under Section 4201.357 for any medical care or
11 health care service affected by the violation.

12 (b) The provisions of this section may not be waived,
13 voided, or nullified by contract.

14 ARTICLE 3. UTILIZATION, INDEPENDENT, AND PEER REVIEW

15 SECTION 3.01. Section 4201.002(12), Insurance Code, is
16 amended to read as follows:

17 (12) "Provider of record" means the physician or other
18 health care provider with primary responsibility for the health
19 care~~[, treatment, and]~~ services provided to or requested on behalf
20 of an enrollee or the physician or other health care provider that
21 has provided or has been requested to provide the health care
22 services to the enrollee. The term includes a health care facility
23 where the health care services are ~~[if treatment is]~~ provided on an
24 inpatient or outpatient basis.

25 SECTION 3.02. Sections 4201.151 and 4201.152, Insurance
26 Code, are amended to read as follows:

27 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization

1 review agent's utilization review plan, including reconsideration
2 and appeal requirements, must be reviewed by a physician licensed
3 to practice medicine in this state and conducted in accordance with
4 standards developed with input from appropriate health care
5 providers and approved by a physician licensed to practice medicine
6 in this state.

7 Sec. 4201.152. UTILIZATION REVIEW UNDER [~~DIRECTION OF~~]
8 PHYSICIAN. A utilization review agent shall conduct utilization
9 review under the direction of a physician licensed to practice
10 medicine in this [~~by a~~] state [~~licensing agency in the United~~
11 ~~States~~].

12 SECTION 3.03. Sections [4201.155](#), [4201.206](#), and [4201.251](#),
13 Insurance Code, are amended to read as follows:

14 Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW
15 PROCEDURES. (a) A utilization review agent may not establish or
16 impose a notice requirement or other review procedure that is
17 contrary to the requirements of the health insurance policy or
18 health benefit plan.

19 (b) This section may not be construed to release a health
20 insurance policy or health benefit plan from full compliance with
21 this chapter or other applicable law.

22 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
23 ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the
24 notice requirements of Subchapter G, before an adverse
25 determination is issued by a utilization review agent who questions
26 the medical necessity, the [~~or~~] appropriateness, or the
27 experimental or investigational nature[~~r~~] of a health care service,

1 the agent shall provide the health care provider who ordered,
2 requested, provided, or is to provide the service a reasonable
3 opportunity to discuss with a physician licensed to practice
4 medicine the patient's treatment plan and the clinical basis for
5 the agent's determination.

6 (b) If the health care service described by Subsection (a)
7 was ordered, requested, or provided, or is to be provided by a
8 physician, the opportunity described by that subsection must be
9 with a physician licensed to practice medicine.

10 Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A
11 utilization review agent may delegate utilization review to
12 qualified personnel in the hospital or other health care facility
13 in which the health care services to be reviewed were or are to be
14 provided. The delegation does not release the agent from the full
15 responsibility for compliance with this chapter or other applicable
16 law, including the conduct of those to whom utilization review has
17 been delegated.

18 SECTION 3.04. Sections [4201.252](#)(a) and (b), Insurance Code,
19 are amended to read as follows:

20 (a) Personnel employed by or under contract with a
21 utilization review agent to perform utilization review must be
22 appropriately trained and qualified and meet the requirements of
23 this chapter and other applicable law, including applicable
24 licensing requirements.

25 (b) Personnel, other than a physician licensed to practice
26 medicine, who obtain oral or written information directly from a
27 patient's physician or other health care provider regarding the

1 patient's specific medical condition, diagnosis, or treatment
2 options or protocols must be a nurse, physician assistant, or other
3 health care provider qualified to provide the requested service.

4 SECTION 3.05. Section 4201.356, Insurance Code, is amended
5 to read as follows:

6 Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY
7 REVIEW. (a) The procedures for appealing an adverse determination
8 must provide that a physician licensed to practice medicine makes
9 the decision on the appeal, except as provided by Subsection (b).

10 (b) If not later than the 10th working day after the date an
11 appeal is requested or denied the enrollee's health care provider
12 requests [~~states in writing good cause for having~~] a particular
13 type of specialty provider review the case, a health care provider
14 who is of the same or a similar specialty as the health care
15 provider who would typically manage the medical or dental
16 condition, procedure, or treatment under consideration for review
17 shall review the denial or the decision denying the appeal. The
18 specialty review must be completed within 15 working days of the
19 date the health care provider's request for specialty review is
20 received.

21 SECTION 3.06. Section 4201.357(a), Insurance Code, is
22 amended to read as follows:

23 (a) The procedures for appealing an adverse determination
24 must include, in addition to the written appeal, a procedure for an
25 expedited appeal of a denial of emergency care, [or] a denial of
26 continued hospitalization, or a denial of another service if the
27 requesting health care provider includes a written statement with

1 supporting documentation that the service is necessary to treat a
2 life-threatening condition or prevent serious harm to the patient.

3 That procedure must include a review by a health care provider who:

4 (1) has not previously reviewed the case; and

5 (2) is of the same or a similar specialty as the health
6 care provider who would typically manage the medical or dental
7 condition, procedure, or treatment under review in the appeal.

8 SECTION 3.07. Sections 4201.453 and 4201.454, Insurance
9 Code, are amended to read as follows:

10 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty
11 utilization review agent's utilization review plan, including
12 reconsideration and appeal requirements, must be:

13 (1) reviewed by a health care provider of the
14 appropriate specialty who is licensed or otherwise authorized to
15 provide the specialty health care service in this state; and

16 (2) conducted in accordance with standards developed
17 with input from a health care provider of the appropriate specialty
18 who is licensed or otherwise authorized to provide the specialty
19 health care service in this state.

20 Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF
21 PROVIDER OF SAME SPECIALTY. A specialty utilization review agent
22 shall conduct utilization review under the direction of a health
23 care provider who is of the same specialty as the agent and who is
24 licensed or otherwise authorized to provide the specialty health
25 care service in this [~~by a~~] state [~~licensing agency in the United~~
26 ~~States~~].

27 SECTION 3.08. Section 4201.455(a), Insurance Code, is

1 amended to read as follows:

2 (a) Personnel who are employed by or under contract with a
3 specialty utilization review agent to perform utilization review
4 must be appropriately trained and qualified and meet the
5 requirements of this chapter and other applicable law of this
6 state, including applicable licensing laws.

7 SECTION 3.09. Section 4201.456, Insurance Code, is amended
8 to read as follows:

9 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
10 ADVERSE DETERMINATION. Subject to the notice requirements of
11 Subchapter G, before an adverse determination is issued by a
12 specialty utilization review agent who questions the medical
13 necessity, the [~~or~~] appropriateness, or the experimental or
14 investigational nature[~~r~~] of a health care service, the agent shall
15 provide the health care provider who ordered, requested, or is to
16 provide the service a reasonable opportunity to discuss the
17 patient's treatment plan and the clinical basis for the agent's
18 determination with a health care provider who is of the same
19 specialty as the agent.

20 SECTION 3.10. Section 408.0043, Labor Code, is amended by
21 adding Subsection (c) to read as follows:

22 (c) Notwithstanding Subsection (b), if a health care
23 service is requested, ordered, provided, or to be provided by a
24 physician, a person described by Subsection (a)(1), (2), or (3) who
25 reviews the service with respect to a specific workers'
26 compensation case must be of the same or a similar specialty as that
27 physician.

1 SECTION 3.11. Section 1305.351(d), Insurance Code, is
2 amended to read as follows:

3 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization
4 review agent or an insurance carrier that uses doctors to perform
5 reviews of health care services provided under this chapter,
6 including utilization review, or peer reviews under Section
7 408.0231(g), Labor Code, may only use doctors licensed to practice
8 in this state.

9 SECTION 3.12. Section 1305.355(d), Insurance Code, is
10 amended to read as follows:

11 (d) The department shall assign the review request to an
12 independent review organization. An [~~Notwithstanding Section~~
13 ~~4202.002, an~~] independent review organization that uses doctors to
14 perform reviews of health care services under this chapter may only
15 use doctors licensed to practice in this state.

16 SECTION 3.13. Section 408.023(h), Labor Code, is amended to
17 read as follows:

18 (h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~]
19 utilization review agent or an insurance carrier that uses doctors
20 to perform reviews of health care services provided under this
21 subtitle, including utilization review, may only use doctors
22 licensed to practice in this state.

23 SECTION 3.14. Section 413.031(e-2), Labor Code, is amended
24 to read as follows:

25 (e-2) An [~~Notwithstanding Section 4202.002, Insurance Code,~~
26 ~~an~~] independent review organization that uses doctors to perform
27 reviews of health care services provided under this title may only

1 use doctors licensed to practice in this state.

2 ARTICLE 4. JOINT INTERIM STUDY

3 SECTION 4.01. CREATION OF JOINT INTERIM COMMITTEE. (a) A
4 joint interim committee is created to study, review, and report on
5 the use of prior authorization and utilization review processes by
6 private health benefit plan issuers in this state, as provided by
7 Section 4.02 of this article, and propose reforms under that
8 section related to the transparency of and improving patient
9 outcomes under the prior authorization and utilization review
10 processes used by private health benefit plan issuers in this
11 state.

12 (b) The joint interim committee shall be composed of four
13 senators appointed by the lieutenant governor and four members of
14 the house of representatives appointed by the speaker of the house
15 of representatives.

16 (c) The lieutenant governor and speaker of the house of
17 representatives shall each designate a co-chair from among the
18 joint interim committee members.

19 (d) The joint interim committee shall convene at the joint
20 call of the co-chairs.

21 (e) The joint interim committee has all other powers and
22 duties provided to a special or select committee by the rules of the
23 senate and house of representatives, by Subchapter B, Chapter 301,
24 Government Code, and by policies of the senate and house committees
25 on administration.

26 SECTION 4.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION
27 AND UTILIZATION REVIEW PROCESSES. (a) The joint interim committee

1 created by Section 4.01 of this article shall study data and other
2 information available from the Texas Department of Insurance, the
3 office of public insurance counsel, or other sources the committee
4 determines relevant to examine and analyze the transparency of and
5 improving patient outcomes under the prior authorization and
6 utilization review processes used by private health benefit plan
7 issuers in this state.

8 (b) The joint interim committee shall propose reforms based
9 on the study required under Subsection (a) of this section to
10 improve the transparency of and patient outcomes under prior
11 authorization and utilization review processes in this state.

12 (c) The joint interim committee shall prepare a report of
13 the findings and proposed reforms.

14 SECTION 4.03. COMMITTEE FINDINGS AND PROPOSED REFORMS.

15 (a) Not later than December 1, 2020, the joint interim committee
16 created under Section 4.01 of this article shall submit to the
17 lieutenant governor, the speaker of the house of representatives,
18 and the governor the report prepared under Section 4.02 of this
19 article. The joint interim committee shall include in its report
20 recommendations of specific statutory and regulatory changes that
21 appear necessary from the committee's study under Section 4.02 of
22 this article.

23 (b) Not later than the 60th day after the effective date of
24 this Act, the lieutenant governor and speaker of the house of
25 representatives shall appoint the members of the joint interim
26 committee in accordance with Section 4.01 of this article.

27 SECTION 4.04. ABOLITION OF COMMITTEE. The joint interim

1 committee created under Section 4.01 of this article is abolished
2 and this article expires December 15, 2020.

3 ARTICLE 5. TRANSITIONS; EFFECTIVE DATE

4 SECTION 5.01. A health benefit plan issuer shall update the
5 issuer's website to conform with Subchapter K, Chapter 1451,
6 Insurance Code, as amended by Article 1 of this Act, not later than
7 January 1, 2020.

8 SECTION 5.02. The changes in law made by Article 2 of this
9 Act apply only to a request for preauthorization of medical care or
10 health care services made on or after January 1, 2020, under a
11 health benefit plan delivered, issued for delivery, or renewed on
12 or after that date. A request for preauthorization of medical care
13 or health care services made before January 1, 2020, or on or after
14 January 1, 2020, under a health benefit plan delivered, issued for
15 delivery, or renewed before that date is governed by the law as it
16 existed immediately before the effective date of this Act, and that
17 law is continued in effect for that purpose.

18 SECTION 5.03. The changes in law made by Article 3 of this
19 Act apply only to utilization, independent, or peer review
20 requested on or after the effective date of this Act. Utilization,
21 independent, or peer review requested before the effective date of
22 this Act is governed by the law as it existed immediately before the
23 effective date of this Act, and that law is continued in effect for
24 that purpose.

25 SECTION 5.04. This Act takes effect September 1, 2019.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 1742 passed the Senate on April 26, 2019, by the following vote: Yeas 30, Nays 0; May 20, 2019, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 22, 2019, House granted request of the Senate; May 26, 2019, Senate adopted Conference Committee Report by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 1742 passed the House, with amendments, on May 17, 2019, by the following vote: Yeas 117, Nays 24, three present not voting; May 22, 2019, House granted request of the Senate for appointment of Conference Committee; May 26, 2019, House adopted Conference Committee Report by the following vote: Yeas 104, Nays 37, two present not voting.

Chief Clerk of the House

Approved:

Date

Governor