BILL ANALYSIS

C.S.H.B. 3459
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

There are concerns that the preauthorization and utilization review processes for health care benefit plan coverage may be burdensome to physicians and providers and may have the potential to prevent patients from receiving the care they need. C.S.H.B. 3459 seeks to address this issue by ensuring that physicians who are the most familiar with the delivery of health care in Texas are involved in utilization reviews for health benefit plan coverage. The bill also exempts certain physicians and providers from preauthorization requirements if they had at least 80 percent of their preauthorization requests approved by the insurer in the preceding calendar year.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3459 amends the Insurance Code to prohibit a health maintenance organization (HMO) or preferred provider benefit plan insurer that uses a preauthorization process for health care services from requiring a physician or provider to obtain preauthorization for a particular health care service if, in the preceding calendar year:

- the physician or provider submitted not less than five preauthorization requests for the particular medical or health care service; and
- the HMO or insurer approved not less than 80 percent of the preauthorization requests submitted by the physician or provider for the particular medical or health care service.

An exemption from preauthorization requirements lasts for one calendar year.

C.S.H.B. 3459 requires an HMO or insurer, not later than January 30 of each calendar year, to provide to a physician or provider who qualifies for the exemption a notice that includes:

- a statement that the physician or provider qualifies for the exemption;
- a list of the medical or health care services to which the exemption applies; and
- a statement that the exemption applies only for the calendar year in which the physician or provider receives the notice.

C.S.H.B. 3459 requires an HMO or insurer, if a physician or provider submits a preauthorization request for a health care service for which the physician or provider qualifies for the exemption, to promptly provide a notice to the physician or provider that includes the information provided in the annual notice and notification of the HMO's or the insurer's payment requirements. The

bill prohibits an HMO or insurer from denying or reducing payment to the physician or provider for the medical or health care service to which the physician or provider qualifies for the exemption based on medical necessity or appropriateness of care.

C.S.H.B. 3459 specifies that the physician to whom a utilization review agent is required to provide a reasonable opportunity to discuss a patient's treatment plan and the clinical basis for the agent's determination is a physician who has the same or similar specialty as the physician who ordered, requested, or provided the health care service.

C.S.H.B. 3459 applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2022.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 3459 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes as an additional qualification for the exemption from preauthorization requirements, which was included in the original, that the physician or provider submitted not less than five preauthorization requests for the particular medical or health care service.

The substitute changes requirements, which were included in the original, for an HMO or insurer to annually and on submission of a preauthorization request notify a physician or provider of an exemption, services for which exemption applies, and the exemption's start and end date by requiring the HMO or insurer to instead provide notice to the physician or provider no later than January 30 of each calendar year and by specifying the statements and lists included in the notice.

The substitute includes a provision, which was not included in the original, making the bill's provisions applicable to a request for preauthorization of medical care or health care services made on or after January 1, 2022.