

By: Raymond

H.B. No. 942

A BILL TO BE ENTITLED

AN ACT

1  
2 relating to the use of clinical decision support software and  
3 laboratory benefits management programs in connection with the  
4 provision of clinical laboratory services to certain managed care  
5 plan enrollees.

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

7 SECTION 1. Chapter 1451, Insurance Code, is amended by  
8 adding Subchapter L to read as follows:

9 SUBCHAPTER L. CLINICAL LABORATORY SERVICES

10 Sec. 1451.551. DEFINITIONS. In this subchapter:

11 (1) "Clinical decision support software" means  
12 computer software that compares patient characteristics to a  
13 database of clinical knowledge to produce patient-specific  
14 assessments or recommendations to assist a physician or health care  
15 provider in making clinical decisions.

16 (2) "Clinical laboratory service" means the  
17 examination of a specimen taken from a human body ordered by a  
18 physician or health care provider for use in the diagnosis,  
19 prevention, or treatment of a disease or the identification or  
20 assessment of a medical or physical condition.

21 (3) "Enrollee" means an individual enrolled in a  
22 managed care plan.

23 (4) "Esoteric molecular and genomic testing" means any  
24 test of a patient specimen analyzing multiple biomarkers of

1 deoxyribonucleic acid, ribonucleic acid, or proteins using a unique  
2 algorithm to yield a patient-specific prognosis or diagnosis.

3 (5) "Laboratory benefits management program" means a  
4 managed care plan issuer protocol or program administered by the  
5 managed care plan issuer or an entity under contract with the  
6 managed care plan issuer that directs or limits decision making of a  
7 physician or health care provider authorized to order clinical  
8 laboratory services. The term includes a requirement for a  
9 physician or health care provider to provide advance notice of an  
10 order for clinical laboratory services.

11 (6) "Managed care plan" means a health benefit plan  
12 under which health care services are provided to enrollees through  
13 contracts with physicians or health care providers and that  
14 requires enrollees to use participating providers or that provides  
15 a different level of coverage for enrollees who use participating  
16 providers. The term includes a health benefit plan issued by:

17 (A) a health maintenance organization;

18 (B) a preferred or exclusive provider benefit  
19 plan issuer; or

20 (C) any other entity that issues a health benefit  
21 plan described by this subdivision, including an insurance company.

22 (7) "National medical consensus guidelines" means  
23 applicable generally accepted practice guidelines that are:

24 (A) supported by peer-reviewed medical  
25 literature; and

26 (B) promulgated by the federal government or by a  
27 national professional medical society, board, or association.

1           (8) "Participating provider" means a physician or  
2 health care provider who has contracted with a managed care plan  
3 issuer to provide services to enrollees.

4           (9) "Physician" means a person licensed to practice  
5 medicine in this state.

6           Sec. 1451.552. CERTAIN REQUIREMENTS FOR CLINICAL  
7 LABORATORY SERVICES PROHIBITED; EXCEPTION. (a) Except as provided  
8 by Subsection (d), a managed care plan issuer may not require the  
9 use of clinical decision support software or a laboratory benefits  
10 management program by an enrollee's physician or health care  
11 provider before, at the time, or after the physician or health care  
12 provider orders a clinical laboratory service for the enrollee.

13           (b) A managed care plan issuer may not direct or limit the  
14 decision making of an enrollee's physician or health care provider  
15 relating to the referral of a patient specimen to a laboratory in  
16 the managed care plan network or a network otherwise designated by  
17 the managed care plan issuer.

18           (c) A managed care plan issuer may not limit, reduce, or  
19 deny payment for a clinical laboratory service based on whether the  
20 ordering physician or health care provider uses clinical decision  
21 support software or a laboratory benefits management program.

22           (d) Subsection (a) does not apply to an order for a clinical  
23 laboratory service if the specimen is not obtained in a hospital or  
24 ambulatory surgical center and:

25           (1) the order is for esoteric molecular and genomic  
26 testing; or

27           (2) there are national medical consensus guidelines

1 available for the clinical laboratory service ordered.

2 Sec. 1451.553. CERTAIN REQUIREMENTS FOR SECOND OPINION  
3 PROHIBITED. A managed care plan issuer may not routinely require a  
4 second opinion of a pathologist's finding from another pathologist  
5 unless the second opinion is medically warranted based on the  
6 specific clinical presentation of the enrollee or other clinical  
7 factors relevant to the enrollee.

8 Sec. 1451.554. CLINICAL DECISION SUPPORT SOFTWARE AND  
9 LABORATORY BENEFITS MANAGEMENT PROGRAM REQUIREMENTS. (a) A  
10 managed care plan issuer may only use clinical decision support  
11 software or a laboratory benefits management program that:

12 (1) is transparently based on published,  
13 peer-reviewed medical literature;

14 (2) is subject to timely and routine updates based on  
15 national medical consensus guidelines and the most current medical  
16 knowledge; and

17 (3) may be immediately overridden by a physician based  
18 on the physician's medical judgment.

19 (b) A managed care plan issuer may not use a laboratory  
20 benefits management program that is administered, created, or owned  
21 by an individual or entity with an interest in a clinical laboratory  
22 in the managed care plan network.

23 Sec. 1451.555. SUPERVISION BY COMPARABLE PROFESSIONAL  
24 REQUIRED. A managed care plan issuer may only use clinical decision  
25 support software, a laboratory benefits management program, or a  
26 prior authorization protocol for clinical laboratory services that  
27 is supervised by a physician of the same or a similar specialty as

1 the ordering physician or health care provider.

2 Sec. 1451.556. APPLICABILITY OF SUBCHAPTER TO ENTITIES  
3 CONTRACTING WITH MANAGED CARE PLAN ISSUER. This subchapter applies  
4 to a person with whom a managed care plan issuer contracts to:

5 (1) manage or administer benefits for clinical  
6 laboratory services;

7 (2) process or pay claims;

8 (3) obtain the services of physicians or other health  
9 care providers to provide health care services to enrollees; or

10 (4) issue verifications or prior authorizations.

11 Sec. 1451.557. CONSTRUCTION OF SUBCHAPTER. This subchapter  
12 may not be construed to regulate the implementation or  
13 administration of clinical decision support software, a laboratory  
14 benefits management program, or a prior authorization protocol by  
15 an entity, including a health care entity, that is not acting on  
16 behalf of or at the direction of a managed care plan issuer in  
17 adopting the software, program, or protocol.

18 SECTION 2. Subchapter L, Chapter 1451, Insurance Code, as  
19 added by this Act, applies only to a contract between a managed care  
20 plan issuer and a physician or health care provider that is entered  
21 into or renewed on or after the effective date of this Act. A  
22 contract entered into or renewed before the effective date of this  
23 Act is governed by the law as it existed immediately before the  
24 effective date of this Act, and that law is continued in effect for  
25 that purpose.

26 SECTION 3. This Act takes effect September 1, 2021.