By: Bonnen, et al. H.B. No. 3459

A BILL TO BE ENTITLED

AN ACT

relating to preauthorization requirements for certain medical and health care services and utilization review for certain health benefit plans.

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

SECTION 1. Subchapter J, Chapter 843, Insurance Code, is amended by adding Section 843.3484 to read as follows:

Sec. 843.3484. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. (a) A health maintenance organization that uses a preauthorization process for health care services may not require a physician or provider to obtain preauthorization for a particular health care service if, in the preceding calendar year:

(1) the physician or provider submitted not less than five preauthorization requests for the particular health care service; and

(2) the health maintenance organization approved not less than 80 percent of the preauthorization requests submitted by the physician or provider for the particular health care service.

(b) An exemption from preauthorization requirements under Subsection (a) lasts for one calendar year.

(c) Not later than January 30 of each calendar year, a health maintenance organization must provide to a physician or provider who qualifies for an exemption from preauthorization

requirements under Subsection (a) a notice that includes:

(1) a statement that the physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a);

(2) a list of the health care services to which the exemption applies; and

(3) a statement that the exemption applies only for the calendar year in which the physician or provider receives the notice.

(d) If a physician or provider submits a preauthorization request for a health care service for which the physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a), the health maintenance organization must promptly provide a notice to the physician or provider that includes:

(1) the information described by Subsection (c); and

(2) a notification of the health maintenance organization payment requirements described by Subsection (e).

(e) A health maintenance organization may not deny or reduce payment to a physician or provider for a health care service to which the physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a) based on medical necessity or appropriateness of care.

SECTION 2. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Section 1301.1354 to read as follows:

Sec. 1301.1354. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING

CERTAIN HEALTH CARE SERVICES. (a) 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 a particular medical or health care service if, in the preceding calendar year:

(1) the physician or health care provider submitted not less than five preauthorization requests for the particular medical or health care service; and

(2) the insurer approved not less than 80 percent of the preauthorization requests submitted by the physician or health care provider for the particular medical or health care service.

(b) An exemption from preauthorization requirements under Subsection (a) lasts for one calendar year.

(c) Not later than January 30 of each calendar year, an insurer must provide to a physician or health care provider who qualifies for an exemption from preauthorization requirements under Subsection (a) a notice that includes:

(1) a statement that the physician or health care provider qualifies for an exemption from preauthorization requirements under Subsection (a);

(2) a list of the medical or health care services to which the exemption applies; and

(3) a statement that the exemption applies only for the calendar year in which the physician or health care provider receives the notice.

(d) If a physician or health care provider submits a preauthorization request for a medical or health care service for

which the physician or health care provider qualifies for an exemption from preauthorization requirements under Subsection (a), the insurer must promptly provide a notice to the physician or health care provider that includes:

(1) the information described by Subsection (c); and

(2) a notification of the insurer payment requirements described by Subsection (e).

(e) An insurer may not deny or reduce payment to a physician or health care provider for a medical or health care service to which the physician or health care provider qualifies for an exemption from preauthorization requirements under Subsection (a) based on medical necessity or appropriateness of care.

SECTION 3. Section 4201.206, Insurance Code, is amended to read as follows:

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, the agent shall provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss with a physician licensed to practice medicine in this state the patient's treatment plan and the clinical basis for the agent's determination.

(b) If the health care service described by Subsection (a) was ordered, requested, or provided, or is to be provided by a

physician, the opportunity described by that subsection must be with a physician licensed to practice medicine in this state and who has the same or similar specialty as the physician.

SECTION 4. The changes in law made by this Act to Chapters 843 and 1301, Insurance Code, apply only to a request for preauthorization of medical care or health care services made on or after January 1, 2022. A request for preauthorization of medical care or health care services made before January 1, 2022, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5. Section 4201.206, Insurance Code, as amended by this Act, applies only to a utilization review requested on or after the effective date of this Act. A utilization review requested before the effective date of this Act is governed by the law as it existed 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, 2021.