

By: Bonnen

H.B. No. 3459

A BILL TO BE ENTITLED

AN ACT

relating to preauthorization 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 843.3483 to read as follows:

Sec. 843.3483. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS. (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, the physician or provider had at least eighty percent of the physician's or provider's preauthorization requests approved by the health maintenance organization for that health care service.

(b) Each exemption from preauthorization requirements described by Subsection (a) shall last for one calendar year and is only available for a health care service for which the physician or provider submitted at least five preauthorization requests in the preceding calendar year.

(c) A health maintenance organization shall notify each physician or provider who qualifies for an exemption from preauthorization requirements under Subsection (a) of the physician's or provider's exempt status, including the health care services for which the exemption applies and the exemption start

1 and end date.

2 (d) If a physician or provider submits a preauthorization
3 request for a health care service for which an exemption applies
4 under Subsection (a), the health maintenance organization shall
5 promptly notify the physician or provider of the applicable
6 exemption, the calendar year and health care services for which the
7 exemption applies, and the health maintenance organization payment
8 requirements under Subsection (e).

9 (e) If a preauthorization exemption applies to a health care
10 service under Subsection (a), a health maintenance organization may
11 not deny or reduce payment to the physician or provider for the
12 health care service based on medical necessity or appropriateness
13 of care.

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

16 Sec. 1301.1354. EXEMPTION FROM PREAUTHORIZATION
17 REQUIREMENTS. (a) An insurer that uses a preauthorization process
18 for medical care or health care services may not require a physician
19 or health care provider to obtain preauthorization for a particular
20 medical care or health care service if, in the preceding calendar
21 year, the physician or health care provider had at least eighty
22 percent of the physician's or health care provider's
23 preauthorization requests approved by the insurer for that medical
24 care or health care service.

25 (b) Each exemption from preauthorization requirements
26 described by Subsection (a) shall last for one calendar year and is
27 only available for a medical care or health care service for which

1 the physician or health care provider submitted at least five
2 preauthorization requests in the preceding calendar year.

3 (c) An insurer shall notify each physician or health care
4 provider who qualifies for an exemption from preauthorization
5 requirements under Subsection (a) of the physician's or health care
6 provider's exempt status, including the medical care or health care
7 services for which the exemption applies and the exemption start
8 and end date.

9 (d) If a physician or health care provider submits a
10 preauthorization request for a medical care or health care service
11 for which an exemption applies under Subsection (a), the insurer
12 shall promptly notify the physician or health care provider of the
13 applicable exemption, the calendar year and medical care or health
14 care services for which the exemption applies, and the insurer
15 payment requirements under Subsection (e).

16 (e) If a preauthorization exemption applies to a medical
17 care or health care service under Subsection (a), an insurer may not
18 deny or reduce payment to the physician or health care provider for
19 the medical care or health care service based on medical necessity
20 or appropriateness of care.

21 SECTION 3. Section [4201.206](#), Insurance Code, is amended to
22 read as follows:

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

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

7 (b) If the health care service described by Subsection (a)
8 was ordered, requested, or provided, or is to be provided by a
9 physician, the opportunity described by that subsection must be
10 with a physician licensed to practice medicine in this state who is
11 of the same or similar specialty as that physician.

12 SECTION 4. The changes in law made by this Act to Section
13 [4201.206](#), Insurance Code, apply only to utilization review
14 requested on or after the effective date of this Act. Utilization
15 review requested before the effective date of this Act is governed
16 by the law as it existed immediately before the effective date of
17 this Act, and that law is continued in effect for that purpose.

18 SECTION 5. This Act takes effect September 1, 2021.