

By: Oliverson

H.B. No. 4531

A BILL TO BE ENTITLED

1 AN ACT
2 relating to preauthorization of medical care or health care
3 services by certain health benefit plan issuers.

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

5 SECTION 1. Section [843.348](#), Insurance Code, is amended by
6 amending Subsections (a) and (g) and adding Subsection (g-1) to
7 read as follows:

8 (a) In this section:

9 (1) "Preauthorization" [~~,"preauthorization"~~] means a
10 determination by a health maintenance organization that health care
11 services proposed to be provided to a patient are medically
12 necessary and appropriate.

13 (2) "Verification" has the meaning assigned by Section
14 [843.347](#).

15 (g) Notwithstanding Section [843.347](#), if [~~if~~] the health
16 maintenance organization has preauthorized health care services,
17 the health maintenance organization may not deny or reduce payment
18 to the physician or provider for those services based on:

19 (1) medical necessity or appropriateness of care
20 unless the physician or provider has materially misrepresented the
21 proposed health care services or has substantially failed to
22 perform the proposed health care services;

23 (2) an eligibility or coverage determination if the
24 proposed health care services are provided to the enrollee before

1 the 31st day after the date the physician or provider received the
2 determination that the health care services were preauthorized
3 unless the physician or provider has materially misrepresented the
4 proposed health care services or has substantially failed to
5 perform the proposed health care services;

6 (3) the fact that a physician or provider did not
7 request or obtain or was not provided a verification from the health
8 maintenance organization; or

9 (4) the health maintenance organization declining or
10 failing to determine an enrollee's eligibility or make coverage
11 determinations in the time frame required for the issuance of a
12 preauthorization determination.

13 (g-1) If a health maintenance organization determines that
14 a health care service is preauthorized, the health maintenance
15 organization shall specify any deductibles, copayments, or
16 coinsurance for which the enrollee is responsible in its
17 determination.

18 SECTION 2. Section 1301.135, Insurance Code, is amended by
19 amending Subsection (f) and adding Subsections (f-1) and (i) to
20 read as follows:

21 (f) Notwithstanding Section 1301.133, if [~~If~~] an insurer
22 has preauthorized medical care or health care services, the insurer
23 may not deny or reduce payment to the physician or health care
24 provider for those services based on:

25 (1) medical necessity or appropriateness of care
26 unless the physician or provider has materially misrepresented the
27 proposed medical or health care services or has substantially

1 failed to perform the proposed medical or health care services;

2 (2) an eligibility or coverage determination if the
3 proposed medical care or health care services are provided to the
4 insured before the 31st day after the date the physician or provider
5 received the determination that the medical care or health care
6 services were preauthorized unless the physician or provider has
7 materially misrepresented the proposed medical care or health care
8 services or has substantially failed to perform the proposed
9 medical care or health care services;

10 (3) the fact that a physician or provider did not
11 request or obtain or was not provided a verification from the
12 insurer; or

13 (4) the insurer declining or failing to determine an
14 insured's eligibility or make coverage determinations in the time
15 frame required for the issuance of a preauthorization
16 determination.

17 (f-1) If an insurer determines that a medical care or health
18 care service is preauthorized, the insurer shall specify any
19 deductibles, copayments, or coinsurance for which the insured is
20 responsible in its determination.

21 (i) In this section, "verification" has the meaning
22 assigned by Section [1301.133](#).

23 SECTION 3. The change in law made by this Act applies only
24 to a health benefit plan that is delivered, issued for delivery, or
25 renewed on or after January 1, 2022. A health benefit plan that is
26 delivered, issued for delivery, or renewed before January 1, 2022,
27 is governed by the law as it existed immediately before the

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1 effective date of this Act, and that law is continued in effect for
2 that purpose.

3 SECTION 4. This Act takes effect September 1, 2021.