By: Buckingham S.B. No. 1883

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

and end date.

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

(e) If a preauthorization exemption applies to a health care service under Subsection (a), a health maintenance organization may not deny or reduce payment to the physician or provider for the health care service 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. (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 care or health care service if, in the preceding calendar year, the physician or health care provider had at least eighty percent of the physician's or health care provider's preauthorization requests approved by the insurer for that medical care or 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 medical care or health care service for which

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

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

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

(e) If a preauthorization exemption applies to a medical care or health care service under Subsection (a), an insurer may not deny or reduce payment to the physician or health care provider for the medical care or health care service 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 who is of the same or similar specialty as that physician.

SECTION 4. The changes in law made by this Act to Section 4201.206, Insurance Code, apply only to utilization review requested on or after the effective date of this Act. 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 5. This Act takes effect September 1, 2021.