SENATE AMENDMENTS

2nd Printing

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.

ADOPTED

MAY 22 2021

Secretary of the Senate

FLOOR AMENDMENT NO. 1 BY:

Amend H.B. 3459 (senate committee report) as follows:

(1) Strike SECTIONS 1 and 2 of the bill (page 1, line 30, through page 2, line 53).

(2) In SECTION 4 of the bill (page 3, lines 3 and 4) strike "The changes in law made by this Act to Chapters 843 and 1301, Insurance Code, apply" and substitute "Subchapter N, Chapter 4201, Insurance Code, as added by this Act, applies".

(3) In SECTION 4 of the bill (page 3, line 5 and lines 6 and 7) strike "medical care or" each time it appears.

(4) Add the following appropriately numbered SECTION to the bill and renumber SECTIONS of the bill accordingly:

SECTION ____. Chapter 4201, Insurance Code, is amended by adding Subchapter N to read as follows:

SUBCHAPTER N. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES

Sec. 4201.651. DEFINITIONS. (a) In this subchapter, "preauthorization" means a determination by a health maintenance organization, insurer, or person contracting with a health maintenance organization or insurer that health care services proposed to be provided to a patient are medically necessary and appropriate.

(b) In this subchapter, terms defined by Section 843.002, including "health care services," "physician," and "provider," have the meanings assigned by that section.

Sec. 4201.652. APPLICABILITY OF SUBCHAPTER. This subchapter

applies only to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843, except that this subchapter does not apply to:

(A) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(B) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(2) a preferred provider benefit plan or exclusive provider benefit plan offered by an insurer under Chapter 1301; and

(3) a person who contracts with a health maintenance organization or insurer to issue preauthorization determinations or perform the functions described in this subchapter for a health benefit plan to which this subchapter applies.

Sec. 4201.653. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. (a) A health maintenance organization or an insurer 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 most recent six-month evaluation period, as described by Subsection (b), the health maintenance organization or insurer has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health

care service.

(b) Except as provided by Subsection (c), a health maintenance organization or insurer shall evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a) once every six months.

(c) A health maintenance organization or insurer may continue an exemption under Subsection (a) without evaluating whether the physician or provider qualifies for the exemption under Subsection (a) for a particular evaluation period.

(d) A physician or provider is not required to request an exemption under Subsection (a) to qualify for the exemption.

Sec. 4201.654. DURATION OF PREAUTHORIZATION EXEMPTION. (a) A physician's or provider's exemption from preauthorization requirements under Section 4201.653 remains in effect until:

(1) the 30th day after the date the health maintenance organization or insurer notifies the physician or provider of the health maintenance organization's or insurer's determination to rescind the exemption under Section 4201.655, if the physician or provider does not appeal the health maintenance organization's or insurer's determination; or

(2) if the physician or provider appeals the determination, the fifth day after the date the independent review organization affirms the health maintenance organization's or insurer's determination to rescind the exemption.

(b) If a health maintenance organization or insurer does not finalize a rescission determination as specified in Subsection

(a), then the physician or provider is considered to have met the criteria under Section 4201.653 to continue to qualify for the exemption.

Sec. 4201.655. DENIAL OR RESCISSION OF PREAUTHORIZATION EXEMPTION. (a) A health maintenance organization or insurer may rescind an exemption from preauthorization requirements under Section 4201.653 only:

(1) during January or June of each year;

(2) if the health maintenance organization or insurer makes a determination, on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted by the physician or provider during the most recent evaluation period described by Section 4201.653(b), that less than 90 percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the health maintenance organization or insurer when conducting preauthorization review for the particular health care service during the relevant evaluation period; and

(3) if the health maintenance organization or insurer complies with other applicable requirements specified in this section, including:

(A) notifying the physician or provider not less than 25 days before the proposed rescission is to take effect; and

(B) providing with the notice under Paragraph (A):

(i) the sample information used to make the determination under Subdivision (2); and

(ii) a plain language explanation of how the

physician or provider may appeal and seek an independent review of the determination.

(b) A determination made under Subsection (a)(2) must be made by an individual licensed to practice medicine in this state. For a determination made under Subsection (a)(2) with respect to a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician.

(c) A health maintenance organization or insurer may deny an exemption from preauthorization requirements under Section 4201.653 only if:

(1) the physician or provider does not have the exemption at the time of the relevant evaluation period; and

(2) the health maintenance organization or insurer provides the physician or provider with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the physician or provider does not meet the criteria for an exemption from preauthorization requirements for the particular health care service under Section 4201.653.

Sec. 4201.656. INDEPENDENT REVIEW OF EXEMPTION DETERMINATION. (a) A physician or provider has a right to a review of an adverse determination regarding a preauthorization exemption be conducted by an independent review organization. A health maintenance organization or insurer may not require a physician or provider to engage in an internal appeal process before requesting a review by an independent review organization

under this section.

(b) A health maintenance organization or insurer shall pay:

(1) for any appeal or independent review of an adverse determination regarding a preauthorization exemption requested under this section; and

(2) a reasonable fee determined by the Texas Medical Board for any copies of medical records or other documents requested from a physician or provider during an exemption rescission review requested under this section.

(c) An independent review organization must complete an expedited review of an adverse determination regarding a preauthorization exemption not later than the 30th day after the date a physician or provider files the request for a review under this section.

(d) A physician or provider may request that the independent review organization consider another random sample of not less than five and no more than 20 claims submitted to the health maintenance organization or insurer by the physician or provider during the relevant evaluation period for the relevant health care service as part of its review. If the physician or provider makes a request under this subsection, the independent review organization shall base its determination on the medical necessity of claims reviewed by the health maintenance organization or insurer under Section 4201.655 and reviewed under this subsection.

Sec. 4201.657. EFFECT OF APPEAL OR INDEPENDENT REVIEW DETERMINATION. (a) A health maintenance organization or insurer is bound by an appeal or independent review determination that

does not affirm the determination made by the health maintenance organization or insurer to rescind a preauthorization exemption.

(b) A health maintenance organization or insurer may not retroactively deny a health care service on the basis of a rescission of an exemption, even if the health maintenance organization's or insurer's determination to rescind the preauthorization exemption is affirmed by an independent review organization.

(c) If a determination of a preauthorization exemption made by the health maintenance organization or insurer is overturned on review by an independent review organization, the health maintenance organization or insurer:

(1) may not attempt to rescind the exemption before the end of the next evaluation period that occurs; and

(2) may only rescind the exemption after if the health maintenance organization or insurer complies with Sections 4201.655 and 4201.656.

Sec. 4201.658. ELIGIBILITY FOR PREAUTHORIZATION EXEMPTION FOLLOWING FINALIZED EXEMPTION RESCISSION OR DENIAL. After a final determination or review affirming the rescission or denial of an exemption for a specific health care service under Section 4201.653, a physician or provider is eligible for consideration of an exemption for the same health care service after the six-month evaluation period that follows the evaluation period which formed the basis of the rescission or denial of an exemption.

Sec. 4201.659. EFFECT OF PREAUTHORIZATION EXEMPTION. (a) A health maintenance organization or insurer may not deny or reduce

payment to a physician or provider for a health care service for which the physician or provider has qualified for an exemption from preauthorization requirements under Section 4201.653 based on medical necessity or appropriateness of care unless the physician or provider:

(1) knowingly and materially misrepresented the health care service in a request for payment submitted to the health maintenance organization or insurer with the specific intent to deceive and obtain an unlawful payment from the health maintenance organization or insurer; or

(2) failed to substantially perform the health care service.

(b) A health maintenance organization or an insurer may not conduct a retrospective review of a health care service subject to an exemption except:

(1) to determine if the physician or provider still qualifies for an exemption under this subchapter; or

(2) if the health maintenance organization or insurer has a reasonable cause to suspect a basis for denial exists under Subsection (a).

(c) For a retrospective review described by Subsection (b)(2), nothing in this subchapter may be construed to modify or otherwise affect:

(1) the requirements under or application of Section 4201.305, including any timeframes specified by that section; or

(2) any other applicable law, except to prescribe the only circumstances under which:

(A) a retrospective utilization review may occur as specified by Subsection (b)(2); or

(B) payment may be denied or reduced as specified by Subsection (a).

(d) Not later than five days after qualifying for an exemption from preauthorization requirements under Section 4201.653, a health maintenance organization or insurer must provide to a physician or provider a notice that includes:

(1) a statement that the physician or provider qualifies for an exemption from preauthorization requirements under Section 4201.653;

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

(3) a statement of the duration of the exemption.

(e) 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 Section 4201.653, the health maintenance organization or insurer must promptly provide a notice to the physician or provider that includes:

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

(2) a notification of the health maintenance organization's or insurer's payment requirements.

(f) Nothing in this subchapter may be construed to:

(1) authorize a physician or provider to provide a health care service outside the scope of the provider's applicable license issued under Title 3, Occupations Code; or

(2) require a health maintenance organization or insurer to pay for a health care service described by Subdivision (1) that is performed in violation of the laws of this state.

ADOPTED

MAY 22 2021

Secretary of the Senate

FLOOR AMENDMENT NO. _____ BY: Joan Huffman

Amend H.B. No. 3459 (senate committee printing) by adding the following appropriately numbered SECTIONS to the bill and renumbering SECTIONS of the bill appropriately:

SECTION _____. Subchapter E, Chapter 1551, Insurance Code, is amended by adding Section 1551.2181 to read as follows:

Sec. 1551.2181. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health benefit plan provided under this chapter is subject to the same limitations and requirements provided by Section 1301.1354 for a preauthorization process used by an insurer.

SECTION _____. Subchapter D, Chapter 1575, Insurance Code, is amended by adding Section 1575.1701 to read as follows:

Sec. 1575.1701. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health benefit plan provided under this chapter is subject to the same limitations and requirements provided by Section 1301.1354 for a preauthorization process used by an insurer.

SECTION _____. Subchapter C, Chapter 1579, Insurance Code, is amended by adding Section 1579.1061 to read as follows:

Sec. 1579.1061. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health coverage plan provided under this chapter is subject to the same limitations and requirements provided by Section 1301.1354 for a preauthorization process used by an insurer.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

May 25, 2021

TO: Honorable Dade Phelan, Speaker of the House, House of Representatives

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB3459** by Bonnen (Relating to preauthorization requirements for certain medical and health care services and utilization review for certain health benefit plans.), **As Passed 2nd House**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to prohibit a health maintenance organization or insurer that uses a preauthorization process to require certain physicians and providers to obtain preauthorization for certain health care services.

This analysis assumes the provisions of the bill do not apply to the Employees Retirement System (ERS) and the Teachers Retirement System (TRS). According to ERS, if the provisions of the bill applied to the Group Benefits Program (GBP), the estimated cost to the state would be $7.5 million in All Funds in fiscal year 2022 and $8.0 million in All Funds in fiscal year 2023. The total estimated cost to GBP, including to the state, members, and other employers, would be $8.9 million in fiscal year 2022 and $9.4 million in fiscal year 2023. According to TRS, if the provisions of the bill applied to TRS plans, the estimated cost would be $8.4 million in fiscal year 2022 and $8.6 million in fiscal year 2023.

The Texas Department of Insurance indicates that any costs associated with the bill could be absorbed within the agency's existing resources.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 323 Teacher Retirement System, 327 Employees Retirement System, 454 Department of Insurance, 529 Hlth & Human Svcs Comm, 720 UT Sys Admin

LBB Staff: JMc, LBO, JLI, RD

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

May 17, 2021

TO: Honorable Jane Nelson, Chair, Senate Committee on Finance

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB3459** by Bonnen (Relating to preauthorization requirements for certain medical and health care services and utilization review for certain health benefit plans.), **As Engrossed**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to prohibit a health maintenance organization or insurer that uses a preauthorization process to require certain physicians and providers to obtain preauthorization for certain health care services.

This analysis assumes that the requirements of the bill would be waived for Medicaid and the Children's Health Insurance Program pursuant to Insurance Code Chapter 1211. The Employees Retirement System, Department of Insurance, Texas A&M University System Administration, and University of Texas System Administration indicate that any costs associated with the bill could be absorbed within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Hlth & Human Svcs Comm, 710 Texas A&M Univ System Admin, 720 UT Sys Admin

LBB Staff: JMc, KK, AAL, JLI, RD

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

April 22, 2021

TO: Honorable Tom Oliverson, Chair, House Committee on Insurance

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB3459** by Bonnen (relating to preauthorization requirements for certain medical and health care services and utilization review for certain health benefit plans.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to prohibit a health maintenance organization or insurer that uses a preauthorization process to require certain physicians and providers to obtain preauthorization for certain health care services.

This analysis assumes that the requirements of the bill would be waived for Medicaid and the Children's Health Insurance Program pursuant to Insurance Code Chapter 1211. The Employees Retirement System, Department of Insurance, Texas A&M University System Administration, and University of Texas System Administration indicate that any costs associated with the bill could be absorbed within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Hlth & Human Svcs Comm, 710 Texas A&M Univ System Admin, 720 UT Sys Admin

LBB Staff: JMc, AAL, JLI, RD

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

April 12, 2021

TO: Honorable Tom Oliverson, Chair, House Committee on Insurance

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB3459** by Bonnen (Relating to preauthorization and utilization review for certain health benefit plans.), **As Introduced**

The fiscal implications of implementing the provisions of the bill cannot be determined at this time because the Health and Human Services Commission does not have the information necessary to estimate the cost of tracking prior authorization approval rates. Additionally, the impact of removing certain prior authorizations on service utilization is unknown.

The bill would amend the Insurance Code to prohibit a health maintenance organization or insurer that uses a preauthorization process to require certain physicians and providers to obtain preauthorization for certain health care services.

According to the Health and Human Services Commission, the agency would have to configure and maintain a new system to track provider prior authorization approvals in order to identify providers and services exempt from prior authorization. Additionally, the removal of prior authorizations may increase service utilization. HHSC does not have the information necessary to estimate the cost of the new system. The cost to client services cannot be determined at this time because is it unknown what impact there will be on service utilization.

The Employees Retirement System, Department of Insurance, Texas A&M University System Administration, and University of Texas System Administration indicate that any costs associated with the bill could be absorbed within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Hlth & Human Svcs Comm, 710 Texas A&M Univ System Admin, 720 UT Sys Admin

LBB Staff: JMc, AAL, JLI, RD