BILL ANALYSIS

C.S.H.B. 4367
By: Cortez
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Various physicians, providers, and their advocacy groups have expressed frustration regarding health maintenance organizations (HMOs) and insurers attempting to deny or reduce payments for medical or health care services that have already been provided to patients after attaining preauthorization to perform the service from the HMO or insurer. C.S.H.B. 4367 seeks to address this issue by prohibiting an HMO or insurer that has preauthorized a medical or health care service from denying or reducing payments to a physician and health care provider based on eligibility or coverage determinations under certain conditions, unless the physician or provider has materially misrepresented or substantively failed to perform the service.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 4367 amends the Insurance Code to prohibit a health maintenance organization (HMO) or insurer that has preauthorized a medical or health care service from denying or reducing payment to the physician or health care provider for the service based on eligibility or coverage determinations if the proposed service is provided to the enrollee or insured before the 31st day after the date the service was preauthorized and coverage is not terminated during that period, unless the physician or provider has materially misrepresented the proposed service or has substantially failed to perform the proposed service. The bill prohibits an HMO or insurer from requiring for purposes of that prohibition that the physician or provider request verification regarding whether the proposed service will be paid by the HMO or insurer. The bill applies only to a request for preauthorization made on or after January 1, 2024, under a health benefit plan delivered, issued for delivery, or renewed on or after that date.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 4367 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

While both the introduced and substitute include prohibitions against an HMO or insurer that has preauthorized a medical or health care service from denying or reducing payment to the physician or health care provider for the service based on eligibility or coverage determinations if the proposed service is provided to the enrollee or insured before the 31st day after the date the service was preauthorized, the substitute includes an additional requisite condition for the prohibition to apply that the coverage is not terminated during that period.