BILL ANALYSIS

C.S.H.B. 3812
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The bill author has informed the committee that during the 87th Regular Session, the Texas Legislature passed H.B. 3459 to address the growing issue of overutilization of prior authorizations for medical services by health insurers through the creation of a process by which physicians could earn an exemption from prior authorization requirements by attaining a 90 percent or higher prior authorization approval rate for a given service. However, the bill author has informed the committee that stakeholders have suggested that the evaluation window for which services can be reviewed is too short and providers cannot reach the threshold for which they can qualify for a gold card. C.S.H.B. 3812 seeks to address these issues by extending the evaluation period from six months to one year, removing physicians who hold a license to practice administrative medicine as an individual who may direct a utilization review, and providing for annual reporting to TDI regarding prior authorization exemptions.

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. 3812 amends the Insurance Code to require a health maintenance organization (HMO) or an insurer, in conducting an evaluation for an exemption from preauthorization requirements for physicians and providers providing certain services, to include all preauthorization requests submitted by a physician or provider to the HMO or insurer, or its affiliate, considering all health insurance policies and health benefit plans issued or administered by the HMO or insurer, or its affiliate, regardless of whether the preauthorization request was made in connection with a health insurance policy or health benefit plan that is subject to statutory provisions relating to exemptions from certain preauthorization requirements. For purposes of those provisions, the bill establishes by reference that a person is considered an affiliate of another if the person directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with the other person. The bill extends from six months to one year the length of the evaluation period that triggers the prohibition against an HMO or insurer requiring a physician or provider to obtain preauthorization for a particular health care service if, in that most recent evaluation period, the HMO or insurer, including any affiliate, 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. The bill additionally conditions that prohibition on the physician or provider having provided the particular health care service at least five times during the evaluation period. The bill changes from once every six months to

once every year the frequency with which an HMO or insurer must evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements.

C.S.H.B. 3812 changes the periods during which an HMO or insurer is authorized to rescind an exemption from preauthorization requirements from January or June of each year to January of a year beginning on or after the first anniversary of the last day of the most recent evaluation period for the exemption. The bill, with respect to determinations made regarding the denial or rescission of such a preauthorization exemption, prohibits a reviewing physician who makes the determination from holding a limited license to practice administrative medicine. The bill requires an HMO or insurer, if there are fewer than five claims submitted by a physician or provider subject to a rescission during the most recent evaluation period for a particular health care service, to review all the claims submitted by the physician or provider during that period for that service. The bill also prohibits a physician that directs utilization review from holding a limited license to practice administrative medicine.

C.S.H.B. 3812 expands a physician's or provider's right to an independent review of an adverse determination regarding a preauthorization exemption to include an HMO's or insurer's determination to deny an exemption from preauthorization requirements to the physician or provider.

C.S.H.B. 3812 replaces the provision prohibiting an HMO or insurer, with certain statutory exceptions, from conducting a retrospective review of a health care service subject to a preauthorization exemption with a provision prohibiting an HMO or insurer, subject to the same statutory exceptions, from conducting a utilization review or requiring another review similar to preauthorization of the service regardless of whether an exemption is rescinded after the provision of a health care service subject to the exemption.

C.S.H.B. 3812 requires each HMO and insurer to submit to the Texas Department of Insurance (TDI) an annual written report, in the form and manner prescribed by the commissioner of insurance, for each health care service subject to an exemption from preauthorization requirements on the following:

- exemptions granted by the HMO or insurer for the service;
- determinations by the HMO or insurer to rescind or deny an exemption for the service, including the number of exemptions denied or rescinded by the HMO or insurer; and
- independent reviews of determinations conducted by an independent review organization, including the number of determinations made by the HMO or insurer for which a physician or provider requested an independent review and the outcome of each such review.

The bill establishes that such a report is public information subject to disclosure under state public information law. The bill requires TDI to ensure that the report does not contain any identifying information before disclosing the report.

C.S.H.B. 3812 applies only to utilization review conducted on or after the bill's effective date. Utilization review conducted before the bill's effective date is governed by the law as it existed immediately before that date, and that law is continued in effect for that purpose. The bill prohibits a preauthorization exemption provided before the bill's effective date from being rescinded before the first anniversary of the last day of the most recent evaluation period for the exemption.

EFFECTIVE DATE

September 1, 2025.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 3812 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.

The substitute omits the following provisions from the introduced:

- the authorization for the Texas Medical Board (TMB), if the TMB believes that a physician has directed a utilization review in an arbitrary manner or without a medical basis or receives a complaint with that allegation, to request TDI to determine whether the health insurance policy or health benefit plan that is the subject of the utilization review covers the health care service being reviewed;
- the requirement for the TMB, if TDI determines the health care service is covered, to notify the physician of the allegation;
- the authorization for the TMB, on that determination, to compel the production of documents or other information as necessary to determine whether the utilization review was directed in an arbitrary manner or without a medical basis;
- a provision limiting an inquiry and determination to whether the utilization review was directed in an arbitrary manner or without a medical basis in accordance with the standards of medical practice;
- the requirement for the TMB, if the commissioner initiates a proceeding in relation to the same utilization review for which the inquiry is being conducted, to suspend the inquiry until the conclusion of the commissioner's proceeding;
- the authorization for the TMB to conduct an inquiry in the manner provided by statutory procedures for expert physician review;
- a provision establishing that the provisions of the introduced providing for an inquiry by the TMB expressly do not apply to chiropractic treatments;
- the authorization for the TMB to initiate a proceeding relating to a utilization review inquiry by the TMB;
- the authorization for the TMB to restrict, suspend, or revoke the license of a physician the TMB determines has directed a utilization review in an arbitrary manner or without a medical basis at the conclusion of the proceeding;
- the authorization for the commissioner, if a utilization review results in the serious injury or death of an individual who is the subject of the review, to temporarily prohibit a physician who directed the utilization review from directing utilization review and the authorization for the TMB to temporarily suspend the physician's license;
- the requirement for the commissioner or the TMB, as applicable, to conduct an applicable proceeding regarding the utilization review and a provision establishing that the prohibition or suspension is effective until the conclusion of the proceeding; and
- a provision including the direction of utilization review conducted by a utilization review agent under the direction of a state-licensed physician as an act of practicing medicine under the Medical Practice Act.