BILL ANALYSIS

Senate Research Center
89R27200 SCF-F

C.S.S.B. 1380
By: Paxton
Health & Human Services
5/20/2025
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Prior authorization is a health plan utilization-management or cost-control process that requires physicians to get approval before a prescribed treatment, test, or medical service qualifies for payment. This can be an administrative burden for physicians' practices and often delays patient care. The American Medical Association conducted a survey of 1,004 physicians, and more than one-third (34 percent) of physicians reported that prior authorization delays led to serious adverse events.[1] This includes hospitalization, disability, or even death for a patient in their care.

More than nine in 10 physicians in the survey (93 percent) reported care delays while waiting for insurers to authorize necessary care, and 82 percent said prior authorization could lead to treatment abandonment because of prior authorization struggles with their insurance company. Over half of the physicians said prior authorization has interfered with a patient's job responsibilities.

Denials and delays in prior authorization create significant risks to patients' mental health and safety. Additionally, harmful utilization review practices by health insurers drive up costs for both patients and physicians, further contributing to the high cost of healthcare in Texas.

Key Provisions:

1. No Preauthorization Needed for Certain Treatments (Page 4)

    • Insurance companies cannot require doctors to get preauthorization for emergency care, urgent outpatient care, primary care visits, outpatient mental health or substance abuse treatment (except for certain drugs), cancer treatments following national guidelines, specific eye treatments to prevent vision loss, certain preventive healthcare services, pediatric hospice care, care for newborns with withdrawal symptoms, and treatments under risk-sharing agreements.

2. Preapproval for Chronic Conditions Stays Valid (Page 5)

    • If a patient gets preauthorization for a chronic condition, it won't expire unless the standard treatment changes.

3. Insurance Companies Can't Deny Payment Without a Good Reason (Page 5)

    • If a treatment does not require preauthorization, insurers must pay for it unless the provider misrepresented the need for the treatment to get payment or failed to perform it properly.

4. Limits on Insurance Reviews After Treatment (Page 5)

    • Insurance companies can't review past treatments to deny payment unless they suspect fraud or improper billing.

5. If a Doctor Requests Preauthorization When It Isn't Required (Page 6)

• The insurance company must inform the physician in writing that it's unnecessary and explain the payment rules.

6. Effective Date (Page 7)

• September 1, 2025, applies to insurance plans starting January 1, 2026

Committee Substitute Changes:

• Addresses a drafting error by adding the word "not" after "may" on page 3, line 19.

• Replaces a reference to C.F.R. with the correct chapter

• Clarifies that the preauthorization exemption is for in-network physicians.

• Removes primary care, antineoplastic cancer treatments, pediatric hospice, neonatal abstinence syndrome programs, and chronic conditions from preauthorization exemptions.

• Ophthalmologists treating serious eye conditions are exempted from preauthorization..

[1] https://www.ama-assn.org/practice-management/prior-authorization/why-prior-authorization-bad-patients-and-bad-business

C.S.S.B. 1380 amends current law relating to health benefit plan preauthorization requirements for participating physicians and providers providing certain health care services.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 4201, Insurance Code, by adding Subchapter O, as follows:

SUBCHAPTER O. PREAUTHORIZATION REQUIREMENTS FOR PARTICIPATING PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES

Sec. 4201.701. DEFINITIONS. Defines "health care services," "intervention-necessary care," "physician," "preauthorization," and "provider."

Sec. 4201.702. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter applies only to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations), except that this subchapter does not apply to the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the health benefits plan for children under Chapter 63 (Health Benefits Plan for Certain Children), Health and Safety Code, or the state Medicaid program, including the Medicaid managed care program operated under Chapter 540 (Medicaid Managed Care Program), Government Code;

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

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

Sec. 4201.703. CONSTRUCTION OF SUBCHAPTER. Prohibits this subchapter from being construed to:

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

Sec. 4201.704. PROHIBITED PREAUTHORIZATION REQUIREMENTS FOR PARTICIPATING PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. Prohibits a health maintenance organization or insurer from requiring a participating physician or provider to obtain preauthorization for certain health care services.

Sec. 4201.705. EFFECT OF PROHIBITED PREAUTHORIZATION REQUIREMENTS. (a) Prohibits a health maintenance organization or insurer from denying or reducing payment to a physician or provider for a health care service for which the physician or provider is not required to obtain preauthorization under Section 4201.704 unless the physician or provider knowingly and materially misrepresented the health care service or the nature of an acute injury, condition, or illness 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 failed to substantially perform the health care service.

(b) Prohibits a health maintenance organization or an insurer from conducting a retrospective review of a health care service for which the physician or provider is not required to obtain preauthorization under Section 4201.704 unless the health maintenance organization or insurer has a reasonable cause to suspect a basis for denial exists under Subsection (a).

(c) Authorizes nothing in this subchapter, for a retrospective review described by Subsection (b), to be construed to modify or otherwise affect the requirements under or application of Section 4201.305 (Notice of Adverse Determination for Retrospective Utilization), including any timeframes specified by that section or any other applicable law, except to prescribe the only circumstances under which a retrospective utilization review is authorized to occur as specified by Subsection (b) or payment is authorized to be denied or reduced as specified by Subsection (a).

(d) Requires the health maintenance organization or insurer, if a physician or provider submits a preauthorization request for a health care service for which the physician or provider is not required to obtain preauthorization under Section 4201.704, to promptly provide a written notice to the physician or provider that includes a statement that the health maintenance organization or insurer is prohibited from requiring preauthorization for that health care service and a notification of the health maintenance organization's or insurer's payment requirements.

SECTION 2. Makes application of Subchapter O, Chapter 4201, Insurance Code, as added by this Act, prospective to January 1, 2026.

SECTION 3. Effective date: September 1, 2025.