By: Bonnen, Oliverson, Jones of Dallas, et al. H.B. No. 3812

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan preauthorization requirements for certain health care services and the direction of utilization review by physicians.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 4201.152, Insurance Code, is amended to read as follows:

Sec. 4201.152. UTILIZATION REVIEW UNDER DIRECTION OF PHYSICIAN. A utilization review agent shall conduct utilization review under the direction of a physician licensed to practice medicine in this state. The physician may not hold a license to practice administrative medicine under Section 155.009, Occupations Code.

SECTION 2. Section 4201.651(a), Insurance Code, is amended to read as follows:

(a) In this subchapter:

(1) "Affiliate" has the meaning assigned by Section 823.003.

(2) "Preauthorization"[~~, "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.

SECTION 3. Section 4201.653, Insurance Code, is amended by

amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows:

(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 one-year [~~six-month~~] evaluation period, as described by Subsection (b):

(1) [~~,~~] the health maintenance organization 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; and

(2) the physician or provider has provided the particular health care service at least five times during the evaluation period.

(a-1) In conducting an evaluation for an exemption under this section, a health maintenance organization or insurer must include all preauthorization requests submitted by a physician or provider to the health maintenance organization or insurer, or its affiliate, considering all health insurance policies and health benefit plans issued or administered by the health maintenance organization 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 this subchapter.

(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 year [~~six months~~].

SECTION 4. Section 4201.655, Insurance Code, is amended by amending Subsections (a) and (b) and adding Subsection (b-1) to read as follows:

(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 a [~~each~~] year beginning on or after the first anniversary of the last day of the most recent evaluation period for the exemption;

(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. The reviewing physician may not hold a license to practice administrative medicine under Section 155.009, Occupations Code.

(b-1) Notwithstanding Subsection (a)(2), if there are fewer than five claims submitted by the physician or provider during the most recent evaluation period described by Section 4201.653(b) for a particular health care service, the health maintenance organization or insurer shall review all the claims submitted by the physician or provider during the most recent evaluation period for that service.

SECTION 5. Section 4201.656(a), Insurance Code, is amended to read as follows:

(a) A physician or provider has a right to a review of an adverse determination regarding a preauthorization exemption, including a health maintenance organization's or insurer's

determination to deny an exemption to the physician or provider under Section 4201.653, to 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.

SECTION 6. Section 4201.658, Insurance Code, is amended to read as follows:

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 one-year [~~six-month~~] evaluation period that follows the evaluation period which formed the basis of the rescission or denial of an exemption.

SECTION 7. Sections 4201.659(b) and (c), Insurance Code, are amended to read as follows:

(b) Regardless of whether an exemption is rescinded after the provision of a health care service subject to the exemption, a [~~A~~] health maintenance organization or an insurer may not conduct a utilization [~~retrospective~~] review or require another review similar to preauthorization of the [~~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 utilization [~~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).

SECTION 8. Subchapter N, Chapter 4201, Insurance Code, is amended by adding Section 4201.660 to read as follows:

Sec. 4201.660. REPORT. (a) Each health maintenance organization and insurer shall submit to the department, in the form and manner prescribed by the commissioner, an annual written report, for each health care service subject to an exemption under Section 4201.653, on the:

(1) exemptions granted by the health maintenance organization or insurer for the service;

(2) determinations by the health maintenance organization or insurer to rescind or deny an exemption for the service, including the number of exemptions denied or rescinded by the health maintenance organization or insurer under Section 4201.655; and

(3) independent reviews of determinations conducted by an independent review organization under Section 4201.656, including:

(A) the number of determinations made by the health maintenance organization or insurer for which a physician or provider requested an independent review under Section 4201.656; and

(B) the outcome of each independent review described by Paragraph (A).

(b) Subject to this subsection, a report submitted under Subsection (a) is public information subject to disclosure under Chapter 552, Government Code. The department shall ensure that the report does not contain any identifying information before disclosing the report in accordance with Chapter 552, Government Code.

SECTION 9. (a) The change in law made by this Act applies only to utilization review conducted on or after the effective date of this Act. Utilization review conducted 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.

(b) A preauthorization exemption provided under Section 4201.653, Insurance Code, before the effective date of this Act may not be rescinded before the first anniversary of the last day of the most recent evaluation period for the exemption.

SECTION 10. This Act takes effect September 1, 2025.