By: Paxton, Hagenbuch, Menéndez S.B. No. 1380

(In the Senate - Filed February 19, 2025; March 6, 2025, read first time and referred to Committee on Health & Human Services; May 22, 2025, reported adversely, with favorable Committee Substitute by the following vote: Yeas 8, Nays 1; May 22, 2025, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Kolkhorst	X			
Perry	X			
Blanco	X			
Cook	X			
Hall	X			
Hancock		X		
Hughes	X			
Miles	X			
Sparks	X			

COMMITTEE SUBSTITUTE FOR S.B. No. 1380 By: Perry

A BILL TO BE ENTITLED
AN ACT

relating to health benefit plan preauthorization requirements for participating physicians and providers providing certain health care services.

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

SECTION 1. Chapter 4201, Insurance Code, is amended by adding Subchapter O to read as follows:

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

Sec. 4201.701. DEFINITIONS. In this subchapter:

(1) "Health care services" has the meaning assigned by Section 843.002.

(2) "Intervention-necessary care" means health care services, other than emergency care:

(A) that are typically provided in a physician's office or other outpatient setting;

(B) that are provided to treat an acute injury, illness, or condition; and

(C) that:

(i) if not provided, would place the individual receiving the health care services at risk of:

(a) acquiring an irreversible injury, illness, or condition; or

(b) requiring emergency care or other health care services provided in an inpatient setting; or

(ii) are provided to an individual with an injury, illness, or condition that is severe or painful enough to lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's injury, illness, or condition is of a nature that failure to obtain treatment within a reasonable amount of time would result in serious deterioration of the injury, illness, or condition.

(3) "Physician" has the meaning assigned by Section 843.002.

(4) "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.

(5) "Provider" has the meaning assigned by Section 843.002.

Sec. 4201.702. 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 540, 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 by this subchapter for a health benefit plan to which this subchapter applies.

Sec. 4201.703. CONSTRUCTION OF SUBCHAPTER. This subchapter may not be 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, 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. A health maintenance organization or insurer may not require a participating physician or provider to obtain preauthorization for the following health care services:

(1) emergency care;

(2) intervention-necessary care provided by an individual licensed to practice medicine in this state;

(3) outpatient mental health care treatment or outpatient substance use disorder treatment, except for the provision of prescription drugs or intravenous infusions;

(4) intravitreal prescription drugs and health care services provided by an ophthalmologist in accordance with National Eye Institute guidelines to treat an eye injury, condition, or illness that may lead to immediate vision loss;

(5) health care services with an "A" or "B" recommendation from the United States Preventive Services Task Force;

(6) preventive health care services described by 45 C.F.R. Section 147.130; or

(7) health care services provided under a fully capitated risk-sharing or capitation arrangement, unless otherwise agreed to by the participating physician or provider.

Sec. 4201.705. EFFECT OF PROHIBITED PREAUTHORIZATION REQUIREMENTS. (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 is not required to obtain preauthorization under Section 4201.704 unless the physician or provider:

(1) 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

(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 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) For a retrospective review described by Subsection (b), 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); or

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

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

(1) a statement that the health maintenance organization or insurer may not require preauthorization for that health care service; and

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

SECTION 2. Subchapter O, Chapter 4201, Insurance Code, as added by this Act, applies only to a request for preauthorization under a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2026.

SECTION 3. This Act takes effect September 1, 2025.

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