

CONFERENCE COMMITTEE REPORT FORM

Austin, Texas

5/25/19

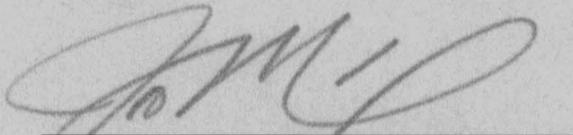
Date

Honorable Dan Patrick  
President of the Senate

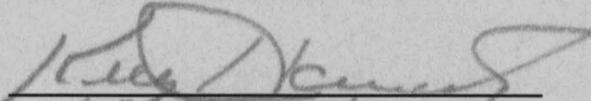
Honorable Dennis Bonnen  
Speaker of the House of Representatives

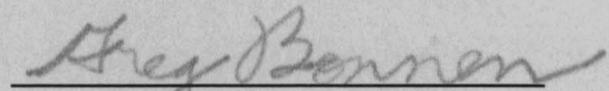
Sirs:

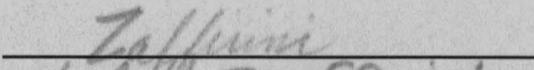
We, Your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on Senate Bill 1742 have had the same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

  
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Jose Mendez

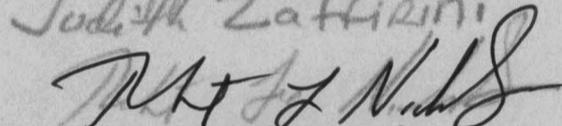
  
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Greg Bonnen

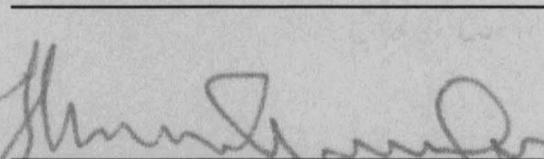
  
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Kelly Hancock

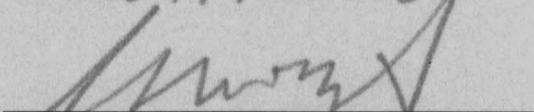
  
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Greg Bonnen

  
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Judith Zaffirini

  
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Matt Krause

  
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Robert Nichols

  
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Charles Schwertner

  
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On the part of the Senate  
Charles Schwertner

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On the part of the House

Note to Conference Committee Clerk:

Please type the names of the members of the Conference Committee under the lines provided for signature. Those members desiring to sign the report should sign each of the six copies. Attach a copy of the Conference Committee Report and a Section by Section side by side comparison to each of the six reporting forms. The original and two copies are filed in house of origin of the bill, and three copies in the other house.



# CONFERENCE COMMITTEE REPORT

3<sup>rd</sup> Printing

S.B. No. 1742

A BILL TO BE ENTITLED

1 AN ACT

2 relating to physician and health care provider directories,  
3 preauthorization, utilization review, independent review, and peer  
4 review for certain health benefit plans and workers' compensation  
5 coverage.

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

7 ARTICLE 1. HEALTH CARE PROVIDER DIRECTORIES

8 SECTION 1.01. Section 1451.501, Insurance Code, is amended  
9 by amending Subdivision (1) and adding Subdivisions (1-a) and (1-b)  
10 to read as follows:

11 (1) "Facility" has the meaning assigned by Section  
12 324.001, Health and Safety Code.

13 (1-a) "Facility-based physician" means a radiologist,  
14 anesthesiologist, pathologist, emergency department physician,  
15 neonatologist, or assistant surgeon:

16 (A) to whom a facility has granted clinical  
17 privileges; and

18 (B) who provides services to patients of the  
19 facility under those clinical privileges.

20 (1-b) "Health care provider" means a practitioner,  
21 institutional provider, or other person or organization that  
22 furnishes health care services and that is licensed or otherwise  
23 authorized to practice in this state. The term includes a  
24 pharmacist, pharmacy, hospital, nursing home, or other medical or

1 health-related service facility that provides care for the sick or  
2 injured or other care. The term does not include a physician.

3 SECTION 1.02. Section 1451.504, Insurance Code, is amended  
4 by amending Subsection (b) and adding Subsections (c) and (d) to  
5 read as follows:

6 (b) The directory must include the name, street address,  
7 specialty, if any, and telephone number of each physician and  
8 health care provider described by Subsection (a) and indicate  
9 whether the physician or provider is accepting new patients.

10 (c) For each health care provider that is a facility  
11 included in the directory under this section, the directory must:

12 (1) list under the facility name separate headings for  
13 radiologists, anesthesiologists, pathologists, emergency  
14 department physicians, neonatologists, and assistant surgeons;

15 (2) list under each heading described by Subdivision  
16 (1) each facility-based physician described by Subsection (a)  
17 practicing in the specialty corresponding with that heading that is  
18 a preferred provider, exclusive provider, or network physician;

19 (3) for the facility and each facility-based physician  
20 described by Subdivision (2), clearly indicate each health benefit  
21 plan issued by the issuer that may provide coverage for the services  
22 provided by that facility or physician; and

23 (4) include the facility in a listing of all  
24 facilities included in the directory indicating:

25 (A) the name of the facility;

26 (B) the municipality in which the facility is  
27 located or county in which the facility is located if the facility

1 is in the unincorporated area of the county;

2 (C) for each specialty of facility-based  
3 physician practicing at the facility, the name, street address, and  
4 telephone number of any facility-based physician that is a  
5 preferred provider, exclusive provider, or network physician or of  
6 the physician group in which the facility-based physician  
7 practices;

8 (D) each health benefit plan issued by the issuer  
9 that may provide coverage for the services provided by the  
10 facility; and

11 (E) each health benefit plan issued by the issuer  
12 that may provide coverage for the services provided by each  
13 facility-based physician group.

14 (d) The directory must list a facility-based physician  
15 individually and, if the physician belongs to a physician group, as  
16 part of the physician group.

17 SECTION 1.03. Section 1451.505(c), Insurance Code, is  
18 amended to read as follows:

19 (c) The directory must be:

20 (1) electronically searchable by physician or health  
21 care provider name, specialty, if any, facility, and location; and

22 (2) publicly accessible without necessity of  
23 providing a password, a user name, or personally identifiable  
24 information.

25 ARTICLE 2. PREAUTHORIZATION

26 SECTION 2.01. Section 843.348(b), Insurance Code, is  
27 amended to read as follows:

1 (b) A health maintenance organization that uses a  
2 preauthorization process for health care services shall provide  
3 each participating physician or provider, not later than the fifth  
4 ~~[10th]~~ business day after the date a request is made, a list of  
5 health care services that ~~[do not]~~ require preauthorization and  
6 information concerning the preauthorization process.

7 SECTION 2.02. Subchapter J, Chapter 843, Insurance Code, is  
8 amended by adding Sections 843.3481, 843.3482, and 843.3483 to read  
9 as follows:

10 Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

11 (a) A health maintenance organization that uses a preauthorization  
12 process for health care services shall make the requirements and  
13 information about the preauthorization process readily accessible  
14 to enrollees, physicians, providers, and the general public by  
15 posting the requirements and information on the health maintenance  
16 organization's Internet website.

17 (b) The preauthorization requirements and information  
18 described by Subsection (a) must:

19 (1) be posted:

20 (A) except as provided by Subsection (c) or (d),  
21 conspicuously in a location on the Internet website that does not  
22 require the use of a log-in or other input of personal information  
23 to view the information; and

24 (B) in a format that is easily searchable and  
25 accessible;

26 (2) except for the screening criteria under Paragraph  
27 (4)(C), be written in plain language that is easily understandable

1 by enrollees, physicians, providers, and the general public;

2 (3) include a detailed description of the  
3 preauthorization process and procedure; and

4 (4) include an accurate and current list of the health  
5 care services for which the health maintenance organization  
6 requires preauthorization that includes the following information  
7 specific to each service:

8 (A) the effective date of the preauthorization  
9 requirement;

10 (B) a list or description of any supporting  
11 documentation that the health maintenance organization requires  
12 from the physician or provider ordering or requesting the service  
13 to approve a request for that service;

14 (C) the applicable screening criteria, which may  
15 include Current Procedural Terminology codes and International  
16 Classification of Diseases codes; and

17 (D) statistics regarding preauthorization  
18 approval and denial rates for the service in the preceding calendar  
19 year, including statistics in the following categories:

20 (i) physician or provider type and  
21 specialty, if any;

22 (ii) indication offered;

23 (iii) reasons for request denial;

24 (iv) denials overturned on internal appeal;

25 (v) denials overturned by an independent  
26 review organization; and

27 (vi) total annual preauthorization

1 requests, approvals, and denials for the service.

2 (c) This section may not be construed to require a health  
3 maintenance organization to provide specific information that  
4 would violate any applicable copyright law or licensing agreement.  
5 To comply with a posting requirement described by Subsection (b), a  
6 health maintenance organization may, instead of making that  
7 information publicly available on the health maintenance  
8 organization's Internet website, supply a summary of the withheld  
9 information sufficient to allow a licensed physician or provider,  
10 as applicable for the specific service, who has sufficient training  
11 and experience related to the service to understand the basis for  
12 the health maintenance organization's medical necessity or  
13 appropriateness determinations.

14 (d) If a requirement or information described by Subsection  
15 (a) is licensed, proprietary, or copyrighted material that the  
16 health maintenance organization has received from a third party  
17 with which the health maintenance organization has contracted, to  
18 comply with a posting requirement described by Subsection (b), the  
19 health maintenance organization may, instead of making that  
20 information publicly available on the health maintenance  
21 organization's Internet website, provide the material to a  
22 physician or provider who submits a preauthorization request using  
23 a nonpublic secured Internet website link or other protected,  
24 nonpublic electronic means.

25 Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.  
26 (a) Except as provided by Subsection (b), not later than the 60th  
27 day before the date a new or amended preauthorization requirement

1 takes effect, a health maintenance organization that uses a  
2 preauthorization process for health care services shall provide  
3 notice of the new or amended preauthorization requirement and  
4 disclose the new or amended requirement in the health maintenance  
5 organization's newsletter or network bulletin, if any, and on the  
6 health maintenance organization's Internet website.

7       (b) For a change in a preauthorization requirement or  
8 process that removes a service from the list of health care services  
9 requiring preauthorization or amends a preauthorization  
10 requirement in a way that is less burdensome to enrollees or  
11 participating physicians or providers, a health maintenance  
12 organization shall provide notice of the change in the  
13 preauthorization requirement and disclose the change in the health  
14 maintenance organization's newsletter or network bulletin, if any,  
15 and on the health maintenance organization's Internet website not  
16 later than the fifth day before the date the change takes effect.

17       (c) Not later than the fifth day before the date a new or  
18 amended preauthorization requirement takes effect, a health  
19 maintenance organization shall update its Internet website to  
20 disclose the change to the health maintenance organization's  
21 preauthorization requirements or process and the date and time the  
22 change is effective.

23       Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to  
24 any other penalty or remedy provided by law, a health maintenance  
25 organization that uses a preauthorization process for health care  
26 services that violates this subchapter with respect to a required  
27 publication, notice, or response regarding its preauthorization

1 requirements, including by failing to comply with any applicable  
2 deadline for the publication, notice, or response, must provide an  
3 expedited appeal under Section 4201.357 for any health care service  
4 affected by the violation.

5 SECTION 2.03. Section 1301.135(a), Insurance Code, is  
6 amended to read as follows:

7 (a) An insurer that uses a preauthorization process for  
8 medical care or [~~and~~] health care services shall provide to each  
9 preferred provider, not later than the fifth [~~10th~~] business day  
10 after the date a request is made, a list of medical care and health  
11 care services that require preauthorization and information  
12 concerning the preauthorization process.

13 SECTION 2.04. Subchapter C-1, Chapter 1301, Insurance Code,  
14 is amended by adding Sections 1301.1351, 1301.1352, and 1301.1353  
15 to read as follows:

16 Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS.

17 (a) An insurer that uses a preauthorization process for medical  
18 care or health care services shall make the requirements and  
19 information about the preauthorization process readily accessible  
20 to insureds, physicians, health care providers, and the general  
21 public by posting the requirements and information on the insurer's  
22 Internet website.

23 (b) The preauthorization requirements and information  
24 described by Subsection (a) must:

25 (1) be posted:

26 (A) except as provided by Subsection (c) or (d),  
27 conspicuously in a location on the Internet website that does not

1 require the use of a log-in or other input of personal information  
2 to view the information; and

3 (B) in a format that is easily searchable and  
4 accessible;

5 (2) except for the screening criteria under Paragraph  
6 (4)(C), be written in plain language that is easily understandable  
7 by insureds, physicians, health care providers, and the general  
8 public;

9 (3) include a detailed description of the  
10 preauthorization process and procedure; and

11 (4) include an accurate and current list of medical  
12 care and health care services for which the insurer requires  
13 preauthorization that includes the following information specific  
14 to each service:

15 (A) the effective date of the preauthorization  
16 requirement;

17 (B) a list or description of any supporting  
18 documentation that the insurer requires from the physician or  
19 health care provider ordering or requesting the service to approve  
20 a request for the service;

21 (C) the applicable screening criteria, which may  
22 include Current Procedural Terminology codes and International  
23 Classification of Diseases codes; and

24 (D) statistics regarding the insurer's  
25 preauthorization approval and denial rates for the medical care or  
26 health care service in the preceding calendar year, including  
27 statistics in the following categories:

- 1                   (i) physician or health care provider type  
2 and specialty, if any;
- 3                   (ii) indication offered;
- 4                   (iii) reasons for request denial;
- 5                   (iv) denials overturned on internal appeal;
- 6                   (v) denials overturned by an independent  
7 review organization; and
- 8                   (vi) total annual preauthorization  
9 requests, approvals, and denials for the service.

10           (c) This section may not be construed to require an insurer  
11 to provide specific information that would violate any applicable  
12 copyright law or licensing agreement. To comply with a posting  
13 requirement described by Subsection (b), an insurer may, instead of  
14 making that information publicly available on the insurer's  
15 Internet website, supply a summary of the withheld information  
16 sufficient to allow a licensed physician or other health care  
17 provider, as applicable for the specific service, who has  
18 sufficient training and experience related to the service to  
19 understand the basis for the insurer's medical necessity or  
20 appropriateness determinations.

21           (d) If a requirement or information described by Subsection  
22 (a) is licensed, proprietary, or copyrighted material that the  
23 insurer has received from a third party with which the insurer has  
24 contracted, to comply with a posting requirement described by  
25 Subsection (b), the insurer may, instead of making that information  
26 publicly available on the insurer's Internet website, provide the  
27 material to a physician or health care provider who submits a

1 preauthorization request using a nonpublic secured Internet  
2 website link or other protected, nonpublic electronic means.

3 (e) The provisions of this section may not be waived,  
4 voided, or nullified by contract.

5 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

6 (a) Except as provided by Subsection (b), not later than the 60th  
7 day before the date a new or amended preauthorization requirement  
8 takes effect, an insurer that uses a preauthorization process for  
9 medical care or health care services shall provide notice of the new  
10 or amended preauthorization requirement and disclose the new or  
11 amended requirement in the insurer's newsletter or network  
12 bulletin, if any, and on the insurer's Internet website.

13 (b) For a change in a preauthorization requirement or  
14 process that removes a service from the list of medical care or  
15 health care services requiring preauthorization or amends a  
16 preauthorization requirement in a way that is less burdensome to  
17 insureds, physicians, or health care providers, an insurer shall  
18 provide notice of the change in the preauthorization requirement  
19 and disclose the change in the insurer's newsletter or network  
20 bulletin, if any, and on the insurer's Internet website not later  
21 than the fifth day before the date the change takes effect.

22 (c) Not later than the fifth day before the date a new or  
23 amended preauthorization requirement takes effect, an insurer  
24 shall update its Internet website to disclose the change to the  
25 insurer's preauthorization requirements or process and the date and  
26 time the change is effective.

27 (d) The provisions of this section may not be waived,

1 voided, or nullified by contract.

2 Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition  
3 to any other penalty or remedy provided by law, an insurer that uses  
4 a preauthorization process for medical care or health care services  
5 that violates this subchapter with respect to a required  
6 publication, notice, or response regarding its preauthorization  
7 requirements, including by failing to comply with any applicable  
8 deadline for the publication, notice, or response, must provide an  
9 expedited appeal under Section 4201.357 for any medical care or  
10 health care service affected by the violation.

11 (b) The provisions of this section may not be waived,  
12 voided, or nullified by contract.

13 ARTICLE 3. UTILIZATION, INDEPENDENT, AND PEER REVIEW

14 SECTION 3.01. Section 4201.002(12), Insurance Code, is  
15 amended to read as follows:

16 (12) "Provider of record" means the physician or other  
17 health care provider with primary responsibility for the health  
18 care~~[, treatment, and]~~ services provided to or requested on behalf  
19 of an enrollee or the physician or other health care provider that  
20 has provided or has been requested to provide the health care  
21 services to the enrollee. The term includes a health care facility  
22 where the health care services are ~~[if treatment is]~~ provided on an  
23 inpatient or outpatient basis.

24 SECTION 3.02. Sections 4201.151 and 4201.152, Insurance  
25 Code, are amended to read as follows:

26 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization  
27 review agent's utilization review plan, including reconsideration

1 and appeal requirements, must be reviewed by a physician licensed  
2 to practice medicine in this state and conducted in accordance with  
3 standards developed with input from appropriate health care  
4 providers and approved by a physician licensed to practice medicine  
5 in this state.

6       Sec. 4201.152. UTILIZATION REVIEW UNDER [~~DIRECTION OF~~]  
7 PHYSICIAN. A utilization review agent shall conduct utilization  
8 review under the direction of a physician licensed to practice  
9 medicine in this [~~by a~~] state [~~licensing agency in the United~~  
10 ~~States~~].

11       SECTION 3.03. Sections 4201.155, 4201.206, and 4201.251,  
12 Insurance Code, are amended to read as follows:

13       Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW  
14 PROCEDURES. (a) A utilization review agent may not establish or  
15 impose a notice requirement or other review procedure that is  
16 contrary to the requirements of the health insurance policy or  
17 health benefit plan.

18       (b) This section may not be construed to release a health  
19 insurance policy or health benefit plan from full compliance with  
20 this chapter or other applicable law.

21       Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE  
22 ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the  
23 notice requirements of Subchapter G, before an adverse  
24 determination is issued by a utilization review agent who questions  
25 the medical necessity, the [~~or~~] appropriateness, or the  
26 experimental or investigational nature[~~r~~] of a health care service,  
27 the agent shall provide the health care provider who ordered,

1 requested, provided, or is to provide the service a reasonable  
2 opportunity to discuss with a physician licensed to practice  
3 medicine the patient's treatment plan and the clinical basis for  
4 the agent's determination.

5 (b) If the health care service described by Subsection (a)  
6 was ordered, requested, or provided, or is to be provided by a  
7 physician, the opportunity described by that subsection must be  
8 with a physician licensed to practice medicine.

9 Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A  
10 utilization review agent may delegate utilization review to  
11 qualified personnel in the hospital or other health care facility  
12 in which the health care services to be reviewed were or are to be  
13 provided. The delegation does not release the agent from the full  
14 responsibility for compliance with this chapter or other applicable  
15 law, including the conduct of those to whom utilization review has  
16 been delegated.

17 SECTION 3.04. Sections 4201.252(a) and (b), Insurance Code,  
18 are amended to read as follows:

19 (a) Personnel employed by or under contract with a  
20 utilization review agent to perform utilization review must be  
21 appropriately trained and qualified and meet the requirements of  
22 this chapter and other applicable law, including applicable  
23 licensing requirements.

24 (b) Personnel, other than a physician licensed to practice  
25 medicine, who obtain oral or written information directly from a  
26 patient's physician or other health care provider regarding the  
27 patient's specific medical condition, diagnosis, or treatment

1 options or protocols must be a nurse, physician assistant, or other  
2 health care provider qualified to provide the requested service.

3 SECTION 3.05. Section 4201.356, Insurance Code, is amended  
4 to read as follows:

5 Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY  
6 REVIEW. (a) The procedures for appealing an adverse determination  
7 must provide that a physician licensed to practice medicine makes  
8 the decision on the appeal, except as provided by Subsection (b).

9 (b) If not later than the 10th working day after the date an  
10 appeal is requested or denied the enrollee's health care provider  
11 requests [~~states in writing good cause for having~~] a particular  
12 type of specialty provider review the case, a health care provider  
13 who is of the same or a similar specialty as the health care  
14 provider who would typically manage the medical or dental  
15 condition, procedure, or treatment under consideration for review  
16 shall review the denial or the decision denying the appeal. The  
17 specialty review must be completed within 15 working days of the  
18 date the health care provider's request for specialty review is  
19 received.

20 SECTION 3.06. Section 4201.357(a), Insurance Code, is  
21 amended to read as follows:

22 (a) The procedures for appealing an adverse determination  
23 must include, in addition to the written appeal, a procedure for an  
24 expedited appeal of a denial of emergency care, ~~[or]~~ a denial of  
25 continued hospitalization, or a denial of another service if the  
26 requesting health care provider includes a written statement with  
27 supporting documentation that the service is necessary to treat a

1 life-threatening condition or prevent serious harm to the patient.

2 That procedure must include a review by a health care provider who:

3 (1) has not previously reviewed the case; and

4 (2) is of the same or a similar specialty as the health  
5 care provider who would typically manage the medical or dental  
6 condition, procedure, or treatment under review in the appeal.

7 SECTION 3.07. Sections 4201.453 and 4201.454, Insurance  
8 Code, are amended to read as follows:

9 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty  
10 utilization review agent's utilization review plan, including  
11 reconsideration and appeal requirements, must be:

12 (1) reviewed by a health care provider of the  
13 appropriate specialty who is licensed or otherwise authorized to  
14 provide the specialty health care service in this state; and

15 (2) conducted in accordance with standards developed  
16 with input from a health care provider of the appropriate specialty  
17 who is licensed or otherwise authorized to provide the specialty  
18 health care service in this state.

19 Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF  
20 PROVIDER OF SAME SPECIALTY. A specialty utilization review agent  
21 shall conduct utilization review under the direction of a health  
22 care provider who is of the same specialty as the agent and who is  
23 licensed or otherwise authorized to provide the specialty health  
24 care service in this [~~by a~~] state [~~licensing agency in the United~~  
25 ~~States~~].

26 SECTION 3.08. Section 4201.455(a), Insurance Code, is  
27 amended to read as follows:

1 (a) Personnel who are employed by or under contract with a  
2 specialty utilization review agent to perform utilization review  
3 must be appropriately trained and qualified and meet the  
4 requirements of this chapter and other applicable law of this  
5 state, including applicable licensing laws.

6 SECTION 3.09. Section 4201.456, Insurance Code, is amended  
7 to read as follows:

8 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE  
9 ADVERSE DETERMINATION. Subject to the notice requirements of  
10 Subchapter G, before an adverse determination is issued by a  
11 specialty utilization review agent who questions the medical  
12 necessity, the [~~or~~] appropriateness, or the experimental or  
13 investigational nature[~~r~~] of a health care service, the agent shall  
14 provide the health care provider who ordered, requested, or is to  
15 provide the service a reasonable opportunity to discuss the  
16 patient's treatment plan and the clinical basis for the agent's  
17 determination with a health care provider who is of the same  
18 specialty as the agent.

19 SECTION 3.10. Section 408.0043, Labor Code, is amended by  
20 adding Subsection (c) to read as follows:

21 (c) Notwithstanding Subsection (b), if a health care  
22 service is requested, ordered, provided, or to be provided by a  
23 physician, a person described by Subsection (a)(1), (2), or (3) who  
24 reviews the service with respect to a specific workers'  
25 compensation case must be of the same or a similar specialty as that  
26 physician.

27 SECTION 3.11. Section 1305.351(d), Insurance Code, is

1 amended to read as follows:

2 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization  
3 review agent or an insurance carrier that uses doctors to perform  
4 reviews of health care services provided under this chapter,  
5 including utilization review, or peer reviews under Section  
6 408.0231(g), Labor Code, may only use doctors licensed to practice  
7 in this state.

8 SECTION 3.12. Section 1305.355(d), Insurance Code, is  
9 amended to read as follows:

10 (d) The department shall assign the review request to an  
11 independent review organization. An [~~Notwithstanding Section~~  
12 ~~4202.002, an~~] independent review organization that uses doctors to  
13 perform reviews of health care services under this chapter may only  
14 use doctors licensed to practice in this state.

15 SECTION 3.13. Section 408.023(h), Labor Code, is amended to  
16 read as follows:

17 (h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~]  
18 utilization review agent or an insurance carrier that uses doctors  
19 to perform reviews of health care services provided under this  
20 subtitle, including utilization review, may only use doctors  
21 licensed to practice in this state.

22 SECTION 3.14. Section 413.031(e-2), Labor Code, is amended  
23 to read as follows:

24 (e-2) An [~~Notwithstanding Section 4202.002, Insurance Code,~~  
25 ~~an~~] independent review organization that uses doctors to perform  
26 reviews of health care services provided under this title may only  
27 use doctors licensed to practice in this state.

ARTICLE 4. JOINT INTERIM STUDY

1 SECTION 4.01. CREATION OF JOINT INTERIM COMMITTEE. (a) A  
2 joint interim committee is created to study, review, and report on  
3 the use of prior authorization and utilization review processes by  
4 private health benefit plan issuers in this state, as provided by  
5 Section 4.02 of this article, and propose reforms under that  
6 section related to the transparency of and improving patient  
7 outcomes under the prior authorization and utilization review  
8 processes used by private health benefit plan issuers in this  
9 state.  
10

11 (b) The joint interim committee shall be composed of four  
12 senators appointed by the lieutenant governor and four members of  
13 the house of representatives appointed by the speaker of the house  
14 of representatives.

15 (c) The lieutenant governor and speaker of the house of  
16 representatives shall each designate a co-chair from among the  
17 joint interim committee members.

18 (d) The joint interim committee shall convene at the joint  
19 call of the co-chairs.

20 (e) The joint interim committee has all other powers and  
21 duties provided to a special or select committee by the rules of the  
22 senate and house of representatives, by Subchapter B, Chapter 301,  
23 Government Code, and by policies of the senate and house committees  
24 on administration.

25 SECTION 4.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION  
26 AND UTILIZATION REVIEW PROCESSES. (a) The joint interim committee  
27 created by Section 4.01 of this article shall study data and other

1 information available from the Texas Department of Insurance, the  
2 office of public insurance counsel, or other sources the committee  
3 determines relevant to examine and analyze the transparency of and  
4 improving patient outcomes under the prior authorization and  
5 utilization review processes used by private health benefit plan  
6 issuers in this state.

7 (b) The joint interim committee shall propose reforms based  
8 on the study required under Subsection (a) of this section to  
9 improve the transparency of and patient outcomes under prior  
10 authorization and utilization review processes in this state.

11 (c) The joint interim committee shall prepare a report of  
12 the findings and proposed reforms.

13 SECTION 4.03. COMMITTEE FINDINGS AND PROPOSED REFORMS. (a)  
14 Not later than December 1, 2020, the joint interim committee  
15 created under Section 4.01 of this article shall submit to the  
16 lieutenant governor, the speaker of the house of representatives,  
17 and the governor the report prepared under Section 4.02 of this  
18 article. The joint interim committee shall include in its report  
19 recommendations of specific statutory and regulatory changes that  
20 appear necessary from the committee's study under Section 4.02 of  
21 this article.

22 (b) Not later than the 60th day after the effective date of  
23 this Act, the lieutenant governor and speaker of the house of  
24 representatives shall appoint the members of the joint interim  
25 committee in accordance with Section 4.01 of this article.

26 SECTION 4.04. ABOLITION OF COMMITTEE. The joint interim  
27 committee created under Section 4.01 of this article is abolished

1 and this article expires December 15, 2020.

2 ARTICLE 5. TRANSITIONS; EFFECTIVE DATE

3 SECTION 5.01. A health benefit plan issuer shall update the  
4 issuer's website to conform with Subchapter K, Chapter 1451,  
5 Insurance Code, as amended by Article 1 of this Act, not later than  
6 January 1, 2020.

7 SECTION 5.02. The changes in law made by Article 2 of this  
8 Act apply only to a request for preauthorization of medical care or  
9 health care services made on or after January 1, 2020, under a  
10 health benefit plan delivered, issued for delivery, or renewed on  
11 or after that date. A request for preauthorization of medical care  
12 or health care services made before January 1, 2020, or on or after  
13 January 1, 2020, under a health benefit plan delivered, issued for  
14 delivery, or renewed before that date is governed by the law as it  
15 existed immediately before the effective date of this Act, and that  
16 law is continued in effect for that purpose.

17 SECTION 5.03. The changes in law made by Article 3 of this  
18 Act apply only to utilization, independent, or peer review  
19 requested on or after the effective date of this Act. Utilization,  
20 independent, or peer review requested before the effective date of  
21 this Act is governed by the law as it existed immediately before the  
22 effective date of this Act, and that law is continued in effect for  
23 that purpose.

24 SECTION 5.04. This Act takes effect September 1, 2019.

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<i>No equivalent provision.</i>	ARTICLE __. PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORIES [FA5,3rd(1)]	Same as Senate version.
SECTIONS 1-3. Sections 1451.501, 1451.504, and 1451.505, Insurance Code, are amended.	SECTIONS __.01- __.03. Same as Senate version.	SECTIONS 1.01-1.03. Same as Senate version.
<i>No equivalent provision.</i>	ARTICLE __. <b>REGULATION OF UTILIZATION REVIEW, INDEPENDENT REVIEW, AND PEER REVIEW AND PREAUTHORIZATION REQUIREMENTS</b> [FA5,3rd(3)]	ARTICLE 2. PREAUTHORIZATION
<i>No equivalent provision.</i>	SECTION __.01. Section 533.005, Government Code, is amended by adding Subsection (e).	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __.02. Section 843.348(b), Insurance Code, is amended to read as follows: (b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the <u>fifth</u> [ <del>10th</del> ] business day after the date a request is made, a list of health care services that [ <del>do not</del> ] require preauthorization and information concerning the preauthorization process. [FA5,3rd(3)]	SECTION 2.01. Same as House version.
<i>No equivalent provision.</i>	SECTION __.03. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.3481, 843.3482, 843.3483, and 843.3484 to read as follows: <u>Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the</u>	SECTION 2.02. Same as House version except as follows:  <u>Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the</u>

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preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the health maintenance organization requires from the physician or provider ordering or requesting the service to approve a request for that service;

(C) the applicable screening criteria *using* Current Procedural Terminology codes and International Classification of Diseases codes; and

preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

*(A) except as provided by Subsection (c) or (d),* conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

*(2) except for the screening criteria under Paragraph (4)(C),* be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the health maintenance organization requires from the physician or provider ordering or requesting the service to approve a request for that service;

(C) the applicable screening criteria, *which may include* Current Procedural Terminology codes and International Classification of Diseases codes; and

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(D) statistics regarding preauthorization approval and denial rates for the service in the preceding year and for each previous year the preauthorization requirement was in effect, including statistics in the following categories:

- (i) physician or provider type and specialty, if any;
- (ii) indication offered;
- (iii) reasons for request denial;
- (iv) denials overturned on internal appeal;
- (v) denials overturned on external appeal; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(D) statistics regarding preauthorization approval and denial rates for the service in the preceding calendar year, including statistics in the following categories:

- (i) physician or provider type and specialty, if any;
- (ii) indication offered;
- (iii) reasons for request denial;
- (iv) denials overturned on internal appeal;
- (v) denials overturned by an independent review organization; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(c) This section may not be construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. To comply with a posting requirement described by Subsection (b), a health maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, supply a summary of the withheld information sufficient to allow a licensed physician or provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the health maintenance organization's medical necessity or appropriateness determinations.

(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the health maintenance organization has received from a third party with which the health maintenance organization has contracted, to comply with a posting requirement described by Subsection (b), the health

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Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide ***each participating physician or provider written*** notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any.  
(b) For a change in a preauthorization requirement or process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance organization shall provide ***each participating physician or provider written*** notice of the change in the preauthorization requirement and disclose the change in the health maintenance organization's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.  
(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization shall update its Internet website to disclose the change to the health maintenance organization's

***maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, provide the material to a physician or provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.***

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any, ***and on the health maintenance organization's Internet website.***  
(b) For a change in a preauthorization requirement or process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance organization shall provide notice of the change in the preauthorization requirement and disclose the change in the health maintenance organization's newsletter or network bulletin, if any, ***and on the health maintenance organization's Internet website*** not later than the fifth day before the date the change takes effect.  
(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization shall update its Internet website to disclose the change to the health maintenance organization's

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preauthorization requirements or process and the date and time the change is effective.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE; ***AUTOMATIC WAIVER.*** In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, ***waives the health maintenance organization's preauthorization requirements with respect to any health care service affected by the violation, and any health care service affected by the violation is considered preauthorized by the health maintenance organization.***

Sec. 843.3484. EFFECT OF PREAUTHORIZATION ***WAIVER.*** A waiver of preauthorization requirements under Section 843.3483 may not be construed to:  
(1) authorize a physician or provider to provide health care services outside of the physician's or provider's applicable scope of practice as defined by state law; or  
(2) require the health maintenance organization to pay for a health care service provided outside of the physician's or provider's applicable scope of practice as defined by state law. [FA5,3rd(3)]

*No equivalent provision.*

SECTION \_\_.04. Section 1301.135(a), Insurance Code, is amended to read as follows:

(a) An insurer that uses a preauthorization process for medical care or ~~and~~ health care services shall provide to

preauthorization requirements or process and the date and time the change is effective.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, ***must provide an expedited appeal under Section 4201.357 for any health care service affected by the violation.***

SECTION 2.03. Same as House version.

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each preferred provider, not later than the fifth ~~[10th]~~ business day after the date a request is made, a list of medical care and health care services that require preauthorization and information concerning the preauthorization process. [FA5,3rd(3)]

*No equivalent provision.*

SECTION \_\_.05. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Sections 1301.1351, 1301.1352, 1301.1353, and 1301.1354 to read as follows:

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

SECTION 2.04. Same as House version except as follows:

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) *except as provided by Subsection (c) or (d)*, conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) *except for the screening criteria under Paragraph (4)(C)*, be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

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(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;  
(B) a list or description of any supporting documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve a request for the service;

(C) the applicable screening criteria *using* Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding *year and for each previous year the preauthorization requirement was in effect*, including statistics in the following categories:

(i) physician or health care provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned *on external appeal*; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;  
(B) a list or description of any supporting documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve a request for the service;

(C) the applicable screening criteria, *which may include* Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding *calendar year*, including statistics in the following categories:

(i) physician or health care provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned *by an independent review organization*; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

*(c) This section may not be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. To comply with a posting requirement described by Subsection (b), an insurer may, instead of making that information publicly available on the insurer's Internet website, supply*

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(c) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide *to each preferred provider written* notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the insurer's newsletter or network bulletin, if any.

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care

*a summary of the withheld information sufficient to allow a licensed physician or other health care provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the insurer's medical necessity or appropriateness determinations.*

*(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the insurer has received from a third party with which the insurer has contracted, to comply with a posting requirement described by Subsection (b), the insurer may, instead of making that information publicly available on the insurer's Internet website, provide the material to a physician or health care provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.*

(e) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the insurer's newsletter or network bulletin, if any, *and on the insurer's Internet website.*

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care

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or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide **each preferred provider written** notice of the change in the preauthorization requirement and disclose the change in the insurer's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an insurer shall update its Internet website to disclose the change to the insurer's preauthorization requirements or process and the date and time the change is effective.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE; **AUTOMATIC WAIVER.** (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, **waives the insurer's preauthorization requirements with respect to** any medical care or health care service affected by the violation, **and any medical care or health care service affected by the violation is considered preauthorized by the insurer.**

(b) The provisions of this section may not be waived, voided, or nullified by contract.

or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide notice of the change in the preauthorization requirement and disclose the change in the insurer's newsletter or network bulletin, if any, **and on the insurer's Internet website** not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an insurer shall update its Internet website to disclose the change to the insurer's preauthorization requirements or process and the date and time the change is effective.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, **must provide an expedited appeal under Section 4201.357 for any medical care or health care service affected by the violation.**

(b) The provisions of this section may not be waived, voided, or nullified by contract.

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**Sec. 1301.1354. EFFECT OF PREAUTHORIZATION WAIVER. (a) A waiver of preauthorization requirements under Section 1301.1353 may not be construed to:**  
**(1) authorize a physician or health care provider to provide medical care or health care services outside of the physician's or health care provider's applicable scope of practice as defined by state law; or**  
**(2) require the insurer to pay for a medical care or health care service provided outside of the physician's or health care provider's applicable scope of practice as defined by state law.**  
**(b) The provisions of this section may not be waived, voided, or nullified by contract. [FA5,3rd(3)]**

*No equivalent provision.*

Same as Senate version.

ARTICLE 3. UTILIZATION, INDEPENDENT, AND PEER REVIEW

*No equivalent provision.*

SECTION \_\_.06. Section 4201.002(12), Insurance Code, is amended to read as follows:  
(12) "Provider of record" means the physician or other health care provider with primary responsibility for the health care~~[, treatment, and]~~ services provided to or requested on behalf of an enrollee or the physician or other health care provider that has provided or has been requested to provide the health care services to the enrollee. The term includes a health care facility where the health care services are are ~~[if treatment is]~~ provided on an inpatient or outpatient basis. [FA5,3rd(3)]

SECTION 3.01. Same as House version.

*No equivalent provision.*

SECTION \_\_.07. Sections 4201.151 and 4201.152, Insurance Code, are amended as follows:

SECTION 3.02. Same as House version except as follows:

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Sec. 4201.151.

Sec. 4201.151. Same as House version.

Sec. 4201.152. UTILIZATION REVIEW UNDER ~~[DIRECTION OF]~~ PHYSICIAN. A utilization review agent shall conduct utilization review under the supervision and direction of a physician licensed to practice medicine in this [by a] state [licensing agency in the United States]. [FA5,3rd(3)]

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 [by a] state [licensing agency in the United States].

*No equivalent provision.*

SECTION \_\_.08. Subchapter D, Chapter 4201, Insurance Code, is amended by adding Section 4201.1525.

Same as Senate version.

*No equivalent provision.*

SECTION \_\_.09. Section 4201.153(d), Insurance Code, is amended.

Same as Senate version.

*No equivalent provision.*

SECTION \_\_.10. Sections 4201.155, 4201.206, and 4201.251, Insurance Code, are amended as follows:

SECTION 3.03. Same as House version except as follows:

Sec. 4201.155.

Sec. 4201.155. Same as House version.

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity, the [or] appropriateness, or the experimental or investigational nature[;] of a health care service, the agent shall provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss with a physician licensed to practice medicine in this state the patient's treatment plan and the clinical basis for the agent's determination.

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity, the [or] appropriateness, or the experimental or investigational nature[;] of a health care service, the agent shall provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss with a physician licensed to practice medicine the patient's treatment plan and the clinical basis for the agent's determination.

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(b) If the health care service described by Subsection (a) was ordered, requested, or provided, or is to be provided by a physician, the opportunity described by that subsection must be with a physician licensed to practice medicine in this state who is of the same or a similar specialty as that physician.

Sec. 4201.251.

SECTION \_\_.11. Subchapter D, Chapter 4201, Insurance Code, is amended by adding Section 4201.156.

SECTION \_\_.12. Sections 4201.252(a) and (b), Insurance Code, are amended to read as follows:

(a) Personnel employed by or under contract with a utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law, including licensing requirements.

(b) Personnel, other than a physician licensed to practice medicine in this state, who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols must be a nurse, physician assistant, or other health care provider qualified and licensed or otherwise authorized by law and the appropriate licensing agency in this state to provide the requested service. [FA5,3rd(3)]

SECTION \_\_.13. Section 4201.356, Insurance Code, is amended to read as follows:

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) The procedures for appealing an

(b) If the health care service described by Subsection (a) was ordered, requested, or provided, or is to be provided by a physician, the opportunity described by that subsection must be with a physician licensed to practice medicine.

Sec. 4201.251. Same as House version.

Same as Senate version.

SECTION 3.04. Same as House version except as follows:

(a) Personnel employed by or under contract with a utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law, including applicable licensing requirements.

(b) Personnel, other than a physician licensed to practice medicine, who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols must be a nurse, physician assistant, or other health care provider qualified to provide the requested service. [FA5,3rd(3)]

SECTION 3.05. Same as House version except as follows:

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) The procedures for appealing an

*No equivalent provision.*

*No equivalent provision.*

*No equivalent provision.*

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adverse determination must provide that a physician licensed to practice medicine in this state makes the decision on the appeal, except as provided by Subsection (b) or (c).

**(b) For a health care service ordered, requested, provided, or to be provided by a physician, the procedures for appealing an adverse determination must provide that a physician licensed to practice medicine in this state who is of the same or a similar specialty as that physician makes the decision on appeal, except as provided by Subsection (c).**

**(c) If not later than the 10th working day after the date an appeal is denied the enrollee's health care provider states in writing good cause for having a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review and who is licensed or otherwise authorized by the appropriate licensing agency in this state to manage the medical or dental condition, procedure, or treatment shall review the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received.**  
[FA5,3rd(3)]

***No equivalent provision.***

SECTION \_\_.14. Sections 4201.357(a), (a-1), and (a-2), Insurance Code, are amended to read as follows:

(a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care or a denial of continued hospitalization.

adverse determination must provide that a physician licensed to practice medicine makes the decision on the appeal, except as provided by Subsection (b).

(b) If not later than the 10th working day after the date an appeal is **requested or** denied the enrollee's health care provider **requests** ~~states in writing good cause for having~~ a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the **denial or the** decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received.

SECTION 3.06. Same as House version except as follows:

(a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, ~~[or]~~ a denial of continued hospitalization, **or a denial of another service if the requesting health care provider includes a**

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That procedure must include a review by a health care provider who:

- (1) has not previously reviewed the case; ~~and~~
- (2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and

**(3) for a review of a health care service:**

**(A) ordered, requested, provided, or to be provided by a health care provider who is not a physician, is licensed or otherwise authorized by the appropriate licensing agency in this state to provide the service in this state; or**

**(B) ordered, requested, provided, or to be provided by a physician, is licensed to practice medicine in this state.**

*(a-1) The procedures for appealing an adverse determination must include, in addition to the written appeal and the appeal described by Subsection (a), a procedure for an expedited appeal of a denial of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy. That procedure must include a review by a health care provider who:*

- (1) has not previously reviewed the case; ~~and~~*
- (2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and*

**(3) for a review of a health care service:**

**(A) ordered, requested, provided, or to be provided by a health care provider who is not a physician, is licensed or**

**written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient.** That procedure must include a review by a health care provider who:

- (1) has not previously reviewed the case; and
- (2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

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**otherwise authorized by the appropriate licensing agency in this state to provide the service in this state; or (B) ordered, requested, provided, or to be provided by a physician, is licensed to practice medicine in this state.**  
**(a-2) An adverse determination under Section 1369.0546 is entitled to an expedited appeal. The physician or, if appropriate, other health care provider deciding the appeal must consider atypical diagnoses and the needs of atypical patient populations. The physician must be licensed to practice medicine in this state and the health care provider must be licensed or otherwise authorized by the appropriate licensing agency in this state. [FA5,3rd(3)]**

*No equivalent provision.*

SECTION \_\_.15. Section 4201.359, Insurance Code, is amended by adding Subsection (c).

Same as Senate version.

*No equivalent provision.*

SECTION \_\_.16. Sections 4201.453 and 4201.454, Insurance Code, are amended to read as follows:  
Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be:  
(1) reviewed by a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state; and  
(2) conducted in accordance with standards developed with input from a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state.  
Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. A specialty utilization review agent shall conduct utilization review under the direction of a health care provider who is

SECTION 3.07. Same as House version.

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of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service in this [by-a] state [licensing agency in the United States]. [FA5,3rd(3)]

*No equivalent provision.*

SECTION \_\_.17. Sections 4201.455(a) and (b), Insurance Code, are amended to read as follows:

(a) Personnel who are employed by or under contract with a specialty utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law of this state, including licensing laws.

*(b) Personnel who obtain oral or written information directly from a physician or other health care provider must be a nurse, physician assistant, or other health care provider of the same specialty as the agent and who are licensed or otherwise authorized to provide the specialty health care service in this [by-a] state [licensing agency in the United States]. [FA5,3rd(3)]*

*No equivalent provision.*

SECTION \_\_.18. Sections 4201.456 and 4201.457, Insurance Code, are amended to read as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity, the [or] appropriateness, or the experimental or investigational nature[.] of a health care service, the agent shall provide the health care provider who ordered, requested, **provided**, or is to provide the service a reasonable opportunity to discuss the

SECTION 3.08. Same as House version except as follows:

(a) Personnel who are employed by or under contract with a specialty utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law of this state, including **applicable** licensing laws.

SECTION 3.09. Section 4201.456, Insurance Code, is amended to read as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity, the [or] appropriateness, or the experimental or investigational nature[,] of a health care service, the agent shall provide the health care provider who ordered, requested, or is to provide the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's

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patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is:  
(1) of the same specialty as the agent; and  
(2) licensed or otherwise authorized to provide the specialty health care service in this state.

determination with a health care provider who is of the same specialty as the agent.

**Sec. 4201.457. APPEAL DECISIONS.** *A specialty utilization review agent shall comply with the requirement that a physician or other health care provider who makes the decision in an appeal of an adverse determination must be:*  
*(1) of the same or a similar specialty as the health care provider who would typically manage the specialty condition, procedure, or treatment under review in the appeal; and*  
*(2) licensed or otherwise authorized to provide the health care service in this state.* [FA5,3rd(3)]

*No equivalent provision.*

SECTION \_\_.19. Section 4202.002, Insurance Code, is amended by adding Subsection (b-1).

Same as Senate version.

*No equivalent provision.*

SECTION \_\_.20. Section 408.0043, Labor Code, is amended by adding Subsection (c) to read as follows:  
(c) Notwithstanding Subsection (b), if a health care service is requested, ordered, provided, or to be provided by a physician, a person described by Subsection (a)(1), (2), or (3) who reviews the service with respect to a specific workers' compensation case must be of the same or a similar specialty as that physician. [FA5,3rd(3)]

SECTION 3.10. Same as House version.

*No equivalent provision.*

SECTION \_\_.21. Subchapter B, Chapter 151, Occupations Code, is amended by adding Section 151.057.

Same as Senate version.

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*No equivalent provision.*

SECTION \_\_.22. Section 1305.351(d), Insurance Code, is amended to read as follows:

(d) A [~~Notwithstanding Section 4201.152, a~~] utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter, including utilization review, or peer reviews under Section 408.0231(g), Labor Code, may only use doctors licensed to practice in this state. [FA5,3rd(3)]

SECTION 3.11. Same as House version.

*No equivalent provision.*

SECTION \_\_.23. Section 1305.355(d), Insurance Code, is amended to read as follows:

(d) The department shall assign the review request to an independent review organization. An [~~Notwithstanding Section 4202.002, an~~] independent review organization that uses doctors to perform reviews of health care services under this chapter may only use doctors licensed to practice in this state. [FA5,3rd(3)]

SECTION 3.12. Same as House version.

*No equivalent provision.*

SECTION \_\_.24. Section 408.023(h), Labor Code, is amended to read as follows:

(h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~] utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this subtitle, including utilization review, may only use doctors licensed to practice in this state. [FA5,3rd(3)]

SECTION 3.13. Same as House version.

*No equivalent provision.*

SECTION \_\_.25. Section 413.031(e-2), Labor Code, is amended to read as follows:

(e-2) An [~~Notwithstanding Section 4202.002, Insurance Code, an~~] independent review organization that uses doctors to perform reviews of health care services provided under

SECTION 3.14. Same as House version.

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this title may only use doctors licensed to practice in this state. [FA5,3rd(3)]

*No equivalent provision.*

Same as Senate version.

*No equivalent provision.*

Same as Senate version.

ARTICLE 4. JOINT INTERIM STUDY

SECTION 4.01. CREATION OF JOINT INTERIM COMMITTEE. (a) A joint interim committee is created to study, review, and report on the use of prior authorization and utilization review processes by private health benefit plan issuers in this state, as provided by Section 4.02 of this article, and propose reforms under that section related to the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in this state.

(b) The joint interim committee shall be composed of four senators appointed by the lieutenant governor and four members of the house of representatives appointed by the speaker of the house of representatives.

(c) The lieutenant governor and speaker of the house of representatives shall each designate a co-chair from among the joint interim committee members.

(d) The joint interim committee shall convene at the joint call of the co-chairs.

(e) The joint interim committee has all other powers and duties provided to a special or select committee by the rules of the senate and house of representatives, by Subchapter B, Chapter 301, Government Code, and by policies of the senate and house committees on administration.

*[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.]*

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*No equivalent provision.*

Same as Senate version.

SECTION 4.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. (a) The joint interim committee created by Section 4.01 of this article shall study data and other information available from the Texas Department of Insurance, the office of public insurance counsel, or other sources the committee determines relevant to examine and analyze the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in this state.

(b) The joint interim committee shall propose reforms based on the study required under Subsection (a) of this section to improve the transparency of and patient outcomes under prior authorization and utilization review processes in this state.

(c) The joint interim committee shall prepare a report of the findings and proposed reforms.

*[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.]*

*No equivalent provision.*

Same as Senate version.

SECTION 4.03. COMMITTEE FINDINGS AND PROPOSED REFORMS. (a) Not later than December 1, 2020, the joint interim committee created under Section 4.01 of this article shall submit to the lieutenant governor, the speaker of the house of representatives, and the governor the report prepared under Section 4.02 of this article. The joint interim committee shall include in its report recommendations of specific statutory and regulatory

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*No equivalent provision.*

Same as Senate version.

changes that appear necessary from the committee's study under Section 4.02 of this article.

(b) Not later than the 60th day after the effective date of this Act, the lieutenant governor and speaker of the house of representatives shall appoint the members of the joint interim committee in accordance with Section 4.01 of this article.

*[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.]*

SECTION 4.04. ABOLITION OF COMMITTEE. The joint interim committee created under Section 4.01 of this article is abolished and this article expires December 15, 2020.

*[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.]*

*No equivalent provision.*

Same as Senate version.

SECTION 4. A health benefit plan issuer shall update the issuer's website to conform with Subchapter K, Chapter 1451, Insurance Code, as amended by this Act, not later than January 1, 2020.

SECTION \_\_.04. Same as Senate version.

ARTICLE 5. TRANSITIONS; EFFECTIVE DATE

SECTION 5.01. Substantially the same as Senate version.

*No equivalent provision.*

SECTION \_\_.26. The changes in law made by this article to Chapters 843 and 1301, Insurance Code, apply only to a request for preauthorization of medical care or health care services made on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed on or after that date. A request for preauthorization of medical

SECTION 5.02. Substantially the same as House version.

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care or health care services made before January 1, 2020, or on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed before that date 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. [FA5,3rd(3)]

*No equivalent provision.*

SECTION \_\_.27. The changes in law made by *this article to Chapters 1305, 4201, and 4202, Insurance Code, Chapters 408 and 413, Labor Code, and Chapter 151, Occupations Code*, apply only to utilization, independent, or peer review that was requested on or after the effective date of this Act. Utilization, independent, or peer review requested 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. [FA5,3rd(3)]

SECTION 5.03. The changes in law made by *Article 3 of this Act* apply only to utilization, independent, or peer review that was requested on or after the effective date of this Act. Utilization, independent, or peer review requested 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.

*No equivalent provision.*

SECTION \_\_.28. Procedural provision.

Same as Senate version.

*No equivalent provision.*

SECTION \_\_.29. If before implementing any provision of this article a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted. [FA5,3rd(3)]

Same as Senate version.

*No equivalent provision.*

ARTICLE \_\_. DISCLOSURES REGARDING CERTAIN PREAUTHORIZED MEDICAL AND HEALTH CARE SERVICES [FA5,3rd(3)]

Same as Senate version.

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<i>No equivalent provision.</i>	SECTION __.01. Subchapter F, Chapter 843, Insurance Code, is amended by adding Section 843.2025.	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __.02. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Section 1301.1355.	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __.03. Procedural provision.	Same as Senate version.
<i>No equivalent provision.</i>	ARTICLE __. MISCELLANEOUS PROVISIONS	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 843.321, Insurance Code, is amended by adding Subsection (a-1). [FA1,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 1301.136, Insurance Code, is amended by adding Subsection (a-1). [FA1,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Chapter 1452, Insurance Code, is amended by adding Subchapter F. [FA1,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. The heading to Chapter 1453, Insurance Code, is amended. [FA1,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 1453.001(1), Insurance Code, is amended. [FA1,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Chapter 1453, Insurance Code, is amended by adding Section 1453.004. [FA1,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 842.261, Insurance Code, is amended by adding Subsection (a-1) and amending Subsection (c). [FA2,3rd]	Same as Senate version.

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<i>No equivalent provision.</i>	SECTION __. Section 843.2015, Insurance Code, is amended by adding Subsection (a-1) and amending Subsection (c). [FA2,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Sections 1301.0056(a) and (d), Insurance Code, are amended. [FA2,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 1301.1591, Insurance Code, is amended by adding Subsection (a-1) and amending Subsection (c). [FA2,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. The heading to Section 1451.505, Insurance Code, is amended. [FA2,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 1451.505, Insurance Code, is amended by amending Subsections (d) and (e) and adding Subsections (d-1), (d-2), and (f) through (p). [FA1,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. The heading to Chapter 1467, Insurance Code, is amended. [FA2,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. The heading to Subchapter D, Chapter 1467, Insurance Code, is amended. [FA2,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Subchapter D, Chapter 1467, Insurance Code, is amended by adding Sections 1467.152 and 1467.153. [FA2,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 843.348, Insurance Code, is amended by adding Subsection (g-1). [FA3,3rd]	Same as Senate version.

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<i>No equivalent provision.</i>	SECTION __. The heading to Chapter 1217, Insurance Code, is amended. [FA3,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Chapter 1217, Insurance Code, is amended by adding Section 1217.008. [FA3,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 1301.135, Insurance Code, is amended by adding Subsection (f-1). [FA3,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Section 843.010, Insurance Code, is amended. [FA4,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Subchapter I, Chapter 843, Insurance Code, is amended by adding Section 843.322. [FA4,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Subchapter B, Chapter 1301, Insurance Code, is amended by adding Section 1301.0642. [FA4,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	SECTION __. Saving provision. [FA4,3rd]	Same as Senate version.
<i>No equivalent provision.</i>	ARTICLE __. EFFECTIVE DATE [FA5,3rd(4)]	Same as Senate version.
SECTION 5. This Act takes effect September 1, 2019.	SECTION __.__. Same as Senate version.	SECTION 5.04. Same as Senate version.

**LEGISLATIVE BUDGET BOARD**  
**Austin, Texas**

**FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION**

**May 25, 2019**

**TO:** Honorable Dan Patrick, Lieutenant Governor, Senate  
Honorable Dennis Bonnen, Speaker of the House, House of Representatives

**FROM:** John McGeady, Assistant Director    Sarah Keyton, Assistant Director  
Legislative Budget Board

**IN RE: SB1742** by Menéndez (Relating to physician and health care provider directories, preauthorization, utilization review, independent review, and peer review for certain health benefit plans and workers' compensation coverage.), **Conference Committee Report**

<p><b>No significant fiscal implication to the State is anticipated.</b></p>
--

The bill would amend the Insurance Code and Labor Code relating to physician and health care provider directories, preauthorization, utilization review, independent review, and peer review for certain health benefit plans and workers' compensation coverage.

Based on information provided by Texas Department of Insurance, Employees Retirement System, Teacher Retirement System, The University of Texas System Administration, Texas A&M University System Administration, State Office of Risk Management, and Texas Department of Transportation, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

The Health and Human Services Commission (HHSC) indicates federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

**Local Government Impact**

No significant fiscal implication to units of local government is anticipated.

**Source Agencies:**        327 Employees Retirement System, 454 Department of Insurance, 529 Health and Human Services Commission, 710 Texas A&M University System Administrative and General Offices

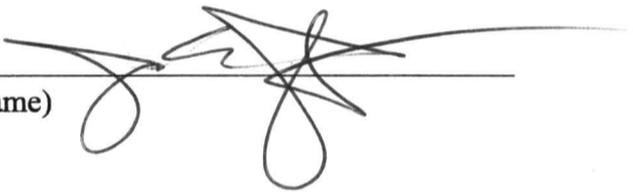
**LBB Staff:** WP, CMa, SGr, CP, KFB

**Certification of Compliance with  
Rule 13, Section 6(b), House Rules of Procedure**

Rule 13, Section 6(b), House Rules of Procedure, requires a copy of a conference committee report signed by a majority of each committee of the conference to be furnished to each member of the committee in person or, if unable to deliver in person, by placing a copy in the member's newspaper mailbox at least one hour before the report is furnished to each member of the house under House Rule 13, Section 10(a). The paper copies of the report submitted to the chief clerk under Rule 13, Section 10(b), must contain a certificate that the requirement of Rule 13, Section 6(b), has been satisfied, and that certificate must be attached to the copy of the report furnished to each member under Rule 13, Section 10(d). Failure to comply with this requirement is not subject to a point of order under Rule 13.

I certify that a copy of the conference committee report on SB 1742 was furnished to each member of the conference committee in compliance with Rule 13, Section 6(b), House Rules of Procedure, before submission of the paper copies of the report to the chief clerk under Rule 13, Section 10(b), House Rules of Procedure.

(name)

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke extending to the right.

(date)

5/25/19