SUBJECT: Establishing preauthorization exemption for certain health care providers

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Oliverson, Vo, J. González, Israel, Middleton, Romero, Sanford

2 nays — Hull, Paul

WITNESSES: For — Lisa Ehrlich and Ezequiel Silva, Texas Medical Association; John Flores, Texas Medical Association and Texas Chapter of the American College of Physicians; Lillian Timon, Texas MGMA; (*Registered, but did not testify*: Allison Greer, CHCS; Kyle Frazier, Patient Choice Coalition of Texas; Rebecca Galinsky, Protect TX Fragile Kids; Marshall Kenderdine, Texas Academy of Family Physicians; David Reynolds, Texas Chapter of the American College of Physicians; Kaden Norton, Texas Chiropractic Association; Carrie De Moor, Texas College of Emergency Physicians; Cameron Duncan, Texas Hospital Association; Clayton Stewart, Texas Medical Association; Bobby Hillert, Texas Orthopaedic Association; Jill Sutton, Texas Osteopathic Medical Association; Michael Grimes, Texas Radiological Society; Khrystal Davis, Texas Rare Alliance; Bonnie Bruce and Michael Warner, Texas Society of Anesthesiologists; Price Ashley, Texas Society of Pathologists; Thomas Parkinson)

Against — Jamie Dudensing, Texas Association of Health Plans; (*Registered, but did not testify*: Will Temple, America's Health Insurance Plans; Patricia Kolodzey, Blue Cross Blue Shield of Texas; Eric Glenn, Superior Health Plan; Shannon Meroney, Texas Association of Health Underwriters; Bill Hammond, Texas Employers for Insurance Reform)

On — (*Registered, but did not testify*: Libby Elliott, Texas Department of Insurance)

BACKGROUND: Insurance Code sec. 843.348 governs the preauthorization process used by health maintenance organizations for health care services.

Sec. 1301.135 governs the preauthorization process used by insurers of preferred provider benefit plans for medical care and health care services.

Utilization review agents evaluate the medical necessity and appropriateness of health care services that are ordered, requested, or provided by a physician. Sec. 4201.206 requires that before a utilization review agent determines a health care service is not medically necessary or is experimental or investigational, the agent must provide the health care provider a reasonable opportunity to discuss with another licensed physician the patient's treatment plan and the clinical basis for the agent's determination.

Concerns have been raised that preauthorization requirements and utilization review processes are burdensome for health care providers and can prevent patients from accessing the health care they need. Some have called for an exemption to preauthorization requirements for health care providers who submit and receive approval for a certain number of preauthorization requests every year. Suggestions also have been made to ensure physicians who are most familiar with the delivery of health care in Texas are involved in utilization reviews.

DIGEST:

CSHB 3459 would prohibit a health maintenance organization (HMO) and a preferred provider benefit plan insurer that used a preauthorization process for certain health care services from requiring a physician or provider to obtain a preauthorization if specified criteria were met. The bill also would revise certain provisions relating to utilization review.

Preauthorization exemption. Under the bill, a physician or provider would not be required to obtain preauthorization for a particular health care service if, in the previous year:

- the physician or provider submitted at least five preauthorization requests for a health care service; and
- the HMO or insurer approved at least 80 percent of the physician or provider's submitted preauthorization requests.

The bill would establish that an exemption from preauthorization would last for one year.

Notice. By January 30 of every year, an HMO and insurer would have to provide to a physician or provider who qualified for a preauthorization exemption a notice, including:

- a statement that the physician or provider qualified for an exemption;
- a list of the health care services to which the exemption applied; and
- a statement that the exemption would apply only for the calendar year in which the physician or provider received the notice.

Payment of claims. The bill would prohibit an HMO and insurer from denying or reducing payment to a physician or provider for a health care service to which the physician or provider qualified for an exemption from preauthorization requirements based on medical necessity or appropriateness of care. The bill would require the HMO and insurer to promptly notify the physician or provider of this payment information.

Utilization review. The bill would specify that the physician to whom a utilization review agent was required to provide a reasonable opportunity under current law would have to be a physician licensed to practice in the state and who had the same or similar specialty as the physician who ordered, requested, or provided the health care service.

The bill would apply only to a request for preauthorization of health care services made on or after January 1, 2022.

The bill would take effect September 1, 2021, and would apply only to a utilization review requested on or after the effective date.