BILL ANALYSIS

Senate Research Center
87R16947 RDS-F

H.B. 3459
By: Bonnen (Nelson)
Finance
5/12/2021
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

There are concerns that the preauthorization and utilization review processes for health care benefit plan coverage may be burdensome to physicians and providers and may have the potential to prevent patients from receiving the care they need. H.B. 3459 seeks to address this issue by ensuring that physicians who are the most familiar with the delivery of health care in Texas are involved in utilization reviews for health benefit plan coverage. The bill also exempts certain physicians and providers from preauthorization requirements if they had at least 80 percent of their preauthorization requests approved by the insurer in the preceding calendar year.

H.B. 3459 amends current law relating to preauthorization requirements for certain medical and health care services and utilization review for certain health benefit plans.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter J, Chapter 843, Insurance Code, by adding Section 843.3484, as follows:

Sec. 843.3484. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. (a) Prohibits a health maintenance organization that uses a preauthorization process for health care services from requiring a physician or provider to obtain preauthorization for a particular health care service if, in the preceding calendar year:

(1) the physician or provider submitted not less than five preauthorization requests for the particular health care service; and

(2) the health maintenance organization approved not less than 80 percent of the preauthorization requests submitted by the physician or provider for the particular health care service.

(b) Provides that an exemption from preauthorization requirements under Subsection (a) lasts for one calendar year.

(c) Requires a health maintenance organization, not later than January 30 of each calendar year, to provide to a physician or provider who qualifies for an exemption from preauthorization requirements under Subsection (a) a notice that includes:

(1) a statement that the physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a);

(2) a list of the health care services to which the exemption applies; and

(3) a statement that the exemption applies only for the calendar year in which the physician or provider receives the notice.

(d) Requires the health maintenance organization, if a physician or provider submits a preauthorization request for a health care service for which the physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a), to promptly provide a notice to the physician or provider that includes:

(1) the information described by Subsection (c); and

(2) a notification of the health maintenance organization payment requirements described by Subsection (e).

(e) Prohibits a health maintenance organization from denying or reducing payment to a physician or provider for a health care service to which the physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a) based on medical necessity or appropriateness of care.

SECTION 2. Amends Subchapter C-1, Chapter 1301, Insurance Code, by adding Section 1301.1354, as follows:

Sec. 1301.1354. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. (a) Prohibits an insurer that uses a preauthorization process for medical care or health care services from requiring a physician or health care provider to obtain preauthorization for a particular medical or health care service if, in the preceding calendar year:

(1) the physician or health care provider submitted not less than five preauthorization requests for the particular medical or health care service; and

(2) the insurer approved not less than 80 percent of the preauthorization requests submitted by the physician or health care provider for the particular medical or health care service.

(b) Provides that an exemption from preauthorization requirements under Subsection (a) lasts for one calendar year.

(c) Requires an insurer, not later than January 30 of each calendar year, to provide to a physician or health care provider who qualifies for an exemption from preauthorization requirements under Subsection (a) a notice that includes:

(1) a statement that the physician or health care provider qualifies for an exemption from preauthorization requirements under Subsection (a);

(2) a list of the medical or health care services to which the exemption applies; and

(3) a statement that the exemption applies only for the calendar year in which the physician or health care provider receives the notice.

(d) Requires the insurer, if a physician or health care provider submits a preauthorization request for a medical or health care service for which the physician or health care provider qualifies for an exemption from preauthorization requirements under Subsection (a), to promptly provide a notice to the physician or health care provider that includes:

(1) the information described by Subsection (c); and

(2) a notification of the insurer payment requirements described by Subsection (e).

(e) Prohibits an insurer from denying or reducing payment to a physician or health care provider for a medical or health care service to which the physician or health

care provider qualifies for an exemption from preauthorization requirements under Subsection (a) based on medical necessity or appropriateness of care.

SECTION 3. Amends Section 4201.206, Insurance Code, as follows:

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Requires the agent, subject to Subsection (b) and the notice requirements of Subchapter G (Notice of Determination), before an adverse determination is issued by a utilization review agent who questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, to 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, rather than licensed to practice medicine, the patient's treatment plan and the clinical basis for the agent's determination.

(b) Provides that 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 is required to be with a physician licensed to practice medicine in this state and who has the same or similar specialty as the physician.

SECTION 4. Provides that the changes in law made by this Act 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, 2022. Provides that a request for preauthorization of medical care or health care services made before January 1, 2022, 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.

SECTION 5. Makes application of Section 4201.206, Insurance Code, as amended by this Act, prospective.

SECTION 6. Effective date: September 1, 2021.