BILL ANALYSIS

Senate Research Center

H.B. 1609
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Business & Commerce
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Engrossed

DIGEST AND PURPOSE

Under current law, there is not a system in place to allow an insured or health care provider acting on behalf of an insured to request information regarding services, treatment, or supplies that may be rendered to the insured or by the provider. This lack of information has resulted in problems concerning retrospective review and denial of claims. H.B. 1609 sets forth provisions regarding preauthorization retrospective review, and scheduled benefit reviews of medical and health care services by a health maintenance organization or a preferred provider organization.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

H.B. 1609 amends the Insurance Code to require a preferred provider organization (PPO) that uses a preauthorization process for medical and health care services (treatment) to make available to each insured, on issuance of the certificate of insurance, general information concerning the preauthorization process. The bill requires a PPO to provide each participating physician or health care provider (provider), not later than the 10th working day after the date a request is made, a list of treatments that require preauthorization and information concerning the preauthorization process (Sec. 3B, Art. 3.70-3C). The bill requires a health maintenance organization (HMO) that uses a preauthorization process for treatment to provide each insured, on issuance of the evidence of coverage, general information concerning the preauthorization process. The bill requires an HMO to provide each participating provider, not later than the 10th working day after the date a request is made, a list of treatments that do not require preauthorization and information concerning the preauthorization process (Sec. 18D Art. 20A).

If proposed treatment requires preauthorization or a request is made for preauthorization, the bill requires the HMO or PPO to determine whether the treatment to be provided to the insured is medically necessary and appropriate in a manner consistent with provisions governing health care utilization review agents. The bill requires the HMO or PPO, within the time frame for a utilization review, to review and issue a determination of medical necessity and appropriateness of the proposed treatment, including any limitation on eligibility for payment, and specify additional information as necessary. If an HMO or PPO has preauthorized treatments as medically necessary and appropriate, the bill requires the HMO or PPO to provide verification to the provider that the treatment is eligible for payment from the HMO or PPO to the provider for those services unless the provider has intentionally or negligently materially misrepresented the medical necessity or appropriateness of the proposed treatment or has substantially failed to perform the proposed treatment (Sec. 3B, Art. 3.70-3C and Sec. 18D, Art. 20A).

The bill provides that a retrospective review of medical necessity and appropriateness of treatment conducted by an HMO or PPO must comply with certain standards for a utilization review. The bill requires an HMO or PPO that makes an adverse determination based on a retrospective review of the

medical necessity and appropriateness of a treatment to notify, in a specified time period, the insured and the insured's provider of record of the determination. The bill specifies the contents of the notice of an adverse determination. The bill provides that the appeal procedure for an adverse determination must be reasonable and comply with provisions governing utilization reviews (Sec. 3C, Art. 3.70-3C and Sec. 18E, Art. 20A).

The bill requires an HMO or PPO, on written request from an insured or a provider acting on behalf of an insured, to conduct a scheduled benefit review (review). The bill establishes conditions under which a provider is considered to be acting on behalf of an insured. The bill requires an HMO or PPO to provide written notification to an insured and provider, if the provider made the request, of a determination made in the scheduled benefit review and sets forth notification requirements. The bill authorizes an HMO or PPO to delegate to its third party administrator or utilization review agent the performance of a scheduled benefit review (Sec. 9, Art. 3.70-3C and Sec. 15, Art. 20A).

The bill modifies the deadlines for notification of adverse determination by a health care utilization review agent (Sec. 5, Art. 21.58A). The bill modifies requirements for the telephone access to a utilization review agent (Sec. 7, Art. 21.58A). The bill specifies that a retrospective review of the medical necessity and appropriateness of health care services is required to comply with specified standards for health care utilization review. The bill requires authorization review agents to notify the insured or the insured's provider of record within a specified time period of an adverse determination. The bill specifies the contents of a notice of adverse determination (Sec. 11, Art. 21.58A).

The bill specifies to whom these provisions do and do not apply (Secs. 3B and 3C, Art. 3.70-3C and Secs. 18D and 18E, Art. 20A) A PPO or HMO is not required to provide a scheduled benefit review before January 1,2002 (SECTION 10).

EFFECTIVE DATE: September 1, 2001, and applies only to the preauthorization of medical or health care services and utilization review of medical and health care services occurring on or after January 1, 2002.