BILL ANALYSIS

Senate Research Center

S.B. 1742
By: Menéndez
Business & Commerce
6/20/2019
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Physicians often have to refer patients to a facility setting to seek further care of health conditions that need surgical care or laboratory analysis. In an effort to stay in-network and prevent the occurrence of a surprise bill, patients and referring physicians often review plan directories that show the network status of facility-based physicians at in-network facilities. Unfortunately, current health plan provider directories do not typically display this information in a uniform or user-friendly manner.

This legislation would require a health plan's network directory to clearly identify which radiologists, anesthesiologists, pathologists, emergency physicians, neonatologists, and assistant surgeons are in-network at network facilities. "Facility" includes: ambulatory surgery center, birthing center, hospital, and freestanding emergency center. (Original Author's/Sponsor's Statement of Intent)

S.B. 1742 amends current law 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.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

ARTICLE 1. HEALTH CARE PROVIDER DIRECTORIES

SECTION 1.01. Amends Section 1451.501, Insurance Code, by amending Subdivision (1) and adding Subdivisions (1-a) and (1-b), as follows:

(1) Defines "facility."

(1-a) Defines "facility-based physician."

(1-b) Redesignates existing Subdivision (1), defining "health care provider," as Subdivision (1-b).

SECTION 1.02. Amends Section 1451.504, Insurance Code, by amending Subsection (b) and adding Subsections (c) and (d), as follows:

(b) Requires the physician and health care provider directory to include the name, street address, specialty, if any, and telephone number of each physician and health care provider described by Subsection (a) (relating to requiring health benefit plan issuers to develop and maintain a physician and health care provider directory) and indicate whether the physician or provider is accepting new patients.

(c) Requires the directory, for each health care provider that is a facility included in the directory under this section (Physician and Health Care Provider Directories), to include certain information in a certain format.

(d) Requires the directory to list a facility-based physician individually and, if the physician belongs to a physician group, as part of the physician group.

SECTION 1.03. Amends Section 1451.505(c), Insurance Code, as follows:

(c) Requires the directory to be:

(1) electronically searchable by physician or health care provider name, specialty, if any, and location, rather than electronically searchable by physician or health care provider name and location; and

(2) makes no changes to this subdivision.

ARTICLE 2. PREAUTHORIZATION

SECTION 2.01. Amends Section 843.348(b), Insurance Code, as follows:

(b) Requires a health maintenance organization that uses a preauthorization process for health care services to provide each participating physician or provider, not later than the fifth business day, rather than the 10th business day, after the date a request is made, a list of health care services that require preauthorization and information concerning the preauthorization process, rather than a list of health care services that do not require preauthorization, and information concerning the preauthorization process.

SECTION 2.02. Amends Subchapter J, Chapter 843, Insurance Code, by adding Sections 843.3481, 843.3482, and 843.3483, as follows:

Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) Requires a health maintenance organization that uses a preauthorization process for health care services to make the requirements and information about the 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) Requires the preauthorization requirements and information described by Subsection (a) to:

(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 Subdivision (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

(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) Prohibits this section from being construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. Authorizes a health maintenance organization, to comply with a posting requirement described by Subsection (b), to, 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) Authorizes the health maintenance organization, 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), to, 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) Requires a health maintenance organization that uses a preauthorization process for health care services, except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, to 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) Requires a health maintenance organization, 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, to 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) Requires a health maintenance organization, not later than the fifth day before the date a new or amended preauthorization requirement takes effect, to update its Internet website to disclose the change to the health maintenance organization's preauthorization requirements or process and the date and time the change is effective.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. Requires a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter (Payment of Claims to Physicians and Providers) 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, in addition to any other penalty or remedy provided by law, to provide an expedited appeal under Section 4201.357 (Expedited Appeal For Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions) for any health care service affected by the violation.

SECTION 2.03. Amends Section 1301.135(a), Insurance Code, to make conforming and nonsubstantive changes.

SECTION 2.04. Amends Subchapter C-1, Chapter 1301, Insurance Code, by adding Sections 1301.1351, 1301.1352, and 1301.1353, as follows:

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) Requires an insurer that uses a preauthorization process for medical care or health care services to 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) Requires the preauthorization requirements and information described by Subsection (a) to:

(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 Subdivision (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

(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) Prohibits this section from being construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. Authorizes an insurer, to comply with a posting requirement described by Subsection (b), to, instead of making that information publicly available on the insurer's Internet website, supply 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) Authorizes the insurer, 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), to, 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) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Requires an insurer that uses a preauthorization process for medical care or health care services, except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, to 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) Requires an insurer, for a change in a preauthorization requirement or process that removes a service from the list of medical care 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, to 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) Requires an insurer, not later than the fifth day before the date a new or amended preauthorization requirement takes effect, to 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) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) Requires 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, in addition to any other penalty or remedy provided by law, to provide an expedited appeal under Section 4201.357 for any medical care or health care service affected by the violation.

(b) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

ARTICLE 3. UTILIZATION, INDEPENDENT, AND PEER REVIEW

SECTION 3.01. Amends Section 4201.002(12), Insurance Code, to redefine "provider of record."

SECTION 3.02. Amends Sections 4201.151 and 4201.152, Insurance Code, as follows:

Sec. 4201.151. UTILIZATION REVIEW PLAN. Requires a utilization review agent's utilization review plan, including reconsideration and appeal requirements, to be reviewed by a physician licensed to practice medicine in this state, rather than a physician, and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician licensed to practice medicine in this state, rather than a physician.

Sec. 4201.152. New heading: UTILIZATION REVIEW UNDER PHYSICIAN. Requires a utilization review agent to conduct utilization review under the direction of a physician licensed to practice medicine in this state, rather than licensed to practice medicine in this by a state licensing agency in the United States.

SECTION 3.03. Amends Sections 4201.155, 4201.206, and 4201.251, Insurance Code, as follows:

Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW PROCEDURES. (a) Creates this subsection from existing text and makes no further changes.

(b) Prohibits this section from being construed to release a health insurance policy or health benefit plan from full compliance with this chapter (Utilization Review Agents) or other applicable law.

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Creates this subsection from existing text. Requires a utilization review agent who questions the medical necessity, the appropriateness, or the

experimental or investigational nature of a health care service, subject to Subsection (b) and the notice requirements of Subchapter G (Notice of Determinations), before an adverse determination is issued by the agent, to provide the health care provider who ordered, requested, provided, or is to provide the served 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, rather than requiring a utilization review agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, subject to the notice requirements of Subchapter G, before an adverse determination is issued by the agent, to provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the agent's determination.

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

Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. Provides that delegation by a utilization review agent under this section does not release the agent from the full responsibility for compliance with this chapter or other applicable law, including the conduct of those to whom utilization review has been delegated.

SECTION 3.04. Amends Sections 4201.252(a) and (b), Insurance Code, as follows:

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

(b) Requires personnel, other than a physician licensed to practice medicine, rather than a physician, 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 to be a nurse, physician assistant, or other health care provider qualified to provide the requested service.

SECTION 3.05. Amends Section 4201.356, Insurance Code, as follows:

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

(b) Requires 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, if not later than the 10th working day after the date an appeal is requested or denied the enrollee's health care provider requests a particular type of specialty provider review the case, rather than if not later than the 10th working day after the date an appeal is denied the enrollee's health care provider requests states in writing good cause for having a particular type of specialty provider review the case, to review the denial or the decision denying the appeal, rather than review the decision denying the appeal.

SECTION 3.06. Amends Section 4201.357(a), Insurance Code, as follows:

(a) Requires the procedures for appealing an adverse determination to include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient, rather than for an expedited appeal of a denial of emergency care or a denial of continued hospitalization.

SECTION 3.07. Amends Sections 4201.453 and 4201.454, Insurance Code, as follows:

Sec. 4201.453. UTILIZATION REVIEW PLAN. Creates Subdivision (1)–(2) from existing text. Requires a specialty utilization review agent's utilization review plan, including reconsideration and appeal requirements, to 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. Makes a conforming change to this section.

SECTION 3.08. Amends Section 4201.455(a), Insurance Code, as follows:

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

SECTION 3.09. Amends Section 4201.456, Insurance Code to make conforming changes.

SECTION 3.10. Amends Section 408.0043, Labor Code, by adding Subsection (c), as follows:

(c) Requires a person described by Subsection (a)(1), (2), or (3), (relating to doctors performing certain reviews) who reviews the service with respect to a specific workers' compensation case, notwithstanding Subsection (b) (relating to requiring a reviewer to hold appropriate certifications), if a health care service is requested, ordered, provided, or to be provided by a physician, to be of the same or a similar specialty as that physician.

SECTION 3.11. Amends Section 1305.351(d), Insurance Code, as follows:

(d) Authorizes a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter (Workers' Compensation Health Care Networks), including utilization review, or peer reviews under Section 408.0231(g) (relating to requiring the commissioner of insurance to adopt rules regarding doctors who perform peer review functions for insurance carriers), Labor Code, to only use doctors licensed to practice in this state, rather than authorizing, notwithstanding Section 4201.152 (Utilization Review Under Direction of Physician), 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, to only use doctors licensed to practice in this state.

SECTION 3.12. Amends Section 1305.355(d), Insurance Code, as follows:

(d) Authorizes an independent review organization that uses doctors to perform reviews of health care services under this chapter, rather than authorizing, notwithstanding Section 4202.002 (Adoption of Standards For Independent Review Organizations), an independent review organization that uses doctors to perform reviews of health care services under this chapter, to only use doctors licensed to practice in this state.

SECTION 3.13. Amends Section 408.023(h), Labor Code, as follows:

(h) Authorizes a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this subtitle (Texas Workers' Compensation Act), including utilization review, rather than authorizing, 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, to only use doctors licensed to practice in this state.

SECTION 3.14. Amends Section 413.031(e-2), Labor Code, as follows:

(e-2) Authorizes an independent review organization that uses doctors to perform reviews of health care services provided under this title (Workers' Compensation), rather than authorizing, notwithstanding Section 4202.002, Insurance Code, an independent review organization that uses doctors to perform reviews of health care services provided under this title, to only use doctors licensed to practice in this state.

ARTICLE 4. JOINT INTERIM STUDY

SECTION 4.01. CREATION OF JOINT INTERIM COMMITTEE. (a) Provides that 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) Requires the joint interim committee to 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) Requires the lieutenant governor and speaker of the house of representatives to each designate a co-chair from among the joint interim committee members.

(d) Requires the joint interim committee to convene at the joint call of the co-chairs.

(e) Provides that 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 (Legislative Reorganization Act), Chapter 301, Government Code, and by policies of the senate and house committees on administration.

SECTION 4.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. (a) Requires the joint interim committee created by Section 4.01 of this article to 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) Requires the joint interim committee to 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) Requires the joint interim committee to prepare a report of the findings and proposed reforms.

SECTION 4.03. COMMITTEE FINDINGS AND PROPOSED REFORMS. (a) Requires the joint interim committee created under Section 4.01 of this article, not later than December 1, 2020, to 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. Requires the joint interim committee to include in its report recommendations of specific statutory and regulatory changes that appear necessary from the committee's study under Section 4.02 of this article.

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

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

ARTICLE 5. TRANSITIONS; EFFECTIVE DATE

SECTION 5.01. Requires a health benefit plan issuer to update the issuer's website to conform with Subchapter K (Health Care Provider Directories), Chapter 1451, Insurance Code, as amended by Article 1 of this Act, not later than January 1, 2020.

SECTION 5.02. Makes application of the changes in law made by Article 2 of this Act with respect to a request for preauthorization of medical care or health care service prospective to January 1, 2020.

SECTION 5.03. Makes application of the changes in law made by Article 3 of this Act, prospective with respect to requests for utilization, independent, or peer review prospective.

SECTION 5.04. Effective date: September 1, 2019.