BILL ANALYSIS

C.S.H.B. 3990
By: Raymond
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Informed observers contend that requiring healthcare providers to use clinical decision support software before ordering lab tests is unnecessarily burdensome because it may increase the time a provider spends at the computer and decrease the time a provider spends with patients. Informed observers also note that the required use of a laboratory benefits management program could present business competition issues. C.S.H.B. 3990 seeks to address this issue by prohibiting a managed care plan issuer from requiring the use of such software or a laboratory benefits management program in relation to ordering clinical laboratory services for a plan enrollee.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3990 amends the Insurance Code to prohibit a managed care plan issuer from requiring the use of clinical decision support software or a laboratory benefits management program that dictates, directs, or limits decision making of a physician or health care provider who is authorized to order clinical laboratory services by an enrollee's physician or health care provider before, at the time, or after the physician or health care provider orders a clinical laboratory service for the enrollee. The bill prohibits a managed care plan issuer from limiting, reducing, or denying payment of a claim for a clinical laboratory service based on whether the ordering physician or health care provider uses or fails to use clinical decision support software or a laboratory benefits management program. The bill expressly provides that these provisions do not prohibit a managed care plan issuer from requiring a prior authorization for clinical laboratory services provided that the managed care plan issuer imposes the requirement uniformly to all laboratories providing clinical laboratory services in the managed care plan's provider network. The bill applies to a person with whom a managed care plan issuer contracts to manage or administer laboratory benefits, process or pay claims, obtain the services of physicians or other providers to provide health care services to enrollees, or issue verifications or preauthorizations.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 3990 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Chapter 1451, Insurance Code, is amended by adding Subchapter M to read as follows: SUBCHAPTER M. CLINICAL LABORATORIES	SECTION 1. Chapter 1451, Insurance Code, is amended by adding Subchapter M to read as follows: SUBCHAPTER M. CLINICAL LABORATORIES
Sec. 1451.601. DEFINITIONS.	Sec. 1451.601. DEFINITIONS
Sec. 1451.602. CERTAIN REQUIREMENTS FOR USE OF CLINICAL LABORATORIES AND LABORATORY SERVICES PROHIBITED. (a) A managed care plan issuer may not by contract or otherwise require the use of clinical decision support software or a laboratory benefits management program by an enrollee's physician or health care provider before, at the time, or after the physician or health care provider orders a clinical laboratory service for the enrollee.	Sec. 1451.602. CERTAIN REQUIREMENTS FOR USE OF CLINICAL LABORATORIES AND LABORATORY SERVICES PROHIBITED. (a) A managed care plan issuer may not require the use of clinical decision support software or a laboratory benefits management program by an enrollee's physician or health care provider before, at the time, or after the physician or health care provider orders a clinical laboratory service for the enrollee.
(b) A managed care plan issuer may not by contract or otherwise direct or limit an enrollee's physician or health care provider in the physician's or provider's clinical decision making relating to the use of a clinical laboratory service or the referral of a patient specimen to a clinical laboratory.	
(c) A managed care plan issuer may not by contract or otherwise require, steer, encourage, or otherwise direct an enrollee's physician or health care provider to refer a patient specimen to a particular clinical laboratory in the managed care plan network designated by the managed care plan issuer other than the clinical laboratory in the network selected by the physician or health care provider.	
(d) A managed care plan issuer may not by contract or otherwise limit or deny payment of a claim for a clinical laboratory service based on whether the ordering physician or health care provider uses or fails to use clinical decision support software or a laboratory benefits management program.	(b) A managed care plan issuer may not limit, reduce, or deny payment of a claim for a clinical laboratory service based on whether the ordering physician or health care provider uses or fails to use clinical decision support software or a laboratory benefits management program.
(e) Nothing in this section prohibits a managed care plan issuer from requiring a	(c) Nothing in this section prohibits a managed care plan issuer from requiring a

prior authorization for clinical laboratory services provided that the managed care plan issuer imposes the requirement uniformly to all laboratories providing clinical laboratory services in the managed care plan's provider network.	prior authorization for clinical laboratory services provided that the managed care plan issuer imposes the requirement uniformly to all laboratories providing clinical laboratory services in the managed care plan's provider network.
Sec. 1451.603. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH MANAGED CARE PLAN ISSUER.	Sec. 1451.603. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH MANAGED CARE PLAN ISSUER.
SECTION 2. Subchapter M, Chapter 1451, Insurance Code, as added by this Act, applies only to a contract between a managed care plan and a physician or provider that is entered into or renewed on or after the effective date of this Act. A contract entered into or renewed 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.	SECTION 2. Same as introduced version.
SECTION 3. This Act takes effect September 1, 2017.	SECTION 3. Same as introduced version.