SUBJECT: Requiring certain health insurance plans to post preauthorization criteria

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Lucio, Oliverson, S. Davis, Julie Johnson, Lambert, C. Turner, Vo

0 nays

2 absent — G. Bonnen, Paul

WITNESSES: For — Krista Armstrong, Advanced Orthopedics and Sports Medicine; Doug Curran, Texas Medical Association; (*Registered, but did not testify*: Duane Galligher, Association of Substance Abuse Programs; Chase Bearden, Coalition of Texans with Disabilities; Jeffery Addicks, Hospitality Health ER; James Mathis, Houston Methodist Hospital; Marshall Kenderdine, Texas Academy of Family Physicians, Texas Society for Gastroenterology and Endoscopy; Courtney Hoffman, Texas Association for Behavior Analysis PPG; Price Ashley, Texas College of Emergency Physicians; Cameron Duncan, Texas Hospital Association; Bobby Hillert, Texas Orthopaedic Association; Michael Grimes, Texas Radiological Society; Bonnie Bruce, Texas Society of Anesthesiologists; Jenna Courtney, Texas Society of Pathologists; John Henderson, Texas Organization of Rural and Community Hospitals)

Against — Karen Hill, Texas Association of Health Plans, Texas Association of Community Health Plans, Community Health Choice; (*Registered, but did not testify*: Billy Phenix, America's Health Insurance Plans; Jamie Dudensing, Texas Association of Health Plans)

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

BACKGROUND: Insurance Code sec. 843.348(b) requires a health maintenance organization that uses a preauthorization process for health care services to provide each participating physician or provider with a list of health

care services that do not require preauthorization and information about the preauthorization process within 10 business days of a request.

Sec. 1301.135(a) requires an insurer that uses a preauthorization process for medical care and health care services to provide each preferred provider with a list of medical and health care services that require preauthorization and information regarding the preauthorization process within 10 business days after a request was made.

DIGEST:

CSHB 2327 would require health maintenance organizations (HMOs) and insurers that used a preauthorization process for health care services to provide a list of health care services that required preauthorization to participating physicians or providers within five business days of a request.

Posting requirements. The bill would require HMOs and insurers to post information about and requirements for the preauthorization process on their websites. A posting would have to:

- be posted in a conspicuous location that was easily searchable and accessible to enrollees, insureds, physicians, providers, and the public;
- be written in plain language; and
- include a detailed description of the preauthorization process.

The posting also would have to include an accurate and current list of services for which the HMO or insurer required preauthorization that included the following information for each service:

- the preauthorization requirement's effective date;
- the list of supporting documentation the HMO or insurer required from the physician or provider to approve a request;
- the applicable screening criteria using certain billing codes; and
- certain statistics regarding the HMO or insurer's preauthorization approval and denial rates.

Preauthorization requirement changes. The bill would require an HMO or insurer to provide written notice of any new or amended preauthorization requirement to each participating physician or provider no later than 60 days before the change took effect.

For any changes to the preauthorization requirement or process that removed a service from the list of health care services requiring preauthorization or that amended a preauthorization requirement in a way that was less burdensome to enrollees or insureds, participating physicians, and providers, an HMO or insurer would have to provide each participating physician or provider with written notice of the change by the fifth day before the change took effect.

By the fifth day before a change to a preauthorization requirement was to take effect, an HMO or insurer would be required to disclose the change on its website, along with the date and time the change would be effective.

Noncompliance and preauthorization waiver. Under the bill, an HMO or insurer that violated the required posting or notice provisions would waive its preauthorization requirements with respect to any health care service affected by the violation.

A waiver of preauthorization requirements could not be construed to:

- authorize a physician or provider to provide services outside the scope of the provider's applicable license; or
- require an HMO or insurer to pay for a service provided outside the scope of a health provider's applicable license.

Other provisions. The bill would prohibit its provisions regarding an insurer from being waived, voided, or nullified by contract.

The bill would take effect September 1, 2019, and would apply only to a request for preauthorization of medical care or health care services made under a health benefit plan delivered, issued, or renewed on or after January 1, 2020.

SUPPORTERS SAY:

CSHB 2327 would provide clarity to health providers and patients about a health maintenance organization (HMO) or insurer's preauthorization requirements, which would increase patients' access to needed health care.

Health insurance plans increasingly require preauthorizations for standard health care services, which can lead to patient abandonment and delay patient care. Preauthorizations burden patients and physicians and can prevent Texans from accessing the health care they need. Information about preauthorization standards is often unavailable or unclear, further burdening providers and patients.

By requiring health plans to post detailed preauthorization criteria on their website and issue information about the process and criteria to health care providers and physicians, the bill would help physicians, providers, and patients better understand an often complicated process. The bill would enhance transparency, improve access to essential services, and increase efficiency.

OPPONENTS SAY:

CSHB 2327 would establish overly punitive sanctions for health plans that did not comply with certain posting requirements. Waiving a health plan's entire preauthorization criteria if it violated the posting requirements created by the bill could endanger patient safety. The preauthorization process is designed to ensure patients receive the best health care possible, prevent inappropriate tests ordered by physicians, and reduce health care costs. The bill should create administrative penalties that more closely align with a health plan's violation instead of waiving preauthorization requirements altogether.

Requiring health plans to post extensive preauthorization criteria also would be burdensome because health plans would have to purchase that data through third party vendors, which could increase administrative costs.