SUBJECT: Requiring state-licensed health providers to conduct utilization reviews

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 — Carrie De Moor, Code 3 Emergency Partners; Doug Curran, Texas Medical Association; (*Registered, but did not testify*: Krista Armstrong, Advanced Orthopaedics and Sports Medicine; Duane Galligher, Association of Substance Abuse Programs; James Mathis, Houston Methodist Hospital; Simone Nichols-Segers, National MS Society; Marshall Kenderdine, Texas Academy of Family Physicians, Texas Society for Gastroenterology and Endoscopy; Bradford Shields, Texas Association of Freestanding Emergency Centers; 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, Community Health Choice, Texas Association of Community Health Plans, and Texas Association of Health Plans; (*Registered, but did not testify*: Billy Phenix, America's Health Insurance Plans; Bill Kelly, City of Houston Mayor’s Office; Jamie Dudensing, Texas Association of Health Plans)

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

BACKGROUND: Insurance Code sec. 4201.002 defines utilization review as a system for prospective, concurrent, or retrospective review of medical necessity and

appropriateness of health care services and a determination of the experimental or investigational nature of those services. The term excludes a review in response to an elective request for clarification of coverage. A utilization review agent is an entity that conducts utilization review for:

- an employer with employees in this state who are covered under a health benefit plan or health insurance policy;
- a payor, which means a preferred provider organization, health maintenance organization, self-insurance plan, or certain persons or entities that provide health benefits; or
- a third-party administrator holding a certificate of authority.

Sec. 4201.151 requires an agent's utilization review plan, including reconsideration and appeal requirements, to be reviewed by a physician and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician. Sec. 4201.152 requires a utilization review agent to conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

Sec. 4201.153 requires a utilization review agent to use written medically acceptable screening criteria to determine whether to approve the requested treatment. A denial of requested treatment must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Sec. 4202.002 requires the commissioner of the Texas Department of Insurance to adopt certain standards and rules for independent review organizations.

Occupations Code ch. 151 establishes the Medical Practice Act for physicians.

DIGEST:

CSHB 2387 would require physicians and certain specialty health providers licensed in Texas to conduct utilization, independent, and peer

reviews, discuss treatment before an adverse determination was made, and appeal certain decisions. The bill would make other conforming changes regarding these requirements.

Definitions. The bill would define "utilization review agent" under Occupations Code ch. 151 as:

- an entity that conducted utilization review under Insurance Code ch. 4201;
- a payor that conducted utilization review on the payor's own behalf or on behalf of another person or entity;
- a certified independent review organization; or
- a certified worker's compensation health care network.

The definition of "utilization review" would include a review of a step therapy protocol exception request for certain prescription drugs, devices, and benefits. The bill also would define "adverse determination" as a determination that health care services proposed, requested, or ordered to be provided to an individual in this state by a physician were not medically necessary or were experimental or investigational.

Application of utilization review. Under the bill, a person would be considered to be practicing medicine and subject to appropriate regulation by the Texas Medical Board, if they:

- made on behalf of or directed a utilization review agent to make certain adverse determinations as specified in the bill;
- served as a medical director of a certified independent review organization;
- reviewed or approved a utilization review plan;
- supervised and directed utilization review; or
- discussed a patient's treatment plan and the clinical basis for an adverse determination before such determination was issued.

A denial of health care services based on the failure to request prospective or concurrent review would not be considered an adverse determination.

Utilization review by physician. The bill would require a utilization review agent, including a payor, that used a physician to conduct utilization review to only use a physician licensed to practice medicine in Texas.

Utilization review screening criteria. Before issuing an adverse determination, the bill would require a utilization review agent to obtain a determination of medical necessity by referring a proposed denial of requested treatment to a Texas-licensed physician who was of the same or similar specialty as the physician who requested, ordered, or provided that treatment.

Independent review organizations. The bill would require the commissioner of insurance's adopted standards for independent review organizations to:

- ensure personnel conducting independent review for a health care service were licensed or otherwise authorized to provide the same or a similar service in Texas; and
- be consistent with the state's licensing laws.

The bill would take effect September 1, 2019, and would apply to utilization, independent, or peer review that was requested on or after that date.

SUPPORTERS SAY:

By requiring utilization reviewers to be licensed and supervised by physicians licensed in Texas, CSHB 2387 would ensure health providers who were most familiar and qualified with this state's delivery of health care were involved in utilization reviews for health benefit plan coverage. Reviewers who grant or deny services for coverage are making medical judgments and should be subject to the same requirements of any other physician practicing medicine in Texas.

Although using out-of-state practitioners for utilization reviews may produce cost savings for health plans, the process has become ineffective

and burdensome to health providers, ultimately denying many Texans essential health services.

OPPONENTS SAY:

By requiring health insurance plans to only use Texas-licensed physicians in utilization reviews, CSHB 2387 would limit a health plan's ability to leverage out-of-state resources, like practitioners in specialty areas in which Texas has shortages. Health plans and utilization review agents generally use Texas-licensed physicians for initial reviews and appeals but may need to contract with out-of-state physicians for certain specialty reviews. Removing these specialty review opportunities with out-of-state practitioners could create substantial indirect costs for patients. The bill also would be unnecessary because current law already provides extensive patient protection requirements in the utilization review management process.