BILL ANALYSIS

Senate Research Center

S.B. 384
By: Nelson
Economic Development
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As Filed

DIGEST

Currently, utilization review (UR) agents are licensed and regulated under the Insurance Code. UR is a system for prospective or concurrent review to determine the medical necessity and appropriateness of health care services provided to an individual. Standards and complaint and appeals processes do not apply to all regulated health care entities or agents performing UR functions. This bill provides uniform requirements for all health care entities performing UR; provisions for patient access to their confidential medical records; and standards for specialty agents who conduct UR for specialty health care services such as dentistry, chiropractic, or physical therapy.

PURPOSE

As proposed, S.B. 384 expands the utilization review (UR) process by providing uniform requirements for health care agencies performing UR and places the UR process under the purview of the commissioner of insurance. Also, this bill provides access to certain confidential medical records for patients and establishes standards for specialty agents who conduct UR for certain health care services.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the commissioner of insurance in SECTION 9 (Section 13, Article 21.58A, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 2, Article 21.58A, Insurance Code, to redefine "administrative procedure act," "certificate," "emergency care," "open meetings law," and "open records law." Deletes definition of "board." Makes conforming changes.

SECTION 2. Amends Sections 3(b), (d), (e), and (f), Article 21.58A, Insurance Code, to authorize the commissioner of insurance (commissioner) to only issue a certificate to an applicant who has met the applicable requirements of this article and rules of the commissioner rather than the State Board of Insurance (board). Makes conforming changes.

SECTION 3. Amends Sections 4(c), (h), (i), (k), (m), and (n), Article 21.58A, Insurance Code, to require personnel obtaining information directly from health care providers who are not a physicians to be licensed or certified nurses or physician assistants. Deletes a requirement for personnel to have received formal orientation and training. Requires utilization review to be conducted under the direction of a physician licensed to practice medicine in the State of Texas, rather than by a state licensing agency in the United States. Sets forth requirements for utilization review decisions and screening criteria used by utilization review agents (agent). Deletes a provision requiring the health care provider to discuss the treatment plan with a dentist. Requires an agent to maintain a complaint system providing procedures for the resolution of oral or written complaints and to maintain records for three years, rather than two. Requires the complaint procedure to include a response within 30 days, rather than 60. Prohibits a delegation from relieving the agent of full responsibility for compliance with this article, including the conduct of those to whom utilization review has been delegated. Makes conforming changes.

SECTION 4. Amends Sections 5(c) and (d), Article 21.58A, Insurance Code, to require the clinical

basis for the adverse determination and a description of the procedure for the complaint and appeal process to be included in the notification by the agent. Sets forth requirements for the notification of adverse determinations by the agent. Makes conforming changes.

SECTION 5. Amends Section 6, Article 21.58A, Insurance Code, to set forth new procedures for appeals. Makes conforming changes.

SECTION 6. Amends Section 7, Article 21.58A, Insurance Code, by adding Subsection (c), to require an agent to provide a written description to the commissioner that establishes procedures to be used when responding to poststabilization care subsequent to emergency treatment requested by a treating physician or health care provider.

SECTION 7. Amends Section 8, Article 21.58A, Insurance Code, to prohibit personal information from being disclosed by an agent. Sets forth requirements for an authorization if it is submitted by anyone other than the individual who is the subject of the personal or confidential information requested. Sets forth requirements for submitting requests for information about patients to an agent. Makes conforming changes.

SECTION 8. Amends Sections 9(a), (b), and (d), Article 21.58A, Insurance Code, to require the commissioner to notify the health maintenance organization or insurer of the alleged violations if the commissioner believes any person or entity conducting utilization review is in violation of this article. Authorizes the commissioner to assess administrative penalties under Article 1.10E of this code if an HMO or insurer has violated any provision of this article. Makes conforming changes.

SECTION 9. Amends Section 13, Article 21.58A, Insurance Code, to authorize the commissioner to adopt rules to implement this article. Requires the commissioner to appoint an advisory committee to advise the commissioner in developing rules to administer this article as authorized by Section 2001.031, Government Code. Makes conforming changes.

SECTION 10. Amends Section 14, Article 21.58A, Insurance Code, by amending Subsections (e), (g), and (h) and adding Subsection (j), to set forth exemptions of and requirements for a specialty agent, and establishes policies to which a specialty agent is required to comply. Deletes provisions for which the board is required to establish and maintain a system. Makes conforming changes.

SECTION 11. Effective date: September 1, 1997.

SECTION 12. Emergency clause.