BILL ANALYSIS

Senate Research Center

H.B. 3041
By: Turner, Chris; Kacal (Buckingham)
Business & Commerce
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

H.B. 3041 amends current law relating to the renewal of a preauthorization for a medical or health care service.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle A, Title 8, Insurance Code, by adding Chapter 1222, as follows:

CHAPTER 1222. PREAUTHORIZATION FOR MEDICAL OR HEALTH CARE SERVICE

Sec. 1222.0001. DEFINITIONS. Defines "health benefit plan," "health benefit plan issuer," and "preauthorization."

Sec. 1222.0002. APPLICABILITY OF CHAPTER. (a) Provides that this chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations);

(3) a health maintenance organization operating under Chapter 843 (Health Maintenance Organization);

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporation);

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements);

(6) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

(7) a fraternal benefit society operating under Chapter 885 (Fraternal Benefit Societies);

(8) a Lloyd's plan operating under Chapter 941 (Lloyd's Plan); or

(9) an exchange operating under Chapter 942 (Reciprocal and

Interinsurance Exchanges).

(b) Provides that, notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501 (Health Insurance Portability and Availability Act), including coverage provided through a health group cooperative under Subchapter B (Coalitions and Cooperatives) of that chapter;

(2) a standard health benefit plan issued under Chapter 1507 (Consumer Choice of Benefits Plans);

(3) a basic coverage plan under Chapter 1551 (Texas Employees Group Benefits Act);

(4) a basic plan under Chapter 1575 (Texas Public School Employees Group Benefits Program);

(5) a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage);

(6) a plan providing basic coverage under Chapter 1601 (Uniform Insurance Benefits Act For Employees of The University of Texas System and The Texas A&M University System);

(7) health benefits provided by or through a church benefits board under Subchapter I (Church Benefit Boards), Chapter 22 (Nonprofit Corporations), Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004 (Group Health Benefits For School Employees), Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533 (Medicare Managed Care Program), Government Code;

(10) the child health plan program under Chapter 62 (Child Health Plan For Certain Low-Income Children), Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104 (Health Care Services), Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91 (Professional Employer Organizations), Labor Code.

Sec. 1222.0003. PREAUTHORIZATION RENEWAL REQUEST. Requires a health benefit plan issuer that requires preauthorization as a condition of payment for a medical or health care service to provide a preauthorization renewal process that allows a renewal of an existing preauthorization to be requested by a physician or health care provider at least 60 days before the date the preauthorization expires.

Sec. 1222.0004. DETERMINATION REQUIRED. Requires a health benefit plan issuer, if the health benefit plan issuer receives a preauthorization renewal request before the existing preauthorization expires, to, if practicable, review the request and issue a determination indicating whether the medical or health care service is preauthorized before the existing preauthorization expires.

SECTION 2. Makes application of this Act prospective to January 1, 2020.

SECTION 3. Effective date: September 1, 2019.