

1-1 By: Bonnen of Galveston, Guillen H.B. No. 2327
 1-2 (Senate Sponsor - Buckingham, Schwertner)
 1-3 (In the Senate - Received from the House April 24, 2019;
 1-4 April 25, 2019, read first time and referred to Committee on
 1-5 Business & Commerce; May 20, 2019, reported adversely, with
 1-6 favorable Committee Substitute by the following vote: Yeas 9,
 1-7 Nays 0; May 20, 2019, sent to printer.)

1-8 COMMITTEE VOTE

	Yea	Nay	Absent	PNV
1-9				
1-10	X			
1-11	X			
1-12	X			
1-13	X			
1-14	X			
1-15	X			
1-16	X			
1-17	X			
1-18	X			

1-19 COMMITTEE SUBSTITUTE FOR H.B. No. 2327 By: Nichols

1-20 A BILL TO BE ENTITLED
 1-21 AN ACT

1-22 relating to preauthorization of certain medical care and health
 1-23 care services by certain health benefit plan issuers and to the
 1-24 regulation of utilization review, independent review, and peer
 1-25 review for health benefit plan and workers' compensation coverage.

1-26 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-27 ARTICLE 1. PREAUTHORIZATION

1-28 SECTION 1.01. Section 843.348(b), Insurance Code, is
 1-29 amended to read as follows:

1-30 (b) A health maintenance organization that uses a
 1-31 preauthorization process for health care services shall provide
 1-32 each participating physician or provider, not later than the fifth
 1-33 [~~10th~~] business day after the date a request is made, a list of
 1-34 health care services that [~~do not~~] require preauthorization and
 1-35 information concerning the preauthorization process.

1-36 SECTION 1.02. Subchapter J, Chapter 843, Insurance Code, is
 1-37 amended by adding Sections 843.3481, 843.3482, and 843.3483 to read
 1-38 as follows:

1-39 Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

1-40 (a) A health maintenance organization that uses a
 1-41 preauthorization process for health care services shall make the
 1-42 requirements and information about the preauthorization process
 1-43 readily accessible to enrollees, physicians, providers, and the
 1-44 general public by posting the requirements and information on the
 1-45 health maintenance organization's Internet website.

1-46 (b) The preauthorization requirements and information
 1-47 described by Subsection (a) must:

1-48 (1) be posted:

1-49 (A) except as provided by Subsection (c) or (d),
 1-50 conspicuously in a location on the Internet website that does not
 1-51 require the use of a log-in or other input of personal information
 1-52 to view the information; and

1-53 (B) in a format that is easily searchable and
 1-54 accessible;

1-55 (2) except for the screening criteria under Paragraph
 1-56 (4)(C), be written in plain language that is easily understandable
 1-57 by enrollees, physicians, providers, and the general public;

1-58 (3) include a detailed description of the
 1-59 preauthorization process and procedure; and

1-60 (4) include an accurate and current list of the health

2-1 care services for which the health maintenance organization
2-2 requires preauthorization that includes the following information
2-3 specific to each service:

2-4 (A) the effective date of the preauthorization
2-5 requirement;

2-6 (B) a list or description of any supporting
2-7 documentation that the health maintenance organization requires
2-8 from the physician or provider ordering or requesting the service
2-9 to approve a request for that service;

2-10 (C) the applicable screening criteria, which may
2-11 include Current Procedural Terminology codes and International
2-12 Classification of Diseases codes; and

2-13 (D) statistics regarding preauthorization
2-14 approval and denial rates for the service in the preceding year,
2-15 including statistics in the following categories:

2-16 (i) physician or provider type and
2-17 specialty, if any;

2-18 (ii) indication offered;

2-19 (iii) reasons for request denial;

2-20 (iv) denials overturned on appeal; and

2-21 (v) total annual preauthorization
2-22 requests, approvals, and denials for the service.

2-23 (c) This section may not be construed to require a health
2-24 maintenance organization to provide specific information that
2-25 would violate any applicable copyright law or licensing agreement.
2-26 A health maintenance organization is required to supply, in lieu of
2-27 any information withheld on the basis of copyright law or a
2-28 licensing agreement, a summary of the withheld information
2-29 sufficient to allow a licensed physician or provider, as applicable
2-30 for the specific service, who has sufficient training and
2-31 experience related to the service to understand the basis for the
2-32 health maintenance organization's medical necessity or
2-33 appropriateness determinations.

2-34 (d) If a requirement or information described by Subsection
2-35 (a) is licensed, proprietary, or copyrighted material that the
2-36 health maintenance organization has received from a third party
2-37 with which the health maintenance organization has contracted, the
2-38 health maintenance organization may, instead of making that
2-39 information publicly available on the health maintenance
2-40 organization's Internet website, provide the material to a
2-41 physician or provider who submits a preauthorization request using
2-42 a nonpublic secured Internet website link or other protected,
2-43 nonpublic electronic means.

2-44 Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

2-45 (a) Except as provided by Subsection (b), not later than the 60th
2-46 day before the date a new or amended preauthorization requirement
2-47 takes effect, a health maintenance organization that uses a
2-48 preauthorization process for health care services shall provide
2-49 notice of the new or amended preauthorization requirement in the
2-50 health maintenance organization's newsletter or network bulletin,
2-51 if any, and on the health maintenance organization's Internet
2-52 website.

2-53 (b) For a change in a preauthorization requirement or
2-54 process that removes a service from the list of health care services
2-55 requiring preauthorization or amends a preauthorization
2-56 requirement in a way that is less burdensome to enrollees or
2-57 participating physicians or providers, a health maintenance
2-58 organization shall provide notice of the change in the
2-59 preauthorization requirement in the health maintenance
2-60 organization's newsletter or network bulletin, if any, and on the
2-61 health maintenance organization's Internet website not later than
2-62 the fifth day before the date the change takes effect.

2-63 (c) Not later than the fifth day before the date a new or
2-64 amended preauthorization requirement takes effect, a health
2-65 maintenance organization shall update its Internet website to
2-66 disclose the change to the health maintenance organization's
2-67 preauthorization requirements or process and the date and time the
2-68 change is effective.

2-69 Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to

3-1 any other penalty or remedy provided by law, a health maintenance
3-2 organization that uses a preauthorization process for health care
3-3 services that violates this subchapter with respect to a required
3-4 publication, notice, or response regarding its preauthorization
3-5 requirements, including by failing to comply with any applicable
3-6 deadline for the publication, notice, or response, must provide an
3-7 expedited appeal under Section 4201.357 for any health care service
3-8 affected by the violation.

3-9 SECTION 1.03. Section 1301.135(a), Insurance Code, is
3-10 amended to read as follows:

3-11 (a) An insurer that uses a preauthorization process for
3-12 medical care or ~~and~~ health care services shall provide to each
3-13 preferred provider, not later than the fifth ~~10th~~ business day
3-14 after the date a request is made, a list of medical care and health
3-15 care services that require preauthorization and information
3-16 concerning the preauthorization process.

3-17 SECTION 1.04. Subchapter C-1, Chapter 1301, Insurance Code,
3-18 is amended by adding Sections 1301.1351, 1301.1352, and 1301.1353
3-19 to read as follows:

3-20 Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS.

3-21 (a) An insurer that uses a preauthorization process for medical
3-22 care or health care services shall make the requirements and
3-23 information about the preauthorization process readily accessible
3-24 to insureds, physicians, health care providers, and the general
3-25 public by posting the requirements and information on the insurer's
3-26 Internet website.

3-27 (b) The preauthorization requirements and information
3-28 described by Subsection (a) must:

3-29 (1) be posted:

3-30 (A) except as provided by Subsection (c) or (d),
3-31 conspicuously in a location on the Internet website that does not
3-32 require the use of a log-in or other input of personal information
3-33 to view the information; and

3-34 (B) in a format that is easily searchable and
3-35 accessible;

3-36 (2) except for the screening criteria under Paragraph
3-37 (4)(C), be written in plain language that is easily understandable
3-38 by insureds, physicians, health care providers, and the general
3-39 public;

3-40 (3) include a detailed description of the
3-41 preauthorization process and procedure; and

3-42 (4) include an accurate and current list of medical
3-43 care and health care services for which the insurer requires
3-44 preauthorization that includes the following information specific
3-45 to each service:

3-46 (A) the effective date of the preauthorization
3-47 requirement;

3-48 (B) a list or description of any supporting
3-49 documentation that the insurer requires from the physician or
3-50 health care provider ordering or requesting the service to approve
3-51 a request for the service;

3-52 (C) the applicable screening criteria, which may
3-53 include Current Procedural Terminology codes and International
3-54 Classification of Diseases codes; and

3-55 (D) statistics regarding the insurer's
3-56 preauthorization approval and denial rates for the medical care or
3-57 health care service in the preceding year, including statistics in
3-58 the following categories:

3-59 (i) physician or health care provider type
3-60 and specialty, if any;

3-61 (ii) indication offered;

3-62 (iii) reasons for request denial;

3-63 (iv) denials overturned on appeal; and

3-64 (v) total annual preauthorization
3-65 requests, approvals, and denials for the service.

3-66 (c) This section may not be construed to require an insurer
3-67 to provide specific information that would violate any applicable
3-68 copyright law or licensing agreement. An insurer is required to
3-69 supply, in lieu of any information withheld on the basis of

4-1 copyright law or a licensing agreement, a summary of the withheld
 4-2 information sufficient to allow a licensed physician or other
 4-3 health care provider, as applicable for the specific service, who
 4-4 has sufficient training and experience related to the service to
 4-5 understand the basis for the insurer's medical necessity or
 4-6 appropriateness determinations.

4-7 (d) If a requirement or information described by Subsection
 4-8 (a) is licensed, proprietary, or copyrighted material that the
 4-9 insurer has received from a third party with which the insurer has
 4-10 contracted, the insurer may, instead of making that information
 4-11 publicly available on the insurer's Internet website, provide the
 4-12 material to a physician or health care provider who submits a
 4-13 preauthorization request using a nonpublic secured Internet
 4-14 website link or other protected, nonpublic electronic means.

4-15 (e) The provisions of this section may not be waived,
 4-16 voided, or nullified by contract.

4-17 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

4-18 (a) Except as provided by Subsection (b), not later than the 60th
 4-19 day before the date a new or amended preauthorization requirement
 4-20 takes effect, an insurer that uses a preauthorization process for
 4-21 medical care or health care services shall provide notice of the new
 4-22 or amended preauthorization requirement in the insurer's
 4-23 newsletter or network bulletin, if any, and on the insurer's
 4-24 Internet website.

4-25 (b) For a change in a preauthorization requirement or
 4-26 process that removes a service from the list of medical care or
 4-27 health care services requiring preauthorization or amends a
 4-28 preauthorization requirement in a way that is less burdensome to
 4-29 insureds, physicians, or health care providers, an insurer shall
 4-30 provide notice of the change in the preauthorization requirement in
 4-31 the insurer's newsletter or network bulletin, if any, and on the
 4-32 insurer's Internet website not later than the fifth day before the
 4-33 date the change takes effect.

4-34 (c) Not later than the fifth day before the date a new or
 4-35 amended preauthorization requirement takes effect, an insurer
 4-36 shall update its Internet website to disclose the change to the
 4-37 insurer's preauthorization requirements or process and the date and
 4-38 time the change is effective.

4-39 (d) The provisions of this section may not be waived,
 4-40 voided, or nullified by contract.

4-41 Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition
 4-42 to any other penalty or remedy provided by law, an insurer that uses
 4-43 a preauthorization process for medical care or health care services
 4-44 that violates this subchapter with respect to a required
 4-45 publication, notice, or response regarding its preauthorization
 4-46 requirements, including by failing to comply with any applicable
 4-47 deadline for the publication, notice, or response, must provide an
 4-48 expedited appeal under Section 4201.357 for any medical care or
 4-49 health care service affected by the violation.

4-50 (b) The provisions of this section may not be waived,
 4-51 voided, or nullified by contract.

4-52 ARTICLE 2. UTILIZATION, INDEPENDENT, AND PEER REVIEW

4-53 SECTION 2.01. Section 4201.002(12), Insurance Code, is
 4-54 amended to read as follows:

4-55 (12) "Provider of record" means the physician or other
 4-56 health care provider with primary responsibility for the health
 4-57 care[, treatment, and] services provided to or requested on behalf
 4-58 of an enrollee or the physician or other health care provider that
 4-59 has provided or has been requested to provide the health care
 4-60 services to the enrollee. The term includes a health care facility
 4-61 where the health care services are [if treatment is] provided on an
 4-62 inpatient or outpatient basis.

4-63 SECTION 2.02. Sections 4201.151 and 4201.152, Insurance
 4-64 Code, are amended to read as follows:

4-65 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization
 4-66 review agent's utilization review plan, including reconsideration
 4-67 and appeal requirements, must be reviewed by a physician licensed
 4-68 to practice medicine in this state and conducted in accordance with
 4-69 standards developed with input from appropriate health care

5-1 providers and approved by a physician licensed to practice medicine
 5-2 in this state.

5-3 Sec. 4201.152. UTILIZATION REVIEW UNDER [~~DIRECTION OF~~]
 5-4 PHYSICIAN. A utilization review agent shall conduct utilization
 5-5 review under the direction of a physician licensed to practice
 5-6 medicine in this [~~by a~~] state [~~licensing agency in the United~~
 5-7 ~~States~~].

5-8 SECTION 2.03. Section 4201.153(d), Insurance Code, is
 5-9 amended to read as follows:

5-10 (d) Screening criteria must be used to determine only
 5-11 whether to approve the requested treatment. Before issuing an
 5-12 adverse determination, a utilization review agent must obtain a
 5-13 determination of medical necessity and appropriateness by
 5-14 referring a proposed [A] denial of requested treatment [~~must be~~
 5-15 ~~referred~~] to:

5-16 (1) an appropriate physician, dentist, or other health
 5-17 care provider; or

5-18 (2) if the treatment is requested, ordered, provided,
 5-19 or to be provided by a physician, a physician licensed to practice
 5-20 medicine who is of the same or a similar specialty as that physician
 5-21 [to determine medical necessity].

5-22 SECTION 2.04. Sections 4201.155, 4201.206, and 4201.251,
 5-23 Insurance Code, are amended to read as follows:

5-24 Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW
 5-25 PROCEDURES. (a) A utilization review agent may not establish or
 5-26 impose a notice requirement or other review procedure that is
 5-27 contrary to the requirements of the health insurance policy or
 5-28 health benefit plan.

5-29 (b) This section may not be construed to release a health
 5-30 insurance policy or health benefit plan from full compliance with
 5-31 this chapter or other applicable law.

5-32 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
 5-33 ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the
 5-34 notice requirements of Subchapter G, before an adverse
 5-35 determination is issued by a utilization review agent who questions
 5-36 the medical necessity, the [~~or~~] appropriateness, or the
 5-37 experimental or investigational nature[~~r~~] of a health care service,
 5-38 the agent shall provide the health care provider who ordered,
 5-39 requested, provided, or is to provide the service a reasonable
 5-40 opportunity to discuss with a physician licensed to practice
 5-41 medicine the patient's treatment plan and the clinical basis for
 5-42 the agent's determination.

5-43 (b) If the health care service described by Subsection (a)
 5-44 was ordered, requested, or provided, or is to be provided by a
 5-45 physician, the opportunity described by that subsection must be
 5-46 with a physician licensed to practice medicine who is of the same or
 5-47 a similar specialty as that physician.

5-48 Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A
 5-49 utilization review agent may delegate utilization review to
 5-50 qualified personnel in the hospital or other health care facility
 5-51 in which the health care services to be reviewed were or are to be
 5-52 provided. The delegation does not release the agent from the full
 5-53 responsibility for compliance with this chapter or other applicable
 5-54 law, including the conduct of those to whom utilization review has
 5-55 been delegated.

5-56 SECTION 2.05. Sections 4201.252(a) and (b), Insurance Code,
 5-57 are amended to read as follows:

5-58 (a) Personnel employed by or under contract with a
 5-59 utilization review agent to perform utilization review must be
 5-60 appropriately trained and qualified and meet the requirements of
 5-61 this chapter and other applicable law, including applicable
 5-62 licensing requirements.

5-63 (b) Personnel, other than a physician licensed to practice
 5-64 medicine, who obtain oral or written information directly from a
 5-65 patient's physician or other health care provider regarding the
 5-66 patient's specific medical condition, diagnosis, or treatment
 5-67 options or protocols must be a nurse, physician assistant, or other
 5-68 health care provider qualified and licensed or otherwise authorized
 5-69 by law and an appropriate licensing agency in the United States to

6-1 provide the requested service.

6-2 SECTION 2.06. Section 4201.356, Insurance Code, is amended
6-3 to read as follows:

6-4 Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY
6-5 REVIEW. (a) The procedures for appealing an adverse determination
6-6 must provide that a physician licensed to practice medicine makes
6-7 the decision on the appeal, except as provided by Subsection (b).

6-8 (b) If not later than the 10th working day after the date an
6-9 appeal is requested or denied the enrollee's health care provider
6-10 requests [~~states in writing good cause for having~~] a particular
6-11 type of specialty provider review the case, a health care provider
6-12 who is of the same or a similar specialty as the health care
6-13 provider who would typically manage the medical or dental
6-14 condition, procedure, or treatment under consideration for review
6-15 and who is licensed or otherwise authorized by the appropriate
6-16 licensing agency in the United States to manage the medical or
6-17 dental condition, procedure, or treatment shall review the denial
6-18 or the decision denying the appeal. The specialty review must be
6-19 completed within 15 working days of the date the health care
6-20 provider's request for specialty review is received.

6-21 SECTION 2.07. Sections 4201.357(a), (a-1), and (a-2),
6-22 Insurance Code, are amended to read as follows:

6-23 (a) The procedures for appealing an adverse determination
6-24 must include, in addition to the written appeal, a procedure for an
6-25 expedited appeal of a denial of emergency care, ~~[or]~~ a denial of
6-26 continued hospitalization, or a denial of another service if the
6-27 requesting health care provider includes a written statement with
6-28 supporting documentation that the service is necessary to treat a
6-29 life-threatening condition or prevent serious harm to the patient.
6-30 That procedure must include a review by a health care provider who:

- 6-31 (1) has not previously reviewed the case; ~~[and]~~
6-32 (2) is of the same or a similar specialty as the health
6-33 care provider who would typically manage the medical or dental
6-34 condition, procedure, or treatment under review in the appeal; and
6-35 (3) for a review of a health care service:
6-36 (A) ordered, requested, or to be provided by a
6-37 health care provider who is not a physician, is licensed or
6-38 otherwise authorized by an appropriate licensing agency in the
6-39 United States; or
6-40 (B) ordered, requested, or to be provided by a
6-41 physician, is licensed to practice medicine in the United States.

6-42 (a-1) The procedures for appealing an adverse determination
6-43 must include, in addition to the written appeal and the appeal
6-44 described by Subsection (a), a procedure for an expedited appeal of
6-45 a denial of prescription drugs or intravenous infusions for which
6-46 the patient is receiving benefits under the health insurance
6-47 policy. That procedure must include a review by a health care
6-48 provider who:

- 6-49 (1) has not previously reviewed the case; ~~[and]~~
6-50 (2) is of the same or a similar specialty as the health
6-51 care provider who would typically manage the medical or dental
6-52 condition, procedure, or treatment under review in the appeal; and
6-53 (3) for a review of a health care service:
6-54 (A) ordered, requested, or to be provided by a
6-55 health care provider who is not a physician, is licensed or
6-56 otherwise authorized by the appropriate licensing agency in this
6-57 state to provide the service in this state; or
6-58 (B) ordered, requested, or to be provided by a
6-59 physician, is licensed to practice medicine in this state.

6-60 (a-2) An adverse determination under Section 1369.0546 is
6-61 entitled to an expedited appeal. The physician or, if appropriate,
6-62 other health care provider deciding the appeal must consider
6-63 atypical diagnoses and the needs of atypical patient populations.
6-64 The physician must be licensed to practice medicine in the United
6-65 States and the health care provider must be licensed or otherwise
6-66 authorized by an appropriate licensing agency in the United States.

6-67 SECTION 2.08. Section 4201.359, Insurance Code, is amended
6-68 by adding Subsection (c) to read as follows:

6-69 (c) A physician described by Subsection (b)(2) must comply

7-1 with this chapter and other applicable laws and be licensed to
7-2 practice medicine. A health care provider described by Subsection
7-3 (b)(2) must comply with this chapter and other applicable laws and
7-4 be licensed or otherwise authorized by an appropriate licensing
7-5 agency in the United States.

7-6 SECTION 2.09. Sections 4201.453 and 4201.454, Insurance
7-7 Code, are amended to read as follows:

7-8 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty
7-9 utilization review agent's utilization review plan, including
7-10 reconsideration and appeal requirements, must be:

7-11 (1) reviewed by a health care provider of the
7-12 appropriate specialty who is licensed or otherwise authorized to
7-13 provide the specialty health care service in this state; and

7-14 (2) conducted in accordance with standards developed
7-15 with input from a health care provider of the appropriate specialty
7-16 who is licensed or otherwise authorized to provide the specialty
7-17 health care service in this state.

7-18 Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF
7-19 PROVIDER OF SAME SPECIALTY. A specialty utilization review agent
7-20 shall conduct utilization review under the direction of a health
7-21 care provider who is of the same specialty as the agent and who is
7-22 licensed or otherwise authorized to provide the specialty health
7-23 care service in this [by a] state [~~licensing agency in the United~~
7-24 ~~States~~].

7-25 SECTION 2.10. Sections 4201.455(a) and (b), Insurance Code,
7-26 are amended to read as follows:

7-27 (a) Personnel who are employed by or under contract with a
7-28 specialty utilization review agent to perform utilization review
7-29 must be appropriately trained and qualified and meet the
7-30 requirements of this chapter and other applicable law of this
7-31 state, including applicable licensing laws.

7-32 (b) Personnel who obtain oral or written information
7-33 directly from a physician or other health care provider must be a
7-34 nurse, physician assistant, or other health care provider of the
7-35 same specialty as the agent and who are licensed or otherwise
7-36 authorized to provide the specialty health care service by a
7-37 [~~state~~] licensing agency in the United States.

7-38 SECTION 2.11. Sections 4201.456 and 4201.457, Insurance
7-39 Code, are amended to read as follows:

7-40 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
7-41 ADVERSE DETERMINATION. Subject to the notice requirements of
7-42 Subchapter G, before an adverse determination is issued by a
7-43 specialty utilization review agent who questions the medical
7-44 necessity, the [~~or~~] appropriateness, or the experimental or
7-45 investigational nature[~~r~~] of a health care service, the agent shall
7-46 provide the health care provider who ordered, requested, or is to
7-47 provide the service a reasonable opportunity to discuss the
7-48 patient's treatment plan and the clinical basis for the agent's
7-49 determination with a health care provider who is:

7-50 (1) of the same specialty as the agent; and

7-51 (2) licensed or otherwise authorized to provide the
7-52 specialty health care service by a licensing agency in the United
7-53 States.

7-54 Sec. 4201.457. APPEAL DECISIONS. A specialty utilization
7-55 review agent shall comply with the requirement that a physician or
7-56 other health care provider who makes the decision in an appeal of an
7-57 adverse determination must be:

7-58 (1) of the same or a similar specialty as the health
7-59 care provider who would typically manage the specialty condition,
7-60 procedure, or treatment under review in the appeal; and

7-61 (2) licensed or otherwise authorized to provide the
7-62 health care service by a licensing agency in the United States.

7-63 SECTION 2.12. Section 408.0043, Labor Code, is amended by
7-64 adding Subsection (c) to read as follows:

7-65 (c) Notwithstanding Subsection (b), if a health care
7-66 service is requested, ordered, provided, or to be provided by a
7-67 physician, a person described by Subsection (a)(1), (2), or (3) who
7-68 reviews the service with respect to a specific workers'
7-69 compensation case must be of the same or a similar specialty as that

8-1 physician.

8-2 SECTION 2.13. Section 1305.351(d), Insurance Code, is
8-3 amended to read as follows:

8-4 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization
8-5 review agent or an insurance carrier that uses doctors to perform
8-6 reviews of health care services provided under this chapter,
8-7 including utilization review, or peer reviews under Section
8-8 408.0231(g), Labor Code, may only use doctors licensed to practice
8-9 in this state.

8-10 SECTION 2.14. Section 1305.355(d), Insurance Code, is
8-11 amended to read as follows:

8-12 (d) The department shall assign the review request to an
8-13 independent review organization. An [~~Notwithstanding Section~~
8-14 ~~4202.002, an~~] independent review organization that uses doctors to
8-15 perform reviews of health care services under this chapter may only
8-16 use doctors licensed to practice in this state.

8-17 SECTION 2.15. Section 408.023(h), Labor Code, is amended to
8-18 read as follows:

8-19 (h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~]
8-20 utilization review agent or an insurance carrier that uses doctors
8-21 to perform reviews of health care services provided under this
8-22 subtitle, including utilization review, may only use doctors
8-23 licensed to practice in this state.

8-24 SECTION 2.16. Section 413.031(e-2), Labor Code, is amended
8-25 to read as follows:

8-26 (e-2) An [~~Notwithstanding Section 4202.002, Insurance Code,~~
8-27 ~~an~~] independent review organization that uses doctors to perform
8-28 reviews of health care services provided under this title may only
8-29 use doctors licensed to practice in this state.

8-30 ARTICLE 3. JOINT INTERIM STUDY

8-31 SECTION 3.01. CREATION OF JOINT INTERIM COMMITTEE. (a) A
8-32 joint interim committee is created to study, review, and report on
8-33 the use of prior authorization and utilization review processes by
8-34 private health benefit plan issuers in this state, as provided by
8-35 Section 3.02 of this article, and propose reforms under that
8-36 section related to the transparency of and improving patient
8-37 outcomes under the prior authorization and utilization review
8-38 processes used by private health benefit plan issuers in this
8-39 state.

8-40 (b) The joint interim committee shall be composed of four
8-41 senators appointed by the lieutenant governor and four members of
8-42 the house of representatives appointed by the speaker of the house
8-43 of representatives.

8-44 (c) The lieutenant governor and speaker of the house of
8-45 representatives shall each designate a co-chair from among the
8-46 joint interim committee members.

8-47 (d) The joint interim committee shall convene at the joint
8-48 call of the co-chairs.

8-49 (e) The joint interim committee has all other powers and
8-50 duties provided to a special or select committee by the rules of the
8-51 senate and house of representatives, by Subchapter B, Chapter 301,
8-52 Government Code, and by policies of the senate and house committees
8-53 on administration.

8-54 SECTION 3.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION
8-55 AND UTILIZATION REVIEW PROCESSES. (a) The joint interim committee
8-56 created by Section 3.01 of this article shall study data and other
8-57 information available from the Texas Department of Insurance, the
8-58 office of public insurance counsel, or other sources the committee
8-59 determines relevant to examine and analyze the transparency of and
8-60 improving patient outcomes under the prior authorization and
8-61 utilization review processes used by private health benefit plan
8-62 issuers in this state.

8-63 (b) The joint interim committee shall propose reforms based
8-64 on the study required under Subsection (a) of this section to
8-65 improve the transparency of and patient outcomes under prior
8-66 authorization and utilization review processes in this state.

8-67 (c) The joint interim committee shall prepare a report of
8-68 the findings and proposed reforms.

8-69 SECTION 3.03. COMMITTEE FINDINGS AND PROPOSED REFORMS.

9-1 (a) Not later than December 1, 2020, the joint interim committee
9-2 created under Section 3.01 of this article shall submit to the
9-3 lieutenant governor, the speaker of the house of representatives,
9-4 and the governor the report prepared under Section 3.02 of this
9-5 article. The joint interim committee shall include in its report
9-6 recommendations of specific statutory and regulatory changes that
9-7 appear necessary from the committee's study under Section 3.02 of
9-8 this article.

9-9 (b) Not later than the 60th day after the effective date of
9-10 this Act, the lieutenant governor and speaker of the house of
9-11 representatives shall appoint the members of the joint interim
9-12 committee in accordance with Section 3.01 of this article.

9-13 SECTION 3.04. ABOLITION OF COMMITTEE. The joint interim
9-14 committee created under Section 3.01 of this article is abolished
9-15 and this article expires December 15, 2020.

9-16 ARTICLE 4. TRANSITIONS; EFFECTIVE DATE

9-17 SECTION 4.01. The changes in law made by Article 1 of this
9-18 Act apply only to a request for preauthorization of medical care or
9-19 health care services made on or after January 1, 2020, under a
9-20 health benefit plan delivered, issued for delivery, or renewed on
9-21 or after that date. A request for preauthorization of medical care
9-22 or health care services made before January 1, 2020, or on or after
9-23 January 1, 2020, under a health benefit plan delivered, issued for
9-24 delivery, or renewed before that date is governed by the law as it
9-25 existed immediately before the effective date of this Act, and that
9-26 law is continued in effect for that purpose.

9-27 SECTION 4.02. The changes in law made by Article 2 of this
9-28 Act apply only to utilization, independent, or peer review
9-29 requested on or after the effective date of this Act. Utilization,
9-30 independent, or peer review requested before the effective date of
9-31 this Act is governed by the law as it existed immediately before the
9-32 effective date of this Act, and that law is continued in effect for
9-33 that purpose.

9-34 SECTION 4.03. This Act takes effect September 1, 2019.

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