

By: Lalani

H.B. No. 2641

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan preauthorization requirements for physicians and providers providing certain health care services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 4201, Insurance Code, is amended by adding Subchapter O to read as follows:

SUBCHAPTER O. PROHIBITED PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES

Sec. 4201.701. DEFINITIONS. In this subchapter:

(1) "Chronic health condition" means a health condition that:

(A) is expected to last one or more years;

(B) requires ongoing health care services to manage the condition or prevent an adverse health event; or

(C) limits one or more of the following daily activities:

(i) bathing;

(ii) personal hygiene;

(iii) eating;

(iv) toileting;

(v) dressing;

(vi) bed mobility; or

(vii) walking or locomotion.

(2) "Emergency care" and "health care services" have

1 the meanings assigned by Section 843.002.

2 (3) "Intervention-necessary care" means health care  
3 services, other than emergency care:

4 (A) that are typically provided in a physician's  
5 office or other outpatient setting;

6 (B) that are provided to treat an acute injury,  
7 illness, or condition that is severe or painful enough to lead a  
8 prudent layperson possessing an average knowledge of medicine and  
9 health who is experiencing the injury, illness, or condition to  
10 believe that the injury, illness, or condition will seriously  
11 deteriorate if the person does not receive treatment within a  
12 reasonable amount of time; and

13 (C) without which there is a risk that the  
14 individual experiencing the injury, illness, or condition will:

15 (i) acquire an irreversible injury,  
16 illness, or condition; or

17 (ii) require emergency care or another  
18 inpatient health care service.

19 (4) "Physician" has the meaning assigned by Section  
20 843.002.

21 (5) "Preauthorization" means a determination by a  
22 health maintenance organization, insurer, or person contracting  
23 with a health maintenance organization or insurer that health care  
24 services proposed to be provided to a patient are medically  
25 necessary and appropriate.

26 (6) "Provider" has the meaning assigned by Section  
27 843.002.

1       Sec. 4201.702. APPLICABILITY OF SUBCHAPTER. This  
2 subchapter applies only to:

3           (1) a health benefit plan offered by a health  
4 maintenance organization operating under Chapter 843, except that  
5 this subchapter does not apply to:

6                   (A) the child health plan program under Chapter  
7 62, Health and Safety Code, or the health benefits plan for children  
8 under Chapter 63, Health and Safety Code; or

9                   (B) the state Medicaid program, including the  
10 Medicaid managed care program operated under Chapter 540,  
11 Government Code;

12           (2) a preferred provider benefit plan or exclusive  
13 provider benefit plan offered by an insurer under Chapter 1301; and

14           (3) a person who contracts with a health maintenance  
15 organization or insurer to issue preauthorization determinations  
16 or perform the functions described by this subchapter for a health  
17 benefit plan to which this subchapter applies.

18       Sec. 4201.703. CONSTRUCTION OF SUBCHAPTER. This subchapter  
19 may be construed to:

20           (1) authorize a physician or provider to provide a  
21 health care service outside the scope of the physician's or  
22 provider's applicable license issued under Title 3, Occupations  
23 Code; or

24           (2) require a health maintenance organization or  
25 insurer to pay for a health care service described by Subdivision  
26 (1) that is performed in violation of the laws of this state.

27       Sec. 4201.704. PROHIBITED PREAUTHORIZATION REQUIREMENTS

1 FOR PHYSICIANS AND PROVIDERS PROVIDING CERTAIN HEALTH CARE  
2 SERVICES. (a) A health maintenance organization or insurer may not  
3 require a physician or provider to obtain preauthorization for the  
4 following health care services:

5 (1) emergency care;

6 (2) intervention-necessary care provided by an  
7 individual licensed to practice medicine in this state;

8 (3) primary care provided by an individual licensed to  
9 practice medicine in this state;

10 (4) outpatient mental health care treatment or  
11 outpatient substance use disorder treatment, except for the  
12 provision of prescription drugs or intravenous infusions;

13 (5) antineoplastic cancer treatments provided in  
14 accordance with National Comprehensive Cancer Network guidelines,  
15 except for the provision of prescription drugs or intravenous  
16 infusions;

17 (6) intravitreal prescription drugs and health care  
18 services provided in accordance with National Eye Institute  
19 guidelines to treat macular degeneration, diabetic retinopathy, or  
20 another eye injury, condition, or illness that may lead to vision  
21 loss;

22 (7) health care services with an "A" or "B"  
23 recommendation from the United States Preventative Services Task  
24 Force;

25 (8) preventative health care services described by 42  
26 C.F.R. Section 147.130;

27 (9) pediatric hospice services provided by a person

1 licensed under Chapter 142, Health and Safety Code;

2 (10) health care services provided under a neonatal  
3 abstinence syndrome program operated by a physician specializing in  
4 pediatric pain or pediatric palliative care; or

5 (11) health care services provided under a  
6 risk-sharing or capitation arrangement.

7 (b) An approved preauthorization request for a chronic  
8 health condition does not expire unless the standard treatment for  
9 that condition changes.

10 Sec. 4201.705. EFFECT OF PROHIBITED PREAUTHORIZATION  
11 REQUIREMENTS. (a) A health maintenance organization or insurer  
12 may not deny or reduce payment to a physician or provider for a  
13 health care service for which the physician or provider is not  
14 required to obtain preauthorization under Section 4201.704 unless  
15 the physician or provider:

16 (1) knowingly and materially misrepresented the  
17 health care service or the nature of an acute injury, condition, or  
18 illness in a request for payment submitted to the health  
19 maintenance organization or insurer with the specific intent to  
20 deceive and obtain an unlawful payment from the health maintenance  
21 organization or insurer; or

22 (2) failed to substantially perform the health care  
23 service.

24 (b) A health maintenance organization or an insurer may not  
25 conduct a retrospective review of a health care service for which  
26 the physician or provider is not required to obtain  
27 preauthorization under Section 4201.704 unless the health

1 maintenance organization or insurer has a reasonable cause to  
2 suspect a basis for denial exists under Subsection (a).

3 (c) For a retrospective review described by Subsection (b),  
4 nothing in this subchapter may be construed to modify or otherwise  
5 affect:

6 (1) the requirements under or application of Section  
7 4201.305, including any timeframes specified by that section; or

8 (2) any other applicable law, except to prescribe the  
9 only circumstances under which:

10 (A) a retrospective utilization review may occur  
11 as specified by Subsection (b); or

12 (B) payment may be denied or reduced as specified  
13 by Subsection (a).

14 (d) If a physician or provider submits a preauthorization  
15 request for a health care service for which the physician or  
16 provider is not required to obtain preauthorization under Section  
17 4201.704, the health maintenance organization or insurer must  
18 promptly provide a written notice to the physician or provider that  
19 includes:

20 (1) a statement that the health maintenance  
21 organization or insurer may not require preauthorization for that  
22 health care service; and

23 (2) a notification of the health maintenance  
24 organization's or insurer's payment requirements.

25 SECTION 2. Subchapter O, Chapter 4201, Insurance Code, as  
26 added by this Act, applies only to a request for preauthorization  
27 under a health benefit plan that is delivered, issued for delivery,

1 or renewed on or after January 1, 2026.

2 SECTION 3. This Act takes effect September 1, 2025.