Texas’ “Goldcarding” law
HB 3459 (2021)

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Agenda

• Texas “goldcarding” statute.
• Implementation process.
• Outcomes and challenges.
• Overview of law and rules.
• Questions.
• **Bill:** House Bill 3459 (87th Legislature), 2021.

• **Statute:** Texas Insurance Code (TIC) Chapter 4201, Subchapter N: Exemption from preauthorization requirements for physicians and providers providing certain health care services.

• **Applicability:** State-regulated health plans offered by HMOs, PPOs, and EPOs. Also applies to state employee and teacher plans. Doesn’t apply to Medicaid or CHIP.

• **Requirement:** Health plans must provide exemptions from a preauthorization requirement for a particular health care service if the provider has a 90% approval rate for that service.
Rules adopted in 2022:

• Title 28 of the Texas Administrative Code (TAC) 19.1730 – 19.733 – Preauthorization Exemptions.
  • Adoption order
  • Administrative Code

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  • Administrative Code

• Form LHL011 – Notice of Rescission of Preauthorization Exemption and Right to Request an Independent Review.
TDI | Education

• TDI hosted a webinar in September 2022.
• Based on questions received during and after the webinar, TDI published Frequently Asked Questions.
• The biggest source of questions were from providers believing they should qualify but didn’t receive a notice of exemption.
  • In most cases the threshold wasn’t met based on preauthorization requests for TDI-regulated plans.
  • Providers had difficulty distinguishing between requests submitted to affiliated issuers for different plan types.
TDI | Initial outcomes

- TDI conducted a survey in January 2023, following the initial round of exemptions due October 2022. On average:
  - Preauthorization was applied to 21% of claims and 85% of requests were approved, prior to implementation.
  - Preauthorization requirements applied to 3,000 distinct services.
  - Only 4% of providers met the threshold for evaluation for one or more services and only 3% received an exemption.
  - Exemptions were approved for 74% of providers who met the evaluation threshold.
Policy considerations

- Impact was smaller than expected. Things that could increase the impact:
  - Lengthen evaluation period from six months to 12 months.
  - Reduce granularity of “particular health care service.”
  - Reduce the threshold of five preauthorization requests.
  - Require issuers to combine data for providers across all affiliated entities, including those not subject to the law.
- Legislation was considered but not enacted (HB 4343).
Overview of law and rules

• The following slides are an excerpt of the presentation shared with stakeholders in September 2022.
• View the full presentation for more detail.
Key definitions

For more, see TAC 19.1730.

• “Health care services,” “physician” and “provider” are defined broadly: TIC 843.002(13), (22), and (24).

• A “particular health care service” is one that is listed on an issuer’s website as subject to preauthorization.
  • Listing was required by SB 1742 (2019).
  • Rules: TAC 19.1718(j).

• A “preauthorization exemption” is applicable to care rendered or ordered by a “treating physician or provider.”
Eligibility for exemptions

• An exemption for a particular health care service is based on the physician’s or provider’s approval rate based on the outcomes of all “eligible preauthorization requests” for the service that:
  • Are submitted and finalized during the most recent six-month evaluation period (not pending appeal).
  • Result in the issuer either approving or issuing an adverse determination for the particular health care service.
• Modified requests are counted based on updated service requested.
• Outcomes for each separate service are counted individually.
• See TAC 19.1730(3).
Under **TAC 19.1731:**

- Exemptions are granted using the National Provider Identifier (NPI) under which preauthorization requests are made.
- Exemptions apply to care ordered, referred, or provided by the treating provider with the exemption.
- Nurses and PAs practicing under the supervision of a physician can rely on an exemption, as appropriate.
- A provider that performs care ordered or referred by a provider with an exemption must include the name and NPI of the ordering provider on the claim.
A provider could qualify for an exemption for any type of service for which they commonly submit a preauthorization request – even if the service is ultimately provided by a different provider. For example:

- Surgery.
- Prescription drugs.
- Imaging.
- Physical therapy.
Initial evaluation

- Notice is due within five days of completing an evaluation.
  - Deadline for subsequent evaluation periods: two months following the day after the end of the evaluation period.
- By rule, the evaluation to grant an exemption must be based on at least five eligible preauthorization requests; otherwise, no notice is required (**TAC 19.1731(b)** and **TAC 19.1732(c)**).
- The exemption must be in place for at least six months before it may be rescinded (**TAC 19.1732(a)**).
Example: Initial evaluation is denied

- Initial evaluation: Jan. 1-June 30, 2022
- Initial notice of denial issued by: Oct. 1, 2022
- Next evaluation period: July 1-Dec. 31, 2022
- Notice issued by: March 1, 2023
Example: Initial evaluation is granted

- Initial evaluation: Jan. 1-June 30, 2022
- Initial notice of exemption issued by Oct. 1, 2022
- Subject to rescission in June 2023, January 2024, or future
• Issuers may continue exemptions without subsequent evaluations \((\text{TIC 4201.653(c)})\).

• While an exemption is in effect, an issuer:
  • Can’t deny payment based medical necessity, except for material misrepresentation or failure to perform the service.
  • May conduct retrospective reviews only to determine continued eligibility for an exemption (or investigate a basis for denial).
  • Refer to \(\text{TIC 4201.659}\).

• An exemption must last at least six months before it may be rescinded.
• By statute, issuers may rescind an exemption only after they:
  • Select a random sample of five-20 claims to retrospectively review.
  • Determine that less than 90% met the criteria (based on review by TX-licensed physician of the same/similar specialty, if applicable).
  • Provide a 30-day notice in January or June and an opportunity for an independent review.
• Refer to TIC 4201.655(a) and (b).
• Issuers may determine the applicable six-month evaluation period for a notification of rescission but must provide a rescission notice within two months of the end of the evaluation period (TAC 19.1730(5)(C)).
Example: Exemption is rescinded

Rescission evaluation
Oct. 1, 2022-March 31, 2023 (or later)

Rescission notice issued
June 1-30, 2023

Next evaluation period
April 1-Sept. 30, 2023

Notice issued by
Dec. 1, 2023
TDI’s LHL011 form illustrates requirements for issuers to provide rescission notices and IRO request forms.

Notice of Rescission of Preauthorization Exemption and Right to Request an Independent Review

Important information and instructions

Date of notice: ________________

Unless you request an appeal to an independent review organization (IRO) as set forth below, the preauthorization exemption for __________________________ will be rescinded effective ____________.

Health care service

Date
• An “adverse determination regarding a preauthorization exemption” (that one or more claims retrospectively reviewed as part of an evaluation did not meet the issuer’s screening criteria and leads to a rescission) is subject to appeal to an independent review organization.

• A physician or provider may request an independent review by submitting the rescission notice form before the rescission effective date \( \text{TAC 19.1733(c)} \).

• If a rescission is based on failure to provide medical records, the records must be submitted with the request for independent review \( \text{TAC 19.1733(d)} \).
• Issuers will submit IRO requests to TDI for exemptions using existing processes.
• See TDI’s website and Online IRO Request System.
Example: Rescission is appealed to an IRO

- Rescission notice issued June 1, 2023, effective July 1, 2023
- Provider may request appeal by June 30, 2023 (date requested starts 30-day IRO clock)
- Issuer sends IRO request to TDI; TDI assigns to IRO (one working day each)
- IRO must complete review by 30th day; issuer must send decision to provider in five days
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