INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE A. HEALTH COVERAGE IN GENERAL

CHAPTER 1222. PREAUTHORIZATION FOR MEDICAL OR HEALTH CARE SERVICE

Sec. 1222.0001. DEFINITIONS. In this chapter:

(1) "Health benefit plan" means a plan to which this chapter applies under Section 1222.0002.

(2) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state.

(3) "Preauthorization" has the meaning assigned by Section 1301.001.

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. 3041), Sec. 1, eff. September 1, 2019.

Sec. 1222.0002. APPLICABILITY OF CHAPTER. (a) 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;

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

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

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

(6) a stipulated premium company operating under Chapter 884;

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

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

(9) an exchange operating under Chapter 942.

Text of subsection effective until April 01, 2025

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

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

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

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

(10) the child health plan program under Chapter 62, Health and Safety Code;

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

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

Text of subsection effective on April 01, 2025

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

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

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

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

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

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. 3041), Sec. 1, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.121, eff. April 1, 2025.

Sec. 1222.0003. PREAUTHORIZATION RENEWAL REQUEST. A health benefit plan issuer that requires preauthorization as a condition of payment for a medical or health care service shall 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.

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. 3041), Sec. 1, eff. September 1, 2019.

Sec. 1222.0004. DETERMINATION REQUIRED. If a health benefit plan issuer receives a preauthorization renewal request before the existing preauthorization expires, the health benefit plan issuer shall, if practicable, review the request and issue a

determination indicating whether the medical or health care service is preauthorized before the existing preauthorization expires.

Added by Acts 2019, 86th Leg., R.S., Ch. 488 (H.B. 3041), Sec. 1, eff. September 1, 2019.