BILL ANALYSIS

C.S.H.B. 1392
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Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Health benefit plan issuers in Texas have created or are creating rating, tiering, and ranking systems that attempt to assess a physician's professional performance against his or her peers or an objective measurement. Currently, the objective measurement and performance standards are not disclosed to the physician prior to the evaluation period, leaving the physician without the ability to modify his or her practice to meet new standards. The results of the evaluation, which are often imprecise or incorrect, are then made available to the public through a rating or ranking published on a website or through the physician's inclusion in or exclusion from a preferred tier of the health benefit plan network. Participation in the preferred tier is also published. A physician can suffer harm to his or her professional reputation when incorrect ratings, rankings, tiering, or comparisons are made public. Patients who rely on such information may have their medical care interrupted when they change their choice of physician. The bill provides the process and publication requirements to ensure patients have reliable information on which to base their health care decisions.

C.S.H.B. 1392 requires any objective measurement or performance standard to be disclosed to the physician prior to the evaluation period. The bill also requires that the data used to establish the ratings or tiering be made available to the affected physician along with a specified process for the physician to challenge the health benefit plan issuer rating or tiering conclusions.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 1392 amends the Insurance Code to prohibit a health benefit plan issuer, including a subsidiary or an affiliate of the issuer, from disseminating information to the public that compares, rates, tiers, classifies, measures, or ranks a physician's performance, efficiency, or quality of practice against objective standards or the practice of other physicians unless the objective standards or comparison criteria used by the issuer are disclosed to the physician prior to the evaluation period, the data used to establish satisfaction of the objective criteria or to make the comparison are available to the physician for verification before any dissemination of information to the public, and the issuer provides due process to the physician as provided by provisions of the bill.

C.S.H.B. 1392 requires a health plan issuer, before the issuer declines to invite a physician into a preferred tier, classifies a physician into a particular tier, or otherwise differentiates a physician from the physician's peers based on performance, efficiency, or quality, to notify the affected physician of its intent in a written notice and prescribes the content of the notice. The bill sets out requirements relating to due process, physician rights, and hearing procedures on request of a physician who receives notice of intent from a health benefit plan issuer.

C.S.H.B. 1392 requires the commissioner of insurance to adopt rules necessary to implement these provisions, and by rule to prescribe the standards to be used by a health benefit plan issuer that uses a physician ranking, classification, measuring, or tiering system.

C.S.H.B. 1392 makes its provisions applicable to specified types of health benefit plan providers. The bill defines "hearing panel" and "physician."

EFFECTIVE DATE

On passage, or, if the act does not receive the necessary vote, the act takes effect September 1, 2009.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 1392 removes a provision included in the original establishing injunctive relief for a physician if a health benefit plan issuer disseminates or intends to disseminate certain rating information regarding a physician without meeting required criteria. The substitute differs from the original by changing the date by which the hearing requested by a physician is required to be conducted from not less than 60 days and not more than 90 days after the date the notice of the hearing is received by the physician to not less than 30 days after that date. The substitute adds a provision not included in the original authorizing the hearing to be held by teleconference on request of the affected physician. The substitute differs from the original by specifying that the three-physician hearing panel required to conduct the hearing is composed of physicians appointed by the health benefit plan issuer. The substitute omits provisions included in the original establishing the health benefit plan issuer's burden of proof during the hearing and the order of presentation in the hearing, providing for the examination of witnesses, and requiring a health benefit plan issuer to notate a continued disagreement by a physician relating to the issuer's classification of the physician on the issuer's Internet website. The substitute adds a provision not included in the original requiring the commissioner of insurance to adopt rules and by rule prescribe standards relating to a health benefit plan issuer that uses a physician ranking, classification, measuring, or tiering system. The substitute makes conforming changes not included in the original related to the omission of burden-of-proof requirements in provisions establishing that a decision of the hearing panel is binding.