By: Gooden H.B. No. 3124

A BILL TO BE ENTITLED

AN ACT

relating to certain physician-specific comparison data compiled by a health benefit plan issuer, including the release of that data to physicians participating in certain physician-led organizations.

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

SECTION 1. The heading to Chapter 1460, Insurance Code, is amended to read as follows:

CHAPTER 1460. [~~STANDARDS REQUIRED REGARDING~~] CERTAIN PHYSICIAN RANKINGS AND COST COMPARISONS BY HEALTH BENEFIT PLANS

SECTION 2. Chapter 1460, Insurance Code, is amended by designating Sections 1460.001 and 1460.002 as Subchapter A and adding a subchapter heading to read as follows:

SUBCHAPTER A. GENERAL PROVISIONS

SECTION 3. Section 1460.001, Insurance Code, is amended to read as follows:

Sec. 1460.001. DEFINITIONS. In this chapter:

(1) "Accountable care organization" means an entity:

(A) that is composed of physicians or physicians and other health care providers;

(B) that is owned and controlled by one or more physicians licensed in this state and engaged in active clinical practice in this state;

(C) that contracts with a health benefit plan issuer to provide medical or health care services to a defined

population;

(D) that uses a payment structure that takes into account the total costs and quality of the care provided to the defined population served by the entity; and

(E) through which physicians and health care providers, if any:

(i) share in savings created by improvement of the quality of, and reduction of cost increases for, care delivered to the defined population served by the entity; or

(ii) are compensated through another payment methodology intended to reduce the total cost of care delivered to the defined population served by the entity.

(2) "Cost comparison data" means information compiled by a health benefit plan issuer to show the health care costs associated with a physician or other health care provider relative to another physician or health care provider.

(3) "Designated entity" means a limited liability company in which a majority ownership interest is held by an incorporated association whose purpose includes uniting in one organization all physicians licensed to practice medicine in this state and that has been in continued existence for at least 15 years.

(4) "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, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(5) "Participating physician" means a physician who participates in an accountable care organization.

(6) [~~(2)~~] "Physician" means an individual licensed to practice medicine in this state or another state of the United States.

SECTION 4. Chapter 1460, Insurance Code, is amended by designating Sections 1460.003 through 1460.007 as Subchapter B and adding a subchapter heading to read as follows:

SUBCHAPTER B. PHYSICIAN RANKINGS

SECTION 5. Section 1460.003(a), Insurance Code, is amended to read as follows:

(a) Except as provided by Subchapter C, a [~~A~~] health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians, unless:

(1) the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under Section 1460.005;

(2) the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation period used by the health benefit plan issuer; and

(3) each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that, at a minimum, includes due process protections that conform to the following protections:

(A) the health benefit plan issuer provides at least 45 days' written notice to the physician of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the health benefit plan issuer in its rating, tiering, ranking, or comparison decision;

(B) in addition to any written fair reconsideration process, the health benefit plan issuer, upon a request for review that is made within 30 days of receiving the notice under Paragraph (A), provides a fair reconsideration proceeding, at the physician's option:

(i) by teleconference, at an agreed upon time; or

(ii) in person, at an agreed upon time or between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday;

(C) the physician has the right to provide information at a requested fair reconsideration proceeding for determination by a decision-maker, have a representative

participate in the fair reconsideration proceeding, and submit a written statement at the conclusion of the fair reconsideration proceeding; and

(D) the health benefit plan issuer provides a written communication of the outcome of a fair reconsideration proceeding prior to any publication or dissemination of the rating, ranking, tiering, or comparison. The written communication must include the specific reasons for the final decision.

SECTION 6. Section 1460.005(a), Insurance Code, is amended to read as follows:

(a) The commissioner shall adopt rules as necessary to implement this subchapter [~~chapter~~].

SECTION 7. Sections 1460.006 and 1460.007, Insurance Code, are amended to read as follows:

Sec. 1460.006. DUTIES OF HEALTH BENEFIT PLAN ISSUER. A health benefit plan issuer shall ensure that:

(1) physicians currently in clinical practice are actively involved in the development of the standards used under this subchapter [~~chapter~~]; and

(2) the measures and methodology used in the comparison programs described by Section 1460.003 are transparent and valid.

Sec. 1460.007. SANCTIONS; DISCIPLINARY ACTIONS. (a) A health benefit plan issuer that violates this subchapter [~~chapter~~] or a rule adopted under this subchapter [~~chapter~~] is subject to sanctions and disciplinary actions under Chapters 82 and 84.

(b) A violation of this subchapter [~~chapter~~] by a physician

constitutes grounds for disciplinary action by the Texas Medical Board, including imposition of an administrative penalty.

SECTION 8. Chapter 1460, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. COST COMPARISON DATA

Sec. 1460.051. PROVISION OF COST COMPARISON DATA AUTHORIZED. Notwithstanding Section 1460.003, a health benefit plan issuer may provide cost comparison data to a participating physician or a designated entity.

Sec. 1460.052. PROVISION OF CERTAIN COST COMPARISON DATA REQUIRED. If cost comparison data associated with health care providers other than physicians is available to a health benefit plan issuer that provides cost comparison data under Section 1460.051, the plan issuer shall provide the cost comparison data associated with the other health care providers.

Sec. 1460.053. REQUIRED DISCLOSURES. Not later than the 15th business day after the date that a health benefit plan issuer receives a request from a participating physician, the health benefit plan issuer shall disclose to the physician:

(1) the cost comparison data associated with the physician;

(2) the measures and methodology used to compare costs; and

(3) any other information considered in making the cost comparison.

Sec. 1460.054. RIGHT TO DISPUTE. (a) A health benefit plan issuer shall give a physician, regardless of whether the physician

is a participating physician, a fair opportunity to dispute the cost comparison data associated with the physician at least once each calendar quarter and when the health benefit plan issuer changes the measures and methodology described by Section 1460.053.

(b) A physician may initiate a dispute by sending to the health benefit plan issuer a written statement of the dispute.

Sec. 1460.055. DISPUTE PROCEEDING. (a) Not later than the 15th business day after the date a health benefit plan issuer receives a statement of the dispute under Section 1460.054, the plan issuer shall provide the cost comparison data associated with the physician, the measures and methodology used to compare costs, and any other information considered in making the cost comparison, unless the information was already provided under Section 1460.052.

(b) In addition to any written fair reconsideration process, the health benefit plan issuer shall provide a cost comparison data dispute proceeding, at the physician's option:

(1) by teleconference, at an agreed upon time; or

(2) in person, at an agreed upon time.

(c) At the proceeding described by Subsection (b), the physician has the right to:

(1) provide information to a decision-maker;

(2) have a representative participate in the proceeding; and

(3) submit a written statement at the conclusion of the proceeding.

(d) The health benefit plan issuer shall provide to the physician who initiated the dispute process under Section 1460.054

a written communication of the outcome of the proceeding not later than the 60th day after the date the physician initiated the dispute process. The written communication must include the specific reasons for the final decision.

Sec. 1460.056. CORRECTIONS REQUIRED. If in a dispute process initiated under Section 1460.054 the health benefit plan issuer determines that the physician's cost comparison data is inaccurate or the measures and methodology used to compare costs are invalid, the health benefit plan issuer shall promptly correct the data or update the measures and methodology and associated data, as applicable.

Sec. 1460.057. MEASURES AND METHODOLOGY. The measures and methodology used to compare costs under this subchapter must use risk and severity adjustments to account for health status differences among different patient populations.

Sec. 1460.058. NOTICE REQUIRED. A health benefit plan issuer shall provide written notice to a physician who contracts with the plan issuer that:

(1) explains the plan issuer's compilation and use of cost comparison data, the purpose and scope of the plan issuer's release of cost comparison data under this subchapter, and the requirements of this subchapter regarding cost comparison data; and

(2) informs the physician of the physician's rights and duties under this subchapter.

Sec. 1460.059. CONFIDENTIALITY. A physician who receives cost comparison data about another physician under this subchapter may not disclose the data to any other person, except for the

purpose of:

(1) managing an accountable care organization;

(2) managing the receiving physician's practice or referrals;

(3) evaluating or disputing the cost comparison data associated with the receiving physician;

(4) obtaining professional advice related to a legal claim; or

(5) reporting, complaining, or responding to a governmental agency.

Sec. 1460.060. CONSTRUCTION OF SUBCHAPTER. Nothing in this subchapter may be construed to authorize:

(1) the disclosure of a contract rate; or

(2) the publication of cost comparison data to a person other than a participating physician or a designated entity.

Sec. 1460.061. RULES. The commissioner shall adopt rules as necessary to implement this subchapter.

Sec. 1460.062. DUTIES OF HEALTH BENEFIT PLAN ISSUER. A health benefit plan issuer shall ensure that:

(1) physicians currently in clinical practice are actively involved in the development of the standards used under this subchapter; and

(2) the measures and methodology used in the development of cost comparison data described by this subchapter are transparent and valid.

Sec. 1460.063. SANCTIONS; DISCIPLINARY ACTIONS. (a) A

health benefit plan issuer that violates this subchapter or a rule adopted under this subchapter is subject to sanctions and disciplinary actions under Chapters 82 and 84.

(b) A violation of this subchapter by a physician constitutes grounds for disciplinary action by the Texas Medical Board, including imposition of an administrative penalty.

SECTION 9. The change in law made by this Act applies only to a contract between a physician and a health benefit plan issuer entered into or renewed on or after September 1, 2017. A contract between a physician and health benefit plan issuer entered into or renewed before September 1, 2017, is governed by the law as it existed immediately before that date, and that law is continued in effect for that purpose.

SECTION 10. This Act takes effect September 1, 2017.