

By: Gooden

H.B. No. 3124

Substitute the following for H.B. No. 3124:

By: Phillips

C.S.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

1 population;

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

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

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

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

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

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

23 (4) "Health benefit plan issuer" means an entity  
24 authorized under this code or another insurance law of this state  
25 that provides health insurance or health benefits in this state,  
26 including:

27 (A) an insurance company;

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

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

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

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

9 (6) [~~2~~] "Physician" means an individual licensed to  
10 practice medicine in this state or another state of the United  
11 States.

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

15 SUBCHAPTER B. PHYSICIAN RANKINGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 SUBCHAPTER C. COST COMPARISON DATA

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

10 Sec. 1460.052. PROVISION OF CERTAIN COST COMPARISON DATA  
11 REQUIRED. If cost comparison data associated with health care  
12 providers other than physicians is available to a health benefit  
13 plan issuer that provides cost comparison data under Section  
14 1460.051, the plan issuer shall provide the cost comparison data  
15 associated with the other health care providers.

16 Sec. 1460.053. REQUIRED DISCLOSURES. Not later than the  
17 15th business day after the date that a health benefit plan issuer  
18 receives a request from a participating physician, the health  
19 benefit plan issuer shall disclose to the physician:

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

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

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

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

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

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

7 Sec. 1460.055. DISPUTE PROCEEDING. (a) Not later than the  
8 15th business day after the date a health benefit plan issuer  
9 receives a statement of the dispute under Section 1460.054, the  
10 plan issuer shall provide the cost comparison data associated with  
11 the physician, the measures and methodology used to compare costs,  
12 and any other information considered in making the cost comparison,  
13 unless the information was already provided under Section 1460.052.

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

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

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

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

21 (1) provide information to a decision-maker;

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

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

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

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

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

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

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

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

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

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



1 purpose of:

2 (1) managing an accountable care organization;

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

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

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

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

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

13 (1) the disclosure of a contract rate; or

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

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

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

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

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

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

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

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

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

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