SENATE AMENDMENTS

2nd Printing

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.

ADOPTED

MAY 22 2017

Secretary of the Senate

FLOOR AMENDMENT NO. 1 BY: _____

Amend H.B. 3124 (senate committee report) by adding the following appropriately numbered SECTION to the bill and renumbering the SECTIONS of the bill accordingly:

SECTION __. (a) In this section, "department" means the Department of State Health Services.

(b) The department shall conduct a study on the feasibility of using the information provided to the department under the statewide health care data collection system developed under Section 108.006, Health and Safety Code, for creating a database accessible through the Texas Health Care Information Collection website. The database must:

(1) be searchable;

(2) include the average and percentile billed charges for health care procedures performed at inpatient care facilities, outpatient care facilities, and hospital outpatient departments; and

(3) categorize the information described by Subdivision (2) of this subsection according to the American Medical Association's Current Procedural Terminology code for the health care procedure associated with the amount billed.

(c) In conducting the feasibility study under Subsection (b) of this section, the department shall evaluate the cost of making the database accessible to:

(1) the general public at no cost;

(2) health care providers at a cost; and

(3) both the general public at no cost and health care providers at a cost.

(d) Not later than December 1, 2018, the department shall report the results of the study required under this section to

the governor, the lieutenant governor, the speaker of the house of representatives, and members of the appropriate standing committees of the senate and the house of representatives.

(e) The department may contract with a third-party entity to conduct the study required under this section.

(f) This section expires September 1, 2019.

FLOOR AMENDMENT NO. #2

ADOPTED
MAY 22 2017
Secretary of the Senate

Amend H.B. No. 3124 (senate committee report) by adding the following appropriately numbered SECTION to the bill and renumbering the SECTIONS of the bill accordingly:

SECTION ___. Section 20.05, Business & Commerce Code, is amended by amending Subsection (a) and adding Subsection (d) to read as follows:

(a) Except as provided by Subsection (b), a consumer reporting agency may not furnish a consumer report containing information related to:

(1) a case under Title 11 of the United States Code or under the federal Bankruptcy Act in which the date of entry of the order for relief or the date of adjudication predates the consumer report by more than 10 years;

(2) a suit or judgment in which the date of entry predates the consumer report by more than seven years or the governing statute of limitations, whichever is longer;

(3) a tax lien in which the date of payment predates the consumer report by more than seven years;

(4) a record of arrest, indictment, or conviction of a crime in which the date of disposition, release, or parole predates the consumer report by more than seven years; [~~or~~]

(5) a collection account with a medical industry code, if the consumer was covered by a health benefit plan at the time of the event giving rise to the collection and the collection is for an outstanding balance, after copayments, deductibles, and coinsurance, owed to an emergency care provider or a facility-based provider for an out-of-network benefit claim; or

(6) another item or event that predates the consumer

report by more than seven years.

(d) In this section:

(1) "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides emergency care.

(2) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.

(3) "Facility-based provider" means a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility.

(4) "Health care practitioner" means an individual who is licensed to provide health care services.

FLOOR AMENDMENT NO. 3

ADOPTED
RV 21-16
MAY 22 2017 BY:
Secretary of the Senate

Amend H.B. No. 3124 (senate committee printing) as follows:

(1) Add the following appropriately numbered SECTIONS to the bill:

SECTION __. Title 8, Insurance Code, is amended by adding Subtitle M to read as follows:

SUBTITLE M. FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT

CHAPTER 1695. LEGISLATIVE CONSIDERATIONS

Sec. 1695.001. CONSTITUTIONALITY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT. This subtitle does not constitute an acknowledgment by the legislature of the legitimacy of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as a constitutional exercise of the power of the United States Congress.

CHAPTER 1696. COVERAGE FOR ABORTION; PROHIBITIONS AND REQUIREMENTS

Sec. 1696.001. DEFINITIONS. In this chapter:

(1) "Abortion" and "medical emergency" have the meanings assigned by Section 171.002, Health and Safety Code.

(2) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or created under Section 1311(b) of the Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(b)).

(3) "Qualified health plan" has the meaning assigned by Section 1301(a) of the Patient Protection and Affordable Care Act (42 U.S.C. Section 18021(a)).

Sec. 1696.002. PROHIBITED COVERAGE THROUGH HEALTH BENEFIT EXCHANGE. (a) A qualified health plan offered through a health benefit exchange may not provide coverage for an abortion other than coverage for an abortion performed due to a medical

emergency.

(b) This section does not prevent a person from purchasing optional or supplemental coverage for abortions under a health benefit plan other than a qualified health plan offered through a health benefit exchange.

SECTION __. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1218 to read as follows:

CHAPTER 1218. COVERAGE FOR ABORTION; PROHIBITIONS AND REQUIREMENTS

Sec. 1218.001. DEFINITIONS. In this chapter, "abortion" and "medical emergency" have the meanings assigned by Section 171.002, Health and Safety Code.

Sec. 1218.002. 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 offered by:

(1) an insurance company;

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

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

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

(5) an exchange operating under Chapter 942;

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

(7) a multiple employer welfare arrangement that

holds a certificate of authority under Chapter 846; or

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

(b) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(d) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small or large employer health benefit plan subject to Chapter 1501.

(e) Notwithstanding Section 1507.003 or 1507.053, this chapter applies to a standard health benefit plan provided under Chapter 1507.

Sec. 1218.003. COVERAGE BY HEALTH BENEFIT PLAN. A health benefit plan may provide coverage for abortion only if:

(1) the coverage is provided to an enrollee separately from other health benefit plan coverage offered by the health benefit plan issuer;

(2) an enrollee pays separately from, and in addition to, the premium for other health benefit plan coverage a premium for coverage for abortion;

(3) an enrollee provides a signature for coverage for abortion, separately and distinct from the signature required for other health benefit plan coverage offered by the health benefit plan issuer; or

(4) the coverage provides benefits only for an abortion performed due to a medical emergency.

Sec. 1218.004. CALCULATION OF PREMIUM. (a) A health benefit plan issuer that provides coverage for abortion shall calculate the premium for the coverage so that the premium fully covers the estimated cost of abortion per enrollee, determined on an actuarial basis.

(b) In calculating a premium under Subsection (a), the health benefit plan issuer may not take into account any cost savings in other health benefit plan coverage offered by the health benefit plan issuer that is estimated to result from coverage for abortion.

(c) A health benefit plan issuer that provides coverage other than coverage for abortion may not provide a premium discount to or reduce the premium for an enrollee for coverage other than coverage for abortion on the basis that the enrollee has health benefit plan coverage for abortion.

Sec. 1218.005. NOTICE BY ISSUER. A health benefit plan issuer that provides coverage for abortion shall at the time of enrollment in the health benefit plan provide each enrollee with a notice that:

(1) coverage for abortion is optional and separate from other health benefit plan coverage offered by the health benefit plan issuer;

(2) the premium cost for coverage for abortion is a premium paid separately from, and in addition to, the premium for other health benefit plan coverage offered by the health benefit plan issuer; and

(3) the enrollee may enroll in a health benefit plan that provides coverage other than coverage for abortion without obtaining coverage for abortion.

SECTION __. Chapters 1696 and 1218, Insurance Code, as added by this Act, apply only to a qualified health plan offered through a health benefit exchange or a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2018. A qualified health plan offered through a health benefit exchange or a health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2018, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(2) In SECTION 9 of the bill adding transition language (page 4, line 65), strike "The change in law made by this Act" and substitute "Chapter 1460, Insurance Code, as amended by this Act,".

(3) Renumber SECTIONS of the bill appropriately.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 85TH LEGISLATIVE REGULAR SESSION

May 25, 2017

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3124** by Gooden (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.), **As Passed 2nd House**

No significant fiscal implication to the State is anticipated from the provisions of the bill related to the requirements for health benefit plan issuers. The fiscal implications of the bill on the Texas Medical Board cannot be determined at this time due to the unavailability of the estimates on the number of complaints, actions, and administrative penalties that would be subject to physicians under the provisions of the bill.

The bill would amend the Insurance Code 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. The bill would require a health benefit plan issuer to disclose certain cost comparison data to a physician upon request. Under the provisions of the bill, the physicians could dispute the cost comparison. The Commissioner of the Texas Department of Insurance would be required to adopt rules to implement the chapter. A health benefit plan issuer that violates the provisions of the bill would be subject to disciplinary actions and sanctions. Under the provisions of the bill, a violation of the subchapter by a physician would be subject to disciplinary action by the Texas Medical Board.

The bill would require the Department of State Health Services to conduct a study on the feasibility of creating a database accessible through the Texas Health Care Information Collection website.

The bill would amend various statutory provisions relating to health plan and health benefit plan coverage for abortions, including qualified health plans offered through a health benefit exchange. The bill would go into effect on September 1, 2017 and would apply to health insurance plans issued on or after January 1, 2018.

Based on information provided by the Texas Department of Insurance (TDI), Texas A&M University System Administration, The University of Texas System Administration, Employees Retirement System, Department of State Health Services and Teacher Retirement System it is assumed that any costs associated with the implementation of the bill would be absorbed within existing agency resources. Based on information provided by TDI, the bill could result in a slight increase of form filing revenues deposited to the General Revenue-Dedicated Texas Department of Insurance Fund 36 (GR-D Fund 36). Since GR-D Fund 36 is a self-leveling account, this analysis also assumes that any additional revenue resulting from the implementation of the bill would accumulate in account fund balances and that TDI would adjust the assessment of the

maintenance tax or other fees accordingly in the following years.

The Texas Medical Board anticipates an increase in complaints reported to the agency which would result in increased workload for the agency; however, the number of complaints and impact on workload cannot be estimated due to a lack of available data.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 454 Department of Insurance, 503 Texas Medical Board, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: UP, CL, EK, AG, EH, CP

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 85TH LEGISLATIVE REGULAR SESSION

May 10, 2017

TO: Honorable Kelly Hancock, Chair, Senate Committee on Business & Commerce

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3124** by Gooden (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.), **As Engrossed**

No significant fiscal implication to the State is anticipated from the provisions of the bill related to the requirements for health benefit plan issuers. The fiscal implications of the bill on the Texas Medical Board cannot be determined at this time due to the unavailability of the estimates on the number of complaints, actions, and administrative penalties that would be subject to physicians under the provisions of the bill.

The bill would amend the Insurance Code 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. The bill would require a health benefit plan issuer to disclose certain cost comparison data to a physician upon request. Under the provisions of the bill, the physicians could dispute the cost comparison. The Commissioner of the Texas Department of Insurance would be required to adopt rules to implement the chapter. A health benefit plan issuer that violates the provisions of the bill would be subject to disciplinary actions and sanctions. Under the provisions of the bill, a violation of the subchapter by a physician would be subject to disciplinary action by the Texas Medical Board.

The Texas Department of Insurance anticipates any additional work resulting from the passage of the bill could be reasonably absorbed within current resources. The Texas Medical Board anticipates an increase in complaints reported to the agency which would result in increased workload for the agency; however, the number of complaints and impact on workload cannot be estimated due to a lack of available data.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 454 Department of Insurance, 503 Texas Medical Board, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: UP, CL, EK, AG, EH, CP

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 85TH LEGISLATIVE REGULAR SESSION

April 23, 2017

TO: Honorable Larry Phillips, Chair, House Committee on Insurance

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3124** by Gooden (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.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated from the provisions of the bill related to the requirements for health benefit plan issuers. The fiscal implications of the bill on the Texas Medical Board cannot be determined at this time due to the unavailability of the estimates on the number of complaints, actions, and administrative penalties that would be subject to physicians under the provisions of the bill.

The bill would amend the Insurance Code 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. The bill would require a health benefit plan issuer to disclose certain cost comparison data to a physician upon request. Under the provisions of the bill, the physicians could dispute the cost comparison. The Commissioner of the Texas Department of Insurance would be required to adopt rules to implement the chapter. A health benefit plan issuer that violates the provisions of the bill would be subject to disciplinary actions and sanctions. Under the provisions of the bill, a violation of the subchapter by a physician would be subject to disciplinary action by the Texas Medical Board.

The Texas Department of Insurance anticipates any additional work resulting from the passage of the bill could be reasonably absorbed within current resources. The Texas Medical Board anticipates an increase in complaints reported to the agency which would result in increased workload for the agency; however, the number of complaints and impact on workload cannot be estimated due to a lack of available data.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 454 Department of Insurance, 503 Texas Medical Board, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: UP, AG, EH, EK, CP

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 85TH LEGISLATIVE REGULAR SESSION

April 10, 2017

TO: Honorable Larry Phillips, Chair, House Committee on Insurance

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3124** by Gooden (Relating to the release of certain physician-specific comparison data to physicians participating in health benefit plan networks.), **As Introduced**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code relating to the release of certain physician-specific comparison data to physicians participating in health benefit plan networks. Based on information provided by the Texas Department of Insurance and Texas Medical Board, this analysis assumes the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 454 Department of Insurance, 503 Texas Medical Board, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: UP, AG, CP, EK