BILL ANALYSIS

C.S.H.B. 571
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Pensions, Investments & Financial Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Most health care plans use a payment method by which providers are paid separately for each service provided and a patient is billed separately. Enrollees in a plan receive separate bills for each procedure and from the facility in which the procedures are performed. These separate charges may include anesthesia, separate physicians and health care providers, laboratory, prescription and pharmacy services, and facility charges.

There are concerns that this method of billing may lead to overprovision of services, inefficiency, and untenable health care expenses. There are also concerns that participants in the Employees Retirement System of Texas (ERS) group benefits program may not have enough incentive to choose a lower cost option within the HealthSelect network and instead select higher cost providers for a procedure that could be performed for a lower price. C.S.H.B. 571 seeks to address these concerns by requiring the board of trustees of ERS to develop a cost-positive bundled-pricing program for health benefit plans provided under the group benefits program.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the board of trustees of the Employees Retirement System of Texas in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 571 amends the Insurance Code to require the board of trustees of the Employees Retirement System of Texas (ERS) to develop a cost-positive bundled-pricing program for health benefit plans provided under the group benefits program. The bill provides the following:

- the program must be designed to reduce health care costs in the group benefits program by contracting with a health care facility, physician, or health care provider at a consolidated rate for an inpatient or outpatient surgery procedure that is a covered health care or medical service under the health benefit plan;
- the consolidated rate must include all fees related to the covered surgery procedure, including fees for a facility, physician, health care provider, laboratory, anesthesia, perioperative service, prescription drug, or pharmacy service; and
- the board of trustees must contract with a third-party administrator, which may be independent from the administrator of a health benefit plan under the group benefits program, to administer the program.

C.S.H.B. 571, with respect to participation in the bundled-pricing program and cost-sharing obligations, provides the following:

- a participant may have only an inpatient or outpatient surgery procedure under the program;
- the board of trustees or a participating health care facility, physician, or health care provider may not require a participant to pay a deductible, copayment, coinsurance, or other cost-sharing obligation for a covered surgery procedure; and
- the board of trustees may require a participant in the state consumer-directed health plan to meet the participant's deductible before the plan pays for a covered surgery procedure.

C.S.H.B. 571, with respect to provider participation, provides the following:

- a health care facility, physician, or health care provider is not required to participate in the program;
- to participate, a facility, physician, or provider must voluntarily and expressly agree in writing to participate;
- a health care facility may not directly or indirectly do the following:
  - coerce a facility-based provider or physician to participate in the program or accept a lower rate for an inpatient or outpatient surgery procedure;
  - condition a physician's staff membership or privileges on the physician's participation in the program;
  - consider a physician's participation or lack of participation in the program in credentialing the physician;
  - offer preferential scheduling to a participating physician as compared to a physician who elects to not participate; or
  - terminate or otherwise penalize a physician or health care provider for an election to not participate; and
- the board of trustees, a health benefit plan, an administrator of a health benefit plan provided under the group program, or a health benefit plan issuer may not directly or indirectly do the following:
  - coerce a health care facility, physician, or health care provider to participate in the program;
  - condition any plan participation on participation in the program; or
  - terminate or otherwise penalize a health care facility, physician, or health care provider for electing not to participate in the program.

C.S.H.B. 571 requires a participating health care facility, physician, or health care provider to apply for approval from the program administrator, in the form and manner prescribed by the board of trustees, before scheduling a procedure under the program. The bill requires the approval application to include the consolidated rate for the procedure and any other information determined necessary by the program administrator. In determining whether to approve a procedure under these provisions, the program administrator must do the following:

- ensure that the quality of care is comparable to the care provided by a network provider for a health benefit plan under the group benefits program;
- ensure that the procedure's cost is lower than the procedure's cost if performed outside of the program; and
- consider the procedure's consolidated rate and the time the procedure will be performed as the most important factors, if there is not a quality differential and multiple health care facilities, physicians, or health care providers apply to perform the same procedure for a participant.

C.S.H.B. 571 requires the board of trustees to ensure that a participating health care facility, physician, or health care provider receives payment for a covered surgery procedure not later than the 30th day after the date the administrator receives a claim for the procedure that includes, at a minimum, each current procedural terminology code associated with the bundled procedure and each ICD-10 code associated with the patient. The bill provides the following with respect to such payment:

- the program must include the methods by which payments are allocated among a participating health care facility, physician, or health care provider;

- the entity receiving the consolidated payment must be a physician-led organization and have contracting authority on behalf of the other participating physicians, health care providers, and health care facilities, if the consolidated bundled payment is to be paid to an entity for further distribution to other participating physicians, health care providers, or health care facilities; and
- a participating health care facility, physician, or health care provider may submit a request for payment to the administrator for unanticipated services required to be provided while performing a procedure under the program and the request must include information on the reason the services were required.

C.S.H.B. 571 requires a participating health care facility, physician, or health care provider to provide a written disclosure to a participant or the participant's representative of the consolidated rate for a procedure provided under the program before scheduling the procedure. The bill authorizes a participating health care facility, physician, or health care provider to disclose a consolidated rate for an inpatient or outpatient surgery procedure on the facility's, physician's, or provider's website and marketing materials.

C.S.H.B. 571 requires the board of trustees to publish on the ERS website information on the program, including a list of participating health care facilities, physicians, and health care providers, and the consolidated rates offered by each participating facility, physician, and provider.

C.S.H.B. 571 prohibits its provisions from being construed to authorize the following:
- a lay person or entity to supervise or otherwise control the practice of medicine as prohibited under the Medical Practice Act;
- a person or entity to engage in the unauthorized practice of medicine in Texas;
- a person or entity to misrepresent that the person or entity is entitled to practice medicine; or
- a violation of statutory provisions relating to the following:
  - the licensing requirements for practicing medicine;
  - general eligibility requirements for a license to practice medicine;
  - the general authority of a physician to delegate;
  - prohibited practices by a physician or license applicant subjecting both to license denial and disciplinary action; and
  - certain misrepresentations regarding the entitlement to practice medicine.

C.S.H.B. 571 authorizes the ERS board of trustees to adopt rules as necessary to implement the bill's provisions. The bill defines "facility-based provider" by reference and "program" to mean the bundled-pricing program under its provisions.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 571 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes the following provisions not included in the original:
- a provision defining the terms "facility-based provider" and "program";
- a provision requiring the ERS board of trustees to contract with a third-party administrator to administer the bundled-pricing program; and
- a provision specifying that the program administrator may be independent from the administrator of a health benefit plan under the group benefits program.

Whereas the original authorized a person to have an inpatient or outpatient surgery procedure under the bundled-pricing program, the substitute instead provides that a person may have only an inpatient or outpatient surgery procedure under the program.

The substitute changes the following respective provisions of the original as follows:

- with respect to the original's provision requiring that a consolidated rate of a bundled-pricing program include specified fees, the substitute requires that fees for anesthesia and for perioperative service also be included in a consolidated rate;
- with respect to the original's provisions regarding provider participation, the substitute includes a provision requiring a facility, physician, or provider to voluntarily and expressly agree in writing to participate; and
- with respect to the original's provisions prohibiting a health care facility from coercing a facility-based provider to participate in the program or accept a lower rate for an applicable surgery procedure, the substitute provides the following, which are not in the original:
    - the prohibition also applies to coercion of a physician; and
    - the prohibition applies to both direct and indirect coercion.

The substitute includes additional prohibitions, which were not in the original, that prohibit a health care facility from directly or indirectly taking certain actions with respect to a physician's staff membership or privileges, credentialing, and scheduling or a physician's election to not participate in the program.

The substitute includes additional prohibitions, which were not in the original, that prohibit the board of trustees, a health benefit plan, an administrator of a health benefit plan provided under the group program, or a health benefit plan issuer from directly or indirectly taking certain actions with respect to coercing participation, conditioning health benefit plan participation on program participation, or terminating or otherwise penalizing an applicable entity for electing to not participate in the program.

The substitute includes provisions, which were not in the original, that provide for an approval process whereby a participating health care facility, physician, or health care provider must apply for approval from the program administrator in the form and manner prescribed by the board of trustees before scheduling a procedure under the program.

The substitute revises and expands, as follows, the original's provision regarding the requirement that the board of trustees ensure that a health care facility, physician, or health care provider receive payment for a covered surgery procedure by a certain date:

- rather than requiring a claim, as the original does, to include all information necessary for the administrator to pay the claim, the substitute instead specifies that the claim must include, at a minimum, certain specified codes respectively associated with the procedure and with the patient; and
- the substitute adds provisions, which were not in the original, regarding the following:
    - payment allocation methods;
    - a payment paid for further distribution; and
    - procedures for submitting requests for payment for unanticipated services.

The substitute includes a requirement, which was not included in the original, for a participating health care facility, physician, or health care provider to provide written disclosure of the consolidated rate for a procedure before scheduling the procedure.

With respect to the original's requirement for program information to be published on the ERS website, the substitute revises the requirement to require that the information also include the consolidated rates offered by each participating facility, physician, and provider.

The substitute includes a prohibition, which was not in the original, against its provisions being construed to authorize certain conduct with respect to the supervision or control of the practice of medicine, the unauthorized practice of medicine, the misrepresentation of being entitled to practice medicine, or a violation of specified statutory provisions.