87R19598 SCL-D

By:  Gates H.B. No. 571

Substitute the following for H.B. No. 571:

By:  Capriglione C.S.H.B. No. 571

A BILL TO BE ENTITLED

AN ACT

relating to the establishment of a bundled-pricing program to reduce certain health care costs in the state employees group benefits program.

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

SECTION 1.  Chapter 1551, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. BUNDLED-PRICING PROGRAM

Sec. 1551.501.  DEFINITIONS. In this subchapter:

(1)  "Facility-based provider" has the meaning assigned by Section 1551.229.

(2)  "Program" means the bundled-pricing program developed under this subchapter.

Sec. 1551.502.  BUNDLED-PRICING PROGRAM. (a) The board of trustees shall develop a cost-positive bundled-pricing program for health benefit plans provided under the group benefits program.

(b)  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 a health benefit plan provided under the group benefits program.

(c)  A consolidated rate described by Subsection (b) 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.

(d)  The board of trustees shall contract with a third-party administrator to administer the program. The program administrator may be independent from the administrator of a health benefit plan under the group benefits program.

Sec. 1551.503.  PARTICIPATION; COST-SHARING OBLIGATION. (a) A participant may have only an inpatient or outpatient surgery procedure under the program.

(b)  Except as provided by Subsection (c), 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 provided under the program.

(c)  The board of trustees may require a participant in the state consumer-directed health plan established under Section 1551.452 to meet the participant's deductible before the plan pays for a covered surgery procedure provided under the program.

Sec. 1551.504.  PROVIDER PARTICIPATION. (a) 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.

(b)  A health care facility may not directly or indirectly:

(1)  coerce a facility-based provider or physician to participate in the program or accept a lower rate for an inpatient or outpatient surgery procedure;

(2)  condition a physician's staff membership or privileges on the physician's participation in the program;

(3)  consider a physician's participation or lack of participation in the program in credentialing the physician;

(4)  offer preferential scheduling to a participating physician as compared to a physician who elects not to participate; or

(5)  terminate or otherwise penalize a physician or health care provider for an election to not participate in the program.

(c)  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:

(1)  coerce a health care facility, physician, or health care provider to participate in the program;

(2)  condition any plan participation on participation in the program; or

(3)  terminate or otherwise penalize a health care facility, physician, or health care provider for electing not to participate in the program.

Sec. 1551.505.  PROCEDURE APPROVAL. (a) Before scheduling a procedure under the program, 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.

(b)  The approval application must include the consolidated rate for the procedure and any other information determined necessary by the program administrator.

(c)  In determining whether to approve a procedure under this section, the program administrator shall:

(1)  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;

(2)  ensure that the procedure's cost is lower than the procedure's cost if performed outside of the program; and

(3)  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, consider the procedure's consolidated rate and the time the procedure will be performed as the most important factors.

Sec. 1551.506.  PAYMENT. (a) The board of trustees shall 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 program 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.

(b)  The program must include the methods by which payments are allocated among a participating health care facility, physician, or health care provider. 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, 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.

(c)  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. The request must include information on the reason the services were required.

Sec. 1551.507.  BUNDLED-PRICING DISCLOSURE. (a) A participating health care facility, physician, or health care provider shall 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.

(b)  A health care facility, physician, or health care provider that participates in the program may disclose a consolidated rate for an inpatient or outpatient surgery procedure on the facility's, physician's, or provider's Internet website and marketing materials.

Sec. 1551.508.  PUBLICATION OF INFORMATION. The board of trustees shall publish 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, on the Employees Retirement System of Texas website.

Sec. 1551.509.  UNAUTHORIZED PRACTICE OF MEDICINE PROHIBITED. This subchapter may not be construed to authorize:

(1)  a lay person or entity to supervise or otherwise control the practice of medicine as prohibited under Subtitle B, Title 3, Occupations Code;

(2)  a person or entity to engage in the unauthorized practice of medicine in this state;

(3)  a person or entity to misrepresent that the person or entity is entitled to practice medicine; or

(4)  a violation of Section 155.001, 155.003, 157.001, 164.052, or 165.156, Occupations Code.

Sec. 1551.510.  RULEMAKING. The board of trustees may adopt rules as necessary to implement this subchapter.

SECTION 2.  This Act takes effect September 1, 2021.