BILL ANALYSIS

H.B. 840
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Pensions, Investments & Financial Services
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Most health benefit plans use a payment method by which providers are paid separately for each service provided to a patient and the patient is billed separately for the service. When a plan enrollee undergoes a procedure, the enrollee may receive separate bills from the facility in which the procedure was performed for various charges. There are concerns that this method of billing may lead to the overprovision of services, inefficiency, and untenable health care expenses. There are also concerns that participants in the state employees group benefits program may not have enough incentive to choose a lower cost option within the HealthSelect network and instead may select higher cost providers for a procedure that could be performed for a lower price. H.B. 840 seeks to address these concerns by requiring the board of trustees of the Employees Retirement System of Texas 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

H.B. 840 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 state employees group benefits program. The bill provides the following with respect to the bundled-pricing program:

- 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 covered under such a health benefit plan;
- the consolidated rate must include all fees related to the covered surgery procedure, including fees for a health care 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 health benefit plan's administrator, to administer the program.

H.B. 840, 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.

H.B. 840, with respect to provider participation in the bundled-pricing program, provides the following:

- a health care facility, physician, or health care provider is not required to participate;
- to participate, a health care facility, physician, or health care provider must voluntarily and expressly agree in writing to participate;
- a health care facility may not directly or indirectly do the following:
    - coerce a physician or health care provider who provides services to health care facility patients or other physician to participate 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;
    - consider a physician's participation or lack of participation for credentialing purposes;
    - 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, or a health benefit plan administrator or issuer may not directly or indirectly do the following:
    - coerce a health care facility, physician, or health care provider to participate;
    - 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.

H.B. 840 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 bundled-pricing 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.

H.B. 840 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 under the bundled-pricing program 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 facilities, physicians, and

providers, if the consolidated bundled payment is to be paid to an entity for further distribution to other participating health care facilities, physicians, or health care providers; 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.

H.B. 840 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.

H.B. 840 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.

H.B. 840 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 certain medical acts;
    - 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.

H.B. 840 authorizes the ERS board of trustees to adopt rules as necessary to implement the bill's provisions.

EFFECTIVE DATE

September 1, 2023.