BILL ANALYSIS

C.S.H.B. 1073
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The health care market is moving towards capitated value-based care arrangements like advanced primary care and direct primary care where providers take on the risk of caring for patients for a set monthly fee. These arrangements are rapidly gaining traction for employees, employers, and doctors. For example, according to a consumer survey conducted by Hint Health, more than 80 percent of employees say they would be highly or somewhat likely to sign up for an all-inclusive direct primary care plan if given the option.

Decades-old state law limits payment and benefit design innovation. Currently, health maintenance organizations (HMOs) are the only type of health plan in Texas that can partner with doctors for risk-based, value-based payments. Preferred provider organization (PPO) plans and exclusive provider organization (EPO) plans cannot pay a primary care doctor a flat, monthly payment for risk-based direct primary care or advanced primary care because there is no language in law applicable to these plan types expressly allowing capitation. As such, the Texas Department of Insurance has interpreted the law to prohibit risk-based payments.

C.S.H.B. 1073 seeks to resolve this issue by establishing that value-based and capitated payment arrangements with primary care physicians and primary care physician groups are not prohibited.

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 this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 1073 amends the Insurance Code to authorize a preferred provider benefit plan or an exclusive provider benefit plan to provide or arrange for health care services with a primary care physician or primary care physician group through a contract for compensation under any of the following arrangements:

- a fee-for-service arrangement;
- a risk-sharing arrangement;
- a capitation arrangement under which a fixed predetermined payment is made in exchange for the provision of, or for the arrangement to provide and the guaranty of the provision of, a contractually defined set of covered services to covered persons for a specified period without regard to the quantity of services actually provided; or
- any combination of these arrangements.

The bill specifies that a primary care physician or primary care physician group that enters into such a contract is not considered to be engaging in the business of insurance. The bill expressly does not authorize a preferred provider benefit plan or an exclusive provider benefit plan to provide or arrange for health care services with a primary care physician or primary care physician group through a contract for compensation under a global capitation arrangement.

C.S.H.B. 1073 establishes that a primary care physician or primary care physician group is not required to enter into a payment arrangement and prohibits an insurer from discriminating against a physician or physician group that elects not to participate in an arrangement, including by:

- reducing the fee schedule of a physician or physician group because the physician or physician group does not participate in the insurer's value-based or capitated payment arrangement or other payment arrangement; or
- requiring a physician or physician group to participate in the insurer's value-based or capitated payment arrangement or other payment arrangement as a condition of participation in the insurer's provider network.

The bill authorizes a primary care physician or primary care physician group to file a complaint with the Texas Department of Insurance (TDI) if the physician or physician group believes they have been discriminated against in violation of that prohibition.

C.S.H.B. 1073 provides the following with respect to the contents of a contract allowing for a value-based or capitated payment arrangement or other payment arrangement:

- the agreement may not create a disincentive to the provision of medically necessary health care services and may not interfere with the physician's independent medical judgment on which services are medically appropriate or medically necessary;
- the agreement must specify:
    - in writing if compensation is being paid based on satisfaction of performance measures and, if so, specifically provide:
        - the performance measures;
        - the source of the measures;
        - the method and time period for calculating whether the performance measures have been satisfied;
        - access to financial and performance-based information used to determine whether the physician met those measures; and
        - the method by which the physician may request reconsideration;
    - that the attribution process will assign a patient to first the patient's established physician, as determined by a prior annual exam or other office visits, and, if no established physician relationship exists, then a physician chosen by the patient;
    - if payment involves capitation, whether a bridge rate, such as a discounted fee for service, will remain in effect for a certain period until sufficient data has been generated regarding utilization to allow an insurer to make an informed decision regarding fully capitated rates;
    - whether the capitated rate, if any, will provide for a stop-loss threshold or a guaranteed minimum level of payment per month, and whether the physician will obtain stop-loss coverage; and
    - whether payment will take into account patients who are added to or eliminated from the attributed population during the course of a measurement period;
- if payment involves capitation, the agreement must provide for the opportunity to renegotiate in good faith a revised capitation rate, or reimburse on a fee-for-service basis under a contractual fee schedule until a revised capitation rate is agreed to if there is a material increase in the scope of services provided by the physician or a material change by the payer in the benefit structure; and
- the agreement must state whether catastrophic events are excluded from the final cost calculation for an attributed population when compared to the cost target for the measurement period, if applicable, and, if payment involves shared savings, whether the

entire savings is shared when the minimum savings rate is reached, or whether only the amount in excess of the minimum savings rate is shared.

The bill establishes that the parties to such a contract are the primary care physician or primary care physician group and the preferred provider benefit plan or exclusive provider benefit plan and prohibits a party to the contract from subcontracting.

C.S.H.B. 1073 defines "primary care physician" and "primary care physician group" as follows:

- "primary care physician" as a specialist in family medicine, general internal medicine, or general pediatrics who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care, which may include chronic, preventive, and acute care; and
- "primary care physician group" as an entity through which two or more primary care physicians deliver health care to the public through the practice of medicine on a regular basis and that is either owned and operated by two or more physicians or a freestanding clinic, center, or office of a nonprofit health organization that is certified by the Texas Medical Board (TMB) and complies with the requirements of state law providing for the regulation by the TMB of certain nonprofit health corporations.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 1073 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute and introduced both authorize a preferred provider benefit plan to provide or arrange for health care services with a physician or health care provider through a contract and the introduced further specified that a plan may provide or arrange the services through a subcontract. However, the substitute expressly prohibits a party to a contract from subcontracting. The substitute and introduced differ as follows with respect to that shared authorization:

- the substitute, but not the introduced, expressly applies the contracting authority to an exclusive provider benefit plan;
- the substitute, but not the introduced, limits the physicians or health care providers with which a plan may contract to a primary care physician or a primary care physician group;
- the substitute and introduced list the same authorized arrangements types but the substitute also includes an option to enter into any combination of those authorized arrangements; and
- with respect to the authorized capitation arrangements, the substitute, but not the introduced, specifies that the defined set of covered services under the arrangement must be contractually defined.

The substitute includes the following provisions that were not in the introduced:

- provisions defining "primary care physician" and "primary care physician group";
- a provision establishing that a primary care physician or primary care physician group is not required to enter into a payment arrangement;
- provisions prohibiting an insurer from discriminating against a primary care physician or primary care physician group that elects not to participate in an arrangement and authorizing a physician or physician group to file a complaint with TDI if the physician or physician group believes they have been discriminated against in violation of that prohibition;

- provisions establishing a prohibition and requirements regarding the contents of a contract for a value-based or capitated payment arrangement or other payment arrangement;
- a provision establishing that the parties to a contract are the primary care physician or primary care physician group and the preferred provider benefit plan or exclusive provider benefit plan; and
- a provision establishing that the bill does not authorize a preferred provider benefit plan or an exclusive provider benefit plan to provide or arrange for health care services with a primary care physician or primary care physician group through a contract for compensation under a global capitation arrangement.

The substitute does not include the provisions from the introduced excluding a self-funded employee welfare benefit plan entering into a value-based risk sharing contract arrangement with a health care provider or group of health care providers from the acts considered to be engaging in the business of insurance on the basis of contracting to provide indemnification or expense reimbursement for a medical expense by direct payment, reimbursement, or otherwise.