BILL ANALYSIS

C.S.H.B. 3351
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Price transparency helps patients shop for lower-cost services, but patients continue to lack transparency related to the quality of care. Current law prohibits health benefit plan issuers from informing enrollees about physician quality rankings based on national standards without meeting onerous requirements. Those requirements allow a single physician with poor quality rankings, based on nationally recognized standards and guidelines, to slow or stop the process of sharing quality transparency information through health plans. C.S.H.B. 3351 seeks to address this issue by simplifying Insurance Code requirements regarding certain physician rankings by health benefit plan issuers and by providing a process for an affected physician to identify discrepancies and for a health benefit plan issuer to remedy such a discrepancy.

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. 3351 amends the Insurance Code to remove the prohibition against a health benefit plan issuer, including a subsidiary or affiliate, publishing physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians unless certain requirements are met. The bill removes the following as requirements that must be satisfied by a health benefit plan issuer that ranks physicians or classifies physicians into tiers based on performance:

- the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted by the commissioner of insurance;
- the standards and measurements to be used by the plan issuer are disclosed to each affected physician before any evaluation period used by the plan issuer; and
- 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 certain due process protections that conform to the following protections:
    - the 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 plan issuer in its rating, tiering, ranking, or comparison decision;
    - in addition to any written fair reconsideration process and upon receiving a request for review within 30 days of the physician receiving the plan issuer's

notice, the plan issuer provides a fair reconsideration proceeding at certain times by teleconference or in person at the physician's option;
    - the physician has the right to provide information at that proceeding for determination by a decision-maker, have a representative participate in the proceeding, and submit a written statement at the conclusion of the proceeding; and
    - the plan issuer provides a written communication of the proceeding's outcome, including the specific reasons for the final decision, prior to any publication or dissemination of the rating, ranking, tiering, or comparison.

The bill prohibits a health benefit plan issuer instead from ranking physicians or classifying physicians into tiers based on performance unless the following requirements are met:

- the standards used by the health benefit plan issuer to rank or classify are propagated or developed by an organization designated by the commissioner through adopted rules;
- the ranking, comparison, or evaluation:
    - is disclosed to each affected physician at least 45 days before the date the ranking, comparison, or evaluation is released, published, or distributed to enrollees by the health benefit plan issuer; and
    - identifies which products or networks offered by the health benefit plan issuer the ranking, comparison, or evaluation will be used for; and
- each affected physician is given an easy-to-use process to identify discrepancies between the standards and the ranking, comparison, or evaluation as propagated by the health benefit plan issuer.

If a physician submits information to a health benefit plan issuer to establish such a discrepancy, the health benefit plan issuer must remedy the discrepancy by the later of publication or the 30th day after the date the health benefit plan issuer receives the information.

C.S.H.B. 3351 removes the requirement for the commissioner, in adopting rules regarding standards for physician rankings by health benefit plans, to consider the standards, guidelines, and measures prescribed by certain nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care. The bill instead limits the authority of the commissioner to designate an organization in adopting such rules to an organization that meets the following requirements:

- the prescribing organization is bona fide and unbiased toward or against any medical provider;
- the standards to be used in rankings, comparisons, or evaluations:
    - are nationally recognized, or based on expert-provider consensus or leading clinical evidence-based scholarship;
    - have a publicly transparent methodology; and
    - if based on clinical outcomes, are risk-adjusted; and
- the prescribing organization has an easy-to-use process by which a medical provider may report data, evidentiary, factual, or mathematical errors for prompt investigation and, if appropriate, correction.

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. 3351 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 includes a provision that was not in the introduced removing the requirement that a health benefit plan issuer that ranks physicians or classifies physicians into tiers based on performance use standards that conform to nationally recognized standards and guidelines as

required by commissioner rules. The substitute also includes provisions that were not in the introduced setting out the requirements that must be met by a health benefit plan issuer that ranks or classifies physicians into tiers based on performance and providing for a process for remedying discrepancies established by an affected physician.

The substitute omits a provision from the introduced making the physician ranking requirements inapplicable to the provision of physician-specific cost comparison information from a health benefit plan issuer to a network physician whose payment by the plan issuer to the physician is partly based on costs of other health care providers that are attributed by the plan issuer.

The substitute includes provisions that were not in the introduced replacing the requirement for the commissioner of insurance, in adopting rules regarding standards for physician rankings by health benefit plans, to consider the standards, guidelines, and measures prescribed by certain nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care with a limitation on the authority of the commissioner to designate an organization, in adopting such rules, that meets certain requirements.