SUBJECT: Allowing physicians in an accountable care organization to receive data

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Phillips, Muñoz, R. Anderson, Gooden, Oliverson, Paul, Sanford, Turner, Vo

0 nays

WITNESSES: For — Robert Morrow, Blue Cross and Blue Shield of Texas; Dr. Anas Daghestani, Texas Medical Association; (*Registered, but did not testify*: Ian Randolph and John Hubbard, PracticeEdge; Dan Hinkle, Texas Academy of Family Physician; Jaime Capelo, Texas Ambulatory Surgery Center Society; Jamie Dudensing, Texas Association of Health Plans; Clayton Stewart, Texas Medical Association; David Reynolds, Texas Osteopathic Medical Association; Bonnie Bruce, Texas Society of Anesthesiologists; Greg Herzog, Texas Society of Gastroenterology and Endoscopy and Texas Neurology Society)

Against — None

On — (*Registered, but did not testify*: Jamie Walker, Texas Department of Insurance)

BACKGROUND: Insurance Code, ch. 1460 limits how health benefit plan issuers may disclose information to physicians about the total cost of care provided by physicians and requires an evaluation period before disclosing information to physicians and others. Some have called for the statute to be changed to allow physicians participating in accountable care organizations to more easily receive this information.

DIGEST: CSHB 3124 would allow a health benefit plan issuer to provide cost comparison data to physicians participating in accountable care organizations and to a designated entity. A "designated entity" would mean a limited liability company in which a majority ownership interest was held by an incorporated association whose purpose included uniting

in one organization all physicians licensed to practice medicine in Texas and that has been in continued existence for at least 15 years.

Under the bill, within 15 business days of receiving a request from a participating physician, the health benefit plan issuer would be required to disclose to the physician the following information:

- the cost comparison data associated with the physician;
- the measures and methodology used to compare costs; and
- any other information considered in making the cost comparison.

If cost comparison data associated with non-physician health care providers was available to a health benefit plan issuer that provided this data, the plan issuer would provide that data. The bill would prohibit the disclosure of a contract rate or the publication of cost comparison data to anyone other than a participating physician or a designated entity.

The health plan issuer would ensure that physicians currently in clinical practice were actively involved in the development of standards used for cost containment data and that the measures and methodology used to develop cost containment data were transparent and valid.

A health benefit plan issuer would provide written notice to a physician under contract with the plan that explained how the plan issuer would compile and use cost comparison data, the purpose and scope of the issuer's release of cost comparison data, the requirements in statute regarding cost comparison data, and information about physicians' rights and duties. A physician who received cost comparison data about another physician would be prohibited from disclosing the data to any other person, except for the following purposes:

- managing an accountable care organization;
- managing the receiving physician's practice or referrals;
- evaluating or disputing the cost comparison data associated with the receiving physician;
- obtaining professional advice related to a legal claim; or

- reporting, complaining, or responding to a governmental agency.

The bill would set out how a physician could dispute cost comparison data and would specify the rights a physician would have at the dispute proceeding.

The bill would require the health benefit plan issuer to provide the physician with written information about the outcome of the dispute proceeding within 60 days of the date the physician initiated the dispute process, including reasons for the final decision. If the health benefit plan issuer determined that the cost comparison data was inaccurate or the measures and methodology used to compare costs were invalid, the issuer would promptly correct the data or update the measures and methodology and associated data. The bill would require the measures and methodology used to compare costs to account for health status differences between different populations of patients.

The commissioner of insurance would adopt rules as necessary to implement the bill's provisions regarding cost comparison data. A health benefit plan issuer that violated the bill's provisions or a rule adopted by the commissioner of insurance related to the provisions would be subject to sanctions and disciplinary actions. A violation of the provisions of the bill by a physician would constitute grounds for disciplinary action by the Texas Medical Board, including an administrative penalty.

The bill would take effect September 1, 2017, and would apply to a contract entered into or renewed on or after that date. A contract before that date would be governed by the law as it existed immediately before that date and the law would be continued for that purpose.