AN ACT

relating to the establishment of a statewide all payor claims database and health care cost disclosures by health benefit plan issuers and third-party administrators.

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

SECTION 1. Chapter 38, Insurance Code, is amended by adding Subchapter I to read as follows:

SUBCHAPTER I. TEXAS ALL PAYOR CLAIMS DATABASE

Sec. 38.401. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to authorize the department to establish an all payor claims database in this state to increase public transparency of health care information and improve the quality of health care in this state.

Sec. 38.402. DEFINITIONS. In this subchapter:

(1) "Allowed amount" means the amount of a billed charge that a health benefit plan issuer determines to be covered for services provided by a non-network provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(2) "Center" means the Center for Healthcare Data at The University of Texas Health Science Center at Houston.

(3) "Contracted rate" means the fee or reimbursement amount for a network provider's services, treatments, or supplies

as established by agreement between the provider and health benefit plan issuer.

(4) "Data" means the specific claims and encounters, enrollment, and benefit information submitted to the center under this subchapter.

(5) "Database" means the Texas All Payor Claims Database established under this subchapter.

(6) "Geozip" means an area that includes all zip codes with identical first three digits.

(7) "Payor" means any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:

(A) an insurance company providing health or dental insurance;

(B) the sponsor or administrator of a health or dental plan;

(C) a health maintenance organization operating under Chapter 843;

(D) the state Medicaid program, including the Medicaid managed care program operating under Chapter 533, Government Code;

(E) a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including:

(i) a basic coverage plan under Chapter

1551;

(ii) a basic plan under Chapter 1575; and

(iii) a primary care coverage plan under Chapter 1579; or

(F) any other entity providing a health insurance or health benefit plan subject to regulation by the department.

(8) "Protected health information" has the meaning assigned by 45 C.F.R. Section 160.103.

(9) "Qualified research entity" means:

(A) an organization engaging in public interest research for the purpose of analyzing the delivery of health care in this state that is exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt organization in Section 501(c)(3) of that code;

(B) an institution of higher education engaged in public interest research related to the delivery of health care in this state; or

(C) a health care provider in this state engaging in efforts to improve the quality and cost of health care.

(10) "Stakeholder advisory group" means the stakeholder advisory group established under Section 38.403.

Sec. 38.403. STAKEHOLDER ADVISORY GROUP. (a) The center shall establish a stakeholder advisory group to assist the center as provided by this subchapter, including assistance in:

(1) establishing and updating the standards, requirements, policies, and procedures relating to the collection and use of data contained in the database required by Sections

38.404(e) and (f);

(2) evaluating and prioritizing the types of reports the center should publish under Section 38.404(e);

(3) evaluating data requests from qualified research entities under Section 38.404(e)(2); and

(4) assisting the center in developing the center's recommendations under Section 38.408(3).

(b) The advisory group created under this section must be composed of:

(1) the state Medicaid director or the director's designee;

(2) a member designated by the Teacher Retirement System of Texas;

(3) a member designated by the Employees Retirement System of Texas; and

(4) 12 members designated by the center, including:

(A) two members representing the business community, with at least one of those members representing small businesses that purchase health benefits but are not involved in the provision of health care services, supplies, or devices or health benefit plans;

(B) two members who represent consumers and who are not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices or health benefit plans, with at least one member representing the behavioral health community;

(C) two members representing hospitals that are

licensed in this state;

(D) two members representing health benefit plan issuers that are regulated by the department;

(E) two members who are physicians licensed to practice medicine in this state, one of whom is a primary care physician; and

(F) two members who are not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices or health benefit plans and who have expertise in:

(i) health planning;

(ii) health economics;

(iii) provider quality assurance;

(iv) statistics or health data management; or

(v) medical privacy laws.

(c) A person serving on the stakeholder advisory group must disclose any conflict of interest.

(d) Members of the stakeholder advisory group serve fixed terms as prescribed by commissioner rules adopted under this subchapter.

Sec. 38.404. ESTABLISHMENT AND ADMINISTRATION OF DATABASE. (a) The department shall collaborate with the center under this subchapter to aid in the center's establishment of the database. The center shall leverage the existing resources and infrastructure of the center to establish the database to collect, process, analyze, and store data relating to medical, dental,

pharmaceutical, and other relevant health care claims and encounters, enrollment, and benefit information for the purposes of increasing transparency of health care costs, utilization, and access and improving the affordability, availability, and quality of health care in this state, including by improving population health in this state.

(b) The center shall serve as the administrator of the database, design, build, and secure the database infrastructure, and determine the accuracy of the data submitted for inclusion in the database.

(c) In determining the information a payor is required to submit to the center under this subchapter, the center must consider requiring inclusion of information useful to health policy makers, employers, and consumers for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs. The required information at a minimum must include the following information as it relates to all health care services, supplies, and devices paid or otherwise adjudicated by the payor:

(1) the name and National Provider Identifier, as described in 45 C.F.R. Section 162.410, of each health care provider paid by the payor;

(2) the claim line detail that documents the health care services, supplies, or devices provided by the health care provider;

(3) the amount of charges billed by the health care provider and the payor's:

(A) allowed amount or contracted rate for the health care services, supplies, or devices; and

(B) adjudicated claim amount for the health care services, supplies, or devices;

(4) the name of the payor, the name of the health benefit plan, and the type of health benefit plan, including whether health care services, supplies, or devices were provided to an individual through:

(A) a Medicaid or Medicare program;

(B) workers' compensation insurance;

(C) a health maintenance organization operating under Chapter 843;

(D) a preferred provider benefit plan offered by an insurer under Chapter 1301;

(E) a basic coverage plan under Chapter 1551;

(F) a basic plan under Chapter 1575;

(G) a primary care coverage plan under Chapter 1579; or

(H) a health benefit plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and

(5) claim level information that allows the center to identify the geozip where the health care services, supplies, or devices were provided.

(d) Each payor shall submit the required data under Subsection (c) at a schedule and frequency determined by the center and adopted by the commissioner by rule.

(e) In the manner and subject to the standards, requirements, policies, and procedures relating to the use of data contained in the database established by the center in consultation with the stakeholder advisory group, the center may use the data contained in the database for a noncommercial purpose:

(1) to produce statewide, regional, and geozip consumer reports available through the public access portal described in Section 38.405 that address:

(A) health care costs, quality, utilization, outcomes, and disparities;

(B) population health; or

(C) the availability of health care services; and

(2) for research and other analysis conducted by the center or a qualified research entity to the extent that such use is consistent with all applicable federal and state law, including the data privacy and security requirements of Section 38.406 and the purposes of this subchapter.

(f) The center shall establish data collection procedures and evaluate and update data collection procedures established under this section. The center shall test the quality of data collected by and reported to the center under this section to ensure that the data is accurate, reliable, and complete.

Sec. 38.405. PUBLIC ACCESS PORTAL. (a) Except as provided by this section and Sections 38.404 and 38.406 and in a manner consistent with all applicable federal and state law, the center shall collect, compile, and analyze data submitted to or stored in the database and disseminate the information described in Section

38.404(e)(1) in a format that allows the public to easily access and navigate the information. The information must be accessible through an open access Internet portal that may be accessed by the public through an Internet website.

(b) The portal created under this section must allow the public to easily search and retrieve the information disseminated under Subsection (a), subject to data privacy and security restrictions described in this subchapter and consistent with all applicable federal and state law.

(c) Any information or data that is accessible through the portal created under this section:

(1) must be segmented by type of insurance or health benefit plan in a manner that does not combine payment rates relating to different types of insurance or health benefit plans;

(2) must be aggregated by like Current Procedural Terminology codes and health care services in a statewide, regional, or geozip area; and

(3) may not identify a specific patient, health care provider, health benefit plan, health benefit plan issuer, or other payor.

(d) Before making information or data accessible through the portal, the center shall remove any data or information that may identify a specific patient in accordance with the de-identification standards described in 45 C.F.R. Section 164.514.

Sec. 38.406. DATA PRIVACY AND SECURITY. (a) Any information that may identify a patient, health care provider,

health benefit plan, health benefit plan issuer, or other payor is confidential and subject to applicable state and federal law relating to records privacy and protected health information, including Chapter 181, Health and Safety Code, and is not subject to disclosure under Chapter 552, Government Code.

(b) A qualified research entity with access to data or information that is contained in the database but not accessible through the portal described in Section 38.405:

(1) may use information contained in the database only for purposes consistent with the purposes of this subchapter and must use the information in accordance with standards, requirements, policies, and procedures established by the center in consultation with the stakeholder advisory group;

(2) may not sell or share any information contained in the database; and

(3) may not use the information contained in the database for a commercial purpose.

(c) A qualified research entity with access to information that is contained in the database but not accessible through the portal must execute an agreement with the center relating to the qualified research entity's compliance with the requirements of Subsections (a) and (b), including the confidentiality of information contained in the database but not accessible through the portal.

(d) Notwithstanding any provision of this subchapter, the department and the center may not disclose an individual's protected health information in violation of any state or federal

law.

(e) The center shall include in the database only the minimum amount of protected health information identifiers necessary to link public and private data sources and the geographic and services data to undertake studies.

(f) The center shall maintain protected health information identifiers collected under this subchapter but excluded from the database under Subsection (e) in a separate database. The separate database may not be aggregated with any other information and must use a proxy or encrypted record identifier for analysis.

Sec. 38.407. CERTAIN ENTITIES NOT REQUIRED TO SUBMIT DATA. Any sponsor or administrator of a health benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) may elect or decline to participate in or submit data to the center for inclusion in the database as consistent with federal law.

Sec. 38.408. REPORT TO LEGISLATURE. Not later than September 1 of each even-numbered year, the center shall submit to the legislature a written report containing:

(1) an analysis of the data submitted to the center for use in the database;

(2) information regarding the submission of data to the center for use in the database and the maintenance, analysis, and use of the data;

(3) recommendations from the center, in consultation with the stakeholder advisory group, to further improve the transparency, cost-effectiveness, accessibility, and quality of

health care in this state; and

(4) an analysis of the trends of health care affordability, availability, quality, and utilization.

Sec. 38.409. RULES. (a) The commissioner, in consultation with the center, shall adopt rules:

(1) specifying the types of data a payor is required to provide to the center under Section 38.404 to determine health benefits costs and other reporting metrics, including, if necessary, types of data not expressly identified in that section;

(2) specifying the schedule, frequency, and manner in which a payor must provide data to the center under Section 38.404, which must:

(A) require the payor to provide data to the center not less frequently than quarterly; and

(B) include provisions relating to data layout, data governance, historical data, data submission, use and sharing, information security, and privacy protection in data submissions; and

(3) establishing oversight and enforcement mechanisms to ensure that payors submit data to the database in accordance with this subchapter.

(b) In adopting rules governing methods for data submission, the commissioner shall to the maximum extent practicable use methods that are reasonable and cost-effective for payors.

SECTION 2. The heading to Subtitle J, Title 8, Insurance Code, is amended to read as follows:

SUBTITLE J. HEALTH INFORMATION TECHNOLOGY AND AVAILABILITY

SECTION 3. Subtitle J, Title 8, Insurance Code, is amended by adding Chapter 1662 to read as follows:

CHAPTER 1662. HEALTH CARE COST TRANSPARENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1662.001. DEFINITIONS. In this chapter:

(1) "Billed charge" means the total charges for a health care service or supply billed to a health benefit plan by a health care provider.

(2) "Billing code" means the code used by a health benefit plan issuer or administrator or health care provider to identify a health care service or supply for the purposes of billing, adjudicating, and paying claims for a covered health care service or supply, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the Diagnosis-Related Group code, the National Drug Code, or other common payer identifier.

(3) "Bundled payment arrangement" means a payment model under which a health care provider is paid a single payment for all covered health care services and supplies provided to an enrollee for a specific treatment or procedure.

(4) "Copayment assistance" means the financial assistance an enrollee receives from a prescription drug or medical supply manufacturer toward the purchase of a covered health care service or supply.

(5) "Cost-sharing information" means information related to any expenditure required by or on behalf of an enrollee

with respect to health care benefits that are relevant to a determination of the enrollee's cost-sharing liability for a particular covered health care service or supply.

(6) "Cost-sharing liability" means the amount an enrollee is responsible for paying for a covered health care service or supply under the terms of a health benefit plan. The term generally includes deductibles, coinsurance, and copayments but does not include premiums, balance billing amounts by out-of-network providers, or the cost of health care services or supplies that are not covered under a health benefit plan.

(7) "Covered health care service or supply" means a health care service or supply, including a prescription drug, for which the costs are payable, wholly or partly, under the terms of a health benefit plan.

(8) "Derived amount" means the price that a health benefit plan assigns to a health care service or supply for the purpose of internal accounting, reconciliation with health care providers, or submitting data in accordance with state or federal regulations.

(9) "Enrollee" means an individual, including a dependent, entitled to coverage under a health benefit plan.

(10) "Health care service or supply" means any encounter, procedure, medical test, supply, prescription drug, durable medical equipment, and fee, including a facility fee, provided or assessed in connection with the provision of health care.

(11) "Historical net price" means the retrospective

average amount a health benefit plan paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, and fees and any additional price concessions received by the plan or plan issuer or administrator with respect to the prescription drug, determined in accordance with Section 1662.106.

(12) "Machine-readable file" means a digital representation of data in a file that can be imported or read by a computer system for further processing without human intervention while ensuring no semantic meaning is lost.

(13) "National drug code" means the unique 10- or 11-digit 3-segment number assigned by the United States Food and Drug Administration that is a universal product identifier for drugs in the United States.

(14) "Negotiated rate" means the amount a health benefit plan issuer or administrator has contractually agreed to pay a network provider, including a network pharmacy or other prescription drug dispenser, for covered health care services and supplies, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager.

(15) "Network provider" means any health care provider of a health care service or supply with which a health benefit plan issuer or administrator or a third party for the issuer or administrator has a contract with the terms on which a relevant health care service or supply is provided to an enrollee.

(16) "Out-of-network allowed amount" means the maximum amount a health benefit plan issuer or administrator will pay for a covered health care service or supply provided by an

out-of-network provider.

(17) "Out-of-network provider" means a health care provider of any health care service or supply that does not have a contract under an enrollee's health benefit plan.

(18) "Out-of-pocket limit" means the maximum amount that an enrollee is required to pay during a coverage period for the enrollee's share of the costs of covered health care services and supplies under the enrollee's health benefit plan, including for self-only and other than self-only coverage, as applicable.

(19) "Prerequisite" means concurrent review, prior authorization, or a step-therapy or fail-first protocol related to a covered health care service or supply that must be satisfied before a health benefit plan issuer or administrator will cover the service or supply. The term does not include a medical necessity determination generally or another form of medical management technique.

(20) "Underlying fee schedule rate" means the rate for a covered health care service or supply from a particular network provider or health care provider that a health benefit plan issuer or administrator uses to determine an enrollee's cost-sharing liability for the service or supply when that rate is different from the negotiated rate or derived amount.

Sec. 1662.002. DEFINITION OF ACCUMULATED AMOUNTS. (a) In this chapter, "accumulated amounts" means:

(1) the amount of financial responsibility an enrollee has incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit; and

(2) to the extent a health benefit plan imposes a cumulative treatment limitation, including a limitation on the number of health care supplies, days, units, visits, or hours covered in a defined period, on a particular covered health care service or supply independent of individual medical necessity determinations, the amount that has accrued toward the limit on the health care service or supply.

(b) For an individual enrolled in coverage other than self-only coverage, the term includes the financial responsibility the individual has incurred toward meeting the individual's own deductible or out-of-pocket limit and the amount of financial responsibility that all individuals enrolled in the individual's coverage have incurred, in aggregate, toward meeting the plan's other than self-only deductible or out-of-pocket limit, as applicable.

(c) The term includes any expense that counts toward a deductible or out-of-pocket limit, including a copayment or coinsurance, but excludes any expense that does not count toward a deductible or out-of-pocket limit, including a premium payment, out-of-pocket expense for out-of-network health care services or supplies, or an amount for a health care service or supply not covered by the health benefit plan.

Sec. 1662.003. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a

group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843;

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(6) a stipulated premium company operating under Chapter 884;

(7) a fraternal benefit society operating under Chapter 885;

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter

1601;

(7) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(8) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(c) This chapter does not apply to a health reimbursement arrangement or other account-based health benefit plan or a workers' compensation insurance policy.

Sec. 1662.004. RULES. The commissioner may adopt rules necessary to implement this chapter.

SUBCHAPTER B. REQUIRED DISCLOSURES TO ENROLLEES

Sec. 1662.051. REQUIRED DISCLOSURE TO ENROLLEE ON REQUEST. (a) On request of a health benefit plan enrollee, the health benefit plan issuer or administrator shall provide to the enrollee a disclosure in accordance with this subchapter.

(b) A health benefit plan issuer or administrator may allow an enrollee to request cost-sharing information for a specific preventive or non-preventive health care service or supply by including terms such as "preventive," "non-preventive," or "diagnostic" when requesting information under Subsection (a).

Sec. 1662.052. REQUIRED DISCLOSURE INFORMATION. (a) A disclosure provided under this subchapter must have the following information that is accurate at the time the disclosure request is made, with respect to the requesting enrollee's cost-sharing liability for a covered health care service and supply:

(1) an estimate of the enrollee's cost-sharing liability for the requested service or supply provided by a health

care provider that is calculated based on the information described by Subdivisions (4), (5), and (6);

(2) except as provided by Subsection (b), if the request relates to a service or supply that is provided within a bundled payment arrangement and the arrangement includes a service or supply that has a separate cost-sharing liability, an estimate of the cost-sharing liability for:

(A) the requested covered service or supply; and

(B) each service or supply in the arrangement that has a separate cost-sharing liability;

(3) for a requested service or supply that is a recommended preventive service under Section 2713, Public Health Service Act (42 U.S.C. Section 300gg-13), if the health benefit plan issuer or administrator cannot determine whether the request is for preventive or non-preventive purposes, the cost-sharing liability for non-preventive purposes;

(4) accumulated amounts;

(5) the network provider rate that is composed of the following that are applicable to the health benefit plan's payment model:

(A) the negotiated rate, reflected as a dollar amount, for a network provider for the requested service or supply regardless of whether the issuer or administrator uses the rate to calculate the enrollee's cost-sharing liability; and

(B) the underlying fee schedule rate, reflected as a dollar amount, for the requested service or supply, to the extent that is different from the negotiated rate;

(6) the out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount a health benefit plan issuer or administrator will pay for the requested service or supply, reflected as a dollar amount, if the request for cost-sharing information is for a covered service or supply provided by an out-of-network provider;

(7) if an enrollee requests information for a service or supply subject to a bundled payment arrangement, a list of the services and supplies included in the arrangement;

(8) if applicable, notification that coverage of a specific service or supply is subject to a prerequisite; and

(9) notice that includes the following information in plain language:

(A) unless balance billing is prohibited for the requested service or supply, a statement that out-of-network providers may bill an enrollee for the difference between a provider's billed charges and the sum of the amount collected from the health benefit plan issuer or administrator and from the enrollee in the form of a copayment or coinsurance amount and that the cost-sharing information provided for the service or supply does not account for that potential additional charge;

(B) a statement that the actual charges to the enrollee for the requested service or supply may be different from the estimate provided, depending on the actual services or supplies the enrollee receives at the point of care;

(C) a statement that the estimate of cost-sharing liability for the requested service or supply is not a guarantee

that benefits will be provided for that service or supply;

(D) a statement disclosing whether the health benefit plan counts copayment assistance and other third-party payments in the calculation of the enrollee's deductible and out-of-pocket maximum;

(E) for a service or supply that is a recommended preventive service under Section 2713, Public Health Service Act (42 U.S.C. Section 300gg-13), a statement that a service or supply provided by a network provider may not be subject to cost sharing if it is billed as a preventive service or supply when the health benefit plan issuer or administrator cannot determine whether the request is for a preventive or non-preventive service or supply; and

(F) any additional information, including other disclosures, that the health benefit plan issuer or administrator determines is appropriate provided that the additional information does not conflict with the information required to be provided under this section.

(b) A health benefit plan issuer or administrator is not required to provide an estimate of cost-sharing liability for a bundled payment arrangement in which the cost sharing is imposed separately for each health care service or supply included in the arrangement. If an issuer or administrator provides an estimate for multiple health care services or supplies in a situation in which the estimate could be relevant to an enrollee, the issuer or administrator must disclose information about the relevant services or supplies individually as required by Subsection (a).

(c) If a health benefit plan issuer or administrator reimburses an out-of-network provider with a percentage of the billed charge for a covered health care service or supply, the out-of-network allowed amount described by Subsection (a) is that reimbursed percentage.

Sec. 1662.053. METHOD AND FORMAT FOR DISCLOSURE. A health benefit plan issuer or administrator shall provide the disclosure required under this subchapter through an Internet-based self-service tool described by Section 1662.054, a physical copy in accordance with Section 1662.055, or another means authorized by Section 1662.056.

Sec. 1662.054. INTERNET-BASED SELF-SERVICE TOOL. (a) A health benefit plan issuer or administrator may develop and maintain an Internet-based self-service tool to provide a disclosure required under this subchapter.

(b) Information provided on the self-service tool must be made available in plain language, without a subscription or other fee, on an Internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request.

(c) A health benefit plan issuer or administrator shall ensure that the self-service tool allows a user to:

(1) search for cost-sharing information for a covered health care service or supply by a specific network provider or by all network providers by inputting:

(A) a billing code or descriptive term at the option of the user;

(B) the name of the network provider if the user seeks cost-sharing information with respect to a specific network provider; or

(C) other factors used by the issuer or administrator that are relevant for determining the applicable cost-sharing information, including the location in which the service or supply will be sought or provided, the facility name, or the dosage;

(2) search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount the issuer or administrator will pay for a covered health care service or supply provided by an out-of-network provider by inputting:

(A) a billing code or descriptive term at the option of the user; or

(B) other factors used by the issuer or administrator that are relevant for determining the applicable out-of-network allowed amount or other rate, including the location in which the covered health care service or supply will be sought or provided; and

(3) refine and reorder search results based on geographic proximity of network providers and the amount of the enrollee's estimated cost-sharing liability for the covered health care service or supply if the search returns multiple results.

Sec. 1662.055. PHYSICAL COPY OF DISCLOSURE. (a) A health benefit plan issuer or administrator shall make the disclosure required under this subchapter available in a physical form. A

disclosure under this section must be made available in plain language, without a fee, at the request of the enrollee.

(b) In providing a disclosure under this section, a health benefit plan issuer or administrator may limit the number of health care providers with respect to which cost-sharing information for a covered health care service or supply is provided to no fewer than 20 providers per request.

(c) A health benefit plan issuer or administrator providing a disclosure under this section shall:

(1) disclose any applicable provider-per-request limit described by Subsection (b) to the enrollee;

(2) provide the cost-sharing information in a physical form in accordance with the enrollee's request as if the request was made using a self-service tool under Section 1662.054; and

(3) mail the disclosure not later than two business days after the date the enrollee's request is received.

Sec. 1662.056. OTHER MEANS OF DISCLOSURE. If an enrollee requests the disclosure required by this subchapter by a means other than a physical copy or the self-service tool described by Section 1662.054, a health benefit plan issuer or administrator may provide the disclosure through the requested means if:

(1) the enrollee agrees that disclosure through that means is sufficient to satisfy the request;

(2) the request is fulfilled at least as rapidly as required for the physical copy; and

(3) the disclosure includes the information required for a physical copy under Section 1662.055.

Sec. 1662.057. OTHER CONTRACTUAL AGREEMENTS. (a) A health benefit plan issuer or administrator may satisfy the requirements of this subchapter by entering into a written agreement under which another person, including a pharmacy benefit manager or other third party, provides the disclosure required under this subchapter.

(b) If a health benefit plan issuer or administrator and another person enter into an agreement under Subsection (a), the issuer or administrator is subject to an enforcement action for failure to provide a required disclosure in accordance with this subchapter.

Sec. 1662.058. COMPLIANCE WITH SUBCHAPTER. (a) A health benefit plan issuer or administrator that, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under this subchapter does not fail to comply with this subchapter solely because of the error or omission if the issuer or administrator corrects the error or omission as soon as practicable.

(b) A health benefit plan issuer or administrator, acting in good faith and with reasonable diligence, does not fail to comply with this subchapter solely because the issuer's or administrator's Internet website is temporarily inaccessible if the issuer or administrator makes the information available as soon as practicable.

(c) To the extent compliance with this subchapter requires a health benefit plan issuer or administrator to obtain information from another person, the issuer or administrator does not fail to comply with the subchapter because the issuer or administrator

relies in good faith on information from the other person unless the issuer or administrator knows or reasonably should have known that the information is incomplete or inaccurate.

SUBCHAPTER C. REQUIRED PUBLIC DISCLOSURES

Sec. 1662.101. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan for which federal reporting requirements under 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 C.F.R. Parts 147 and 158 do not apply.

Sec. 1662.102. PUBLICATION REQUIRED. A health benefit plan issuer or administrator shall publish on an Internet website the information required under Section 1662.103 in three machine-readable files in accordance with this subchapter.

Sec. 1662.103. REQUIRED INFORMATION. (a) A health benefit plan issuer or administrator shall publish the following information:

(1) a network rate machine-readable file that includes the following information for all covered health care services and supplies, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement:

(A) for each coverage option offered by a health benefit plan issuer or administered by a health benefit plan administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) a billing code, which must be the national drug code for a prescription drug, and a plain-language description for each billing code for each covered service or supply under each coverage option offered by the issuer or administered by the administrator; and

(C) all applicable rates, including negotiated rates, underlying fee schedules, or derived amounts, provided in accordance with Section 1662.104;

(2) an out-of-network allowed amount machine-readable file, including:

(A) for each coverage option offered by a health benefit plan issuer or administered by a health benefit plan administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) a billing code, which must be the national drug code for a prescription drug, and a plain-language description for each billing code for each covered service or supply under each

coverage option offered by the issuer or administered by the administrator; and

(C) except as provided by Subsection (b), unique out-of-network billed charges and allowed amounts provided in accordance with Section 1662.105 for covered health care services or supplies provided by out-of-network providers during the 90-day period that begins on the 180th day before the date the machine-readable file is published; and

(3) a prescription drug machine-readable file that includes:

(A) for each coverage option offered by a health benefit plan issuer or administered by a health benefit plan administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) the national drug code and the proprietary and nonproprietary name assigned to the national drug code by the United States Food and Drug Administration for each covered prescription drug provided under each coverage option offered by the issuer or administered by the administrator;

(C) the negotiated rates, which must be:

(i) reflected as a dollar amount with respect to each national drug code that is provided by a network provider, including a network pharmacy or other prescription drug dispenser;

(ii) associated with the national provider identifier, tax identification number, and place of service code for each network provider, including each network pharmacy or other prescription drug dispenser; and

(iii) associated with the last date of the contract term for each provider-specific negotiated rate that applies to each national drug code; and

(D) except as provided by Subsection (b), historical net prices, which must be:

(i) reflected as a dollar amount with respect to each national drug code that is provided by a network provider, including a network pharmacy or other prescription drug dispenser;

(ii) associated with the national provider identifier, tax identification number, and place of service code for each network provider, including each network pharmacy or other prescription drug dispenser; and

(iii) associated with the 90-day period that begins on the 180th day before the date the machine-readable file is published for each provider-specific historical net price calculated in accordance with Section 1662.106 that applies to each national drug code.

(b) A health benefit plan issuer or administrator shall omit

information described by Subsection (a)(2)(C) or (a)(3)(D) in relation to a particular health care service or supply if compliance with that subsection would require the issuer to report payment information in connection with fewer than 20 different claims for payments under a single health benefit plan.

(c) This section does not require the disclosure of information that would violate any applicable health information privacy law.

Sec. 1662.104. NETWORK RATE DISCLOSURES. (a) If a health benefit plan issuer or administrator does not use negotiated rates for health care provider reimbursement, the issuer or administrator shall disclose for purposes of Section 1662.103(a)(1)(C) derived amounts to the extent those amounts are already calculated in the normal course of business.

(b) If a health benefit plan issuer or administrator uses underlying fee schedule rates for calculating cost sharing, the issuer or administrator shall disclose for purposes of Section 1662.103(a)(1)(C) the underlying fee schedule rates in addition to the negotiated rate or derived amount.

(c) The applicable rates, including for both individual health care services and supplies and services and supplies in a bundled payment arrangement, that a health benefit plan issuer or administrator must provide under Section 1662.103(a)(1)(C) must be:

(1) except as provided by Subdivision (2), reflected as dollar amounts with respect to each covered health care service or supply that is provided by a network provider;

(2) the base negotiated rate applicable to the service or supply before an adjustment for enrollee characteristics if the rate is a negotiated rate subject to change based on enrollee characteristics;

(3) associated with the national provider identifier, tax identification number, and place of service code for each network provider;

(4) associated with the last date of the contract term or expiration date for each health care provider-specific applicable rate that applies to each covered service or supply; and

(5) indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model, including capitation or a bundled payment arrangement, applies.

Sec. 1662.105. OUT-OF-NETWORK ALLOWED AMOUNTS. (a) An out-of-network allowed amount provided under Section 1662.103(a)(2)(C) must be:

(1) reflected as a dollar amount with respect to each covered health care service or supply that is provided by an out-of-network provider; and

(2) associated with the national provider identifier, tax identification number, and place of service code for each out-of-network provider.

(b) This subchapter does not prohibit a health benefit plan issuer or administrator from satisfying the disclosure requirements described by Section 1662.103(a)(2)(C) by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an issuer, a health care provider, or other party

with which the issuer or administrator has entered into a written agreement to provide the information if the minimum claim threshold described by Section 1662.103(b) is independently met for each health care service or supply and for each plan included in an aggregated allowed amount file.

(c) If a health benefit plan issuer or administrator enters into an agreement under Subsection (b), the health benefit plan issuers, health care providers, or other persons with which the issuer or administrator has contracted may aggregate out-of-network allowed amounts for more than one plan.

(d) This subchapter does not prohibit a third party from hosting an allowed amount file on its Internet website or a health benefit plan issuer or administrator from contracting with a third party to post the file. If the issuer or administrator does not host the file separately on its Internet website, the issuer or administrator shall provide a link on its Internet website to the location where the file is made publicly available.

Sec. 1662.106. HISTORICAL NET PRICE. (a) For purposes of determining the historical net price for a prescription drug, the allocation of price concessions is determined by the dollar value for non-product specific and product-specific rebates, discounts, chargebacks, fees, and other price concessions to the extent that the total amount of any such price concession is known to the health benefit plan issuer or administrator at the time of publication of the historical net price under Section 1662.103(a)(3)(D).

(b) To the extent that the total amount of any non-product specific and product-specific rebates, discounts, chargebacks,

fees, or other price concessions is not known to a health benefit plan issuer or administrator at the time of publication of the historical net price under Section 1662.103(a)(3)(D), the issuer or administrator shall allocate those price concessions by using a good faith, reasonable estimate of the average price concessions based on the price concessions received over a period before the current reporting period and of equal duration to the current reporting period.

Sec. 1662.107. REQUIRED METHOD AND FORMAT FOR DISCLOSURE. The machine-readable files described by Section 1662.103 must be available in a form and manner prescribed by department rule. The files must be available and accessible to any person free of charge and without conditions, including establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

Sec. 1662.108. FILE UPDATES. A health benefit plan issuer or administrator shall update the machine-readable files described by Section 1662.103 and the information described by this subchapter monthly. The issuer or administrator must clearly indicate in the files the date that the files were most recently updated.

Sec. 1662.109. OTHER CONTRACTUAL AGREEMENTS. (a) A health benefit plan issuer or administrator may satisfy the requirements of this subchapter by entering into a written agreement under which another person, including a third-party administrator or health care claims clearinghouse, provides the disclosure required under this subchapter in compliance with this subchapter.

(b) If a health benefit plan issuer or administrator and another person enter into an agreement under Subsection (a), the issuer or administrator is subject to an enforcement action for failure to provide a required disclosure in accordance with this subchapter.

Sec. 1662.110. COMPLIANCE WITH SUBCHAPTER. (a) A health benefit plan issuer or administrator that, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under this subchapter does not fail to comply with this subchapter solely because of the error or omission if the issuer or administrator corrects the error or omission as soon as practicable.

(b) A health benefit plan issuer or administrator, acting in good faith and with reasonable diligence, does not fail to comply with this subchapter solely because the issuer's or administrator's Internet website is temporarily inaccessible if the issuer or administrator makes the information available as soon as practicable.

(c) To the extent compliance with this subchapter requires a health benefit plan issuer or administrator to obtain information from another person, the issuer or administrator does not fail to comply with the subchapter because the issuer or administrator relies in good faith on information from the other person unless the issuer or administrator knows or reasonably should have known that the information is incomplete or inaccurate.

SECTION 4. (a) Not later than January 1, 2022, the Center for Healthcare Data at The University of Texas Health Science

Center at Houston shall establish the stakeholder advisory group in accordance with Section 38.403, Insurance Code, as added by this Act.

(b) Not later than June 1, 2022, the Texas Department of Insurance shall adopt rules, and the Center for Healthcare Data at The University of Texas Health Science Center at Houston shall adopt, in consultation with the stakeholder advisory group, standards, requirements, policies, and procedures, necessary to implement Subchapter I, Chapter 38, Insurance Code, as added by this Act.

SECTION 5. As soon as practicable after the effective date of this Act, the Center for Healthcare Data at The University of Texas Health Science Center at Houston shall actively seek financial support from the federal grant program for development of state all payer claims databases established under the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) and from any other available source of financial support provided by the federal government for purposes of implementing Subchapter I, Chapter 38, Insurance Code, as added by this Act.

SECTION 6. If before implementing any provision of Subchapter I, Chapter 38, Insurance Code, as added by this Act, the commissioner of insurance determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the commissioner shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 7. (a) Subchapter B, Chapter 1662, Insurance Code,

as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2024, or for a plan year that begins on or after that date.

(b) Subchapter C, Chapter 1662, Insurance Code, as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2022, or for a plan year that begins on or after that date.

SECTION 8. This Act takes effect September 1, 2021.

President of the Senate

Speaker of the House

I certify that H.B. No. 2090 was passed by the House on April 15, 2021, by the following vote: Yeas 144, Nays 0, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 2090 on May 24, 2021, by the following vote: Yeas 145, Nays 1, 1 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 2090 was passed by the Senate, with amendments, on May 19, 2021, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor