BILL ANALYSIS

C.S.H.B. 888
By: Seaman
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

CSHB 888 will increase the availability and affordability of health coverage for Texas employers and their employees, both private and public, by making health cost information more easily available from insurance carriers and HMOs. Despite several existing Texas statutes that attempt to accomplish this, Texas employers have had difficultly obtaining timely and useful health cost information, including detailed claims information. The employer, as a health plan sponsor, needs this information to perform its duties as plan sponsor, such as obtaining quotes for group health insurance from another insurer or excess loss insurance should the employer consider partial self –funding of its plan.

This information is essential to show the plan sponsor how their health care dollars are being spent and how they can be spent more efficiently. Without this type of data analysis, the plan sponsor in unable to determine where the dollars are being spent and what design changes are appropriate.

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

Section 1 - Amends Subchapter C, Chapter 1501, Insurance Code, as effective April 1, 2005, by adding Section 1501.112 as follows:

Section 1501.112. REPORTING OF CLAIMS INFORMATION.
(a) Provides that the section applies to group health benefit plans described by Chapter 1209 of the Insurance Code.

(b) Provides that not later than the 30th day after the date a health benefit plan issuer receives a written request for a written report of claim information from a plan sponsor, the health benefit plan issuer shall provide the plan sponsor the requested report.

(c) Provides that a report of claim information must contain all information available to the health benefit plan issuer that is responsive to the request for the 36-month period preceding the date of the request or for the entire period coverage, whichever period is shorter.
Subsection (c) further identifies five categories of claim information that must be produced in the report.

(d) Clarifies how a report is made when the request is made after the date of termination of coverage.

(e) Provides for a supplemental written report of the information described by Subsections (c)(1)-(5), to update report of claim information with information that was not included in the original report.

(f) Requires that a plan sponsor must request a report under Subsection (b) before or on the third anniversary of the date of termination of coverage under a health benefit plan.

(g) Provides that a report of claim information provided to a political subdivision is confidential and exempt from disclosure under Chapter 552, Government Code. (Public Information law "Open Records")

(h) Authorizes the commissioner, after notice and hearing, to impose sanctions pursuant to Chapter 82 or to issue an emergency cease and desist order under Chapter 83.

SECTION 2 - Section 1501.614, Insurance Code, as effective April 1, 2005, is repealed. Section 1501.614 relates to the reporting of claims information under the Health Insurance Portability and Availability Act.

SECTION 3 - Provides that the change in law made by this Act applies only to a report of claim information that is requested on or after the effective date of this Act.

SECTION 4 - Effective date: September 1, 2005.

EFFECTIVE DATE

This Act takes effect September 1, 2005.

COMPARISON OF ORIGINAL TO SUBSTITUTE

CSHB 888 deletes the definition of "plan sponsor" in 1501.112 (a) and replaces it with a provision that states that the section applies only to a group health plan described by Chapter 1209, Insurance Code.

CSHB 888 deletes all provisions and references requiring the claims report to include nonpublic personal health information.

CSHB 888, subsection (c)(5), rather than requiring "a separate description" of any claim exceeding $10,000, requires only the total number of claims exceeding $10,000. Additionally, instead of requiring diagnosis codes for individual claims, it only requires an aggregate list of diagnosis codes for claims exceeding $25,000, and only in the case of a large employer that has 200 or more covered employees.

CSHB 888 adds a new subsection (g) to state that a report of claim information provided to a political subdivision is confidential and exempt from open records.