By: Seaman H.B. No. 888

A BILL TO BE ENTITLED

AN ACT

relating to the reporting of cost claims information under certain health benefit plans.

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

SECTION 1. Section 1209.001, Insurance Code, is amended to read as follows:

Sec. 1209.001. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (b), this [~~This~~] chapter applies only to a group health benefit plan, including a small employer health benefit plan written under Chapter 1501, that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(A) an insurance company;

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

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

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

(E) a reciprocal exchange operating under

Chapter 942;

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

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

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

(2) provides health benefits to the employees of one or more employers that sponsor the plan.

(b) This chapter applies to a governmental entity that:

(1) is subject to competitive bidding requirements; and

(2) enters into a contract with an insurance company or other entity described by Subsection (a) under which the insurer or other entity delivers, issues for delivery, or renews a policy, contract, or evidence of coverage that provides health benefits.

SECTION 2. Chapter 1209, Insurance Code, is amended by adding Section 1209.0015 to read as follows:

Sec. 1209.0015. DEFINITIONS. In this chapter:

(1) "Governmental entity" means a state agency or political subdivision of this state.

(2) "Political subdivision" means a county, municipality, school district, special-purpose district, or other subdivision of state government that has jurisdiction limited to a geographic portion of the state.

SECTION 3. Section 1209.002, Insurance Code, is amended to read as follows:

Sec. 1209.002. CLAIMS COST INFORMATION. (a) On the request of an employer sponsoring a group health benefit plan, the health benefit plan issuer shall provide to the employer the claims cost information for all plan participants [~~employees~~] covered by the plan during the periods specified by this section [~~preceding calendar year~~].

(b) Not later than the 30th day after the date a health benefit plan issuer that covers an employer's employees under a health benefit plan receives a written request for a written report of claim information from the employer, the health benefit plan issuer shall provide the employer the information required by this section.

(c) A report of claim information provided under this section must contain all information available to the health benefit plan issuer that is responsive to the request made under this section for the 36-month period preceding the date of the request, except as provided by Subsection (d), or for the entire period of coverage, whichever period is shorter. To the extent allowed by federal law or other laws of this state relating to privacy of an individual's identifiable health information and subject to Subsection (e), a report provided under this section must include:

(1) aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable;

(2) total premium paid by month;

(3) total dollar amount of pending claims as of the

1 date of the report;
2 (4) the total number of covered employees on a monthly
3 basis by coverage tier, including whether coverage was for an
4 employee only, an employee with dependents only, an employee with a
5 spouse only, or an employee with family; and
6 (5) the total number of large or catastrophic claims
7 exceeding $10,000, including the aggregate amounts paid for those
8 claims, and in the case of a large employer that has 200 or more
9 employees covered by the health benefit plan, an aggregate list of
10 all diagnosis codes for claims exceeding $25,000.
11 (d) For purposes of Subsections (c)(3) and (5), a report of
12 claim information provided under this section must contain all
13 information available to the health benefit plan issuer that is
14 responsive to the request made under Subsection (b) for the
15 24-month period preceding the date of the request or for the entire
16 period of coverage, whichever period is shorter.
17 (e) A report of claim information may not include
18 information that can be used to identify a specific individual
19 enrolled in the health benefit plan or the diagnosis of that
20 individual.
21 (f) In the case of a request made under this section after
22 the date of termination of coverage, the report must contain all
23 information available to the health benefit plan issuer as of the
24 date of the request that is responsive to the request, including the
25 information described by Subsections (c)(1)-(5), for applicable
26 periods.
27 (g) After termination of a policy, an employer may request a

health benefit plan issuer to supplement a report provided under this section for any months not included in the initial report. The health benefit plan issuer shall provide a supplement under this subsection not later than the 30th day after the date the health benefit plan issuer receives the request for the supplement.

(h) An employer must request a report under this section on or before the second anniversary of the date of termination of coverage under the health benefit plan.

(i) A report of claim information provided under this section to a governmental entity:

(1) may be used only for contract bidding purposes; and

(2) is confidential and exempt from public disclosure under Chapter 552, Government Code.

(j) A health benefit plan issuer that does not comply with this section is subject to administrative penalties under Chapter 84. [~~Claims cost information provided under this section:~~

[~~(1) may be provided in the aggregate or on a detailed basis;~~

[~~(2) must be provided separately for each month during which the group health benefit plan was in effect; and~~

[~~(3) may not include information, including diagnosis code information, that may be used to identify a specific individual enrolled in the plan or a diagnosis of that individual.~~]

SECTION 4. Section 1501.614 and Article 21.49-15, Insurance Code, are repealed.

SECTION 5. The change in law made by this Act applies only

1 to a report of claim information that is requested on or after the
2 effective date of this Act. A report of claim information that is
3 requested before the effective date of this Act is governed by the
4 law as it existed before the effective date of this Act, and that
5 law is continued in effect for that purpose.

6 SECTION 6. This Act takes effect September 1, 2005.