1-1 By: Seaman (Senate Sponsor - Lucio) H.B. No. 888
1-2 (In the Senate - Received from the House May 10, 2005;
1-3 May 12, 2005, read first time and referred to Committee on State
1-4 Affairs; May 20, 2005, reported favorably by the following vote:
1-5 Yeas 6, Nays 0; May 20, 2005, sent to printer.)

1-6 A BILL TO BE ENTITLED
1-7 AN ACT

1-8 relating to the reporting of cost claims information under certain
1-9 health benefit plans.
1-10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-11 SECTION 1. Section 1209.001, Insurance Code, is amended to
1-12 read as follows:
1-13 Sec. 1209.001. APPLICABILITY OF CHAPTER. (a) Except as
1-14 provided by Subsection (b), this [~~This~~] chapter applies only to a
1-15 group health benefit plan, including a small employer health
1-16 benefit plan written under Chapter 1501, that:
1-17 (1) provides benefits for medical or surgical expenses
1-18 incurred as a result of a health condition, accident, or sickness,
1-19 including a group, blanket, or franchise insurance policy or
1-20 insurance agreement, a group hospital service contract, or a group
1-21 evidence of coverage or similar group coverage document that is
1-22 offered by:
1-23 (A) an insurance company;
1-24 (B) a group hospital service corporation
1-25 operating under Chapter 842;
1-26 (C) a fraternal benefit society operating under
1-27 Chapter 885;
1-28 (D) a stipulated premium company operating under
1-29 Chapter 884;
1-30 (E) a reciprocal exchange operating under
1-31 Chapter 942;
1-32 (F) a health maintenance organization operating
1-33 under Chapter 843;
1-34 (G) a multiple employer welfare arrangement that
1-35 holds a certificate of authority under Chapter 846; or
1-36 (H) an approved nonprofit health corporation
1-37 that holds a certificate of authority under Chapter 844; and
1-38 (2) provides health benefits to the employees of one
1-39 or more employers that sponsor the plan.
1-40 (b) This chapter applies to a governmental entity that:
1-41 (1) is subject to competitive bidding requirements;
1-42 and
1-43 (2) enters into a contract with an insurance company
1-44 or other entity described by Subsection (a) under which the insurer
1-45 or other entity delivers, issues for delivery, or renews a policy,
1-46 contract, or evidence of coverage that provides health benefits.
1-47 SECTION 2. Chapter 1209, Insurance Code, is amended by
1-48 adding Section 1209.0015 to read as follows:
1-49 Sec. 1209.0015. DEFINITIONS. In this chapter:
1-50 (1) "Governmental entity" means a state agency or
1-51 political subdivision of this state.
1-52 (2) "Political subdivision" means a county,
1-53 municipality, school district, special-purpose district, or other
1-54 subdivision of state government that has jurisdiction limited to a
1-55 geographic portion of the state.
1-56 SECTION 3. Section 1209.002, Insurance Code, is amended to
1-57 read as follows:
1-58 Sec. 1209.002. CLAIMS COST INFORMATION. (a) On the
1-59 request of an employer sponsoring a group health benefit plan, the
1-60 health benefit plan issuer shall provide to the employer the claims
1-61 cost information for all plan participants [~~employees~~] covered by
1-62 the plan during the periods specified by this section [~~preceding~~
1-63 ~~calendar year~~].
1-64 (b) Not later than the 30th day after the date a health

2-1 benefit plan issuer that covers an employer's employees under a
2-2 health benefit plan receives a written request for a written report
2-3 of claim information from the employer, the health benefit plan
2-4 issuer shall provide the employer the information required by this
2-5 section.
2-6 (c) A report of claim information provided under this
2-7 section must contain all information available to the health
2-8 benefit plan issuer that is responsive to the request made under
2-9 this section for the 36-month period preceding the date of the
2-10 request, except as provided by Subsection (d), or for the entire
2-11 period of coverage, whichever period is shorter. To the extent
2-12 allowed by federal law or other laws of this state relating to
2-13 privacy of an individual's identifiable health information and
2-14 subject to Subsection (e), a report provided under this section
2-15 must include:
2-16 (1) aggregate paid claims experience by month,
2-17 including claims experience for medical, dental, and pharmacy
2-18 benefits, as applicable;
2-19 (2) total premium paid by month;
2-20 (3) total dollar amount of pending claims as of the
2-21 date of the report;
2-22 (4) the total number of covered employees on a monthly
2-23 basis by coverage tier, including whether coverage was for an
2-24 employee only, an employee with dependents only, an employee with a
2-25 spouse only, or an employee with family; and
2-26 (5) the total number of large or catastrophic claims
2-27 exceeding $10,000, including the aggregate amounts paid for those
2-28 claims, and in the case of a large employer that has 200 or more
2-29 employees covered by the health benefit plan, an aggregate list of
2-30 all diagnosis codes for claims exceeding $25,000.
2-31 (d) For purposes of Subsections (c)(3) and (5), a report of
2-32 claim information provided under this section must contain all
2-33 information available to the health benefit plan issuer that is
2-34 responsive to the request made under Subsection (b) for the
2-35 24-month period preceding the date of the request or for the entire
2-36 period of coverage, whichever period is shorter.
2-37 (e) A report of claim information may not include
2-38 information that can be used to identify a specific individual
2-39 enrolled in the health benefit plan or the diagnosis of that
2-40 individual.
2-41 (f) In the case of a request made under this section after
2-42 the date of termination of coverage, the report must contain all
2-43 information available to the health benefit plan issuer as of the
2-44 date of the request that is responsive to the request, including the
2-45 information described by Subsections (c)(1)-(5), for applicable
2-46 periods.
2-47 (g) After termination of a policy, an employer may request a
2-48 health benefit plan issuer to supplement a report provided under
2-49 this section for any months not included in the initial report. The
2-50 health benefit plan issuer shall provide a supplement under this
2-51 subsection not later than the 30th day after the date the health
2-52 benefit plan issuer receives the request for the supplement.
2-53 (h) An employer must request a report under this section on
2-54 or before the second anniversary of the date of termination of
2-55 coverage under the health benefit plan.
2-56 (i) A report of claim information provided under this
2-57 section to a governmental entity:
2-58 (1) may be used only for contract bidding purposes;
2-59 and
2-60 (2) is confidential and exempt from public disclosure
2-61 under Chapter 552, Government Code.
2-62 (j) A health benefit plan issuer that does not comply with
2-63 this section is subject to administrative penalties under Chapter
2-64 84. [~~Claims cost information provided under this section:~~
2-65 [~~(1) may be provided in the aggregate or on a detailed~~
2-66 ~~basis;~~
2-67 [~~(2) must be provided separately for each month during~~
2-68 ~~which the group health benefit plan was in effect; and~~
2-69 [~~(3) may not include information, including diagnosis~~

3-1 ~~code information, that may be used to identify a specific~~
3-2 ~~individual enrolled in the plan or a diagnosis of that individual.~~]
3-3 SECTION 4. Section 1501.614 and Article 21.49-15, Insurance
3-4 Code, are repealed.
3-5 SECTION 5. The change in law made by this Act applies only
3-6 to a report of claim information that is requested on or after the
3-7 effective date of this Act. A report of claim information that is
3-8 requested before the effective date of this Act is governed by the
3-9 law as it existed before the effective date of this Act, and that
3-10 law is continued in effect for that purpose.
3-11 SECTION 6. This Act takes effect September 1, 2005.

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