Amend **CSHB 522** by striking all below the enacting clause and substituting the following:

SECTION 1. Title 8, Insurance Code, is amended by adding Subtitle J to read as follows:

SUBTITLE J. HEALTH INFORMATION TECHNOLOGY

CHAPTER 1660. ELECTRONIC DATA EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1660.001. FINDINGS AND PURPOSE. (a) The legislature finds that patients deserve accurate, instantaneous information about coverage and financial responsibility to make well-informed decisions about their treatment and spending.

(b) The legislature finds that the ability of health benefit plan issuers and administrators to exchange eligibility and benefit information with physicians, health care providers, hospitals, and patients will ensure a more efficient and effective health care delivery system.

(c) The legislature finds that electronic access to eligibility information will reduce the amount of time and resources spent on administrative functions, prevent abuse and fraud, streamline and simplify processing of insurance claims, and increase transparency in premium cost and health care cost.

(d) The legislature finds that patients often request information about their health care coverage from their health care providers and that health care providers therefore need access to real-time information about their patients' eligibility to receive health care under the health benefit plan, coverage of health care under the health benefit plan, and the benefits associated with the health benefit plan.

(e) The legislature finds that adoption of technology by insurers, health maintenance organizations, and health care providers to facilitate use of electronic data exchange standards currently available will make coverage and health care electronic transactions more predictable, reliable, and consistent.

Sec. 1660.002. DEFINITIONS. In this chapter:

(1) "Administrator" has the meaning assigned by Section 4151.001.

(2) "Advisory committee" means the technical advisory

committee on electronic data exchange.

(3) "Enrollee" means an individual who is insured by or enrolled in a health benefit plan.

(4) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits.

(5) "Transaction standards" means the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) transaction standards of the Centers for Medicare and Medicaid Services under 45 C.F.R. Part 162.

Sec. 1660.003. APPLICABILITY. (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 fraternal benefit society operating under Chapter 885;

(4) a stipulated premium insurance company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

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

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

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

(b) This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 533, Government Code;

(2) a Medicaid program operated under Chapter 32, Human Resources Code; or

(3) the state child health plan or any similar plan operated under Chapter 62 or 63, Health and Safety Code.

Sec. 1660.004. GENERAL RULEMAKING. The commissioner may adopt rules as necessary to implement this chapter, including rules requiring the implementation and provision of the technology recommended by the advisory committee.

[Sections 1660.005-1660.050 reserved for expansion]

SUBCHAPTER B. ADVISORY COMMITTEE

Sec. 1660.051. ADVISORY COMMITTEE; COMPOSITION. (a) The commissioner shall appoint a technical advisory committee on electronic data exchange.

(b) The advisory committee is composed of:

(1) at least one representative from each of the following groups or entities:

(A) health benefit coverage consumers;

(B) physicians;

(C) hospital trade associations;

(D) representatives of medical units of institutions of higher education;

(E) representatives of health benefit plan issuers;

(F) health care providers; and

(G) administrators; and

(2) representatives from:

(A) the office of public insurance counsel;

(B) the Texas Health Insurance Risk Pool; and

(C) the Department of Information Resources.

(c) Members of the advisory committee serve without compensation.

Sec. 1660.052. APPLICABILITY OF CERTAIN LAWS. The following laws do not apply to the advisory committee:

(1) Section 39.003(a); and

(2) Chapter 2110, Government Code.

Sec. 1660.053. ADVISORY COMMITTEE POWERS AND DUTIES. The advisory committee shall advise the commissioner on technical aspects of using the transaction standards and the rules of the Council for Affordable Quality Healthcare Committee on Operating

Rules for Information Exchange to require health benefit plan issuers and administrators to provide access to information technology that will enable physicians and other health care providers, at the point of service, to generate a request for eligibility information that is compliant with the transaction standards.

Sec. 1660.054. DATA ELEMENTS. (a) The advisory committee shall advise the commissioner on data elements required to be made available by health benefit plan issuers and administrators. To the extent possible, the committee shall use the framework adopted by the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange.

(b) The advisory committee shall consider inclusion in the required information of the following data elements:

(1) the name, date of birth, member identification number, and coverage status of the patient;

(2) identification of the payor, insurer, issuer, and administrator, as applicable;

(3) the name and telephone number of the payor's contact person;

(4) the payor's address;

(5) the name and address of the subscriber;

(6) the patient's relationship to the subscriber;

(7) the type of service;

(8) the type of health benefit plan or product;

(9) the effective date of the coverage;

(10) for professional services:

(A) copayment amounts;

(B) individual deductible amounts;

(C) family deductible amounts; and

(D) benefit limitations and maximums;

(11) for facility services:

(A) copayment and coinsurance amounts;

(B) individual deductible amounts;

(C) family deductible amounts; and

(D) benefit limitations and maximums;

(12) precertification or prior authorization

requirements;

(13) policy maximum limits;

(14) patient liability for a proposed service; and

(15) the health benefit plan coverage amount for a proposed service.

Sec. 1660.055. RECOMMENDATIONS REGARDING ADOPTION OF CERTAIN TECHNOLOGIES; REPORT. (a) The advisory committee shall:

(1) make recommendations regarding the use by health benefit plan issuers or administrators of Internet website technologies, smart card technologies, magnetic strip technologies, biometric technologies, or other information technologies to facilitate the generation of a request for eligibility information that is compliant with the transaction standards and the rules of the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange;

(2) ensure that a recommendation made under Subdivision (1) does not endorse or otherwise confine health benefit plan issuers and administrators to any single product or vendor; and

(3) recommend time frames for implementation of the recommendations.

(b) The advisory committee shall:

(1) recommend specific provisions that could be included in a department-issued request for information relating to electronic data exchange, including identification card programs;

(2) provide those recommendations to the commissioner not later than four months after the date on which the committee is appointed; and

(3) issue a final report to the commissioner containing the committee's recommendations for implementation by September 1, 2009.

[Sections 1660.056-1660.100 reserved for expansion]

SUBCHAPTER C. IDENTIFICATION CARD PILOT PROGRAM

Sec. 1660.101. PILOT PROGRAM. (a) The commissioner shall designate a county or counties for initial participation in an identification card pilot program to begin not later than September 1, 2008.

(b) The commissioner shall require the issuer of a health benefit plan that is offered in the county or counties selected for initial participation in the identification card pilot program to issue identification cards that comply with commissioner rules to each enrollee of the plan.

(c) The commissioner may implement the identification card pilot program before, during, or simultaneously with the appointment and formation of the advisory committee.

Sec. 1660.102. PILOT PROGRAM RULES. (a) The commissioner shall adopt rules as necessary to implement the identification card pilot program, including the coordination of a testing phase and incorporation of changes identified in the testing phase.

(b) The commissioner may consider the recommendations of the advisory committee or any information provided in response to a department-issued request for information relating to electronic data exchange, including identification card programs, before adopting rules regarding:

(1) information to be included on the identification cards;

(2) technology to be used to implement the identification card pilot program; and

(3) confidentiality and accuracy of the information required to be included on the identification cards.

(c) The commissioner shall consider the requirements of any federal program requiring health benefit plan issuers and administrators to provide point-of-service access to physicians and other health care providers regarding eligibility information before adopting rules to implement this section.

Sec. 1660.103. REQUESTS FOR INFORMATION. The commissioner may issue requests for information as needed to implement the identification card pilot program under this subchapter.

Sec. 1660.104. HEALTH BENEFIT PLAN ISSUER COMPLIANCE. (a) Each issuer of a health benefit plan that offers a health benefit plan in a county or counties designated by the commissioner under Section 1660.101 for initial participation in the identification card pilot program shall comply with this subchapter and rules adopted under this subchapter.

(b) To ensure timely compliance with the requirements of this subchapter, the commissioner may require the issuer of a health benefit plan to submit its procedures for implementation of the requirements to the department in the form prescribed by the commissioner.

SECTION 2. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2007.