BILL ANALYSIS

C.S.H.B. 2015
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

In order to control health costs, employers (as the sponsors of employee group health plans) must be able to examine how they are currently spending health care dollars. To do this, they must have ready access to “claims information” or “loss experience” that demonstrates how much is being spent on employee health care and what it is being spent on. Without the information, competition is stifled as choices go flat and prices increase.

Currently, there are provisions in Texas law that attempt to assist the employer in obtaining the information. Largely, these laws have been ineffective. Despite the importance of this issue to a competitive health care market, most employers across Texas are routinely unable to obtain timely and meaningful claims information or loss experience pertaining to their health plan.

C.S.H.B 2015 strikes a balance between protecting an individual's privacy while allowing the limited exchange of loss experience information for legitimate health care decisions by employers who are purchasing and providing health care to their employees. The bill consolidates statutes, provides clear timelines for compliance, and allows protected health information to be exchanged consistent with Federal laws. The bill also provides an incentive and protection for good faith efforts to comply with the law and increases transparency in the health care market.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the Commissioner of Insurance in SECTION 1 (Section 1215.001 of the Texas Insurance Code) of this bill.

SECTION 1 (Section 1215.001 of the Texas Insurance Code) grants rulemaking authority to the Commissioner of Insurance to update references to federal statutes or rules if the Commissioner determines it is consistent with the purposes of the chapter and regulatory consistency.

ANALYSIS

C.S.H.B. 2015 relates to the reporting of claim information under certain group health plans; providing administrative penalties.

SECTION 1 amends the Texas Insurance Code by adding a new Chapter 1215 entitled "Reporting of Claims Information".

SECTION 1 Section 1215.001 sets out certain definitions (except as provided by Subsection (b), in this chapter). First, "Employer" has the meaning assigned by 29 U.S.C. Section 1002 (5). Next, "Governmental entity" means a state agency or political subdivision of this state and "Group health plan" has the meaning assigned by 45 C.F.R. Section 160.103, except that the term does not include disability income or long-term care insurance. "Health insurance issuer" has the meaning assigned by 45 C.F.R. Section 160.103 and "Plan" means an employee welfare benefit plan as defined by 29 U.S.C. Section 1002(1). Next, "Plan administrator" means an administrator as defined by 29 U.S.C. Section 1002(16)(A) and "Plan sponsor" has the meaning assigned by 29 U.S.C. Section 1002(16)(B). Finally, "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 and "Protected health information" has the meaning assigned by 45 C.F.R. Section 160.103.

The next Subsection provides that a reference to federal statute or regulation under Subsection (a) means that statute or regulation as it existed on September 1, 2007, except that the

Commissioner of Insurance, by rule, may adopt a definition based on a later amended, enacted, or adopted federal statute or regulation if the commissioner determines that use of the later amended, enacted, or adopted statute or regulation is consistent with the purposes of this chapter and promotes regulatory consistency.

Next, SECTION 1 Section 1215.002 of C.S.H.B. 2015 states the applicability of chapter to governmental entity; applicability of other law with reference to governmental entity. It says that this chapter applies to a governmental entity that enters into a contract with a health insurance issuer that results in the health insurance issuer delivering, issuing for delivery, or renewing group health plan. Also, for purpose of this chapter, a health insurance issuer shall treat a governmental entity described by Subsection (a) as a plan sponsor or plan administrator. Finally, a report of claim information provided under this section to a governmental entity is confidential and exempt from public disclosure under Chapter 552 of the Government Code.

C.S.H.B. 2015 SECTION 1 Section 1215.003 discusses receipt and response to request for claim information. The first Subsection states that not later than the 30th day after the date a health insurance issuer receives a written request for a written report of claim information from a plan, plan sponsor, or plan administrator, the health insurance issuer shall provide the requesting party the report, subject to Subsections (d), (e), and (f). The health insurance issuer is not obligated to provide a report under this subsection regarding a particular employer or group health plan more than twice in any 12-month period. The next Subsection states that a health insurance insurer shall provide the report of claim information under Subsection (a) either in a written report or through electronic file transmitted by secure electronic mail or a file transfer protocol site or by making the required information available through a secure website or web portal accessible by the requesting plan, plan sponsor, or plan administrator. A report of claim information provided under Subsection (a) must contain all information available to the health insurance issuer that is responsive to the request made under Subsection (a), including, subject to Subsections (d), (e) and (f), protected health information for the 36-month period preceding the date of the report, or the period specified by Subdivisions (4), (5) and (6), if applicable, or for the entire period of coverage, whichever period is shorter. Subject to Subsections (d), (e) and (f), a report provided under Subsection (a) must include aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable; total premium paid by month; total number of covered employees on a monthly basis by coverage tier, including whether coverage was for an employee only, an employee with dependents only, an employee with a spouse only, or an employee with a spouse and dependents; the total dollar amount of claims pending as of the date of the report; and a separate description and individual claims report for any individual whose total paid claims exceed $15,000 during the 12-month period preceding the date of the report, including the following information related to the claims for that individual: a unique identifying number, characteristic, or code for the individual, the amounts paid, dates of service and applicable procedure codes and diagnosis codes; and for claims that are not part of the report described by Subdivisions (1)-(5), a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report. Also, the next Subsection states that a health insurance issuer may not disclose protected health information in a report of claim information provided under this section if the health insurance issuer is prohibited from disclosing that information under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191). To withhold information in accordance with this subsection, the health insurance issuer must notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld; and provide to the plan, plan sponsor, or plan administrator a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another state or federal law.

The next Subsection states that a plan sponsor is entitled to receive protected health information under Subsections (c) (5) and (6) and Section 1215.004 only after an appropriately authorized representative of the plan sponsor makes to the health insurance issuer a certification substantially similar to the following certification: "I hereby certify that the plan documents comply with the requirements of 45 C.F.R. Section 164.504(f) (2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions." The next Subsection states that a plan sponsor that does not provide the certification required by

Subsection (e) is not entitled to receive the protected health information described by Subsections (c) (5) and (6) and Section 1215.004, but is entitled to receive a report of claim information that includes the information described by Subsections (c) (1) – (4).

SECTION 1 Section 1215.003(g) provides that in the case of a request made under Subsection (a) after the date of termination of coverage, the report must contain all information available to the health insurance issuer as of the date of the report that is responsive to the request, including protected health information, and including the information described by Subsections (c) (1)-(6), for the period described by Subsection (c) preceding the date of termination of coverage or for the entire policy period, whichever period is shorter. It further states that notwithstanding this subsection, the report may not include the protected health information described by Subsections (c) (5) and (6) unless a certification has been provided in accordance with Subsection (e). The next subsection provides that a plan, plan sponsor, or plan administrator must request a report under Subsection (a) before or on the second anniversary of the date of termination of coverage under a group health plan issued by the health benefit plan issuer.

Next, SECTION 1 Section 1215.004 discusses the request for additional information. It states that on receipt of the report required by Section 1215.003(a), the plan, plan sponsor, or plan administrator may review the report and, not later than the 10th day after the date the report is received, may make a written request to the health insurance issuer for additional information in accordance with this section for specified individuals. The next Subsection states that with respect to a request for additional information concerning specified individuals for whom claims information has been provided under Section 1215.003 (c) (5), the health insurance issuer shall provide additional information on the prognosis or recovery if available and, for individuals in active case management, the most recent case management information, including any future expected costs and treatment plan, that relate to the claims for that individuals. Also, the health insurance issuer must respond to the request for additional information under this section not later than the 15th day after the date of the request under this section unless the requesting plan, plan sponsor, or plan administrator agrees to a request for additional time. Finally, the health insurance issuer is not required to produce the report described by this section unless a certification has been provided in accordance with Section 1215.003(e).

SECTION 1 Section 1215.005, provides that compliance with chapter does not create liability. It states that a health insurance issuer that releases information, including protected health information, in accordance with this chapter has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information. The next section, SECTION 1 Section 1215.006, states the administrative penalties and provides that a health insurance issuer that does not comply with this chapter is subject to administrative penalties under Chapter 84.

Next, SECTION 2 repeals Article 21.49-15, Insurance Code; Chapter 1209, Insurance Code; and Section 1501.614 of the Insurance Code. SECTION 3 of C.S.H.B. 2015 provides that the change in law made by this Act applies only to a report of claim information that is requested on or after January 1, 2008. A report of claim information that is requested before January 1, 2008, is governed by the law as it existed before the effective date of this Act, and that law is continued in effect for that purpose.

Finally, SECTION 4 gives the effective date, September 1, 2007.

EFFECTIVE DATE

September 1, 2007.

COMPARISON OF ORIGINAL TO SUBSTITUTE

SECTION 1 of C.S.H.B. 2015 changes the original house bill in several ways. First, "(a) Except as provided by Subsection (b)" is added to Section 1215.001. Next, "except that the term does not include disability income or long-term care insurance" was added to the definition of "Group health plan". Also, the definitions of "Health benefit plan issuer" and "Health maintenance

organization" are deleted in C.S.H.B. 2015 and thus SECTION 1 Section 1215.001(a) is now renumbered so that (4) now defines "Health insurance issuer", (5) defines "Plan", (6) defines "Plan administrator", (7) defines "Plan sponsor", (8) defines "Political subdivision" and (9) defines "Protected health information".

Next, C.S.H.B. 2015 adds Subsection (b) to SECTION 1 Section 1215.001. This is new subsection provides that a reference to federal statute or regulation under Subsection (a) means that statute or regulation as it existed on September 1, 2007, except that the Commissioner of Insurance, by rule, may adopt a definition based on a later amended, enacted, or adopted federal statute or regulation if the commissioner determines that use of the later amended, enacted, or adopted statute or regulation is consistent with the purposes of this chapter and promotes regulatory consistency.

Also, C.S.H.B. 2015 changes the heading of SECTION 1 Section 1215.002. The original house bill read "Applicability of Chapter To Political Subdivisions; Applicability Of Other Law With Reference To Political Subdivisions". This substitute changes the heading to now read "Applicability of Chapter To Governmental Entity; Applicability of Other Law With Reference To Governmental Entity". The phrase "Health benefit plan issuer" as found in the original house bill, is continuously replaced with "Health insurance issuer" in C.S.H.B. 2015.

Next, C.S.H.B. 2015 amends some of the language of Section 1215.003 (a) to now read "Not later than the 30th day after the date a health insurance issuer receives a written request for a written report of claim information from a plan , plan sponsor, or plan administrator, the health insurance issuer shall provide the requesting party the report, subject to Subsections (d), (e), and (f). The health insurance issuer is not obligated to provide a report under this subsection regarding a particular employer or group health plan more than twice in any 12-month period." The original house bill stated "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, plan sponsor, or plan administrator, the health benefit plan issuer shall provide the requesting party the report, subject to Subsection (c)."

C.S.H.B. 2015 adds new language to Section 1215.003. Section 1215.003(b) of C.S.H.B. 2015 now reads that a health insurance issuer shall provide the report of claim information under Subsection (a) in a written report, through an electronic file transmitted by secure electronic mail or a file transfer protocol site or by making the required information available through a secure website or web portal accessible by the requesting plan, plan sponsor, or plan administrator. The language that was originally in Section 1215.003(b) of the original house bill was moved to Section 1215.003(c) of C.S.H.B. 2015. However, the substitutes does amend the language of the original house bill to conform to the changes made in the substitute. Thus, C.S.H.B. 2015 adds "subject to Subsections (d), (e), and (f)" and "the report or the period specified by Subdivisions (4), (5), and (6), if applicable," to the original house bill. Also, "Subject to Subsections (d), (e), and (f)" were added by C.S.H.B. 2015 as well.

C.S.H.B. 2015 goes on to amend other language found in the original house bill and Section 1215.003(c)(4) now reads "the total dollar amount of claims pending as of the date of the report". Section 1215.003(c)(5) and (6) were added in C.S.H.B. 2015 and use some of the language found in the original house bill. They state that "a separate description and individual claims report for any individual whose total paid claims exceed $15,000 during the 12-month period preceding the date of the report, including the following information related to the claims for that individual: a unique identifying number, characteristic, or code for the individual; the amounts paid; dates of service; and applicable procedure codes and diagnosis codes; and (6) for claims that are not part of the report described by Subdivisions (1)-(5), a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report".

C.S.H.B. 2015 proceeds to add more new language to Section 1215.003. As found in the substitute, Section 1215.003(d) now states that "A health insurance issuer may not disclose protected health information in a report of claim information provided under this section if the health insurance issuer is prohibited from disclosing that information under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

To withhold information in accordance with this subsection, the health insurance issuer must notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld; and provide to the plan, plan sponsor, or plan administrator a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another state or federal law." The language of Section 1215.003(c) of the original house bill was moved to Section 1215.003(e) of C.S.H.B. 2015 and modified to read "A plan sponsor is entitled to receive protected health information under Subsections (c) (5) and (6) and Section 1215.004 only after an appropriately authorized representative of the plan sponsor makes to the health insurance issuer a certification substantially similar to the following certification:".

Next, C.S.H.B. 2015 modifies the original house bill by stating, in Section 1215.003(f) of the substitute, that "A plan sponsor that does not provide the certification required by Subsection (e) is not entitled to receive the protected health information described by Subsections (c) (5) and (6) and Section 1215.004, but is entitled to receive a report of claim information that includes the information described by Subsections (c) (1)-(4)". Also, C.S.H.B. 2015 moves and changes the language of Section 1215.004(d) of the original house bill to Section 1215.004(g) of the substitute. Section 1215.004(g) now conforms to the rest of the bill and reads that in the case of a request made under Subsection (a) after the date of termination of coverage, the report must contain all information available to the health insurance issuer as of the date of the report that is responsive to the request, including protected health information, and including the information described by Subsections (c) (1)-(6), for the period described by Subsection (c) preceding the date of termination of coverage or for the entire policy period, whichever period is shorter. It further states that notwithstanding this subsection, the report may not include the protected heath information described by Subsections (c) (5) and (6) unless a certification has been provided in accordance with Subsection (e). C.S.H.B. 2015 does not include the exact language found in Section 1215.003(e) and (f) of the original house bill. The language in the original house bill, Section 1215.003(g), is moved to Section 1215.003(h) in C.S.H.B. 2015.

Next, C.S.H.B. 2015 changes the heading of SECTION 1 Section 1215.004 from "Use of Information by Certain Parties", as found in the original house bill, to "Request for Additional Information". C.S.H.B. 2015 also changes the language in Section 1215.004, thus it now reads "On receipt of the report required by Section 1215.003(a), the plan, plan sponsor, or plan administrator may review the report and, not later than the 10th day after the date the report is received, may make a written request to the health insurance issuer for additional information in accordance with this section for specified individuals. With respect to a request for additional information concerning specified individuals for whom claims information has been provided under Section 1215.003 (c) (5), the health insurance issuer shall provide additional information on the prognosis or recovery if available and, for individuals in active case management, the most recent case management information, including any future expected costs and treatment plan, that relate to the claims for that individual. The health insurance issuer must respond to the request for additional information under this section not later than the 15th day after the date of the request under this section unless the requesting plan, plan sponsor, or plan administrator agrees to a request for additional time. The health insurance issuer is not required to produce the report described by this section unless a certification has been provided in accordance with Section 1215.003(e)". Section 1215.004 of the original house bill merely stated that "A plan, plan sponsor, or plan administrator may use information in a written report of claim information provided under this chapter only as necessary to perform treatment, payment, or health care operations as those activities are described by 45 C.F.R. Section 164.501."

Sections 1215.005 and 1215.006 in C.S.H.B. 2015 are the same as in the original house bill except that "health benefit plan issuer" is replaced with "health insurance issuer".

Lastly, C.S.H.B. 2015 changes SECTION 3 of the original house bill by amending the dates. C.S.H.B. 2015 states that "The changes in law made by this Act applies only to a report of claim information that is requested on or after January 1, 2008. A report of claim information that is requested before January 1, 2008, is governed by the law as it existed before the effective date of this Act, and that law is continued in effect for that purpose." The original house bill stated 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. A report of claim information that is requested before

the effective date of this Act is governed by the law as it existed before the effective date of this Act, and that law is continued in effect for that purpose.