By: Smithee (Senate Sponsor - Duncan) H.B. No. 2015

(In the Senate - Received from the House May 7, 2007; May 8, 2007, read first time and referred to Committee on State Affairs; May 15, 2007, reported favorably by the following vote: Yeas 8, Nays 0; May 15, 2007, sent to printer.)

A BILL TO BE ENTITLED
AN ACT

relating to the reporting of claim information under certain group health plans; providing administrative penalties.

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

SECTION 1. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1215 to read as follows:

CHAPTER 1215. REPORTING OF CLAIMS INFORMATION

Sec. 1215.001. DEFINITIONS. (a) Except as provided by Subsection (b), in this chapter:

(1) "Employer" has the meaning assigned by 29 U.S.C. Section 1002(5).

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

(3) "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.

(4) "Health insurance issuer" has the meaning assigned by 45 C.F.R. Section 160.103.

(5) "Plan" means an employee welfare benefit plan as defined by 29 U.S.C. Section 1002(1).

(6) "Plan administrator" means an administrator as defined by 29 U.S.C. Section 1002(16)(A).

(7) "Plan sponsor" has the meaning assigned by 29 U.S.C. Section 1002(16)(B).

(8) "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.

(9) "Protected health information" has the meaning assigned by 45 C.F.R. Section 160.103.

(b) A reference to a federal statute or regulation under Subsection (a) means that statute or regulation as it existed on September 1, 2007, except that the commissioner, 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.

Sec. 1215.002. APPLICABILITY OF CHAPTER TO GOVERNMENTAL ENTITY; APPLICABILITY OF OTHER LAW WITH REFERENCE TO GOVERNMENTAL ENTITY. (a) 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 a group health plan.

(b) For purposes of this chapter, a health insurance issuer shall treat a governmental entity described by Subsection (a) as a plan sponsor or plan administrator.

(c) A report of claim information provided under this section to a governmental entity is confidential and exempt from public disclosure under Chapter 552, Government Code.

Sec. 1215.003. RECEIPT OF AND RESPONSE TO REQUEST FOR CLAIM INFORMATION. (a) 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.

(b) A health insurance issuer shall provide the report of

claim information under Subsection (a):

(1) in a written report;

(2) through an electronic file transmitted by secure electronic mail or a file transfer protocol site; or

(3) by making the required information available through a secure website or web portal accessible by the requesting plan, plan sponsor, or plan administrator.

(c) 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:

(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 number of covered employees on a monthly basis by coverage tier, including whether coverage was for:

(A) an employee only;

(B) an employee with dependents only;

(C) an employee with a spouse only; or

(D) an employee with a spouse and dependents;

(4) the total dollar amount of claims pending as of the date of the report;

(5) 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) a unique identifying number, characteristic, or code for the individual;

(B) the amounts paid;

(C) dates of service; and

(D) 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.

(d) 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:

(1) notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld; and

(2) 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.

(e) 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."

(f) 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).

(g) 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. 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).

(h) 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.

Sec. 1215.004. REQUEST FOR ADDITIONAL INFORMATION. (a) 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.

(b) 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.

(c) 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.

(d) 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).

Sec. 1215.005. COMPLIANCE WITH CHAPTER DOES NOT CREATE LIABILITY. 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.

Sec. 1215.006. ADMINISTRATIVE PENALTIES. A health insurance issuer that does not comply with this chapter is subject to administrative penalties under Chapter 84.

SECTION 2. The following laws are repealed:

(1) Article 21.49-15, Insurance Code;

(2) Chapter 1209, Insurance Code; and

(3) Section 1501.614, Insurance Code.

SECTION 3. 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.

SECTION 4. This Act takes effect September 1, 2007.

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