BILL ANALYSIS

C.S.H.B. 1342
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

As the Texas health insurance market shifts away from one that is dominated by employer-sponsored coverage to a market that more often serves individual consumers, managed care plans are offering insurance products tailored to individual needs, including high deductible plans and limited benefit plans. Individuals enrolled in these plans, as well as their physicians, are typically unaware of what these insurance policies cover and what portion of the cost may be borne by the patient. They have no way of easily accessing that information.

C.S.H.B. 1342 provides physicians and patients with information, at the point of care, about copayment, coinsurance, and deductibles; what benefits and services the health plan covers; and an estimate of what the health plan's and patient's financial responsibilities are. This will provide transparency to health insurance and better inform patients about their health insurance coverage, allowing them to be better consumers of health care. H.B. 1342 will streamline and simplify the overly complex and administratively burdensome systems that exist today, which should provide cost savings throughout the entire system.

C.S.H.B. 1342 requires health insurers to use information technology to provide physicians and patients with real-time information electronically.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 1342 amends the Insurance Code to require a health benefit plan issuer to use information technology that provides a physician, hospital, or other health care provider with real-time information at the point of care concerning the enrollee's copayment and coinsurance; applicable deductibles; and covered benefits and services; and the enrollee's estimated total financial responsibility for the care. The bill requires a health benefit plan issuer to use information technology that provides an enrollee with information concerning the enrollee's copayment and coinsurance; applicable deductibles; covered benefits and services; and estimated financial responsibility for the health care provided to the enrollee. The bill establishes that nothing in provisions regarding the use of certain required information technology may be interpreted as a guarantee of payment for health care services.

C.S.H.B. 1342 requires a physician, hospital, or other health care provider to use information technology as required by the bill's provisions beginning not later than September 1, 2013. The bill requires a physician, hospital, or other health care provider that receives an overpayment from an enrollee to refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. The bill makes this provision inapplicable to overpayment by a preferred provider benefit plan or a health maintenance organization. The bill prohibits a contract between a health benefit plan issuer and a physician, hospital, or other health care provider from

prohibiting the physician, hospital, or health care provider from collecting, at the time of care, the estimated amount for which the enrollee may be financially responsible.

C.S.H.B. 1342 prohibits a health benefit plan issuer from directly charging or collecting a fee from an enrollee or physician, or other health care provider to cover the costs incurred by the issuer in complying with the bill's provisions. The bill requires the commissioner of insurance to adopt rules as necessary to implement the bill's provisions, including rules that ensure that the information technology used by a health benefit plan issuer does not have legal or technical restrictions for encoding, displaying, exchanging, reading, printing, transmitting, or storing information or data in electronic form.

C.S.H.B. 1342 authorizes a health benefit plan issuer to apply to the commissioner for a waiver of the requirement to use information technology. The bill requires the commissioner by rule to identify circumstances that justify a waiver, including undue hardship, including financial or operational hardship; the geographical area in which the health benefit plan issuer operates; the number of enrollees covered by a health benefit plan issuer; and other special circumstances. The bill requires the commissioner to approve or deny a waiver application not later than the 60th day after the date of receipt of the application. The bill establishes that the waiver expires January 1, 2012.

C.S.H.B. 1342 defines "health benefit plan" to mean a 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 that is offered by specified types of insurance providers. The bill defines "health benefit plan issuer."

EFFECTIVE DATE

On passage, or, if the act does not receive the necessary vote, the act takes effect January 1, 2010.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 1342 differs from the original by removing health and accident coverage through a risk pool from the definition of "health benefit plan." The substitute differs from the original by expanding the items for which a health benefit plan issuer is required to use information technology to provide information to an enrollee.

C.S.H.B. 1342 differs from the original in provisions on information required to be provided to the enrollee by adding covered benefits information, by requiring copayment and coinsurance information to be given to the enrollee, rather than out-of-network payables, and by removing the specification that the information be provided in real-time at the point of service.

C.S.H.B. 1342 differs from the original in provisions on information provided to health care providers by including hospitals as recipients of the information, by specifying the information the plan issuer must provide, and by specifying that the real-time information must be provided at point of care.

C.S.H.B. 1342 differs from the original by adding the requirement that a physician, hospital, or other health care provider use information technology as required by the substitute beginning not later than September 1, 2013. The substitute differs from the original by adding provisions that requires a physician, hospital, or other health care provider to refund overpayments under certain conditions. The substitute differs from the original by prohibiting a contract between a health benefit plan issuer and a physician, hospital, or other health care provider from prohibiting the physician, hospital, or health care provider from collecting, at the time of care, the estimated amount for which the enrollee may be financially responsible.

C.S.H.B. 1342 differs from the original by authorizing a health benefit plan issuer to apply to the commissioner for a waiver of the requirement to use information technology, requiring the commissioner of insurance by rule to identify circumstances that justify a waiver, requiring the commissioner to approve or deny a waiver application within a certain timeframe, and establishing that the waiver provisions expire January 1, 2012.

C.S.H.B. 1342 differs from the original by changing the effective date.