By: Thompson, Maldonado H.B. No. 1932

Substitute the following for H.B. No. 1932:

By: Thompson C.S.H.B. No. 1932

A BILL TO BE ENTITLED

AN ACT

relating to consumer labeling requirements for certain health benefit plans; providing penalties.

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

SECTION 1. PURPOSE AND FINDINGS. The legislature finds that health care coverage is one of the most important purchases many Texans make, yet basic information that allows comparison between health benefit plans is difficult to find, if the information is available at all. Further, the large number of health benefit plans available in Texas with differing benefits, exclusions, and costs creates a complex array of information that complicates consumer decision making. The legislature further finds that important information typically considered to be indecipherable in health benefit plan documents must be brought to consumers' attention. A standard labeling requirement is, therefore, necessary to allow consumers to gain the information needed to make reasoned health benefit plan purchases.

SECTION 2. Chapter 541, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. REQUIRED LABELING FOR HEALTH BENEFIT PLANS

Sec. 541.501. DEFINITIONS. In this subchapter:

(1) "Direct losses incurred" means the sum of direct losses paid plus an estimate of losses to be paid in the future for all claims arising from all prior and current reporting periods,

minus the corresponding estimate made at the close of business for the preceding period. This amount does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(2) "Direct losses paid" means the sum of all payments made during the reporting period for claimants before reinsurance has been ceded or assumed. This amount does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(3) "Direct premiums earned" means the amount of premium attributable to the coverage already provided in a given period before reinsurance has been ceded or assumed.

(4) "Enrollee" means an individual who is eligible to receive health care services under a health benefit plan.

(5) "Insurance facts label" means a notice that complies with the requirements of this subchapter.

(6) "Covered days for inpatient mental health" means a limitation on the number of days covered for inpatient treatment related to mental health, detoxification, or treatment for addiction.

Sec. 541.502. APPLICABILITY OF SUBCHAPTER; EXCEPTION. (a) This subchapter applies to any health benefit plan that:

(1) 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:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

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

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

(G) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This subchapter does not apply to a health maintenance organization or exclusive provider organization that provides:

(1) managed care services under Chapter 533, Government Code; or

(2) managed care services or exclusive provider services under Chapters 62 and 63, Health and Safety Code.

Sec. 541.503. INSURANCE FACTS LABEL REQUIRED; NOTICE OF LABEL REQUIRED. (a) The following written communications must contain an insurance facts label:

(1) a document used by a health benefit plan issuer to advertise a health benefit plan or the health benefit plan issuer;

(2) a written communication, other than an explanation of benefits, from a health benefit plan issuer to an enrollee; and

(3) a written communication from a health benefit plan issuer to a potential enrollee or policyholder.

(b) The following communications, if made for the purpose of advertising a health benefit plan, must include the phrase "Check our label at:" followed by the Internet web page address where a health benefit plan issuer's insurance facts label can be viewed:

(1) a television or radio advertisement;

(2) a billboard advertisement;

(3) an advertisement published or posted on the Internet; and

(4) any nonwritten media not otherwise described in this section.

Sec. 541.504. GENERAL FORMAT OF INSURANCE FACTS LABEL. (a) An insurance facts label must include a box outline that contains only white background and black text.

(b) An insurance facts label must:

(1) be conspicuous and not less than three inches in height and two inches in width;

(2) be enclosed by a one-half point box rule within three points of text measure; and

(3) separate all lines of text by two points, leading above and below.

(c) The phrase "Insurance Facts" must:

(1) appear in a widely used sans serif font that is no smaller than 13 point; and

(2) be located inside and at the top of the box to fit the width of the label flush left and right.

(d) The health benefit plan name and the name of the company must:

(1) appear in a widely used sans serif font that is no smaller than 10 point; and

(2) be located immediately below the phrase "Insurance Facts" and separated from the phrase "Insurance Facts" by a seven-point rule.

(e) Any disclaimer or other information not otherwise required to appear at a specific location on the label by this subchapter must appear in a widely used sans serif font that is no smaller than six point and located at the bottom of the label box as the commissioner permits by rule.

Sec. 541.505. REQUIRED HEADINGS; FORMAT. (a) An insurance facts label must contain the following headings:

(1) "Monthly Premium";

(2) "Percent of Expense Paid by Plan In-Network";

(3) "Percent of Expense Paid by Plan Out-of-Network";

(4) "Annual Out-of-Pocket Expense (est.)";

(5) "Your Total Annual Cost (est.)";

(6) "Justified Complaints";

(7) "Premium to Direct Patient Care Ratio";

(8) "Expected Profit"; and

(9) "Benefit Levels."

(b) The headings described by this section must be flush left in the label box and appear in a widely used sans serif font that is no smaller than eight point.

(c) "Monthly Premium" must be the first heading and must be:

(1) located immediately below the health benefit plan and health benefit plan issuer name; and

(2) separated from all other headings by a three-point rule.

(d) A numeric value that corresponds to a heading must appear flush right in a widely used sans serif font that is no smaller than eight point.

(e) Each heading must be separated from another heading and any applicable subheadings by a one-quarter-point rule.

(f) Benefit levels have no value and must be the final heading immediately preceding the required subheadings.

Sec. 541.506. REQUIRED HEADINGS; DEFINITIONS. For the purposes of Section 541.505, the following terms have the following meanings:

(1) "Monthly Premium" means the average dollar amount an enrollee pays each month for coverage under a health benefit plan.

(2) "Percent of Expense Paid by Plan In-Network" means

the percentage of a submitted charge for an in-network service that a health benefit plan pays.

(3) "Percent of out-of-network expense paid by plan" means:

(A) the total dollar amount paid under the health benefit plan for covered services that are rendered by out-of-network providers divided by the total billed charges submitted under the plan for payment for the services provided by out-of-network providers; or

(B) if the total dollar amount paid under a particular health benefit plan for covered out-of-network services is not available, the total dollar amount paid by the issuer of the health benefit plan under all plans for covered services that are rendered by out-of-network providers divided by the total billed charges submitted to the issuer for payment of all services provided by out-of-network providers.

(4) "Annual Out-of-Pocket Expense (est.)" means the estimated dollar amount of the cost incurred by a consumer with average health care needs over 12 months. "Average health care need" means health care service required by a health benefit plan's enrollees under 60 years of age who:

(A) were not required to pass a medical examination for coverage; or

(B) were required to pass a medical examination by the health benefit plan, if the plan requires all enrollees to pass a medical examination.

(5) "Your Total Annual Cost (est.)" is the dollar

amount of the sum of annual out-of-pocket expense estimate and annual premium.

(6) "Justified Complaints" means complaints for the previous two years submitted to the department against a health benefit plan issuer for which the department determined that:

(A) a violation of a policy provision, contract provision, rule, or statute occurred; or

(B) a prudent layperson may regard a practice or service below customary business practice.

(7) "Premium to Direct Patient Care Ratio" means the ratio of a health benefit plan's direct losses incurred to the direct premiums earned.

(8) "Expected Profit" means the actuarially set percentage of premium allowed for profit.

Sec. 541.507. REQUIRED SUBHEADINGS; FORMAT. (a) Subheadings under the "Benefit Levels" heading must disclose the dollar value provided by the underlying certificate, policy, or contract, and must be as follows:

(1) "Annual Deductible";

(2) "Annual Family Deductible";

(3) "Annual In-Network Deductible";

(4) "Annual Out-of-Network Deductible";

(5) "Out-of-Pocket Maximum";

(6) "Office Visit Copayment" listed separately for primary care providers and specialists;

(7) "Prescription Copayment";

(8) "Lifetime Maximum Benefit";

(9) "Emergency Room Visit Copayment";

(10) "Covered Days for Inpatient Mental Health";

(11) "Outpatient Surgery Copayment"; and

(12) "Inpatient Cost Sharing."

(b) Each subheading required by this section must be indented six points from the left and appear in a widely used sans serif font that is no smaller than eight point.

(c) A numeric value that corresponds to a subheading must appear flush right in a widely used sans serif font that is no smaller than eight point.

(d) Each subheading must be separated from another subheading by a one-quarter-point rule.

Sec. 541.508. RULES. (a) The commissioner may:

(1) require differing titles, headings, and subheadings as may otherwise be required by this subchapter as necessary to prevent confusion between insurance and noninsurance products; and

(2) adopt rules as necessary to implement and administer this subchapter.

(b) The commissioner shall adopt rules regulating:

(1) the use of insurance and noninsurance terms in the insurance facts label to prevent confusion in the marketplace between insurance and noninsurance products;

(2) the manner in which a health benefit plan may use space available in the label box after disclosure of the consumer information required by this subchapter;

(3) allowable disclaimers that may appear in a

separate section at the bottom of an insurance facts label box below all headings and subheadings on the label; and

(4) the format for a label containing information about multiple health benefit plans for an advertisement or communication that promotes or relates to multiple plans or promotes or relates to a health benefit plan issuer that issues multiple plans.

Sec. 541.509. REMEDIES AND ENFORCEMENT. (a) A violation of this subchapter is an unfair and deceptive act or practice in the business of insurance under this chapter.

(b) The department may examine records and investigate to determine whether a violation of this subchapter has occurred.

(c) All procedures, settlements, sanctions, and penalties provided under Subchapters C, E, G, and H are available under this subchapter.

SECTION 3. As soon as practicable, but not later than October 31, 2009, the commissioner of insurance shall prepare an exemplar of an insurance facts label to aid compliance with Subchapter K, Chapter 541, Insurance Code, as added by this Act, and publish an Internet web page to explain the insurance facts label to consumers.

SECTION 4. 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, 2009.