By: Thompson 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.

Sec. 541.502. APPLICABILITY OF SUBCHAPTER. 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.

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;

(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

1 issuer to a potential enrollee.
2 (b) The following communications, if made for the purpose of
3 advertising a health benefit plan, must include the phrase "Check
4 our label at:" followed by the Internet website address where a
5 health benefit plan issuer's insurance facts label can be viewed:
6 (1) a television or radio advertisement;
7 (2) a billboard advertisement;
8 (3) an advertisement published or posted on the
9 Internet; and
10 (4) any nonwritten media not otherwise described in
11 this section.
12 Sec. 541.504. GENERAL FORMAT OF INSURANCE FACTS LABEL. (a)
13 An insurance facts label must include a box outline that contains
14 only white background.
15 (b) An insurance facts label must:
16 (1) be conspicuous and not less than three inches in
17 height and two inches in width;
18 (2) be enclosed by a one-half point box rule within
19 three points of text measure; and
20 (3) separate all lines of text by two points, leading
21 above and below.
22 (c) The phrase "Insurance Facts" must:
23 (1) appear in a widely used sans serif font that is no
24 smaller than 13 point; and
25 (2) be located inside and at the top of the box to fit
26 the width of the label flush left and right.
27 (d) The health benefit plan name and the name of the company

1 must:

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

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

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

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

13 (1) "Monthly Premium";

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

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

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

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

18 (6) "Justified Complaints";

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

20 (8) "Expected Profit"; and

21 (9) "Benefit Levels."

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

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

26 (1) located immediately below the health benefit plan
27 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) Any heading that is immediately followed by a disclaimer or information other than another heading or a subheading must be separated from the disclaimer or other information by a seven-point rule.

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

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 Expense Paid by Plan Out-of-Network" means the percentage of a submitted charge a health benefit plan pays for services provided out-of-network.

(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

1 enrollees under 60 years of age who:
2 (A) were not required to pass a medical
3 examination for coverage; or
4 (B) were required to pass a medical examination
5 by the health benefit plan, if the plan requires all enrollees to
6 pass a medical examination.
7 (5) "Your Total Annual Cost (est.)" is the dollar
8 amount of the sum of annual out-of-pocket expense estimate and
9 annual premium.
10 (6) "Justified Complaints" means complaints for the
11 previous two years submitted to the department against a health
12 benefit plan issuer for which the department determined that:
13 (A) after examination and investigation, a
14 violation of a policy provision, contract provision, rule, or
15 statute occurred; or
16 (B) a prudent layperson may regard a practice or
17 service below customary business practice.
18 (7) "Premium to Direct Patient Care Ratio" means the
19 ratio of a health benefit plan's direct losses incurred to the
20 direct premiums earned.
21 (8) "Expected Profit" means the actuarially set
22 percentage of premium allowed for profit.
23 (9) "Benefit Levels" means the dollar value of the
24 items listed in Section 541.507(a)(1)-(13).
25 Sec. 541.507. REQUIRED SUBHEADINGS; FORMAT. (a)
26 Subheadings under the "Benefit Levels" heading must disclose the
27 dollar value provided by the underlying certificate, policy, or

1 contract, and must be as follows:
2 (1) "Annual Deductible";
3 (2) "Annual Family Deductible";
4 (3) "Annual In-Network Deductible";
5 (4) "Annual Out-of-Network Deductible";
6 (5) "Out-of-Pocket Maximum";
7 (6) "Office Visit Copayment" listed separately for
8 primary care providers and specialists;
9 (7) "Prescription Copayment";
10 (8) "Lifetime Maximum Benefit";
11 (9) "Emergency Room Visit Copayment";
12 (10) "Number of Electric Wheelchairs per Lifetime";
13 (11) "Outpatient Surgery Copayment";
14 (12) "Inpatient Cost Sharing"; and
15 (13) "Number of Justified Complaints."
16 (b) Each subheading required by this section must be
17 indented six points from the left and appear in a widely used sans
18 serif font that is no smaller than eight point.
19 (c) A numeric value that corresponds to a subheading must
20 appear flush right in a widely used sans serif font that is no
21 smaller than eight point.
22 (d) Each subheading must be separated from another
23 subheading and the heading "Monthly Premium" by a one-quarter-point
24 rule.
25 Sec. 541.508. RULES. (a) The commissioner may:
26 (1) require differing titles, headings, and
27 subheadings as may otherwise be required by this subchapter as

1 necessary to prevent confusion between insurance and noninsurance
2 products; and
3 (2) adopt rules as necessary to implement and
4 administer this subchapter.
5 (b) The commissioner shall adopt rules regulating:
6 (1) the use of insurance and noninsurance terms in the
7 insurance facts label to prevent confusion in the marketplace
8 between insurance and noninsurance products;
9 (2) the manner in which a health benefit plan may use
10 space available in the label box after disclosure of the consumer
11 information required by this subchapter;
12 (3) allowable disclaimers below the headings and
13 subheadings on the label; and
14 (4) the format for a label containing information
15 about a multiple health benefit plan.
16 Sec. 541.509. REMEDIES AND ENFORCEMENT. (a) A violation of
17 this subchapter is an unfair and deceptive act or practice in the
18 business of insurance under this chapter.
19 (b) The department may examine records and investigate to
20 determine whether a violation of this subchapter has occurred.
21 (c) All procedures, settlements, sanctions, and penalties
22 provided under Subchapters C, E, G, and H are available under this
23 subchapter.
24 SECTION 3. This Act takes effect immediately if it receives
25 a vote of two-thirds of all the members elected to each house, as
26 provided by Section 39, Article III, Texas Constitution. If this
27 Act does not receive the vote necessary for immediate effect, this

1 Act takes effect September 1, 2009.