By: Smithee H.B. No. 1624

A BILL TO BE ENTITLED

AN ACT

relating to transparency of certain information related to certain health benefit plan coverage.

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

SECTION 1. Subchapter B, Chapter 1369, Insurance Code, is amended by adding Sections 1369.0542, 1369.0543, and 1369.0544 to read as follows:

Sec. 1369.0542. FORMULARY INFORMATION ON INTERNET WEBSITE. (a) A health benefit plan issuer shall display on a public Internet website maintained by the issuer formulary information as required by the commissioner by rule.

(b) A direct electronic link to the formulary information must be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the health benefit plan issuer's Internet website. The information must be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information.

Sec. 1369.0543. FORMULARY DISCLOSURE REQUIREMENTS. (a) The commissioner shall develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans.

(b) The requirements adopted under Subsection (a) must

apply to each prescription drug:

(1) included in a formulary and dispensed in a network pharmacy; or

(2) covered under a health benefit plan and typically administered by a physician or health care provider.

(c) The formulary disclosures must:

(1) be electronically searchable by drug name;

(2) include for each drug the information required by Subsection (d) in the order listed in that subsection; and

(3) indicate each formulary that applies to each health benefit plan issued by the issuer.

(d) The formulary disclosures must include for each drug:

(1) the cost-sharing amount for each drug, including as applicable:

(A) the dollar amount of a copayment; or

(B) for a drug subject to coinsurance:

(i) an enrollee's cost-sharing amount stated in dollars; or

(ii) a cost-sharing range, denoted as follows:

(a) under $100 - $;

(b) $100-$250 - $$;

(c) $251-$500 - $$$;

(d) $501-$1,000 - $$$$; or

(e) over $1,000 - $$$$$;

(2) a disclosure of prior authorization, step therapy, or other protocol requirements for each drug;

(3) if the health benefit plan uses a tier-based formulary, the specific tier for each drug listed in the formulary and the specific copayments for each tier as set out in the coverage document;

(4) a description of how prescription drugs will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs for a prescription drug that may not apply to the deductible;

(5) identification of preferred formulary drugs; and

(6) an explanation of coverage of each formulary drug.

(e) The commissioner by rule may allow disclosures other than the disclosures required under Subsection (d)(1) relating to cost-sharing through a web-based tool that must:

(1) be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information;

(2) allow consumers to electronically search formulary information by the name under which the health benefit plan is marketed; and

(3) be accessible through a direct link that is displayed on each page of the formulary disclosure that lists each drug as required under Subsection (c).

Sec. 1369.0544. FORMULARY INFORMATION PROVIDED BY TOLL-FREE TELEPHONE NUMBER. In addition to providing the information described by Section 1369.0543(d)(1), a health benefit plan issuer may make the information available to enrollees, prospective enrollees, and others through a toll-free telephone number that

operates at least during normal business hours.

SECTION 2. Chapter 1451, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. HEALTH CARE PROVIDER DIRECTORIES

Sec. 1451.501. DEFINITIONS. In this subchapter:

(1) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist, pharmacy, hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care. The term does not include a physician.

(2) "Physician" means an individual licensed to practice medicine in this state.

Sec. 1451.502. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit 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 a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

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

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

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

(5) a reciprocal exchange operating under Chapter 942;

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

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

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Sec. 1451.503. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1451.502;

(6) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(7) a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Sec. 1451.504. PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORIES. (a) A health benefit plan issuer that offers coverage for health care services through preferred providers, exclusive providers, or a network of physicians or health care providers shall develop and maintain a physician and health care provider directory in accordance with this subchapter.

(b) The directory must include the name, street address, and telephone number of each physician and health care provider described by Subsection (a) and indicate whether the physician or provider is accepting new patients.

Sec. 1451.505. PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORY ON INTERNET WEBSITE. (a) A health benefit plan issuer shall display on a public Internet website maintained by the issuer the directory

required by Section 1451.504. A direct electronic link to the directory must be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the Internet website.

(b) The health benefit plan issuer shall clearly indicate in the directory each health benefit plan issued by the issuer that may provide coverage for services provided by each physician or health care provider included in the directory.

(c) The directory must be:

(1) electronically searchable by physician or health care provider name and location; and

(2) publicly accessible without necessity of providing a password, a user name, or personally identifiable information.

(d) The health benefit plan issuer shall conduct an ongoing review of the directory and correct or update the information as necessary. Except as provided by Subsection (e), corrections and updates, if any, must be made not less than once each month.

(e) The health benefit plan issuer shall conspicuously display in the directory required by Section 1451.504 an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in the directory. If the issuer receives a report from any person that specifically identified directory information may be inaccurate, the issuer shall investigate the report and correct the information, as necessary, not later than the seventh day after the date the report is received.

SECTION 3. The commissioner of insurance shall adopt rules as required by Section 1369.0543, Insurance Code, as added by this Act, not later than January 1, 2016.

SECTION 4. This Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2016. A plan delivered, issued for delivery, or renewed before January 1, 2016, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2015.