By: Muñoz, Jr. H.B. No. 1718

A BILL TO BE ENTITLED

AN ACT

relating to participation in the health care market by managed care plan enrollees.

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

SECTION 1. Subtitle C, Title 8, Insurance Code, is amended by adding Chapter 1275 to read as follows:

CHAPTER 1275. HEALTH CARE MARKET PARTICIPATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1275.0001. DEFINITIONS. In this chapter:

(1) "Allowed amount" means the amount paid by a health benefit plan issuer to a participating provider for a covered service under a contract between the issuer and provider.

(2) "Enrollee" means an individual who is eligible to receive benefits for health care services through a health benefit plan.

(3) "Health benefit plan" means:

(A) an individual, group, blanket, or franchise insurance policy, a certificate issued under an individual or group policy, or a group hospital service contract that provides benefits for health care services; or

(B) a group subscriber contract or group or individual evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

(4) "Health benefit plan issuer" means a health

maintenance organization operating under Chapter 843, a preferred provider organization operating under Chapter 1301, an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, and any other entity that issues a health benefit plan, including:

(A) an insurance company;

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

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

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

(5) "Health care provider" means a physician, hospital, pharmacy, pharmacist, laboratory, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state.

(6) "Health care service" means a service for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(7) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers.

(8) "Out-of-network provider," with respect to a managed care plan, means a health care provider who is not a participating provider of the plan.

(9) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide health care services to enrollees.

Sec. 1275.0002. APPLICABILITY OF CHAPTER; EXEMPTION. (a) This chapter applies only with respect to nonemergency health care services covered under a managed care plan.

(b) Notwithstanding Subsection (a), Subchapters B and C do not apply to a covered health care service described by Subsection (a) for which the commissioner approves an application for exemption filed by the issuer with the department in the form and manner prescribed by the commissioner that includes sufficient evidence to demonstrate that the variation in allowed amounts for the service among participating providers is less than $50.

Sec. 1275.0003. RULES. The commissioner may adopt rules to implement this chapter.

SUBCHAPTER B. TRANSPARENCY TOOLS

Sec. 1275.0051. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a small employer health benefit plan written under Chapter 1501;

(2) an individual insurance policy or insurance agreement; or

(3) an individual evidence of coverage or similar coverage document.

Sec. 1275.0052. AVAILABILITY OF PRICE AND QUALITY INFORMATION. (a) A health benefit plan issuer shall provide on its publicly available Internet website an interactive mechanism that,

for a specific health care service, allows an enrollee to:

(1) request and obtain from the issuer:

(A) information on the payments made by the issuer to participating providers under the enrollee's health benefit plan; and

(B) quality data on participating providers to the extent that data is available;

(2) compare allowed amounts among participating providers;

(3) estimate the enrollee's out-of-pocket costs under the enrollee's health benefit plan; and

(4) view the median or mode amount paid to participating providers under the enrollee's health benefit plan within a reasonable time not to exceed one year.

(b) A health benefit plan issuer may contract with a third party to provide the interactive mechanism described by Subsection (a).

Sec. 1275.0053. ESTIMATE REQUIREMENTS. To satisfy the requirement under Section 1275.0052(a)(3), a health benefit plan issuer shall provide a good-faith estimate of the amount the enrollee will be responsible to pay for a health care service provided by a participating provider based on the information available to the issuer at the time the estimate is requested.

Sec. 1275.0054. NOTICE TO ENROLLEES. A health benefit plan issuer shall inform an enrollee requesting an estimate under Section 1275.0052(a)(3) that the actual amount of the charges and the amount the enrollee is responsible to pay for the service may

vary based upon unforeseen services that arise from the proposed service.

Sec. 1275.0055. WAIVER. (a) A health benefit plan issuer may file with the department a request for a waiver from compliance with this subchapter for a health care service for which the issuer determines that the issuer is unable to comply with Section 1275.0052.

(b) A health benefit plan issuer filing a request under Subsection (a) must:

(1) file the request in the form and manner prescribed by the commissioner; and

(2) include evidence supporting the issuer's determination that the issuer cannot comply with Section 1275.0052 for the health care service.

(c) The commissioner shall approve a waiver request under this section if the commissioner determines that the issuer provided sufficient evidence to support the waiver. If the commissioner approves a waiver request, the commissioner shall publicly release the contents of the request.

Sec. 1275.0056. EFFECT OF SUBCHAPTER. This subchapter does not prohibit a health benefit plan issuer from imposing deductibles, copayments, or coinsurance under the health benefit plan for an unforeseen health care service:

(1) arising from the health care service that is the basis for the original estimate to the enrollee provided under Section 1275.0052; and

(2) that was not included in the original estimate

provided under Section 1275.0052.

SUBCHAPTER C. INCENTIVE PROGRAM

Sec. 1275.0101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to:

(1) a small employer health benefit plan written under Chapter 1501;

(2) an individual insurance policy or insurance agreement; or

(3) an individual evidence of coverage or similar coverage document.

(b) This subchapter does not apply to a health benefit plan for which an enrollee receives a premium subsidy under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

Sec. 1275.0102. ESTABLISHMENT OF INCENTIVE PROGRAM. A health benefit plan issuer shall establish an incentive program for each health benefit plan subject to this subchapter. The program must provide an incentive paid in accordance with this subchapter to an enrollee who elects to receive a health care service from a participating provider who provides that service at a cost that is lower than the median or mode allowed amount for that service.

Sec. 1275.0103. PROGRAM DESCRIPTION REQUIRED. Before offering the program required by this subchapter, a health benefit plan issuer shall file a description of the program with the department in the form and manner prescribed by the commissioner.

Sec. 1275.0104. NOTICE TO ENROLLEES. Annually and at enrollment or renewal of a health benefit plan, the health benefit plan issuer shall provide written notice to enrollees about:

(1) the availability of the program;

(2) the program's incentives; and

(3) methods to obtain the program's incentives.

Sec. 1275.0105. INCENTIVE PAYMENTS. (a) A health benefit plan issuer shall pay an incentive under the program regardless of whether the enrollee has exceeded the out-of-pocket limit under the enrollee's health benefit plan.

(b) A health benefit plan issuer may pay a program incentive in the form of:

(1) cash;

(2) a gift card; or

(3) a credit or reduction in the health benefit plan's premium, deductible, copayment, or coinsurance.

(c) An incentive payment made in accordance with this section is not an administrative expense of a health benefit plan issuer for purposes of rate development or rate filing.

SUBCHAPTER D. PARTICIPATION IN OUT-OF-NETWORK PROVIDER MARKET

Sec. 1275.0151. ENROLLEE ELECTION OF CERTAIN OUT-OF-NETWORK CARE; PROVIDER REIMBURSEMENT. (a) If an enrollee elects to receive a covered health care service from an out-of-network provider who is based in the United States and the provider makes the agreement described by Subsection (b), the enrollee's health benefit plan issuer shall:

(1) allow the enrollee to obtain the service from the out-of-network provider; and

(2) pay the provider an amount not to exceed the median or mode contracted amount for the service during a reasonable

period not to exceed one year.

(b) An out-of-network provider may elect to receive a payment under Subsection (a) if the provider agrees to not charge the enrollee an amount that exceeds the enrollee's responsibility under the health benefit plan for the same service provided by a participating provider.

Sec. 1275.0152. APPLICATION OF ENROLLEE PAYMENT. (a) An enrollee who makes an election under Section 1275.0151(a) may file with a health benefit plan issuer a request for the enrollee's payment to the out-of-network provider to be treated as a payment to a participating provider under the enrollee's health benefit plan for purposes of a deductible or out-of-pocket maximum if:

(1) the out-of-network provider made the election described by Section 1275.0151(b) with respect to the service that is the basis for the request; and

(2) the enrollee provides proof of payment to the out-of-network provider.

(b) A health benefit plan issuer shall provide a downloadable or interactive online form for submitting a request under Subsection (a).

(c) A health benefit plan issuer shall grant a request that complies with Subsection (a) and rules adopted under this chapter.

Sec. 1275.0153. NOTICE TO ENROLLEES. A health benefit plan issuer shall provide written notice to enrollees on the issuer's Internet website and in the enrollees' health benefit plan materials of the enrollees' rights to make an election under Section 1275.0151 and a request under Section 1275.0152 and the

process for making the election and request.

SECTION 2. Chapter 1275, Insurance Code, as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2020. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2020, 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 3. This Act takes effect September 1, 2019.