BILL ANALYSIS

H.B. 2090
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Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Historically, the rapid growth in health care spending has been driven by increases in price, rather than the overall utilization of health care services. Furthermore, the variation in the price paid for the same health care services is also rising. Price variation in traditional markets allows consumers to pick the product or service that is right for them, but a persistent issue in health care markets is that prices remain opaque, leaving health care consumers without adequate information to make decisions regarding health care services. With better information, health benefit plan enrollees would be able to make more informed decisions about where to get the health care services they need at the most valuable price, while employers would be able to make more informed decisions with regard to the value of health benefit plans purchased on behalf of employees. H.B. 2090 seeks to address these issues by requiring health benefit plan issuers and third-party administrators to disclose to enrollees the real, provider-specific price of a health care service, as well as the out-of-pocket expense incurred by a patient.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance and the Texas Department of Insurance in SECTION 2 of this bill.

ANALYSIS

H.B. 2090 amends the Insurance Code to set out provisions regarding health care cost transparency that require applicable health benefit plan issuers and third-party administrators to disclose to enrollees, on request of the enrollee, and to the public certain information about health care costs. The bill authorizes the commissioner of insurance to adopt rules necessary to implement its provisions.

Required Disclosures to Enrollees

H.B. 2090 requires an applicable health benefit plan issuer or administrator, on request of a plan enrollee, to provide to the enrollee a health care cost disclosure that is made in accordance with the bill's provisions. A plan issuer or administrator may allow an enrollee to request cost-sharing information for a specific preventive or non-preventive health care service or supply by including terms such as "preventive," "non-preventive," or "diagnostic" when requesting the information. The bill does the following:

- sets out the information that must be included in a request;
- requires certain plain-language statements in the required information;

- provides that the information must be accurate at the time a disclosure request is made, with respect to the enrollee's cost-sharing liability for a covered service and supply; and
- sets out the conditions under which a plan issuer or administrator is required or is not required to provide an estimate of cost-sharing liability for a bundled payment arrangement.

With respect to the information in a request regarding the reimbursement of an out-of-network provider, if a plan issuer or administrator reimburses an out-of-network provider with a percentage of the billed charge for a covered health care service or supply, the out-of-network allowed amount described in the required information is the reimbursed percentage.

H.B. 2090 gives the plan issuer or administrator the option of providing the requested disclosure through an Internet-based self-service tool, a physical copy, or other authorized means. With respect to those methods and formats for disclosure:

- the Internet-based self-service tool must be made available in plain language, without a subscription or other fee, on a website that provides real-time responses based on cost-sharing information that is accurate at the time of the request;
- the plan issuer or administrator must ensure that the tool allows a user to perform certain described searches and to refine and reorder search results based on geographic proximity of network providers and the amount of the enrollee's estimated cost-sharing liability; and
- the physical copy must be made available in plain language, without a fee, at the request of the enrollee, as follows:
  - the plan issuer or administrator may limit the number of health care providers with respect to which cost-sharing information for a service or supply is provided to no fewer than 20 providers per request;
  - the plan issuer or administrator must disclose any applicable prover-per-request limit to the enrollee; and
  - the plan issuer or administrator must mail the disclosure not later than two business days after the date the enrollee's request is received.

The bill provides for other means of disclosure on request of an enrollee as long as the request is fulfilled at least as rapidly as required for a physical copy, includes the information required for a physical copy, and the enrollee agrees the means is sufficient to satisfy the request.

H.B. 2090 provides for contractual agreements by which a plan issuer or administrator may satisfy the disclosure requirement by entering into a written agreement under which another person, including a pharmacy benefit manager or other third party, provides the required disclosure. The bill subjects a plan issuer or administrator who enters into such an agreement to an enforcement action for failure to provide the required disclosure in accordance with the applicable bill provisions.

H.B. 2090 sets out the circumstances under which a plan issuer or administrator acting in good faith and with reasonable diligence does not fail to comply with the bill's provisions regarding the required disclosure to an enrollee.

Required Disclosures to the Public

H.B. 2090 sets out provisions requiring the public disclosure of certain information published in specified machine-readable files regarding covered health care services and supplies. The bill requires the prescribed information to be updated monthly and provides the following with respect to such disclosure:

- a plan issuer or administrator must publish on a website the following machine-readable files, which must be updated monthly, that are available free of charge and without conditions in a form and manner prescribed by Texas Department of Insurance rule and that contain information prescribed by the bill:
  - a network rate machine-readable file;
  - an out-of-network allowed amount machine-readable file; and

- a prescription drug machine-readable file;
- a plan issuer or administrator must omit certain information from such files if compliance with the applicable publication requirement for such information would require the issuer to report payment information in connection with fewer than 20 different claims for payments under a single health benefit plan; and
- the bill's provisions expressly do not require the disclosure of information in such files that would violate any applicable health information privacy law.

H.B. 2090 provides for the following matters applicable to public disclosure of the prescribed information:

- network rate disclosures for a plan issuer or administrator that does not use negotiated rates for provider reimbursement and for a plan issuer or administrator that uses underlying fee schedule rates for calculating cost sharing;
- requirements for the way out-of-network allowed amounts are reflected and associated with other out-of-network provider information; and
- determinations of the historical net price for prescription drugs.

H.B. 2090, with respect to the out-of-network allowed amount file, provides that the bill's public disclosure provisions expressly do not prohibit the following:

- a third party from hosting such a file on its website; or
- a plan issuer or administrator from contracting with a third party to post the file.

However, the plan issuer or administrator must provide a link on its website to the location where the file is made publicly available if the issuer or administrator does not host the file separately on its website.

H.B. 2090 sets out the following provisions regarding authorized contractual agreements used to satisfy the public disclosure requirement:

- a plan issuer or administrator may enter into a written agreement under which another person, including a third-party administrator or health care claims clearinghouse, provides the disclosure; and
- if the issuer or administrator and another person enter into the agreement, the issuer or administrator is subject to an enforcement action for failure to provide a required disclosure.

H.B. 2090 establishes the following with respect to compliance with the public disclosure requirements by a plan issuer or administrator:

- a plan issuer or administrator acting in good faith and with reasonable diligence does not fail to comply solely because, as follows:
  - an error or omission is made in a disclosure, if the issuer or administrator corrects the error or omission as soon as practicable; or
  - the issuer's or administrator's website is temporarily inaccessible, if the issuer or administrator makes the information available as soon as practicable; and
- a plan issuer or administrator does not fail to comply, to the extent compliance requires the issuer or administrator to obtain information from another person, because the issuer or administrator relies in good faith on information from the other person, unless the issuer or administrator knows or reasonably should have known that the information is incomplete or inaccurate.

Applicability and Other Provisions

H.B. 2090 establishes the applicability of its provisions with respect to plan issuers and third-party administrators, sets out applicable definitions, and provides the following:

- the bill does not apply to a health reimbursement arrangement or other account-based health benefit plan;

- with respect to its provisions relating to required disclosures to enrollees, the bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2024, or for a plan year that begins on or after that date; and
- with respect to its provisions relating to required public disclosures, the bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2022, or for a plan year that begins on or after that date.

EFFECTIVE DATE

September 1, 2021.