By: Muñoz, Jr. H.B. No. 3947

A BILL TO BE ENTITLED

AN ACT

relating to health care cost transparency by health benefit plan issuers.

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

SECTION 1. The heading to Subtitle J, Title 8, Insurance Code, is amended to read as follows:

SUBTITLE J. HEALTH INFORMATION TECHNOLOGY AND TRANSPARENCY

SECTION 2. Subtitle J, Title 8, Insurance Code, is amended by adding Chapter 1663 to read as follows:

CHAPTER 1663. HEALTH CARE COST TRANSPARENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1663.001. 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

1 individual evidence of coverage issued by a health maintenance
2 organization that provides benefits for health care services.
3 (4) "Health benefit plan issuer" means a health
4 maintenance organization operating under Chapter 843, a preferred
5 provider organization operating under Chapter 1301, an approved
6 nonprofit health corporation that holds a certificate of authority
7 under Chapter 844, and any other entity that issues a health benefit
8 plan, including:
9 (A) an insurance company;
10 (B) a group hospital service corporation
11 operating under Chapter 842;
12 (C) a fraternal benefit society operating under
13 Chapter 885; or
14 (D) a stipulated premium company operating under
15 Chapter 884.
16 (5) "Health care provider" means a physician,
17 hospital, pharmacy, pharmacist, laboratory, or other person or
18 organization that furnishes health care services and that is
19 licensed or otherwise authorized to practice in this state.
20 (6) "Health care service" means a service for the
21 diagnosis, prevention, treatment, cure, or relief of a health
22 condition, illness, injury, or disease.
23 (7) "Managed care plan" means a health benefit plan
24 under which health care services are provided to enrollees through
25 contracts with health care providers and that requires enrollees to
26 use participating providers or that provides a different level of
27 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. 1663.002. APPLICABILITY OF CHAPTER. (a) This chapter 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 an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

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

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

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

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

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

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

(8) a Lloyd's plan operating under Chapter 941; or

1 (9) an exchange operating under Chapter 942.
2 (b) Notwithstanding any other law, this chapter applies to:
3 (1) a small employer health benefit plan subject to
4 Chapter 1501, including coverage provided through a health group
5 cooperative under Subchapter B of that chapter;
6 (2) a standard health benefit plan issued under
7 Chapter 1507;
8 (3) a basic coverage plan under Chapter 1551;
9 (4) a basic plan under Chapter 1575;
10 (5) a primary care coverage plan under Chapter 1579;
11 (6) a plan providing basic coverage under Chapter
12 1601;
13 (7) health benefits provided by or through a church
14 benefits board under Subchapter I, Chapter 22, Business
15 Organizations Code;
16 (8) the state Medicaid program, including the Medicaid
17 managed care program operated under Chapter 533, Government Code;
18 (9) the child health plan program under Chapter 62,
19 Health and Safety Code;
20 (10) a regional or local health care program operated
21 under Section 75.104, Health and Safety Code;
22 (11) a self-funded health benefit plan sponsored by a
23 professional employer organization under Chapter 91, Labor Code;
24 (12) county employee group health benefits provided
25 under Chapter 157, Local Government Code; and
26 (13) health and accident coverage provided by a risk
27 pool created under Chapter 172, Local Government Code.

1 Sec. 1663.003. RULES. The commissioner may adopt rules to
2 implement this chapter.
3 SUBCHAPTER B. TRANSPARENCY TOOLS
4 Sec. 1663.051. AVAILABILITY OF PRICE AND QUALITY
5 INFORMATION. (a) A health benefit plan issuer shall provide on its
6 publicly available Internet website an interactive mechanism that,
7 for a health care service classified by the Current Procedural
8 Terminology code associated with the service, allows an enrollee
9 to:
10 (1) request and obtain from the issuer:
11 (A) information on the payments made by the
12 issuer to participating providers under the enrollee's health
13 benefit plan; and
14 (B) the payment methodology for and an estimate
15 of the dollar amount the issuer will pay for a health care service
16 provided by a health care provider who is not a participating
17 provider, including an out-of-network provider;
18 (2) compare allowed amounts among participating
19 providers; and
20 (3) estimate the enrollee's out-of-pocket costs under
21 the enrollee's health benefit plan.
22 (b) The interactive mechanism must:
23 (1) have a brief description of each Current
24 Procedural Terminology code that allows an enrollee to find the
25 appropriate code for a particular health care service;
26 (2) allow an enrollee to receive the requested
27 information before the enrollee receives the health care service or

1 an associated supply for which the enrollee requested information;
2 and
3 (3) provide the information to the enrollee using
4 plain language.
5 (c) A health benefit plan issuer shall update the
6 interactive mechanism for a health benefit plan with each payment
7 made by the issuer with respect to the plan.
8 (d) A health benefit plan issuer may contract with a third
9 party to provide the interactive mechanism.
10 Sec. 1663.052. ESTIMATE REQUIREMENTS. To satisfy the
11 requirement under Section 1663.051(a)(3), a health benefit plan
12 issuer shall provide a good-faith estimate of the amount the
13 enrollee will be responsible to pay for a health care service based
14 on the information available to the issuer at the time the estimate
15 is requested.
16 Sec. 1663.053. NOTICE TO ENROLLEES. A health benefit plan
17 issuer shall inform an enrollee requesting an estimate under
18 Section 1663.051(a)(3) that the actual amount of the charges and
19 the amount the enrollee is responsible to pay for the service may
20 vary based upon unforeseen services that arise from the proposed
21 service.
22 SECTION 3. Chapter 1663, Insurance Code, as added by this
23 Act, applies only to a health benefit plan delivered, issued for
24 delivery, or renewed on or after January 1, 2022. A health benefit
25 plan that is delivered, issued for delivery, or renewed before
26 January 1, 2022, is governed by the law as it existed immediately
27 before the effective date of this Act, and that law is continued in

1 effect for that purpose.

2 SECTION 4. This Act takes effect September 1, 2021.