BILL ANALYSIS

C.S.H.B. 138
By: Dean
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The bill's author has informed the committee that while legislation establishing insurance mandates has been introduced in past legislative sessions, the impact of these mandates on the cost of health insurance is not readily known when the legislation is filed. House rules require the estimated cost of insurance mandates that apply to a state-funded plan to be evaluated, such as the Employees Retirement System of Texas, but there is no process for the evaluation of the costs to private insurance. In fact, the legislature may decide to exempt state-funded plans so that there will not be a cost to the state or a fiscal note generated. According to the trade association America's Health Insurance Plans, at least 28 other states have a process to estimate how legislation will affect the cost of private health coverage, which can help lawmakers in those states make informed decisions. C.S.H.B. 138 seeks to address this issue by establishing the Health Impact, Cost, and Coverage Analysis Program (HICCAP) at The University of Texas Health Science Center at Houston to prepare analyses of proposed legislative documents that would impose new mandates on health benefit plan issuers in Texas.

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 comptroller of public accounts in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 138 amends the Insurance Code to require the Center for Health Care Data at The University of Texas Health Science Center at Houston, not later than January 1, 2026, to establish the Health Impact, Cost, and Coverage Analysis Program to prepare analyses of legislative documents that would impose new mandates on health benefit plan issuers or administrators in Texas. The bill authorizes the lieutenant governor, the speaker of the house of representatives, or the chair or vice chair of the appropriate committee in either house of the legislature, regardless of whether the legislature is in session, to submit a request to the analysis program to prepare and develop an analysis of proposed legislation that imposes a new mandate on health benefit plan issuers or administrators in Texas. The bill prohibits a request from being submitted for an analysis of legislation that has already been enacted and requires a request to include a copy of the relevant legislative document.

C.S.H.B. 138 requires the analysis program upon receiving such a request to conduct, using data compiled by the statewide all payor claims database and data from scientific or peer-reviewed academic literature, an analysis of the following factors, as applicable, and prepare an estimate of, as applicable, the extent to which:

- based on a review of scientific or peer-reviewed academic literature, the legislation is expected to impact public health and the health of communities in Texas, including by reducing hospitalizations and instances of communicable disease and by providing other benefits of prevention;
- the legislation is expected to increase or decrease the total cost of health coverage in Texas, including the estimated dollar amount of that increase or decrease;
- the legislation is expected to increase the use of any relevant health care service in Texas;
- the legislation is expected to increase or decrease administrative expenses of health benefit plan issuers or administrators and expenses of enrollees, plan sponsors, policyholders, and health care providers;
- the legislation is expected to increase or decrease spending by all persons in the private sector, by public sector entities, including state or local retirement systems and political subdivisions, by employers or plan sponsors, and by individuals purchasing individual health insurance or health benefit plan coverage in Texas;
- the legislation is expected to reduce instances of premature death;
- health benefit plans offered or administered in Texas currently deny access to a relevant benefit or service;
- coverage for any relevant health care service is, without the legislation, generally available or used, including an analysis and identification of the plans in the group and individual insurance markets in Texas that, without the legislation, already offer coverage for the relevant health care service;
- any relevant health care service is supported by existing medical and scientific evidence, including the following:
    - the extent to which, based on a review of scientific or peer-reviewed academic literature, the health care service is recognized by the medical community as being effective in the screening, diagnosis, treatment, or amelioration of a condition or disease;
    - determinations made by the FDA and the United States Preventive Services Task Force;
    - coverage determinations made by the Centers for Medicare and Medicaid Services; and
    - nationally recognized clinical practice guidelines; and
- the legislation is expected to increase or decrease the cost of any relevant benefit or health care service in Texas, including an estimate of the impact of the legislation on anticipated costs or savings for:
    - the short term by estimating costs or savings for the first calendar year after the legislation takes effect; and
    - the long term by estimating costs or savings for at least the first two calendar years after the legislation takes effect.

The bill requires the analysis program, if in conducting an analysis the program determines that it is unable to provide a reliable assessment of such a factor, to include in the analysis a statement providing the basis for that determination. The bill authorizes the analysis program, in conducting an analysis, to consult with the Legislative Budget Board or other persons with relevant knowledge and expertise, including independent actuaries.

C.S.H.B. 138 requires the comptroller of public accounts to do the following for purposes of funding the analysis program:

- assess an annual fee on each health benefit plan issuer in the amount necessary to implement the bill's provisions; and
- in consultation with the center, determine the amount of the fee and adjust that amount for each state fiscal biennium to address any estimated increase in costs to implement the bill's provisions or deficits incurred during the preceding year as a result of implementing the bill's provisions.

The bill prohibits the comptroller from assessing a fee under these provisions as follows:

- for a health benefit plan issued under the Texas Employees Group Benefits Act, TRS-Care, TRS-ActiveCare, or under the State University Employees Uniform Insurance Benefits Act; or
- on a health benefit plan issuer operating solely as a Medicaid managed care organization.

The bill requires a health benefit plan issuer, not later than August 1 of each year, to pay the assessed fee to the comptroller. The legislature may appropriate money received from the fee only to the center to be used by the center to administer the center's duties. The bill requires the comptroller, not later than January 1, 2026, to adopt rules to administer these provisions.

C.S.H.B. 138 requires the commissioner of insurance to issue a special data call for an estimate of administrative expenses related to specific legislation analyzed by the analysis program not later than:

- the 30th day after the date the commissioner receives a request from the center; or
- if the commissioner receives a request from the center during a regular legislative session, the 10th day after the date the commissioner receives the request.

The bill requires the commissioner of insurance to provide the special data call to health benefit plan issuers affected by the legislation subject to the special data call, to the extent determined necessary by the commissioner. The bill requires such a special data call to be organized in standardized fields and categories of information and ensure that responses to the special data call enable a valid comparison among health benefit plan issuers. The bill requires a health benefit plan issuer to which the commissioner provides a special data call under these provisions to submit a response to the special data call in the form and manner prescribed by the commissioner before the later of the following:

- the 10th day after the date the commissioner issues the special data call; or
- a date determined by the center.

The bill establishes that a response to the special data call must disclose the calculation methodology used by the health benefit plan issuer to develop the response and is not subject to disclosure under state public information law.

C.S.H.B. 138 requires the center, not later than the 60th day after the date the analysis program receives a request under the bill's provisions for an analysis of proposed legislation, or, if the analysis program receives such a request during a regular legislative session, not later than the 30th day after the date the analysis program receives that request, to prepare a written report containing the results of the impact analysis performed under the bill's provisions and to do the following:

- deliver the report to the lieutenant governor, the speaker of the house of representatives, and the appropriate committees in each house of the legislature; and
- make the report available on a generally accessible website.

The bill prohibits the report from disclosing a health benefit plan issuer's individual response to a special data call issued under the bill's provisions. The bill requires the report to include the following:

- a copy of the special data call; and
- the aggregated responses to the special data call in their entirety, which must:
    - be organized by category and field in the same manner as the special data call; and
    - include any calculation methodology disclosed in a response to the special data call.

The bill requires the center to ensure that employees of the center who are assigned to the analysis program are not simultaneously employed by a health benefit plan issuer or administrator and do not possess an ownership or other personal interest in a health benefit plan issuer or administrator. The bill authorizes the center to require an employee assigned to the analysis program to file a conflict of interest statement and a statement of ownership interests with the center to ensure compliance with these provisions.

C.S.H.B. 138 requires the center, as soon as practicable after the bill's effective date, to develop a cost estimate of the amount necessary to fund the actual and necessary expenses of

implementing the bill's provisions for the first state fiscal biennium in which the analysis program will operate.

C.S.H.B. 138 defines the following terms for purposes of the analysis program:

- "enrollee" as an individual who is enrolled in a health benefit plan, including a covered dependent;
- "health benefit plan issuer" as an insurer, health maintenance organization, or other entity authorized to provide health benefits coverage under the laws of the state, including a Medicaid managed care organization but not including an issuer of workers' compensation insurance;
- "health benefits coverage" as excluding workers' compensation;
- "health care provider" means a physician, facility, or other person who is licensed, certified, registered, or otherwise authorized to provide a health care service in this state;
- "health care service" means a service, procedure, drug, or device to diagnose, prevent, alleviate, cure, or heal a human disease, injury, or unhealthy or abnormal physical or mental condition, including a service, procedure, drug, or device related to pregnancy or delivery; and
- "mandate" as a provision contained in a legislative document that requires a health benefit plan issuer or administrator, with respect to health benefits coverage to provide coverage for a health care service, increase or decrease payments to health care providers for a health care service, or implement a new contractual or administrative requirement.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2025.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 138 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute authorizes the lieutenant governor, the speaker of the house of representatives, or the chair or vice chair of the appropriate committee in either house of the legislature to submit a request to the analysis program to prepare and develop an analysis of proposed legislation that imposes a new mandate on health benefit plan issuers or administrators in Texas, whereas the introduced authorized the lieutenant governor, the speaker of the house of representatives, or only the chair of the appropriate committee in either house of the legislature to do so. The introduced and the substitute both require the analysis program to conduct an analysis of, as applicable, and prepare an estimate of, as applicable, certain impacts of legislation on health coverage costs, but differ in the following ways:

- the substitute specifies that the analysis program must conduct the legislative analysis using data compiled by the statewide all payor claims database and data from scientific or peer-reviewed academic literature, whereas the introduced did not;
- the substitute includes among the impacts included in the analysis the extent, based on a review of scientific or peer-reviewed academic literature, to which the legislation is expected to impact public health and the health of communities in Texas, including by reducing hospitalizations and instances of communicable disease and by providing other benefits of prevention, which was not present in the introduced;
- with respect to the impact the legislation is expected to have on increasing or decreasing expenses of enrollees, plan sponsors, and policyholders, as in the introduced, the substitute includes the impact the legislation is expected to have on increasing or decreasing expenses of health care providers, whereas the introduced did not;
- with respect to the impact the legislation is expected to have on increasing or decreasing spending by certain entities, the substitutes includes the impact the legislation is

expected to have on increasing or decreasing spending by employers or plan sponsors, whereas the introduced did not;

- with respect to the impact the legislation is expected to have on reducing instances of premature death or economic loss associated with disaster included in the introduced, the substitute omits the impact the legislation is expected to have on reducing such economic loss;
- with respect to the extent to which coverage for any relevant health care service is, without the applicable legislation, generally available or used, the substitute specifies that the extent includes an analysis and identification of the plans in the group and individual insurance markets in Texas that, without the legislation, already offer coverage for the relevant health care service, whereas the introduced did not;
- with respect to the extent to which any relevant health care service is supported by medical and scientific evidence, the substitute does the following:
    - includes a specification absent from the introduced that the medical and scientific evidence is existing medical and scientific evidence; and
    - includes a specification absent from the introduced that the extent includes the extent to which, based on a review of scientific or peer-reviewed academic literature, the health care service is recognized by the medical community as being effective in the screening, diagnosis, treatment, or amelioration of a condition or disease; and
- the substitute includes among the impacts included in the legislative analysis the extent to which the legislation is expected to increase or decrease the cost of any relevant benefit or health care service in Texas, including an estimate of the impact of the legislation on anticipated costs or savings for the short term by estimating costs or savings for the first calendar year after the legislation takes effect and the long term by estimating costs or savings for at least the first two calendar years after the legislation takes effect, which was not present in the introduced.

Whereas the introduced authorized the analysis program, in conducting an analysis, to consult with persons with relevant knowledge and expertise, the substitute authorizes the analysis program to consult with the Legislative Budget Board or other persons with relevant knowledge and expertise, including independent actuaries.

Whereas the introduced required the comptroller to assess an annual fee on each health benefit plan issuer that is not operating solely as a Medicaid managed care organization in the amount necessary to implement the bill's provisions, the substitute requires the comptroller to assess that fee on each health benefit plan issuer in the amount necessary to implement those provisions. The substitute includes a prohibition absent from the introduced against the comptroller assessing such an annual fee for a health benefit plan under the Texas Employees Group Benefits Act, TRS-Care, TRS-ActiveCare, or under the State University Employees Uniform Insurance Benefits Act, or on a health benefit plan issuer operating solely as a Medicaid managed care organization.

While both the introduced and substitute require the commissioner of insurance to issue a special data call for an estimate of administrative expenses related to specific legislation analyzed by the analysis program not later than the 30th day after the date the commissioner receives a request from the center, the substitute includes a deadline absent from the introduced for the commissioner, if the commissioner receives a request from the center during the regular legislative session, to issue such a special data call not later than the 10th day after the commissioner receives the request. Whereas the introduced required the commissioner to provide the special data call to only the five largest health benefit plan issuers affected by the legislation subject to the data call, as measured by a health benefit plan issuer's total number of enrollees, the substitute requires the commissioner to provide that special data call to health benefit plan issuers affected by the legislation subject to the call, to the extent determined necessary by the commissioner. The substitute includes the following provisions absent from the introduced:

- a requirement that the special data call be organized in standardized fields and categories of information and to ensure that responses to the special data call enable a valid comparison among health benefit plan issuers;
- a requirement for an applicable health benefit plan issuer to submit a response to the special data call in the form and manner prescribed by the commissioner before the later of the 10th day after the date the commissioner issues the call or a date determined by the center; and
- a requirement that a response to a special data call disclose the calculation methodology used by the health benefit plan issuer to develop the response.

The substitute changes the deadline for the center to prepare a written report containing the results of the impact analysis regarding a request for an analysis of proposed legislation during a regular legislative session from not later than the 45th day after the date the analysis program receives the request, as in the introduced, to not later than the 30th day after the date the analysis program receives the request. The substitute includes the following provisions absent from the introduced:

- a requirement for the report to include a copy of the special data call and the aggregated responses to the special data call in their entirety, which must be organized by category and field in the same manner as the special data call, and include any calculation methodology disclosed in a response to the special data call;
- a requirement for the center to ensure that employees of the center who are assigned to the analysis program are not simultaneously employed by a health benefit plan issuer or administrator, and do not possess an ownership or other personal interest in a health benefit plan issuer or administrator; and
- an authorization for the center to require an employee assigned to the analysis program to file a conflict of interest statement and a statement of ownership interests with the center to ensure compliance with the bill's provisions relating to conflict of interest.