SUBJECT: Requiring disclosures of certain health care costs to enrollees and public

COMMITTEE: Insurance — favorable, without amendment

VOTE: 9 ayes — Oliverson, Vo, J. González, Hull, Israel, Middleton, Paul, Romero, Sanford

0 nays

WITNESSES: For — Daniel Chepkauskas, Patient Choice Coalition; Charles Miller, Texas 2036; Carl Isett, Texas Association of Benefit Administrators; Doug Aldeen; (*Registered, but did not testify*: Kyle Frazier, Kyle Frazier Consulting)

Against — Cameron Duncan, Texas Hospital Association

On — Jamie Dudensing, Texas Association of Health Plans; (*Registered, but did not testify*: Luke Bellsnyder, Texas Department of Insurance)

DIGEST: HB 2090 would require a health benefit plan issuer or administrator to disclose to enrollees and the public certain health care cost information. The bill would specify formats for disclosing information electronically and in hard copy and would define several terms, including "bundled payment arrangement," "cost-sharing liability," "negotiated rate," and "accumulated amounts."

Definitions. "Bundled payment" would be defined as a payment model under which a health care provider was paid a single payment for all covered services and supplies provided to an enrollee for a specific treatment or procedure.

"Cost-sharing liability" would mean the amount an enrollee was responsible for paying for a covered health care service or supply under a health benefit plan's terms. The term would generally include deductibles, coinsurance, and copayments but would not include premiums, balance billing amounts by out-of-network providers, or the cost of health care

services or supplies not covered under a health plan.

"Negotiated rate" would mean the amount a health plan issuer or administrator had contractually agreed to pay a network provider, including a network pharmacy or other prescription drug dispenser, for covered health care services and supplies, including through a third-party administrator or pharmacy benefit manager.

"Accumulated amounts" would mean the amount of financial responsibility an enrollee incurred at the time a request for cost-sharing information was made, with respect to a deductible or out-of-pocket limit and the amount that accrued toward a cumulative treatment limit on the health care service or supply. The bill would include other specified provisions in the definition.

Applicability. The bill would apply only to certain health plans issued by a specified organization, including:

- a plan issued by a health maintenance organization;
- a small employer health plan subject to the Health Insurance Portability and Availability Act;
- a consumer choice of benefits plan;
- a basic coverage plan under the Texas Employees Group Benefits Act;
- a basic plan under the Texas Public School Retired Employees Group Benefits Act;
- a primary care coverage plan under the Texas School Employees Uniform Group Health Coverage Act; and
- a basic coverage plan under the Uniform Insurance Benefits Act for employees of the University of Texas and Texas A&M systems.

The bill would not apply to a health reimbursement arrangement or other account-based health benefit plan.

Enrollee disclosures. The bill would require a health plan to disclose certain cost-sharing liability information to the enrollee upon request. If

allowed by the health plan, an enrollee could request cost-sharing information for a specific preventive or non-preventive health care service or supply by including terms like "preventive," "non-preventive," or "diagnostic" when making the request.

The cost-sharing information provided to the enrollee would have to be accurate and include:

- an estimate of the enrollee's cost-sharing liability for the requested service or supply;
- the cost-sharing liability for non-preventive purposes under certain circumstances;
- accumulated amounts;
- the network provider rate containing the negotiated rate and underlying fee schedule rate, as applicable; and
- the out-of-network allowed amount; and
- notice that applicable coverage of a service or supply was subject to a prerequisite, among other specified provisions.

The information also would have to explain in plain language balance billing, actual charges, cost-sharing liability, copayment assistance, and other information deemed appropriate.

Bundled payment arrangement. A health plan would not have to provide an estimate of cost-sharing liability for a bundled payment arrangement in which the cost sharing was imposed separately for each service or supply. If a health plan provided relevant estimates for multiple services or supplies, the health plan would have to disclose the information for relevant services or supplies individually.

Formats. The bill would require a health plan to disclose the cost-sharing liability information through an internet-based self-service tool, a physical copy, or another specified way.

Information provided on the self-service tool would have to be available in plain language, without a subscription or other fee, on a website

providing real-time responses based on accurate cost-sharing information. The self-service tool would have to allow a user to:

- search for cost-sharing information by inputting a billing code, the network provider's name, or other relevant factors;
- search for an out-of-network allowed amount, percentage of billed charges, or other rate providing a reasonably accurate estimate of the amount a health plan would pay for a covered service or supply by inputting a billing code or other relevant factors; and
- refine and reorder search results based on geographic proximity of network providers and the amount of the enrollee's estimated cost-sharing liability.

A physical copy of a disclosure would have to be provided in plain language, without a fee, at the enrollee's request.

These provisions would only apply to a health benefit plan issued or renewed on or after January 1, 2024.

Public disclosures. Under the bill, a health plan would have to publish on a website three machine-readable files containing a network rate for all covered health care services and supplies, with some exceptions, and an out-of-network allowed amount and prescription drug for each coverage option.

Network rates. The file for network rates would have to include the following for all covered health care services and supplies, except for prescription drugs subject to a fee-for-service reimbursement arrangement:

- for each coverage option, the option's name and unique identifiers;
- a plain-language description of each billing code; and
- all applicable rates, including negotiated rates, underlying fee schedules, or derived amounts as specified in the bill.

The bill would specify other amounts required to be disclosed by health

plans that did not use negotiated rates for provider reimbursement and/or those that used the underlying fee schedule rates for calculating cost sharing.

The applicable rates, including for individual health care services and supplies and those in a bundled payment arrangement, that a health plan would have to provide would include:

- with some exceptions, the dollar amounts for each covered service or supply provided by a network provider; and
- the base negotiated rate applicable to the service or supply before an adjustment for enrollee characteristics if the rate was a negotiated rate subject to change based on those characteristics; and
- other specified provisions.

Out-of-network allowed amounts. The file for out-of-network allowed amounts would include the following information:

- for each coverage option, the option's name and unique identifiers;
- a plain-language description of each billing code; and
- unique out-of-network billed charges and allowed amounts as specified in the bill.

Certain out-of-network allowed amounts would have to be reflected as a dollar amount for each service or supply and other identifiers.

Prescription drugs. The file for prescription drugs would include the following information:

- for each coverage option, the option's name and unique identifiers;
- the national drug code and the proprietary and nonproprietary name assigned by the U.S. Food and Drug Administration;
- the negotiated rates; and
- historical net prices with certain exceptions.

The bill would not require the disclosure of information that would violate any applicable health information privacy law.

These provisions would only apply to a health benefit plan issued or renewed on or after January 1, 2022.

Other provisions. The bill would specify provisions in which a health plan issuer or administrator that acted in good faith and with reasonable diligence met compliance standards.

The commissioner of the Texas Department of Insurance could adopt rules to implement the bill's provisions.

The bill would take effect September 1, 2021.

SUPPORTERS SAY:

HB 2090 would improve price transparency for consumers by codifying federal rule that requires health plans to disclose certain health care cost information.

Currently, health care prices often are opaque, leaving consumers without adequate information to make decisions regarding health care services. The bill would increase consumers' access to health care cost information, empowering them to make more informed choices about their health care prior to receiving services. The bill also would help address a lack of provider competition and unsustainable health care price growth in Texas.

Any concerns about the bill conflicting with federal rules if those rules changed could be addressed in a floor amendment.

CRITICS SAY:

By permanently codifying into state law a federal price transparency rule, the HB 2090 could make it more difficult for health plans to adhere to current law if the federal rule changed. Rather than potentially creating two separate price transparency structures under federal and state law, the bill should include a reference to the federal rule in case that rule changed.

Additionally, by requiring the public disclosure of privately negotiated rates, the bill could create scenarios in which reimbursement rates decreased for health care providers decreased.

NOTES:

The author intends to offer a floor amendment that would specify that Insurance Code ch. 1662, subch. C would apply only to a health benefit plan for which federal reporting requirements under 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 C.F.R. Parts 147 and 158 did not apply.