BILL ANALYSIS

Senate Research Center
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C.S.H.B. 2090
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

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. H.B. 2090 codifies the federal price transparency rules for health plans into Texas statute.

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.

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 provider-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.

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.

(Original Author's / Sponsor's Statement of Intent)

C.S.H.B. 2090 amends current law relating to the establishment of a statewide all payor claims database and health care cost disclosures by health benefit plan issuers and third-party administrators.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 38.409, Insurance Code) and SECTION 3 (Section 1662.004, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the Texas Department of Insurance in SECTION 4 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 38, Insurance Code, by adding Subchapter I, as follows:

SUBCHAPTER I. TEXAS ALL PAYOR CLAIMS DATABASE

Sec. 38.401. PURPOSE OF SUBCHAPTER. Provides that the purpose of this subchapter is to authorize the Texas Department of Insurance (TDI) to establish an all payor claims database in this state to increase public transparency of health care information and improve the quality of health care in this state.

Sec. 38.402. DEFINITIONS. Defines "allowed amount," "center," "contracted rate," "data," "database," "geozip," "payor," "protected health information," "qualified research entity," and "stakeholder advisory group."

Sec. 38.403. STAKEHOLDER ADVISORY GROUP. (a) Requires the Center for Healthcare Data at The University of Texas Health Science Center at Houston (center) to establish a stakeholder advisory group to assist the center as provided by this subchapter, including assistance in:

(1) establishing and updating the standards, requirements, policies, and procedures relating to the collection and use of data contained in the database required by Sections 38.404(e) and (f);

(2) evaluating and prioritizing the types of reports the center should publish under Section 38.404(e);

(3) evaluating data requests from qualified research entities under Section 38.404(e)(2); and

(4) assisting the center in developing the center's recommendations under Section 38.408(3).

(b) Requires the advisory group created under this section to be composed of:

(1) the state Medicaid director or the director's designee;

(2) a member designated by the Teacher Retirement System of Texas;

(3) a member designated by the Employees Retirement System of Texas; and

(4) 12 members designated by the center, including:

(A) two members representing the business community, with at least one of those members representing small businesses that purchase health benefits but are not involved in the provision of health care services, supplies, or devices or health benefit plans (HBPs);

(B) two members who represent consumers and who are not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices or HBPs, with at least one member representing the behavioral health community;

(C) two members representing hospitals that are licensed in this state;

(D) two members representing HBP issuers that are regulated by TDI;

(E) two members who are physicians licensed to practice medicine in this state, one of whom is a primary care physician; and

(F) two members who are not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices or HBPs and who have expertise in health planning, health economics, provider quality assurance, statistics or health data management, or medical privacy laws.

(c) Requires a person serving on the stakeholder advisory group to disclose any conflict of interest.

(d) Provides that members of the stakeholder advisory group serve fixed terms as prescribed by commissioner of insurance (commissioner) rules adopted under this subchapter.

Sec. 38.404. ESTABLISHMENT AND ADMINISTRATION OF DATABASE. (a) Requires TDI to collaborate with the center under this subchapter to aid in the center's establishment of the database. Requires the center to leverage the existing resources and infrastructure of the center to establish the database to collect, process, analyze, and store data relating to medical, dental, pharmaceutical, and other relevant health care claims and encounters, enrollment, and benefit information for the purposes of increasing transparency of health care costs, utilization, and access and improving the affordability, availability, and quality of health care in this state, including by improving population health in this state.

(b) Requires the center to serve as the administrator of the database, design, build, and secure the database infrastructure, and determine the accuracy of the data submitted for inclusion in the database.

(c) Requires the center, in determining the information a payor is required to submit to the center under this subchapter, to consider requiring inclusion of information useful to health policy makers, employers, and consumers for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs. Requires that the required information at a minimum include certain information as it relates to all health care services, supplies, and devices paid or otherwise adjudicated by the payor.

(d) Requires each payor to submit the required data under Subsection (c) at a schedule and frequency determined by the center and adopted by the commissioner by rule.

(e) Authorizes the center, in the manner and subject to the standards, requirements, policies, and procedures relating to the use of data contained in the database established by the center in consultation with the stakeholder advisory group, to use the data contained in the database for a noncommercial purpose:

(1) to produce statewide, regional, and geozip consumer reports available through the public access portal described in Section 38.405 that address health care costs, quality, utilization, outcomes, and disparities, address population health, or address the availability of health care services; and

(2) for research and other analysis conducted by the center or a qualified research entity to the extent that such use is consistent with all applicable federal and state law, including the data privacy and security requirements of Section 38.406 and the purposes of this subchapter.

(f) Requires the center to establish data collection procedures and evaluate and update data collection procedures established under this section. Requires the center to test the quality of data collected by and reported to the center under this section to ensure that the data is accurate, reliable, and complete.

Sec. 38.405. PUBLIC ACCESS PORTAL. (a) Requires the center, except as provided by this section and Sections 38.404 and 38.406 and in a manner consistent with all applicable federal and state law, to collect, compile, and analyze data submitted to or stored in the database and disseminate the information described in Section 38.404(e)(1) in a format that allows the public to easily access and navigate the information. Requires that the information be accessible through an open access Internet portal that may be accessed by the public through an Internet website.

(b) Requires that the portal created under this section allow the public to easily search and retrieve the information disseminated under Subsection (a), subject to data privacy and security restrictions described in this subchapter and consistent with all applicable federal and state law.

(c) Provides that any information or data that is accessible through the portal created under this section:

(1) is required to be segmented by type of insurance or HBP in a manner that does not combine payment rates relating to different types of insurance or HBPs;

(2) is required to be aggregated by like Current Procedural Terminology codes and health care services in a statewide, regional, or geozip area; and

(3) is prohibited from identifying a specific patient, health care provider, HBP, HBP issuer, or other payor.

(d) Requires the center, before making information or data accessible through the portal, to remove any data or information that may identify a specific patient in accordance with the de-identification standards described in 45 C.F.R. Section 164.514.

Sec. 38.406. DATA PRIVACY AND SECURITY. (a) Provides that any information that may identify a patient, health care provider, HBP, HBP issuer, or other payor is confidential and subject to applicable state and federal law relating to records privacy and protected health information, including Chapter 181 (Medical Records Privacy), Health and Safety Code, and is not subject to disclosure under Chapter 552 (Public Information), Government Code.

(b) Provides that a qualified research entity with access to data or information that is contained in the database but not accessible through the portal described in Section 38.405:

(1) is authorized to use information contained in the database only for purposes consistent with the purposes of this subchapter and is required to use the information in accordance with standards, requirements, policies, and procedures established by the center in consultation with the stakeholder advisory group;

(2) is prohibited from selling or sharing any information contained in the database; and

(3) is prohibited from using the information contained in the database for a commercial purpose.

(c) Requires a qualified research entity with access to information that is contained in the database but not accessible through the portal to execute an agreement with the center relating to the qualified research entity's compliance with the requirements of Subsections (a) and (b), including the confidentiality of information contained in the database but not accessible through the portal.

(d) Prohibits TDI and the center, notwithstanding any provision of this subchapter, from disclosing an individual's protected health information in violation of any state or federal law.

(e) Requires the center to include in the database only the minimum amount of protected health information identifiers necessary to link public and private data sources and the geographic and services data to undertake studies.

(f) Requires the center to maintain protected health information identifiers collected under this subchapter but excluded from the database under Subsection (e) in a separate database. Prohibits the separate database from being aggregated with any other information and requires the separate database to use a proxy or encrypted record identifier for analysis.

Sec. 38.407. CERTAIN ENTITIES NOT REQUIRED TO SUBMIT DATA. Authorizes any sponsor or administrator of an HBP subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) to elect or decline to participate in or submit data to the center for inclusion in the database as consistent with federal law.

Sec. 38.408. REPORT TO LEGISLATURE. Requires the center, not later than September 1 of each even-numbered year, to submit to the legislature a written report containing:

(1) an analysis of the data submitted to the center for use in the database;

(2) information regarding the submission of data to the center for use in the database and the maintenance, analysis, and use of the data;

(3) recommendations from the center, in consultation with the stakeholder advisory group, to further improve the transparency, cost-effectiveness, accessibility, and quality of health care in this state; and

(4) an analysis of the trends of health care affordability, availability, quality, and utilization.

Sec. 38.409. RULES. (a) Requires the commissioner, in consultation with the center, to adopt rules:

(1) specifying the types of data a payor is required to provide to the center under Section 38.404 to determine health benefits costs and other reporting metrics, including, if necessary, types of data not expressly identified in that section;

(2) specifying the schedule, frequency, and manner in which a payor is required to provide data to the center under Section 38.404, which is required to require the payor to provide data to the center not less frequently than quarterly and to include provisions relating to data layout, data governance, historical data, data submission, use and sharing, information security, and privacy protection in data submissions; and

(3) establishing oversight and enforcement mechanisms to ensure that payors submit data to the database in accordance with this subchapter.

(b) Requires the commissioner, in adopting rules governing methods for data submission, to the maximum extent practicable, to use methods that are reasonable and cost-effective for payors.

SECTION 2. Amends the heading to Subtitle J, Title 8, Insurance Code, to read as follows:

SUBTITLE J. HEALTH INFORMATION TECHNOLOGY AND AVAILABILITY

SECTION 3. Amends Subtitle J, Title 8, Insurance Code, by adding Chapter 1662, as follows:

CHAPTER 1662. HEALTH CARE COST TRANSPARENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1662.001. DEFINITIONS. Defines "billed charge," "billing code," "bundled payment arrangement," "copayment assistance," "cost-sharing information," "cost-sharing liability," "covered health care service or supply," "derived amount," "enrollee," "health care service or supply," "historical net price," "machine-readable file," "national drug code," "negotiated rate," "network provider," "out-of-network allowed amount," "out-of-network provider," "out-of-pocket limit," "prerequisite," and "underlying fee schedule rate."

Sec. 1662.002. DEFINITION OF ACCUMULATED AMOUNTS. (a) Defines "accumulated amounts."

(b) Provides that for an individual enrolled in coverage other than self-only coverage, the term includes the financial responsibility the individual has incurred toward meeting the individual's own deductible or out-of-pocket limit and the amount of financial responsibility that all individuals enrolled in the individual's coverage have incurred, in aggregate, toward meeting the plan's other than self-only deductible or out-of-pocket limit, as applicable.

(c) Provides that the term includes any expense that counts toward a deductible or out-of-pocket limit, including a copayment or coinsurance, but excludes any expense that does not count toward a deductible or out-of-pocket limit, including a premium payment, out-of-pocket expense for out-of-network health care services or supplies, or an amount for a health care service or supply not covered by the HBP.

Sec. 1662.003. APPLICABILITY OF CHAPTER. (a) Provides that this chapter applies only to an HBP 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 certain health insurance entities.

(b) Provides that, notwithstanding any other law, this chapter applies to certain HBPs.

(c) Provides that this chapter does not apply to a health reimbursement arrangement or other account-based HBP or a workers' compensation insurance policy.

Sec. 1662.004. RULES. Authorizes the commissioner to adopt rules necessary to implement this chapter.

SUBCHAPTER B. REQUIRED DISCLOSURES TO ENROLLEES

Sec. 1662.051. REQUIRED DISCLOSURE TO ENROLLEE ON REQUEST. (a) Requires an HBP issuer or administrator, on request of an HBP enrollee, to provide to the enrollee a disclosure in accordance with this subchapter.

(b) Authorizes an HBP issuer or administrator to 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 information under Subsection (a).

Sec. 1662.052. REQUIRED DISCLOSURE INFORMATION. (a) Requires that a disclosure provided under this subchapter have the following information that is accurate at the time the disclosure request is made, with respect to the requesting enrollee's cost-sharing liability for a covered health care service and supply:

(1) an estimate of the enrollee's cost-sharing liability for the requested service or supply provided by a health care provider that is calculated based on the information described by Subdivisions (4), (5), and (6);

(2) except as provided by Subsection (b), if the request relates to a service or supply that is provided within a bundled payment arrangement and the arrangement includes a service or supply that has a separate cost-sharing liability, an estimate of the cost-sharing liability for the requested covered service or supply and for each service or supply in the arrangement that has a separate cost-sharing liability;

(3) for a requested service or supply that is a recommended preventive service under Section 2713, Public Health Service Act (42 U.S.C. Section 300gg-13), if the HBP issuer or administrator cannot determine whether the request is for preventive or non-preventive purposes, the cost-sharing liability for non-preventive purposes;

(4) accumulated amounts;

(5) the network provider rate that is composed of the following that are applicable to the HBP's payment model:

(A) the negotiated rate, reflected as a dollar amount, for a network provider for the requested service or supply regardless of whether the issuer or administrator uses the rate to calculate the enrollee's cost-sharing liability; and

(B) the underlying fee schedule rate, reflected as a dollar amount, for the requested service or supply, to the extent that is different from the negotiated rate;

(6) the out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount an HBP issuer or administrator will pay for the requested service or supply, reflected as a dollar amount, if the request for cost-sharing information is for a covered service or supply provided by an out-of-network provider;

(7) if an enrollee requests information for a service or supply subject to a bundled payment arrangement, a list of the services and supplies included in the arrangement;

(8) if applicable, notification that coverage of a specific service or supply is subject to a prerequisite; and

(9) notice that includes the following information in plain language:

(A) unless balance billing is prohibited for the requested service or supply, a statement that out-of-network providers are authorized to bill an enrollee for the difference between a provider's billed charges and the sum of the amount collected from the HBP issuer or administrator and from the enrollee in the form of a copayment or coinsurance amount and that the cost-sharing information provided for the service or supply does not account for that potential additional charge;

(B) a statement that the actual charges to the enrollee for the requested service or supply is authorized to be different from the estimate provided, depending on the actual services or supplies the enrollee receives at the point of care;

(C) a statement that the estimate of cost-sharing liability for the requested service or supply is not a guarantee that benefits will be provided for that service or supply;

(D) a statement disclosing whether the HBP counts copayment assistance and other third-party payments in the calculation of the enrollee's deductible and out-of-pocket maximum;

(E) for a service or supply that is a recommended preventive service under Section 2713, Public Health Service Act (42 U.S.C. Section 300gg-13), a statement that a service or supply provided by a network provider is prohibited from being subject to cost sharing if it is billed as a preventive service or supply when the HBP issuer or administrator cannot determine whether the request is for a preventive or non-preventive service or supply; and

(F) any additional information, including other disclosures, that the HBP issuer or administrator determines is appropriate provided that the additional information does not conflict with the information required to be provided under this section.

(b) Provides that an HBP issuer or administrator is not required to provide an estimate of cost-sharing liability for a bundled payment arrangement in which the cost sharing is imposed separately for each health care service or supply included in the arrangement. Requires an issuer or administrator, if the issuer or administrator provides an estimate for multiple health care services or supplies in a situation in which the estimate could be relevant to an enrollee, to disclose information about the relevant services or supplies individually as required by Subsection (a).

(c) Provides that if an HBP 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 by Subsection (a) is that reimbursed percentage.

Sec. 1662.053. METHOD AND FORMAT FOR DISCLOSURE. Requires an HBP issuer or administrator to provide the disclosure required under this subchapter through an Internet-based self-service tool described by Section 1662.054, a physical copy in accordance with Section 1662.055, or another means authorized by Section 1662.056.

Sec. 1662.054. INTERNET-BASED SELF-SERVICE TOOL. (a) Authorizes an HBP issuer or administrator to develop and maintain an Internet-based self-service tool to provide a disclosure required under this subchapter.

(b) Requires that information provided on the self-service tool be made available in plain language, without a subscription or other fee, on an Internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request.

(c) Requires an HBP issuer or administrator to ensure that the self-service tool allows a user to:

(1) search for cost-sharing information for a covered health care service or supply by a specific network provider or by all network providers by inputting:

(A) a billing code or descriptive term at the option of the user;

(B) the name of the network provider if the user seeks cost-sharing information with respect to a specific network provider; or

(C) other factors used by the issuer or administrator that are relevant for determining the applicable cost-sharing information, including the location in which the service or supply will be sought or provided, the facility name, or the dosage;

(2) search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount the issuer or administrator will pay for a covered health care service or supply provided by an out-of-network provider by inputting:

(A) a billing code or descriptive term at the option of the user; or

(B) other factors used by the issuer or administrator that are relevant for determining the applicable out-of-network allowed amount or other rate, including the location in which the covered health care service or supply will be sought or provided; and

(3) refine and reorder search results based on geographic proximity of network providers and the amount of the enrollee's estimated cost-sharing liability for the covered health care service or supply if the search returns multiple results.

Sec. 1662.055. PHYSICAL COPY OF DISCLOSURE. (a) Requires an HBP issuer or administrator to make the disclosure required under this subchapter available in a physical form. Requires that a disclosure under this section be made available in plain language, without a fee, at the request of the enrollee.

(b) Authorizes an HBP issuer or administrator, in providing a disclosure under this section, to limit the number of health care providers with respect to which cost-sharing information for a covered health care service or supply is provided to no fewer than 20 providers per request.

(c) Requires an HBP issuer or administrator providing a disclosure under this section to:

(1) disclose any applicable provider-per-request limit described by Subsection (b) to the enrollee;

(2) provide the cost-sharing information in a physical form in accordance with the enrollee's request as if the request was made using a self-service tool under Section 1662.054; and

(3) mail the disclosure not later than two business days after the date the enrollee's request is received.

Sec. 1662.056. OTHER MEANS OF DISCLOSURE. Authorizes an HBP issuer or administrator, if an enrollee requests the disclosure required by this subchapter by a means other than a physical copy or the self-service tool described by Section 1662.054, to provide the disclosure through the requested means if:

(1) the enrollee agrees that disclosure through that means is sufficient to satisfy the request;

(2) the request is fulfilled at least as rapidly as required for the physical copy; and

(3) the disclosure includes the information required for a physical copy under Section 1662.055.

Sec. 1662.057. OTHER CONTRACTUAL AGREEMENTS. (a) Authorizes an HBP issuer or administrator to satisfy the requirements of this subchapter by entering into a written agreement under which another person, including a pharmacy benefit manager or other third party, provides the disclosure required under this subchapter.

(b) Provides that if an HBP issuer or administrator and another person enter into an agreement under Subsection (a), the issuer or administrator is subject to an enforcement action for failure to provide a required disclosure in accordance with this subchapter.

Sec. 1662.058. COMPLIANCE WITH SUBCHAPTER. (a) Provides that an HBP issuer or administrator that, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under this subchapter does not fail to comply with this subchapter solely because of the error or omission if the issuer or administrator corrects the error or omission as soon as practicable.

(b) Provides that an HBP issuer or administrator, acting in good faith and with reasonable diligence, does not fail to comply with this subchapter solely because the issuer's or administrator's Internet website is temporarily inaccessible if the issuer or administrator makes the information available as soon as practicable.

(c) Provides that, to the extent compliance with this subchapter requires an HBP issuer or administrator to obtain information from another person, the issuer or administrator does not fail to comply with the subchapter 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.

SUBCHAPTER C. REQUIRED PUBLIC DISCLOSURES

Sec. 1662.101. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter applies only to an HBP 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 do not apply.

Sec. 1662.102. PUBLICATION REQUIRED. Requires an HBP issuer or administrator to publish on an Internet website the information required under Section 1662.103 in three machine-readable files in accordance with this subchapter.

Sec. 1662.103. REQUIRED INFORMATION. (a) Requires an HBP issuer or administrator to publish the following information:

(1) a network rate machine-readable file that includes the following information for all covered health care services and supplies, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement:

(A) for each coverage option offered by an HBP issuer or administered by an HBP administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) a billing code, which is required to be the national drug code for a prescription drug, and a plain-language description for each billing code for each covered service or supply under each coverage option offered by the issuer or administered by the administrator; and

(C) all applicable rates, including negotiated rates, underlying fee schedules, or derived amounts, provided in accordance with Section 1662.104;

(2) an out-of-network allowed amount machine-readable file, including:

(A) for each coverage option offered by an HBP issuer or administered by an HBP administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) a billing code, which is required to be the national drug code for a prescription drug, and a plain-language description for each billing code for each covered service or supply under each coverage option offered by the issuer or administered by the administrator; and

(C) except as provided by Subsection (b), unique out-of-network billed charges and allowed amounts provided in accordance with Section 1662.105 for covered health care services or supplies provided by out-of-network providers during the 90-day period that begins on the 180th day before the date the machine-readable file is published; and

(3) a prescription drug machine-readable file that includes:

(A) for each coverage option offered by an HBP issuer or administered by an HBP administrator, the option's name and:

(i) the option's 14-digit health insurance oversight system identifier;

(ii) if the 14-digit identifier is not available, the option's 5-digit health insurance oversight system identifier; or

(iii) if the 14- and 5-digit identifiers are not available, the employer identification number associated with the option;

(B) the national drug code and the proprietary and nonproprietary name assigned to the national drug code by the United States Food and Drug Administration for each covered prescription drug provided under each coverage option offered by the issuer or administered by the administrator;

(C) the negotiated rates, which are required to be:

(i) reflected as a dollar amount with respect to each national drug code that is provided by a network provider, including a network pharmacy or other prescription drug dispenser;

(ii) associated with the national provider identifier, tax identification number, and place of service code for each network provider, including each network pharmacy or other prescription drug dispenser; and

(iii) associated with the last date of the contract term for each provider-specific negotiated rate that applies to each national drug code; and

(D) except as provided by Subsection (b), historical net prices, which are required to be:

(i) reflected as a dollar amount with respect to each national drug code that is provided by a network provider, including a network pharmacy or other prescription drug dispenser;

(ii) associated with the national provider identifier, tax identification number, and place of service code for each network provider, including each network pharmacy or other prescription drug dispenser; and

(iii) associated with the 90-day period that begins on the 180th day before the date the machine-readable file is published for each provider-specific historical net price calculated in accordance with Section 1662.106 that applies to each national drug code.

(b) Requires an HBP issuer or administrator to omit information described by Subsection (a)(2)(C) or (a)(3)(D) in relation to a particular health care service or supply if compliance with that subsection would require the issuer to report payment information in connection with fewer than 20 different claims for payments under a single HBP.

(c) Provides that this section does not require the disclosure of information that would violate any applicable health information privacy law.

Sec. 1662.104. NETWORK RATE DISCLOSURES. (a) Requires an HBP issuer or administrator, if the issuer or administrator does not use negotiated rates for health care provider reimbursement, to disclose for purposes of Section 1662.103(a)(1)(C) derived amounts to the extent those amounts are already calculated in the normal course of business.

(b) Requires an HBP issuer or administrator, if the issuer or administrator uses underlying fee schedule rates for calculating cost sharing, to disclose for purposes of Section 1662.103(a)(1)(C) the underlying fee schedule rates in addition to the negotiated rate or derived amount.

(c) Requires that the applicable rates, including for both individual health care services and supplies and services and supplies in a bundled payment arrangement, that an HBP issuer or administrator is required to provide under Section 1662.103(a)(1)(C), be:

(1) except as provided by Subdivision (2), reflected as dollar amounts with respect to each covered health care service or supply that is provided by a network provider;

(2) the base negotiated rate applicable to the service or supply before an adjustment for enrollee characteristics if the rate is a negotiated rate subject to change based on enrollee characteristics;

(3) associated with the national provider identifier, tax identification number, and place of service code for each network provider;

(4) associated with the last date of the contract term or expiration date for each health care provider-specific applicable rate that applies to each covered service or supply; and

(5) indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model, including capitation or a bundled payment arrangement, applies.

Sec. 1662.105. OUT-OF-NETWORK ALLOWED AMOUNTS. (a) Requires that an out-of-network allowed amount provided under Section 1662.103(a)(2)(C) be:

(1) reflected as a dollar amount with respect to each covered health care service or supply that is provided by an out-of-network provider; and

(2) associated with the national provider identifier, tax identification number, and place of service code for each out-of-network provider.

(b) Provides that this subchapter does not prohibit an HBP issuer or administrator from satisfying the disclosure requirements described by Section 1662.103(a)(2)(C) by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an issuer, a health care provider, or other party with which the issuer or administrator has entered into a written agreement to provide the information if the minimum claim threshold described by Section 1662.103(b) is independently met for each health care service or supply and for each plan included in an aggregated allowed amount file.

(c) Authorizes the HBP issuers, health care providers, or other persons with which an HBP issuer or administrator has contracted to aggregate out-of-network allowed amounts for more than one plan if the issuer or administrator enters into an agreement under Subsection (b).

(d) Provides that this subchapter does not prohibit a third party from hosting an allowed amount file on its Internet website or an HBP issuer or administrator from contracting with a third party to post the file. Requires the issuer or administrator, if the issuer or administrator does not host the file separately on its Internet website, to provide a link on its Internet website to the location where the file is made publicly available.

Sec. 1662.106. HISTORICAL NET PRICE. (a) Provides that for purposes of determining the historical net price for a prescription drug, the allocation of price concessions is determined by the dollar value for non-product specific and product-specific rebates, discounts, chargebacks, fees, and other price concessions to the extent that the total amount of any such price concession is known to the HBP issuer or administrator at the time of publication of the historical net price under Section 1662.103(a)(3)(D).

(b) Requires an HBP issuer or administrator, to the extent that the total amount of any non-product specific and product-specific rebates, discounts, chargebacks, fees, or other price concessions is not known to the issuer or administrator at the time of publication of the historical net price under Section 1662.103(a)(3)(D), to

allocate those price concessions by using a good faith, reasonable estimate of the average price concessions based on the price concessions received over a period before the current reporting period and of equal duration to the current reporting period.

Sec. 1662.107. REQUIRED METHOD AND FORMAT FOR DISCLOSURE. Requires that the machine-readable files described by Section 1662.103 be available in a form and manner prescribed by TDI rule. Requires that the files be available and accessible to any person free of charge and without conditions, including establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

Sec. 1662.108. FILE UPDATES. Requires an HBP issuer or administrator to update the machine-readable files described by Section 1662.103 and the information described by this subchapter monthly. Requires the issuer or administrator to clearly indicate in the files the date that the files were most recently updated.

Sec. 1662.109. OTHER CONTRACTUAL AGREEMENTS. (a) Authorizes an HBP issuer or administrator to satisfy the requirements of this subchapter by entering into a written agreement under which another person, including a third-party administrator or health care claims clearinghouse, provides the disclosure required under this subchapter in compliance with this subchapter.

(b) Provides that if an HBP issuer or administrator and another person enter into an agreement under Subsection (a), the issuer or administrator is subject to an enforcement action for failure to provide a required disclosure in accordance with this subchapter.

Sec. 1662.110. COMPLIANCE WITH SUBCHAPTER. (a) Provides that an HBP issuer or administrator that, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under this subchapter does not fail to comply with this subchapter solely because of the error or omission if the issuer or administrator corrects the error or omission as soon as practicable.

(b) Provides that an HBP issuer or administrator, acting in good faith and with reasonable diligence, does not fail to comply with this subchapter solely because the issuer's or administrator's Internet website is temporarily inaccessible if the issuer or administrator makes the information available as soon as practicable.

(c) Provides that, to the extent compliance with this subchapter requires an HBP issuer or administrator to obtain information from another person, the issuer or administrator does not fail to comply with the subchapter 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.

SECTION 4. (a) Requires the center, not later than January 1, 2022, to establish the stakeholder advisory group in accordance with Section 38.403, Insurance Code, as added by this Act.

(b) Requires TDI to adopt rules, and requires the center to adopt, in consultation with the stakeholder advisory group, standards, requirements, policies, and procedures, necessary to implement Subchapter I, Chapter 38, Insurance Code, as added by this Act, not later than June 1, 2022.

SECTION 5. Requires the center, as soon as practicable after the effective date of this Act, to actively seek financial support from the federal grant program for development of state all payer claims databases established under the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) and from any other available source of financial support provided by the federal government for purposes of implementing Subchapter I, Chapter 38, Insurance Code, as added by this Act.

SECTION 6. Requires the commissioner, if necessary for implementation of any provision of Subchapter I, Chapter 38, Insurance Code, as added by this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 7. (a) Provides that Subchapter B, Chapter 1662, Insurance Code, as added by this Act, applies only to an HBP delivered, issued for delivery, or renewed on or after January 1, 2024, or for a plan year that begins on or after that date.

(b) Provides that Subchapter C, Chapter 1662, Insurance Code, as added by this Act, applies only to an HBP delivered, issued for delivery, or renewed on or after January 1, 2022, or for a plan year that begins on or after that date.

SECTION 8. Effective date: September 1, 2021.