SUBJECT: Claims information reporting for health benefit plans

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Smithee, T. Smith, Taylor, Eiland, Hancock, Vo, Woolley

0 nays

2 absent — Martinez, Thompson

WITNESSES: *(On original version):*
For — Sam Francis, Texas Association of Benefit Administrators, JI Specialty Services; Edward A. Jacobson, TPAC Underwriters, Inc.; Robyn Jacobson, EnTrust, Inc. and related employer groups; Rolando G. Berrera, Brian Davidson; (*Registered, but did not testify:* Shelton Green, Texas Association of Business; Patricia Kolodzey, Texas Hospital Association)

Against — Mike Pollard and Jay Thompson, Texas Association of Life & Health Insurers; Jared Wolfe, TAHP (*Registered, but did not testify:* Jenny Fowler, Humana, Inc.; Shannon Meroney, Aetna)

On — Phyllis Brasher, Blue Cross and Blue Shield of Texas; Douglas Danzeiser, Texas Department of Insurance

BACKGROUND: Three different sections of the Insurance Code govern reporting of claims information by health insurers and HMOs to employers. Art. 21.49-15 requires insurers that contract with government entities to provide detailed reports that include the claims experience of the government entity during the preceding year and the dollar amount of each large claim.

Chapter 1209 requires insurers and HMOs, at the request of private employers with which they contract, to provide monthly claims cost information for the preceding year.

Insurance Code, sec. 1501.614, requires a health insurer or HMO to report to an employer the total amount of charges submitted to the carrier for persons covered under the plan, payments made by the insurer, and, to the extent available, information on claims paid by type of health care

provider, including total hospital charges, physician charges, pharmaceutical charges, and other charges. This information must be provided annually but not later than the 30th day before the renewal date of the employer's health benefit plan.

DIGEST:

CSHB 2015 would repeal Art. 21.49-15, ch. 1209, and sec. 1501.614 of the Insurance Code and establish new claims reporting requirements for health insurance plan carriers that contract with employers.

Within 30 days of a request by an employer, a plan issuer would have to provide a report containing all of the information that was responsive to the request, including protected health information except information subject to certain privacy restrictions, for the 36-month period preceding the date of the report, or under other time periods specified in the bill. The report would have to include:

- aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable;
- total premium paid by month;
- total number of covered employees on a monthly basis by coverage tier;
- the total dollar amount of claims pending as of the date of the report;
- a separate description and individual claims report for any individual whose total paid claims exceeded $15,000 during the 12-month period preceding the date of the report, including the following information — a unique identifying number or code for the individual, the amounts paid, dates of service, and applicable procedure codes; and
- for claims that were not part of the report, a statement of pre-certification requests for hospital stays of five days or longer made during the 30 days preceding the date of the report.

A health insurance issuer could not disclose protected health information if prohibited by federal or state laws that impose more stringent privacy requirements than those imposed under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the issuer withheld information because of these privacy restrictions, it would have to notify the plan, plan sponsor, or plan administrator and provide a list of categories that the issuer had determined were subject to these privacy

restrictions.
A plan sponsor could receive protected health information only after an appropriately authorized plan representative certified that it would be safeguarded and that the use and disclosure of the information would be limited. The certification would have to include language substantially similar to certification language in the bill.

If a request for claims information was made after coverage had been terminated, the report would have to contain all information that was responsive to the request, subject to the same privacy restrictions as current claims information. Reports could only be requested on or before the second anniversary of the date of termination of coverage.

On receipt of the report from the health issuer, the plan, plan sponsor or plan administrator could make a written request for additional information no later than the 10th day after the report was received. The issuer would have to respond to this request no later than the 15th day after the date of the request.

The issuer would not have to provide information regarding a particular employer group or group health plan more than twice in any 12-month period. The information could be provided in a written report, through an electronic file submitted by secure electronic mail, or by making the information available through a secure website portal.

A health insurance issuer that released information in accordance with the guidelines in the bill would not be liable for civil damages or prosecution for release of that information. An issuer that did not comply with the provisions of the bill would be subject to administrative penalties.

The bill would take effect September 1, 2007, and would apply to requests for a report of claims information made on or after January 1, 2008.

SUPPORTERS SAY:

CSHB 2015 would help control health care costs and increase competition in the health insurance marketplace by giving employers greater access to more detailed information about health insurance claims for their employees. The bill would allow the exchange of meaningful information in a more timely manner while protecting individual privacy.

Three separate provisions in current law governing the release of claims information have largely been ineffective in giving employers access to

this information. Employers across Texas routinely are unable to obtain timely and meaningful claims information or loss experience pertaining to their health plan. The information is critical when an employer wants to get a bid from another carrier to compare rates with a current carrier and when an employer is considering the option of self-insurance.

CSHB 2015 would address a recommendation in TDI's Biennial Report to the 80th Legislature by unifying the requirements for claims cost information to employers under one statute to simplify compliance and enhance information available in the marketplace.

CSHB 2015 would ensure that health plan issuers and HMOs provide specific claims information in a timely manner. The bill would provide sufficient protections to ensure that state and federal privacy laws would be observed.

OPPONENTS SAY:

It would be difficult for health insurance issuers to provide some of the authorized claims information under the timelines established in the bill. Some of this information is not necessary to compare insurance prices or to determine whether or not a company should self-insure. Insurers could be overwhelmed with requests from employers to provide detailed claims information for which they would have limited use.

A related bill, HB 2552 by T. Smith, would provide a simpler solution by consolidating three conflicting statutes but not dictating in such detail the type of claims information that would have to be provided. This would address TDI's recommendations regarding conflicting statutes governing claims information without imposing such detailed requirements on health plan issuers.

NOTES:

The committee substitute added provisions governing conflicts with state and federal privacy laws and revised some reporting deadlines.

The companion bill, SB 1166 by Duncan, has been referred to the Senate State Affairs Committee.