ATTACHMENT A
HOUSE AND SENATE BILLS RELATING TO
LIFE, ACCIDENT, ANNUITY, CREDIT, OR HEALTH COVERAGE*

HOUSE BILLS

HB 574 ***Out-of-Network Provider Referrals***

HB 574 provides that a Health Maintenance Organization (HMO) or the issuer of a preferred provider or exclusive provider benefit plan may not: (1) terminate a network provider solely because the provider informed the insured of out-of-network options, or (2) prohibit, discourage, or penalize a provider for discussing the availability of out-of-network providers or facilities with the insured. HMOs and preferred provider benefit plans may not require a physician or provider to give a notification form stating that the physician or provider is an out-of-network provider if the form contains additional information intended to intimidate the patient.

The bill is effective September 1, 2015. Certain provisions apply to a provider contract entered into or renewed on or after the effective date. The remaining provisions apply to a policy or HMO evidence of coverage issued or delivered on or after January 1, 2016.

HB 1514 ***Health Insurance Identification Cards***

HB 1514 requires identification cards or other similar documents issued by qualified health plan (QHP) issuers to enrollees of QHPs purchased through the exchanges to display the abbreviation "QHP" on the card or document in a location of the issuer's choice. Note that both individual coverage issued through the exchange and small employer coverage issued through the Small Business Health Options Program must comply with this requirement. The bill directs the commissioner to monitor 45 C.F.R. Section 155.20 for amendments to the definitions of terms listed in the bill and adopt the amended definitions if the commissioner determines it is in the state's best interest. The commissioner must file a report to the legislature regarding any determinations as required by the bill.

The bill is effective September 1, 2015.

HB 1621 ***Notice and Appeal of Certain Adverse Determinations***

SB 1621 requires a utilization review agent (URA) to provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions that a patient is currently receiving. The URA must provide the notice not later than the 30th day before the date the prescription drugs or intravenous infusions will be discontinued and include a description of the enrollee's right to an immediate review by an independent review organization (IRO) and the procedures to obtain that review. An IRO must make its determination no later than the third day after the IRO receives the information necessary to make its determination.

The bill is effective September 1, 2015, and applies only to an adverse determination made under a health insurance policy or health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2016.

HB 1624

Transparency of Formulary Information and Provider Directories

Formulary Information -

HB 1624 requires issuers of health benefit plans to publicly display formulary information on the issuer's website as required by rule, and link to the formulary information from each plan's electronic summary of benefits and coverage. The bill requires certain information be disclosed, and directs the commissioner to adopt requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans.

Health Care Provider Directories -

HB 1624 also requires issuers of health benefit plans that use networks to maintain provider directories that

- contain each provider's address and telephone number, and indicate whether they are accepting new patients
- are available publicly online
- are linked to each plan's summary of benefits and coverage on the issuer's website
- are electronically searchable by name and location
- are updated at least once a month, and
- contain an email address and toll-free number for individuals to report inaccurate information, which must be corrected within seven days.

The bill is effective September 1, 2015, and applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2016. TDI will adopt rules to implement the bill's formulary requirements.

HB 2813

Health Benefit Plan Coverage for Ovarian Cancer Screening

HB 2813 requires coverage for an annual medically recognized diagnostic examination for the early detection of ovarian cancer for women 18 years of age or older, that includes at a minimum a CA 125 blood test. The bill does not apply to a qualified health plan if federal regulators determine that this mandate requires plans to offer benefits in addition to the essential health benefits and the state is required to defray the costs of these benefits. If federal regulators determine this mandate exceeds the essential health benefit requirement, TDI will post notice on its website letting issuers know that they are not required to provide this coverage on qualified health plans.

Note: Texas Insurance Code Section 1370.004 requires issuers provide each enrolled woman 18 years of age or older written notice of the coverage required under Chapter 1370. TDI's current rules (Title 28 Texas Administrative Code Chapter 21, Subchapter M) contain the requirements for the HPV and cervical cancer notices required under Chapter 1370 prior to amendment by HB 2813, including form text for the notice at Section 21.2106(b)(7). Issuers may add notice regarding the early detection of ovarian cancer to the current HPV and cervical cancer notice.

The bill is effective September 1, 2015, and applies only to a health benefit plan delivered, issued for delivery, or renewed on or after September 1, 2015.

HB 3024

Coordination of Dental Benefits

HB 3024 establishes provisions for coordination of benefits for insureds covered by two insurance policies that provide dental benefits. The bill does not apply to a separate dental policy that exclusively provides a noncoordinated, fixed indemnity benefit, regardless of expenses incurred that are paid directly to the policyholder or to the provider under an assignment of benefits provision.

The bill is effective September 1, 2015, and applies only to an insurance policy delivered, issued for delivery, or renewed on or after January 1, 2016.

SENATE BILLS

SB 94

Fees Charged for the Adjudication of Pharmacy Benefit Claims

SB 94 prohibits issuers of health benefit plans or pharmacy benefit managers (PBM) from charging a claim adjudication fee. It prohibits issuers and PBMs from holding a pharmacy or pharmacist responsible for a fee for any step, component, or mechanism related to the claims adjudication process, including the processing, transmission, or adjudication of a pharmacy benefit claim; the development or management of a claim processing or adjudication network; or participation in a claim processing or adjudication network.

The bill is effective September 1, 2015; however, the bill's provisions do not affect the terms of a contract entered into or renewed before the effective date until a renewal of the contract that occurs on or after that date.

SB 332

Pharmacy Benefits Maximum Allowable Cost Lists

SB 332 regulates the use of maximum allowable cost lists by health benefit plan issuers and pharmacy benefit managers. The bill establishes criteria for which drugs may be included on maximum allowable cost lists, how to formulate maximum allowable costs, required disclosures, and how frequently the lists must be reviewed and updated. The bill also requires issuers and pharmacy benefit managers to provide contracted pharmacists with access to the maximum allowable cost lists, and to disclose the sources of pricing data used to develop the lists. The bill also provides for an appeals process to enable contracted pharmacists to challenge the price of a drug on the lists. Finally, the bill states that it applies to all health benefit plan issuers and pharmacy benefit managers, except those specifically excluded, unless otherwise prohibited by federal law.

The bill is effective January 1, 2016, and applies only to a contract between an issuer or pharmacy benefit manager and a pharmacist or pharmacy that is entered into or renewed on or after the effective date.

SB 425

Freestanding Emergency Medical Care Facilities

SB 425 requires a freestanding emergency medical care facility to post a notice indicating that it charges rates similar to a hospital emergency room and may charge a facility fee. The notice must also state that the physicians may bill separately, and that the facility and physicians may not be a participating provider in the patient's provider network. The facility must post the notice prominently and conspicuously at the facility's primary entrance, in each patient treatment room, at each location in the facility at which a person pays for health care services, and on the facility's website.

This bill is effective on September 1, 2015; however, a freestanding emergency medical care facility is not required to comply until January 1, 2016.

SB 481

Mediation of Out-of-Network Billing Disputes; Consumer Information

SB 481 lowers the threshold amount for health insurance claims to qualify for mediation under Insurance Code Chapter 1456 to balance bills greater than $500. It also expands the definition of facility-based physicians subject to the mediation process to include assistant surgeons. The bill also requires out-of-network, facility-based physicians to include a conspicuous, plain-language explanation of the mediation process when sending a balance bill statement greater than $500 to a patient covered by a preferred provider benefit plan or the state employee health plan.

The bill is effective September 1, 2015, and it applies to charges for medical services or supplies provided on or after that date.

SB 550

Dental Support in Child Support Orders

SB 550 requires dental support for a child subject to a child support order in addition to medical child support. If a parent is eligible for dependent dental coverage and a court or administrative order requires the parent to provide dental insurance, the issuer shall permit the parent to enroll the child regardless of enrollment period restrictions. The child, the custodial parent, or a child support enforcement or collection agency may enroll the child if the parent fails to act.

The bill is effective September 1, 2018, and applies to a suit affecting the parent-child relationship filed on or after that date.

SB 684

Optometrists, Therapeutic Optometrists, and Ophthalmologists

SB 684 adds Insurance Code Section 1301.0522, which states that an issuer of a preferred provider benefit plan may not withhold designation as a preferred provider to an optometrist, therapeutic optometrist, or ophthalmologist who joins the practice of a preferred provider, applies for designation as a preferred provider, and complies with the terms and conditions of eligibility to be a preferred provider. The bill also prohibits a managed care plan from directly or indirectly attempting to control an optometrist's or therapeutic optometrist's professional judgment, manner of practice or practice, or choice of service or material suppliers.

The bill is effective September 1, 2015, and applies only to a contract between a preferred provider and an insurer that is entered into or renewed on or after the effective date.

SB 784

Texas Department of Insurance Data Collection and Use

SB 784 repeals or amends unnecessary data calls and reporting requirements in the Insurance Code. Relating to health insurance, the bill repeals

- the requirement in Section 1501.056(c) that health cooperatives file annual statements with the commissioner of amounts collected and expenses incurred
- the requirement in Section 1501.101(a) that small and large employer health benefit plans file their geographic service areas with the commissioner, and
- the requirement in Section 4201.204(c) that utilization review agents submit summary reports of complaints.

The bill is effective September 1, 2015.

SB 979

Individual Indemnity Health Insurance

SB 979 changes one type of permitted individual accident and health insurance policy from hospital confinement to hospital indemnity or other fixed indemnity.

The bill is effective May 15, 2015.

SB 1107

Contingent Deferred Annuity Contracts

SB 1107 allows the commissioner to adopt reasonable standards for contingent deferred annuity contracts, including standards for TDI's review and approval of contracts and for replacement, suitability, disclosure, and advertising consistent with applicable model regulations developed by the National Association of Insurance Commissioners.

The bill is effective on June 9, 2015.

SB 1196

Funding Agreements, Guaranteed Investment Contracts, and Synthetic Guaranteed Investment Contracts

SB 1196 provides certain regulatory standards for funding agreements and guaranteed investment contracts, and synthetic guaranteed investment contracts. The bill gives the commissioner authority to adopt rules to implement or clarify these provisions.

The bill is effective September 1, 2015.

SB 1296

Nonsubstantive Changes

SB 1296, in addition to other nonsubstantive changes to Texas statutes not summarized in this bulletin, reenacts the following life, accident, or health provisions in the Insurance Code to correct

- the duplication of the paragraph (a) numbering in Section 1355.015, relating to autism coverage, by merging the language of the second paragraph (a) into paragraph (a-1) and repealing unnecessary existing language in paragraph (a-1)

- the duplication of the paragraph (f) numbering in Section 1355.015, relating to autism coverage, by redesignating the second paragraph (f) to (g), and
- the duplication of the Subchapter F numbering in Chapter 1369 by redesignating the second Subchapter F (relating to standard request forms for prior authorization of drug benefits) as Subchapter G and renumbering the sections that were previously located in the second Subchapter F to Sections 1369.301 through 1369.306.

The bill is effective September 1, 2015.

*** This listing MAY NOT INCLUDE all bills affecting your insurance business.**