INSURANCE CODE

TITLE 2. TEXAS DEPARTMENT OF INSURANCE

SUBTITLE A. ADMINISTRATION OF THE TEXAS DEPARTMENT OF INSURANCE

CHAPTER 38. DATA COLLECTION AND REPORTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 38.001. INQUIRIES. (a) In this section, "authorization" means a permit, certificate of registration, or other authorization issued or existing under this code.

(b) The department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to:

(1) the person's business condition; or

(2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

(c) A person receiving an inquiry under Subsection (b) shall respond to the inquiry in writing not later than the 15th day after the date the inquiry is received. If the department receives written notice from the person that additional time is required to respond to the inquiry, the department shall grant a 10-day extension of the time to respond to the inquiry.

(d) A response made under this section that is otherwise privileged or confidential by law remains privileged or confidential until introduced into evidence at an administrative hearing or in a court.

(e) The department shall maintain a record of all inquiries made by the department under this section.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 1295 (H.B. 2614), Sec. 1, eff. September 1, 2005.

Acts 2013, 83rd Leg., R.S., Ch. 398 (S.B. 183), Sec. 1, eff. September 1, 2013.

Sec. 38.002. UNDERWRITING GUIDELINES FOR PERSONAL AUTOMOBILE AND RESIDENTIAL PROPERTY INSURANCE; FILING; CONFIDENTIALITY. (a) In this section:

(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity engaged in the business of personal automobile insurance or residential property insurance in this state. The term includes:

(A) an affiliate as described by Section 823.003(a) if that affiliate is authorized to write and is writing personal automobile insurance or residential property insurance in this state;

(B) the Texas Windstorm Insurance Association created and operated under Chapter 2210;

(C) the FAIR Plan Association under Chapter 2211; and

(D) the Texas Automobile Insurance Plan Association under Chapter 2151.

(2) "Personal automobile insurance" means motor vehicle insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, mobile home, trailer, or recreational vehicle, that is:

(A) owned or leased by an individual or individuals; and

(B) not primarily used for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to residential real property at a fixed location or tangible personal property provided in a homeowners policy, which includes a tenant policy, a condominium owners policy, or a residential fire and allied lines policy.

(4) "Underwriting guideline" means a rule, standard, guideline, or practice, whether written, oral, or electronic, that is used by an insurer or its agent to decide whether to accept or

reject an application for coverage under a personal automobile insurance policy or residential property insurance policy or to determine how to classify those risks that are accepted for the purpose of determining a rate.

(b) Each insurer shall file with the department a copy of the insurer's underwriting guidelines. The insurer shall update its filing each time the underwriting guidelines are changed. If a group of insurers files one set of underwriting guidelines for the group, they shall identify which underwriting guidelines apply to each company in the group.

(c) The office of public insurance counsel may obtain a copy of each insurer's underwriting guidelines.

(d) The department or the office of public insurance counsel may disclose to the public a summary of an insurer's underwriting guidelines in a manner that does not directly or indirectly identify the insurer.

(e) Underwriting guidelines must be sound, actuarially justified, or otherwise substantially commensurate with the contemplated risk. Underwriting guidelines may not be unfairly discriminatory.

(f) The underwriting guidelines are subject to Chapter 552, Government Code.

Added by Acts 2003, 78th Leg., ch. 206, Sec. 8.01, eff. June 11, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.004, eff. April 1, 2009.

Sec. 38.003. UNDERWRITING GUIDELINES FOR OTHER LINES; CONFIDENTIALITY. (a) This section applies to all underwriting guidelines that are not subject to Section 38.002.

(b) For purposes of this section, "insurer" means a reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, life, accident, or health or casualty insurance company, health maintenance organization, mutual life insurance company, mutual insurance company other than life, mutual, or natural

premium life insurance company, general casualty company, fraternal benefit society, group hospital service company, or other legal entity engaged in the business of insurance in this state. The term includes an affiliate as described by Section 823.003(a) if that affiliate is authorized to write and is writing insurance in this state.

(c) The department or the office of public insurance counsel may obtain a copy of an insurer's underwriting guidelines.

(d) Underwriting guidelines are confidential, and the department or the office of public insurance counsel may not make the guidelines available to the public.

(e) The department or the office of public insurance counsel may disclose to the public a summary of an insurer's underwriting guidelines in a manner that does not directly or indirectly identify the insurer.

(f) When underwriting guidelines are furnished to the department or the office of public insurance counsel, only a person within the department or the office of public insurance counsel with a need to know may have access to the guidelines. The department and the office of public insurance counsel shall establish internal control systems to limit access to the guidelines and shall keep records of the access provided.

(g) This section does not preclude the use of underwriting guidelines as evidence in prosecuting a violation of this code. Each copy of an insurer's underwriting guidelines that is used in prosecuting a violation is presumed to be confidential and is subject to a protective order until all appeals of the case have been exhausted. If an insurer is found, after the exhaustion of all appeals, to have violated this code, a copy of the underwriting guidelines used as evidence of the violation is no longer presumed to be confidential.

(h) A violation of this section is a violation of Chapter 552, Government Code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999. Renumbered from Insurance Code Sec. 38.002 and amended by Acts 2003, 78th Leg., ch. 206, Sec. 8.01, eff. June 11, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.005, eff. April 1, 2009.

Sec. 38.004. BALANCE BILLING PROHIBITION REPORT. (a) The department shall, each biennium, conduct a study on the impacts of S.B. No. 1264, Acts of the 86th Legislature, Regular Session, 2019, on Texas consumers and health coverage in this state, including:

(1) trends in billed amounts for health care or medical services or supplies, especially emergency services, laboratory services, diagnostic imaging services, and facility-based services;

(2) comparison of the total amount spent on out-of-network emergency services, laboratory services, diagnostic imaging services, and facility-based services by calendar year and provider type or physician specialty;

(3) trends and changes in network participation by providers of emergency services, laboratory services, diagnostic imaging services, and facility-based services by provider type or physician specialty, including whether any terminations were initiated by a health benefit plan issuer, administrator, or provider;

(4) trends and changes in the amounts paid to participating providers;

(5) the number of complaints, completed investigations, and disciplinary sanctions for billing by providers of emergency services, laboratory services, diagnostic imaging services, or facility-based services of enrollees for amounts greater than the enrollee's responsibility under an applicable health benefit plan, including applicable copayments, coinsurance, and deductibles;

(6) trends in amounts paid to out-of-network providers;

(7) trends in the usual and customary rate for health care or medical services or supplies, especially emergency services, laboratory services, diagnostic imaging services, and facility-based services; and

(8) the effectiveness of the claim dispute resolution

process under Chapter 1467.

(b) In conducting the study described by Subsection (a), the department shall collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Chapter 1467.

(c) The department may not publish a particular rate paid to a participating provider in the study described by Subsection (a), identifying information of a physician or health care provider, or non-aggregated study results. Information described by this subsection is confidential and not subject to disclosure under Chapter 552, Government Code.

(d) The department:

(1) shall collect data quarterly from a health benefit plan issuer or administrator subject to Chapter 1467 to conduct the study required by this section; and

(2) may utilize any reliable external resource or entity to acquire information reasonably necessary to prepare the report required by Subsection (e).

(e) Not later than December 1 of each even-numbered year, the department shall prepare and submit a written report on the results of the study under this section, including the department's findings, to the legislature.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 4.01, eff. September 1, 2019.

For expiration of this section, see Subsection (c).

Sec. 38.005. COMMERCIAL AUTOMOBILE INSURANCE REPORT. (a) The department shall conduct a study each biennium on the effect, for each year of the biennium, on premiums, deductibles, coverage, and availability of coverage for commercial automobile insurance of H.B. 19, 87th Legislature, Regular Session, 2021.

(b) Not later than December 1 of each even-numbered year, the department shall submit a written report of the results of the study conducted under Subsection (a) for the preceding biennium to the legislature.

(c) This section expires December 31, 2026.

Added by Acts 2021, 87th Leg., R.S., Ch. 785 (H.B. 19), Sec. 5, eff.

September 1, 2021.

SUBCHAPTER B. HEALTH BENEFIT PLAN PROVIDER REPORTING

Sec. 38.051. DEFINITION. In this subchapter, "health benefit plan provider" means an insurance company, group hospital service corporation, or health maintenance organization that issues:

(1) an individual, group, blanket, or franchise insurance policy, an insurance agreement, a group hospital service contract, or an evidence of coverage, that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness; or

(2) a long-term care benefit plan, as defined by Section 1651.003.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.006, eff. April 1, 2009.

Sec. 38.052. REQUIRED INFORMATION; RULES. (a) A health benefit plan provider shall submit information required by the department relating to the health benefit plan provider's:

(1) loss experience;

(2) overhead; and

(3) operating expenses.

(b) The department may also request information about characteristics of persons covered by a health benefit plan provider, including information relating to:

(1) age;

(2) gender;

(3) health status;

(4) job classification; and

(5) geographic distribution.

(c) A health benefit plan provider may not be required to submit information under this section more frequently than annually.

(d) The commissioner shall adopt rules governing the submission of information under this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER E. STATISTICAL DATA COLLECTION

Sec. 38.201. DEFINITION. In this subchapter, "designated statistical agent" means an organization designated or contracted with by the commissioner under Section 38.202.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.202. STATISTICAL AGENT. The commissioner may, for a line or subline of insurance, designate or contract with a qualified organization to serve as the statistical agent for the commissioner to gather data relevant for regulatory purposes or as otherwise provided by this code.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.203. QUALIFICATIONS OF STATISTICAL AGENT. To qualify as a statistical agent, an organization must demonstrate at least five years of experience in data collection, data maintenance, data quality control, accounting, and related areas.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.204. POWERS AND DUTIES OF STATISTICAL AGENT. (a) A designated statistical agent shall collect data from reporting insurers under a statistical plan adopted by the commissioner.

(b) The statistical agent may provide aggregate historical premium and loss data to its subscribers.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.205. DUTY OF INSURER. An insurer shall provide all premium and loss cost data to the commissioner or the designated statistical agent as the commissioner or agent requires.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.206. FEES. (a) A designated statistical agent may

collect from a reporting insurer any fees necessary for the agent to recover the necessary and reasonable costs of collecting data from that reporting insurer.

(b) A reporting insurer shall pay the fee to the statistical agent for the data collection services provided by the statistical agent.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

Sec. 38.207. RULES. The commissioner may adopt rules necessary to accomplish the purposes of this subchapter.

Added by Acts 1999, 76th Leg., ch. 101, Sec. 1, eff. Sept. 1, 1999.

SUBCHAPTER F. DATA COLLECTING AND REPORTING RELATING TO MANDATED HEALTH BENEFITS AND MANDATED OFFERS OF COVERAGE

Sec. 38.251. APPLICABILITY. This subchapter applies to any issuer of a health benefit plan that is subject to this code 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.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001.

Sec. 38.252. COLLECTION OF INFORMATION; REPORT. (a) The commissioner shall require a health benefit plan issuer to collect and report cost and utilization data for each mandated health benefit and mandated offer designated by the commissioner.

(b) The commissioner shall designate by rule:

(1) the issuers of health benefit plans that must collect and report data based on the annual dollar amounts of Texas premium collected by the health benefit plan issuer;

(2) the specific mandated health benefits and mandated offers of coverage for which data must be collected;

(3) a description of the data that must be collected;

(4) the beginning and ending dates of the reporting

periods, which shall be no less than every two years;

(5) the date following the end of the reporting period by which the report shall be submitted to the commissioner;

(6) the detail and form in which the report shall be submitted; and

(7) any other reasonable requirements that the commissioner determines are necessary to determine the impact of mandated benefits and mandated offers of coverage for which data collection and reporting is required.

(c) The commissioner shall not require reporting of data:

(1) that could reasonably be used to identify a specific enrollee in a health benefit plan;

(2) in any way that violates confidentiality requirements of state or federal law applicable to an enrollee in a health benefit plan; or

(3) in which the health maintenance organization operating under Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843, Chapter 1271, and Chapter 1272 does not directly process the claim or does not receive complete and accurate encounter data.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2B.009, eff. April 1, 2009.

Sec. 38.253. MAINTENANCE OF INFORMATION. Each health benefit plan issuer shall maintain at its principal place of business all data collected pursuant to this subchapter, including information and supporting documentation that demonstrates that the report submitted to the commissioner is complete and accurate. Each health benefit plan issuer shall make this information and any supporting documentation available to the commissioner upon request.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001.

Sec. 38.254. UTILIZATION AND COST DATA TO COMMISSIONER.

(a) Upon request from the commissioner, the Texas Health and Human Services Commission shall provide to the commissioner data, including utilization and cost data, which is related to the mandate being assessed to the population covered by the Medicaid program, including a program administered under Chapter 32, Human Resources Code, and a program administered under Chapter 533, Government Code, even if the program is not necessarily subject to the mandate.

(b) The commissioner may utilize data as defined in Subsection (a) to determine the impact of mandated benefits and mandated offers of coverage for which data collection and reporting is requested.

Added by Acts 2001, 77th Leg., ch. 852, Sec. 1, eff. Sept. 1, 2001. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.002, eff. Sept. 1, 2003.

SUBCHAPTER G. DATA REPORTING BY CERTAIN LIABILITY INSURERS

Sec. 38.301. INSURER DATA REPORTING. (a) Each insurer that writes professional liability insurance policies for nursing institutions licensed under Chapter 242, Health and Safety Code, including an insurer whose rates are not regulated, shall, as a condition of writing those policies in this state, comply with a request for information from the commissioner under this section.

(b) The commissioner may require information in rate filings, special data calls, or informational hearings or by any other means consistent with this code applicable to the affected insurer that the commissioner believes will allow the commissioner to:

(1) determine whether insurers writing insurance coverage described by Subsection (a) are passing to insured nursing institutions on a prospective basis the savings that accrue as a result of the reduction in risk to insurers writing that coverage that will result from legislation enacted by the 77th Legislature, Regular Session, including legislation that:

(A) amended Article 5.15-1 to limit the exposure of an insurer to exemplary damages for certain claims against a

nursing institution; and

(B) amended Sections 32.021(i) and (k), Human Resources Code, added Section 242.050, Health and Safety Code, and repealed Section 32.021(j), Human Resources Code, to clarify the admissibility of certain documents in a civil action against a nursing institution; or

(2) prepare the report required of the commissioner under Section 38.252 or any other report the commissioner is required to submit to the legislature in connection with the legislation described by Subdivision (1).

(c) Information provided under this section is privileged and confidential to the same extent as the information is privileged and confidential under this code or any other law governing an insurer described by Subsection (a). The information remains privileged and confidential unless and until introduced into evidence at an administrative hearing or in a court of competent jurisdiction.

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 4.01, eff. June 15, 2001. Renumbered from Insurance Code Sec. 38.251 by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.501, eff. Sept. 1, 2003.

Sec. 38.302. RECOMMENDATIONS TO LEGISLATURE. The commissioner shall assemble information and take other appropriate measures to assess and evaluate changes in the marketplace resulting from the implementation of the legislation described by Section 38.251 and shall report the commissioner's findings and recommendations to the legislature.

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 4.01, eff. June 15, 2001. Renumbered from Insurance Code Sec. 38.252 by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.501, eff. Sept. 1, 2003.

SUBCHAPTER H. HEALTH CARE REIMBURSEMENT RATE INFORMATION

Sec. 38.351. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to authorize the department to:

(1) collect data concerning health benefit plan reimbursement rates in a uniform format; and

(2) disseminate, on an aggregate basis for geographical regions in this state, information concerning health care reimbursement rates derived from the data.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.352. DEFINITION. In this subchapter, "group health benefit plan" means a preferred provider benefit plan as defined by Section 1301.001 or an evidence of coverage for a health care plan that provides basic health care services as defined by Section 843.002.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.353. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to the issuer of a group health benefit plan, including:

(1) an insurance company;

(2) a group hospital service corporation;

(3) a fraternal benefit society;

(4) a stipulated premium company;

(5) a reciprocal or interinsurance exchange; or

(6) a health maintenance organization.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, and except as provided by Subsection (e), this subchapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(c) Except as provided by Subsection (d), this subchapter applies to a small employer health benefit plan provided under Chapter 1501.

(d) This subchapter does not apply to:

(1) standard health benefit plans provided under Chapter 1507;

(2) children's health benefit plans provided under Chapter 1502;

(3) health care benefits provided under a workers' compensation insurance policy;

(4) Medicaid managed care programs operated under Chapter 533, Government Code;

(5) Medicaid programs operated under Chapter 32, Human Resources Code; or

(6) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

(e) The commissioner by rule may exclude a type of health benefit plan from the requirements of this subchapter if the commissioner finds that data collected in relation to the health benefit plan would not be relevant to accomplishing the purposes of this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.354. RULES. The commissioner may adopt rules as provided by Subchapter A, Chapter 36, to implement this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.355. DATA CALL; STANDARDIZED FORMAT. (a) Each health benefit plan issuer shall submit to the department, at the time and in the form and manner required by the department, aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by the department.

(b) The department shall require that data submitted under this section be submitted in a standardized format, established by rule, to permit comparison of health care reimbursement rates. To the extent feasible, the department shall develop the data submission requirements in a manner that allows collection of reimbursement rates as a dollar amount and not by comparison to other standard reimbursement rates, such as Medicare reimbursement rates.

(c) The department shall specify the period for which

reimbursement rates must be filed under this section.

(d) The department may contract with a private third party to obtain the data under this subchapter. If the department contracts with a third party, the department may determine the aggregate data to be collected and published under Section 38.357 if consistent with the purposes of this subchapter described in Section 38.351. The department shall prohibit the third party contractor from selling, leasing, or publishing the data obtained by the contractor under this subchapter.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.356. CONFIDENTIALITY OF DATA. Except as provided by Section 38.357, data collected under this subchapter is confidential and not subject to disclosure under Chapter 552, Government Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.357. PUBLICATION OF AGGREGATE HEALTH CARE REIMBURSEMENT RATE INFORMATION. The department shall provide to the Department of State Health Services for publication, for identified regions of this state, aggregate health care reimbursement rate information derived from the data collected under this subchapter. The published information may not reveal the name of any health care provider or health benefit plan issuer. The department may make the aggregate health care reimbursement rate information available through the department's Internet website.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

Sec. 38.358. PENALTIES. A health benefit plan issuer that fails to submit data as required in accordance with this subchapter is subject to an administrative penalty under Chapter 84. For purposes of penalty assessment, each day the health benefit plan issuer fails to submit the data as required is a separate violation.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 8, eff. September 1, 2007.

SUBCHAPTER I. TEXAS ALL PAYOR CLAIMS DATABASE

Sec. 38.401. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to authorize the department 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.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.402. DEFINITIONS. In this subchapter:

(1) "Allowed amount" means the amount of a billed charge that a health benefit plan issuer determines to be covered for services provided by a non-network provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(2) "Center" means the Center for Healthcare Data at The University of Texas Health Science Center at Houston.

(3) "Contracted rate" means the fee or reimbursement amount for a network provider's services, treatments, or supplies as established by agreement between the provider and health benefit plan issuer.

(4) "Data" means the specific claims and encounters, enrollment, and benefit information submitted to the center under this subchapter.

(5) "Database" means the Texas All Payor Claims Database established under this subchapter.

(6) "Geozip" means an area that includes all zip codes with identical first three digits.

(7) "Payor" means any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:

(A) an insurance company providing health or dental insurance;

(B) the sponsor or administrator of a health or dental plan;

(C) a health maintenance organization operating under Chapter 843;

(D) the state Medicaid program, including the Medicaid managed care program operating under Chapter 533, Government Code;

(E) a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including:

(i) a basic coverage plan under Chapter 1551;

(ii) a basic plan under Chapter 1575; and

(iii) a primary care coverage plan under Chapter 1579; or

(F) any other entity providing a health insurance or health benefit plan subject to regulation by the department.

(8) "Protected health information" has the meaning assigned by 45 C.F.R. Section 160.103.

(9) "Qualified research entity" means:

(A) an organization engaging in public interest research for the purpose of analyzing the delivery of health care in this state that is exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt organization in Section 501(c)(3) of that code;

(B) an institution of higher education engaged in public interest research related to the delivery of health care in this state; or

(C) a health care provider in this state engaging in efforts to improve the quality and cost of health care.

(10) "Stakeholder advisory group" means the stakeholder advisory group established under Section 38.403.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.403. STAKEHOLDER ADVISORY GROUP. (a) The center shall 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) The advisory group created under this section must 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;

(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 health benefit plans, 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 health benefit plan issuers that are regulated by the department;

(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 health benefit plans and who have expertise in:

(i) health planning;

(ii) health economics;

(iii) provider quality assurance;

(iv) statistics or health data management; or

(v) medical privacy laws.

(c) A person serving on the stakeholder advisory group must disclose any conflict of interest.

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

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.404. ESTABLISHMENT AND ADMINISTRATION OF DATABASE. (a) The department shall collaborate with the center under this subchapter to aid in the center's establishment of the database. The center shall 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) The center shall 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) In determining the information a payor is required to submit to the center under this subchapter, the center must 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. The required information at a minimum must include the following information as it relates to all health care services, supplies, and devices paid or otherwise adjudicated by the payor:

(1) the name and National Provider Identifier, as described in 45 C.F.R. Section 162.410, of each health care provider paid by the payor;

(2) the claim line detail that documents the health care services, supplies, or devices provided by the health care provider;

(3) the amount of charges billed by the health care provider and the payor's:

(A) allowed amount or contracted rate for the health care services, supplies, or devices; and

(B) adjudicated claim amount for the health care services, supplies, or devices;

(4) the name of the payor, the name of the health benefit plan, and the type of health benefit plan, including whether health care services, supplies, or devices were provided to an individual through:

(A) a Medicaid or Medicare program;

(B) workers' compensation insurance;

(C) a health maintenance organization operating under Chapter 843;

(D) a preferred provider benefit plan offered by an insurer under Chapter 1301;

(E) a basic coverage plan under Chapter 1551;

(F) a basic plan under Chapter 1575;

(G) a primary care coverage plan under Chapter 1579; or

(H) a health benefit plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section

1001 et seq.); and

(5) claim level information that allows the center to identify the geozip where the health care services, supplies, or devices were provided.

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

(e) 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, the center may 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:

(A) health care costs, quality, utilization, outcomes, and disparities;

(B) population health; or

(C) 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) The center shall establish data collection procedures and evaluate and update data collection procedures established under this section. The center shall 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.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.405. PUBLIC ACCESS PORTAL. (a) 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, the center shall 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. The information must be accessible through an open access Internet portal that may be accessed by the public through an Internet website.

(b) The portal created under this section must 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) Any information or data that is accessible through the portal created under this section:

(1) must be segmented by type of insurance or health benefit plan in a manner that does not combine payment rates relating to different types of insurance or health benefit plans;

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

(3) may not identify a specific patient, health care provider, health benefit plan, health benefit plan issuer, or other payor.

(d) Before making information or data accessible through the portal, the center shall 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.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.406. DATA PRIVACY AND SECURITY. (a) Any information that may identify a patient, health care provider, health benefit plan, health benefit plan 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, Health and Safety Code, and is not subject to disclosure under Chapter 552, Government Code.

(b) 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) may use information contained in the database only for purposes consistent with the purposes of this subchapter and must use the information in accordance with standards, requirements, policies, and procedures established by the center in consultation with the stakeholder advisory group;

(2) may not sell or share any information contained in the database; and

(3) may not use the information contained in the database for a commercial purpose.

(c) A qualified research entity with access to information that is contained in the database but not accessible through the portal must 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) Notwithstanding any provision of this subchapter, the department and the center may not disclose an individual's protected health information in violation of any state or federal law.

(e) The center shall 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) The center shall maintain protected health information identifiers collected under this subchapter but excluded from the database under Subsection (e) in a separate database. The separate database may not be aggregated with any other information and must use a proxy or encrypted record identifier for analysis.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.407. CERTAIN ENTITIES NOT REQUIRED TO SUBMIT DATA. Any sponsor or administrator of a health benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) may elect or decline to participate in

or submit data to the center for inclusion in the database as consistent with federal law.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.408. REPORT TO LEGISLATURE. Not later than September 1 of each even-numbered year, the center shall 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.

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.

Sec. 38.409. RULES. (a) The commissioner, in consultation with the center, shall 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 must provide data to the center under Section 38.404, which must:

(A) require the payor to provide data to the center not less frequently than quarterly; and

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

Added by Acts 2021, 87th Leg., R.S., Ch. 333 (H.B. 2090), Sec. 1, eff. September 1, 2021.