By: Callegari H.B. No. 3923

A BILL TO BE ENTITLED

AN ACT

relating to reform of the manner in which certain public entities are protected from large risks associated with employee health benefits.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Title 8, Insurance Code, is amended by adding Subtitle J to read as follows:

SUBTITLE J. TEXAS STATE MEDICAL REINSURANCE SYSTEM AND RELATED PROGRAMS

CHAPTER 1675. TEXAS STATE MEDICAL REINSURANCE SYSTEM

Sec. 1675.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person classified as an affiliate under Section 823.003.

(2) "Board" means the board of directors of the Texas State Medical Reinsurance System.

(3) "Employer health benefit plan" means:

(A) a small employer health benefit plan offered under Subchapter F, Chapter 1501; or

(B) a large employer health benefit plan that, under Subchapter C or M, Chapter 1501, is offered to a large employer who employed an average of not more than 100 eligible employees on business days during the preceding calendar year and who employed at least two employees on the first day of the plan year.

(4) "Employer health benefit plan issuer" means a health benefit plan issuer that issues an employer health benefit plan.

(5) "Health benefit plan" has the meaning assigned by Section 1501.002. The term does not include the Texas Health Insurance Risk Pool.

(6) "Health benefit plan issuer" has the meaning assigned by Section 1501.002.

(7) "Independent auditor" means the auditor with whom the board contracts under Section 1675.006 to audit the administration, management, and operation of the system.

(8) "Management company" means the entity with whom the board contracts under Section 1675.006 to administer, manage, and operate the system.

(9) "Plan of operation" means the plan of operation of the system established under Section 1675.007.

(10) "Small employer" has the meaning assigned by Section 1501.002.

(11) "Subsidiary" means a person classified as a subsidiary under Section 823.003.

(12) "System" means the Texas State Medical Reinsurance System established under this chapter.

Sec. 1675.002. TEXAS STATE MEDICAL REINSURANCE SYSTEM. The Texas State Medical Reinsurance System is an entity that is:

(1) administered by a board of directors and management company in accordance with this chapter; and

(2) subject to the supervision and control of the

commissioner.

Sec. 1675.003. SYSTEM BOARD OF DIRECTORS. (a) The board of directors of the system is composed of the following seven members:

(1) one member appointed by the governor who is a member of the senate;

(2) one member appointed by the governor who is a member of the house of representatives;

(3) one member appointed by the governor who is a small or large employer covered by a plan described by Section 1675.001(3);

(4) one member appointed by the governor who represents the interests of political subdivisions of this state;

(5) one member who is the executive director of the Employees Retirement System of Texas or that executive director's designee;

(6) one member who is the executive director of the Teacher Retirement System of Texas or that executive director's designee; and

(7) the presiding officer of the Texas Health Insurance Risk Pool or that presiding officer's designee.

(b) A board member may not:

(1) be an officer, director, or employee of a health benefit plan issuer or an affiliate or subsidiary of a health benefit plan issuer;

(2) be a person required to register under Chapter 305, Government Code; or

(3) be related to a person described by Subdivision

(1) or (2) within the second degree by affinity or consanguinity.

(c) Members of the board appointed by the governor serve two-year terms expiring December 31 of each odd-numbered year. A member's term continues until a successor is appointed.

(d) A member of the board may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act.

Sec. 1675.004. OPEN MEETINGS; PUBLIC INFORMATION. The board is subject to:

(1) the open meetings law, Chapter 551, Government Code; and

(2) the public information law, Chapter 552, Government Code.

Sec. 1675.005. BOARD MEMBER IMMUNITY. (a) A member of the board is not liable for an act performed, or omission made, in good faith in the performance of powers and duties under this subchapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a).

Sec. 1675.006. SELECTION OF MANAGEMENT COMPANY AND INDEPENDENT AUDITOR. (a) The board shall contract with:

(1) an entity that is qualified to administer, manage, and operate the system; and

(2) an entity that is qualified to audit the manner in which the entity described by Subdivision (1) performs its duties.

(b) An entity with whom the board contracts under Subsection

(a) may not be a health benefit plan issuer or an affiliate or subsidiary of a health benefit plan issuer.

(c) A management company with whom the board contracts under Subsection (a)(1) must have an electronic database or other electronic information storage system that allows the management company to:

(1) aggregate and compile information received from health benefit plan issuers and health care providers with whom health benefit plan issuers contract; and

(2) prepare reports that, using the information aggregated and compiled under Subdivision (1), predict the estimated cost of a treatment or other medical procedure based on the geographic location of the health care provider providing the treatment or performing the procedure.

Sec. 1675.007. SYSTEM PLAN OF OPERATION. (a) The management company shall submit to the commissioner a plan of operation and any amendments to that plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the system.

(b) The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines the plan:

(1) is suitable to ensure the fair, reasonable, and equitable administration of the system; and

(2) provides for the sharing of system gains or losses on an equitable and proportionate basis in accordance with this chapter.

(c) The plan of operation is effective on the written

approval of the commissioner.

Sec. 1675.008. SYSTEM POWERS AND DUTIES. (a) The system, through the board and the management company, has the general powers and authority granted under state law to an insurer or a health maintenance organization authorized to engage in business, except that the system may not directly issue a health benefit plan.

(b) The system may:

(1) enter into contracts necessary or proper to implement this chapter, including, with the commissioner's approval, contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured health benefit plan issuer;

(3) take legal action necessary to avoid the payment of improper claims against the system;

(4) issue reinsurance contracts in accordance with this chapter;

(5) establish guidelines, conditions, and procedures for reinsuring risks under the plan of operation;

(6) establish actuarial functions as appropriate for the operation of the system;

(7) appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in:

(A) the operation of the system;

(B) policy and other contract design; and

(C) any other function within the authority of the system; and

(8) assess health benefit plan issuers and stop-loss insurers in accordance with Section 1675.013.

Sec. 1675.009. SYSTEM AUDIT; INDEPENDENT AUDIT AND STATE AUDIT. (a) The transactions of the system are subject to audit by the state auditor in accordance with Chapter 321, Government Code. The state auditor shall report the cost of each audit conducted under this subsection to the board, the management company, and the comptroller, and the board shall remit that amount to the comptroller.

(b) The independent auditor shall annually audit the transactions of the system and the manner in which the management company is performing the management company's duties. The independent auditor shall deliver to the board the results of an audit conducted under this subsection.

Sec. 1675.010. REINSURANCE. (a) The following entities shall purchase from the system reinsurance for the following types of health benefit plans:

(1) an employer health benefit plan issuer, for each employer health benefit plan issued;

(2) a health benefit plan issuer from which the Employees Retirement System of Texas, the Teacher Retirement System of Texas, or any entity eligible to participate in the uniform group coverage program under Chapter 1579 purchases a group health benefit plan, for each group health benefit plan purchased;

(3) Texas Health Insurance Risk Pool, for all health insurance coverage provided through the pool; and

(4) an insurer that is authorized to write stop-loss insurance in this state, for each stop-loss policy covering:

(A) a fully self-funded health benefit plan operated by or on behalf of an entity described by Subdivision (2) or (3); or

(B) a small employer, to the extent that the small employer fully self-funds health insurance coverage for employees.

(b) The following entities may purchase reinsurance from the system:

(1) any political subdivision of this state not required to purchase reinsurance from the system under Subsection (a); and

(2) any university system in this state.

(c) An entity that elects to purchase reinsurance from the system under Subsection (a) may not terminate a reinsurance contract issued by the system.

Sec. 1675.011. LIMITS ON REINSURANCE. (a) The system may not reimburse a reinsured health benefit plan issuer for the claims of a reinsured individual until the issuer has incurred more than $50,000 in claims in a policy period for that individual for benefits covered by the system.

(b) The system shall reimburse a reinsured health benefit plan issuer for the claims of a reinsured individual that exceed $50,000 in a policy period for that individual for benefits covered

by the system.

(c) The board annually shall adjust the initial level of claims and the maximum liability to be retained by a reinsured health benefit plan issuer under Subsection (a) to reflect changes in:

(1) costs;

(2) health care utilization in this state; and

(3) the health benefit plan market in this state.

Sec. 1675.012. PREMIUM RATES FOR REINSURANCE. (a) As part of the plan of operation, the management company shall adopt a method to determine premium rates to be charged by the system for reinsurance contracts issued under this chapter.

(b) The method adopted must allow premium rate variations based on:

(1) demographic and geographic factors; and

(2) the level of benefits provided under a reinsured health benefit plan.

Sec. 1675.013. ASSESSMENTS; DEFERMENT OF ASSESSMENTS. (a) The board shall recover any net loss of the system by assessing each reinsured health benefit plan issuer or stop-loss insurer required to purchase reinsurance through the system under Section 1675.010 an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The board shall establish, as part of the plan of operation, a formula by which to make assessments that are made under Subsection (a). With the approval of the commissioner, the

board may periodically change the assessment formula as appropriate. The board shall base the assessment formula on each reinsured health benefit plan issuer's or stop-loss insurer's share of the total premiums earned in the preceding calendar year from health benefit plans and policies of stop-loss insurance described by Section 1675.010.

(c) The maximum assessment amount payable for a calendar year may not exceed five percent of the total premiums earned in the preceding calendar year from health benefit plans and policies of stop-loss insurance described by Section 1675.010.

(d) A reinsured health benefit plan issuer or stop-loss insurer may petition the commissioner for a deferment in whole or in part of an assessment imposed by the board.

(e) The commissioner may defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the reinsured health benefit plan issuer or stop-loss insurer to fulfill its contractual obligations.

(f) The board shall assess the amount of any deferred assessment against other reinsured health benefit plan issuers and stop-loss insurers in a manner consistent with the basis for assessment established by this subchapter.

Sec. 1675.014. RULES. The commissioner may adopt rules necessary to implement this chapter.

CHAPTER 1676. CERTAIN HEALTH SERVICES AND SUPPLIES PROVIDED UNDER REINSURED PLANS

Sec. 1676.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a practitioner,

institutional provider, or other person or organization that furnishes health care services or supplies and that is licensed or otherwise authorized to practice in this state. The term does not include a physician.

(2) "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code.

(3) "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a reinsured plan.

(4) "Physician" means an individual licensed to practice medicine in this state.

(5) "Plan administrator" means the individual or entity responsible for paying claims under a reinsured plan.

(6) "Practitioner" means an individual who practices a healing art. The term includes a practitioner described by Section 1451.001 or 1451.101.

(7) "Reinsured claim" means any part of a claim for health care services or supplies under a reinsured plan that is incurred after the initial level of claims established by Section 1675.011 is incurred under the reinsured plan.

(8) "Reinsured plan" means a health benefit plan that is reinsured under the system as provided by Section 1675.010. The term includes a self-funded health benefit plan covered by a stop-loss policy that is reinsured under the system.

(9) "System" means the Texas State Medical Reinsurance

System established under Chapter 1675.

Sec. 1676.002. DETERMINATION THAT CLAIM IS REINSURED. The plan of operation of the system must establish the manner in which a plan administrator determines, at the time of receipt of a claim under a reinsured plan, whether the claim or part of the claim is a reinsured claim.

Sec. 1676.003. ADJUSTED AMOUNT OF REINSURED CLAIM. (a) On receipt of a reinsured claim, the plan administrator shall adjust the amount of the claim to the lesser of:

(1) the amount charged for the service by the health care provider or physician;

(2) the amount payable for the claim, without regard to whether it is a reinsured claim, under the reinsured plan in accordance with a contract entered into by the health care provider or physician; or

(3) the amount payable for the claim under the reimbursement schedule established under Section 1676.004.

(b) The plan administrator shall pay the adjusted claim in accordance with the terms of the reinsured plan. If the amount paid is reduced from the amount claimed for the health care service or supply, the plan administrator shall notify the claimant, in accordance with rules of the commissioner, that the claim was a reinsured claim and of the reasons for the reduction.

Sec. 1676.004. REIMBURSEMENT SCHEDULE. (a) The system shall establish and maintain a reimbursement schedule for reinsured claims in accordance with the plan of operation and this section.

(b) Under the reimbursement schedule, a plan administrator

may not pay an amount for a reinsured claim if that payment exceeds the lowest amount the health care provider or physician that provided the health care service or supply would be entitled to receive for the same health care service or supply from any other health benefit plan issuer or third-party payor with which the health care provider or physician has contracted.

Sec. 1676.005. DATA CALL FOR REIMBURSEMENT SCHEDULE. (a) The commissioner shall provide the system the information required by the system to establish and maintain the reimbursement schedule under Section 1676.004.

(b) The commissioner may request information necessary to comply with this section from any individual or entity that holds a license or certificate of authority under this code.

(c) An individual or entity that fails to comply with a request for information under this section violates this code and is subject to sanctions under Chapters 82-84.

(d) Information that is obtained by the commissioner under this section and that is exempt from disclosure under Chapter 552, Government Code, including information exempt from disclosure under Section 552.104 or 552.110, Government Code:

(1) may be disclosed by the commissioner only to the system for the purposes of the reimbursement schedule; and

(2) may not be disclosed by the commissioner or the system to any other individual or entity.

Sec. 1676.006. CONTRACTS WITH HEALTH CARE PROVIDERS AND PHYSICIANS; HOLD HARMLESS. (a) A health care provider or physician that contracts to provide health care services or supplies under a

reinsured plan must agree to accept an adjusted payment for a reinsured claim in accordance with Section 1676.003.

(b) A health care provider or physician that enters into a contract described by Subsection (a) and that receives payment for a reinsured claim in accordance with Section 1676.003 may not charge another person, including the patient, for the health care services or supplies that are the subject of the claim.

(c) The commissioner by rule may specify contract terms required to implement this section.

Sec. 1676.007. NOTICE TO COVERED INDIVIDUALS OF BALANCE BILLING. (a) The plan administrator shall notify each individual covered by the reinsured plan of any liability the individual may have to pay any amount to a health care provider or physician who has not entered into a contract under Section 1676.006 in relation to a reinsured claim.

(b) The commissioner by rule may specify the form and content of the notice required to implement this section.

SECTION 2. Section 1579.151, Insurance Code, is amended to read as follows:

Sec. 1579.151. [~~REQUIRED~~] PARTICIPATION OPTIONAL [~~OF SCHOOL DISTRICTS WITH 500 OR FEWER EMPLOYEES~~]. A [~~(a) Each school~~] district, another educational district whose employees are members of the Teacher Retirement System of Texas, a [~~with 500 or fewer employees and each~~] regional education service center, or a charter school that meets the requirements of Section 1579.154 may [~~is required to~~] participate in the program, regardless of the number of employees the district, service center, or charter school

has.

[~~(b) Notwithstanding Subsection (a), a school district otherwise subject to Subsection (a) that, on January 1, 2001, was individually self-funded for the provision of health coverage to its employees may elect not to participate in the program.~~

[~~(c) An educational district described by Section 1579.002(5)(B) that, on January 1, 2001, had 500 or fewer employees may elect not to participate in the program.~~]

SECTION 3. Section 22.004(a), Education Code, is amended to read as follows:

(a) A district may [~~shall~~] participate in the uniform group coverage program established under Chapter 1579, Insurance Code, as provided by Subchapter D of that chapter.

SECTION 4. (a) A select interim committee is created to study the efficacy and feasibility of mandated universal health benefit plan coverage in this state. The committee's study must include an examination of:

(1) the operation of mandated universal health benefit plan coverage programs in other states;

(2) the economic impact a mandated universal health benefit plan coverage program would have in this state; and

(3) the impact a mandated universal health benefit plan coverage program in this state would have on the quality of care provided in this state.

(b) The committee consists of the following nine members:

(1) three members appointed by the lieutenant governor, two of whom must be senators;

(2) three members appointed by the speaker of the house of representatives, two of whom must be representatives; and

(3) three members appointed by the governor.

(c) The members of the committee shall elect a presiding officer from among its members.

(d) The committee shall convene at the call of the presiding officer.

(e) The committee has all other powers and duties provided to a special or select committee by the rules of the senate and house of representatives, by Subchapter B, Chapter 301, Government Code, and by policies of the senate and house committees on administration.

(f) From the contingent expense fund of the senate and the contingent expense fund of the house of representatives equally, the members of the committee are entitled to reimbursement for expenses incurred in carrying out the provisions of this section in accordance with the rules of the senate and house of representatives and the policies of the senate and house committees on administration.

(g) Not later than September 1, 2008, the committee shall report the committee's findings and recommendations to the lieutenant governor, the speaker of the house of representatives, and the members of the 81st Legislature.

(h) Not later than the 60th day after the effective date of this Act, the lieutenant governor, the speaker of the house of representatives, and the governor shall appoint the members of the interim committee created under this section.

SECTION 5. (a) Effective September 1, 2010, Subchapter G, Chapter 1501, Insurance Code, is repealed.

(b) Section 1579.153, Insurance Code, is repealed.

SECTION 6. As soon as practicable after the effective date of this Act, the commissioner of insurance by rule shall develop a transition plan for implementation of Chapters 1675 and 1676, Insurance Code, as added by this Act, and for the orderly termination of the Texas Health Reinsurance System established under Subchapter G, Chapter 1501, Insurance Code. The transition plan must include a timetable with specific steps and deadlines needed to fully implement Chapters 1675 and 1676, Insurance Code. The transition plan must ensure that Chapters 1675 and 1676, Insurance Code, are fully implemented not later than September 1, 2010.

SECTION 7. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2007.