# BILL ANALYSIS

Senate Research Center
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C.S.S.B. 6
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State Affairs
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Committee Report (Substituted)

## AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Texas has the highest rate of uninsured persons in the nation, a large part of whom are employed Texans whose employer is unable to offer insurance or who are unable to afford premiums for their employer sponsored health plan. According to the Texas Department of Insurance (TDI), only 32 percent of small employers offer insurance, as opposed to the 89 percent of large firms that offer insurance. Further, the premiums in the small business insurance market are often much higher than those in a large employer market. This bill would provide predictability and stability to the insurers in the small business market, allowing the premiums to be significantly lower.

C.S.S.B. 6 sets forth the purpose and requirements of the Healthy Texas Program, which will offer TDI-approved health insurance products for certain small businesses. This bill provides that insurers will be responsible for all payments up to an annual threshold of $5,000 per individual, and once that threshold is met, the Healthy Texas Program will cover 80 percent of claims, up to $75,000, through a reinsurance fund for that individual.

## RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1508.003, 1508.052, 1508.101, 1508.153, 1508.202, and 1508.251, Insurance Code) of this bill.

## SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle G, Title 8, Insurance Code, by adding Chapter 1508, as follows:

CHAPTER 1508. HEALTHY TEXAS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1508.001. PURPOSE. (a) Sets forth the purposes of the Healthy Texas Program (program).

(b) Provides that the program is not intended to diminish the availability of traditional small employer health benefit plan coverage under Chapter 1501 (Health Insurance Portability and Availability Act).

Sec. 1508.002. DEFINITIONS. Defines "dependent," "eligible employee," "fund," "health benefit plan" (plan), "health benefit plan issuer" (issuer), "program," "qualifying health benefit plan" (qualifying plan), and "small employer."

Sec. 1508.003. RULES. Authorizes the commissioner of insurance (commissioner) to adopt rules as necessary to implement this chapter.

[Reserves Sections 1508.004-1508.050 for expansion.]

SUBCHAPTER B. EMPLOYER ELIGIBILITY; CONTRIBUTIONS

Sec. 1508.051. EMPLOYER ELIGIBILITY TO PARTICIPATE. (a) Authorizes a small employer to participate in the program if during the 12-month period immediately

preceding the date of application for a qualifying plan, the small employer does not offer employees group health benefits on an expense-reimbursed or prepaid basis, and at least 30 percent of the small employer's eligible employees receive annual wages from the employer in an amount that is equal to or less than 300 percent of the poverty guidelines for an individual, as defined and updated annually by the United States Department of Health and Human Services.

(b) Provides that a small employer ceases to be eligible to participate in the program if any plan that provides employee benefits on an expense-reimbursed or prepaid basis, other than another qualifying plan, is purchased or otherwise takes effect after the purchase of a qualifying plan.

Sec. 1508.052. COMMISSIONER ADJUSTMENTS AUTHORIZED. (a) Authorizes the commissioner by rule to adjust the 12-month period described by Section 1508.051(a)(1) to an 18-month period if the commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other plans for qualifying plan coverage under this chapter.

(b) Authorizes the commissioner by rule to adjust the percentage of the poverty guidelines described by Section 1508.051(a)(2) to a higher or lower percentage if the commissioner determines that the adjustment is necessary to fulfill the purposes of this chapter. Provides that an adjustment made by the commissioner under this subsection takes effect on the first July 1 following the adjustment.

Sec. 1508.053. MINIMUM EMPLOYER PARTICIPATION REQUIREMENTS. Authorizes a small employer that meets the eligibility requirements described by Section 1508.051(a) to apply to purchase a qualifying plan if 60 percent or more of the employer's eligible employees elect to participate in the plan.

Sec. 1508.054. EMPLOYER CONTRIBUTION REQUIREMENTS. (a) Requires a small employer that purchases a qualifying plan to pay 50 percent or more of the premium for each employee covered under the qualifying plan; offer coverage to all eligible employees receiving annual wages from the employer in an amount described by Section 1508.051(a)(2) or 1508.052(b), as applicable; and contribute the same percentage of premium for each covered employee.

(b) Authorizes a small employer that purchases a qualifying plan under the program to elect to pay, but is not required to pay, all or any portion of the premium paid for dependent coverage under the qualifying plan.

[Reserves Sections 1508.055-1508.100 for expansion.]

## SUBCHAPTER C. PROGRAM PARTICIPATION; REQUIRED COVERAGE AND BENEFITS

Sec. 1508.101. PARTICIPATING PLAN ISSUERS. (a) Authorizes any issuer, subject to Subsection (b), to participate in the program.

(b) Authorizes the commissioner by rule to limit which issuers are authorized to participate in the program if the commissioner determines that the limitation is necessary to achieve the purposes of this chapter.

(c) Requires the commissioner, if the commissioner limits participation in the program under Subsection (b), to contract on a competitive procurement basis with one or more issuers to provide qualifying plan coverage under the program.

(d) Provides that nothing in this chapter prohibits a regional or local health care program described by Chapter 75 (Regional or Local Health Care Programs for Employees of Small Employers), Health and Safety Code, from participating in the program. Requires the commissioner by rule to establish participation

requirements applicable to regional and local health care programs that consider the unique plan designs, benefit levels, and participation criteria of each program.

Sec. 1508.102. PREEXISTING CONDITION PROVISION REQUIRED. Requires that a plan offered under the program include a preexisting condition provision that meets the requirements described by Section 1501.102 (Preexisting Condition Provision).

Sec. 1508.103. EXCEPTION FROM MANDATED BENEFIT REQUIREMENTS. Provides that except as expressly provided by this chapter, a small employer plan issued under the program is not subject to a law of this state that requires coverage or the offer of coverage of a health care service or benefit.

Sec. 1508.104. CERTAIN COVERAGE PROHIBITED OR REQUIRED. (a) Authorizes a qualifying plan to only provide coverage for in-plan services and benefits, except for emergency care or other services not available through a plan provider.

(b) Requires that in-plan services and benefits provided under a qualifying plan include certain services and benefits.

(c) Authorizes the commissioner to approve in-plan benefits other than those required under Subsection (b) or emergency care or other services not available through a plan provider if the commissioner determines the inclusion to be essential to achieve the purposes of this chapter.

(d) Authorizes the commissioner, with respect to the categories of services and benefits described by Subsections (b) and (c), to perform certain actions regarding the program.

[Reserves Sections 1508.105-1508.150 for expansion.]

SUBCHAPTER D. PROGRAM ADMINISTRATION

Sec. 1508.151. EMPLOYER CERTIFICATION. (a) Requires an issuer, at the time of initial application, to obtain from a small employer that seeks to purchase a qualifying plan a written certification that the employer meets the eligibility requirements described by Section 1508.051 and the minimum employer participation requirements described by Section 1508.053.

(b) Requires an issuer, not later than the 90th day before the renewal date of a qualifying plan, to obtain from the small employer that purchased the qualifying plan a written certification that the employer continues to meet the eligibility requirements described by Section 1508.051 and the minimum employer participation requirements described by Section 1508.053.

(c) Authorizes a participating issuer to require a small employer to submit appropriate documentation in support of a certification described by Subsection (a) or (b).

Sec. 1508.152. APPLICATION PROCESS. (a) Requires an issuer, subject to Subsection (b), to accept applications from qualifying plan coverage from small employers at all times throughout the calendar year.

(b) Authorizes the commissioner to limit the dates on which an issuer is required to accept applications for qualifying plan coverage if the commissioner determines the limitation to be necessary to achieve the purposes of this chapter.

Sec. 1508.153. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) Requires that a qualifying plan provide employees with an initial enrollment period that is 31 days or longer, and annually at least one open enrollment period that is 31 days or longer. Authorizes the commissioner by rule to require an additional open enrollment period if

the commissioner determines that the additional open enrollment period is necessary to achieve the purposes of this chapter.

(b) Authorizes a small employer to establish a waiting period for employees during which an employee is not eligible for coverage under a qualifying plan. Prohibits the last day of a waiting period established under this subsection from being later than the 90th day after the date on which the employee begins employment with the small employer.

(c) Prohibits an issuer from denying coverage under a qualifying plan to a new employee of a small employer that purchased the qualifying plan if the issuer receives an application for coverage from the employee not later than the 31st day after the latter of the first day of the employee's employment or the first day after the expiration of a waiting period established under Subsection (b).

(d) Authorizes an issuer, subject to Subsection (e), to deny coverage under a qualifying plan to an employee of a small employer who applies for coverage after the period described by Subsection (c).

(e) Authorizes an issuer that denies an employee coverage under Subsection (d) to only deny the employee coverage until the next open enrollment period and subject the enrollee to a one-year preexisting condition provision, as described by Section 1508.102, if the period during which the preexisting condition provision applies does not exceed 18 months from the date of the initial application for coverage under the qualifying plan.

Sec. 1508.154. REPORTS. Requires an issuer that participates in the program to submit reports to the Texas Department of Insurance (TDI) in the form and at the time the commissioner prescribes.

[Reserves Sections 1508.155-1508.200 for expansion.]

SUBCHAPTER E. RATING OF QUALIFIED HEALTH BENEFIT PLANS

Sec. 1508.201. RATING; PREMIUM PRACTICES IN GENERAL. (a) Requires an issuer participating in the program to use rating practices for qualifying plans that are consistent with the purposes of this chapter and in setting premiums for qualifying plans, consider the availability of reimbursement from the healthy Texas small employer premium stabilization fund (fund).

(b) Requires an issuer participating in the program to apply rating factors consistently with respect to all small employers in a class of business.

(c) Requires that differences in premium rates charged for qualifying plans be reasonable and reflect objective differences in plan design.

Sec. 1508.202. PREMIUM RATE DEVELOPMENT AND CALCULATION. (a) Requires that rating factors used to underwrite qualifying plans produce premium rates for identical groups that differ only by the amounts attributable to plan design and do not reflect differences because of the nature of the groups assumed to select a particular plan.

(b) Requires an issuer to treat each qualifying plan that is issued or renewed in a calendar month as having the same rating period.

(c) Authorizes an issuer to use only age and gender as case characteristics, as defined by Section 1501.201(2) (relating to case characteristics), in setting premium rates for a qualifying plan.

(d) Authorizes the commissioner by rule to establish additional rating criteria and requirements for qualifying plans if the commissioner determines that the criteria and requirements are necessary to achieve the purposes of this chapter.

Sec. 1508.203. FILING; APPROVAL. (a) Requires an issuer to file with TDI, for review and approval by the commissioner, premium rates to be charged for qualifying plans.

(b) Provides that if the commissioner limits issuer participation in the program under Section 1508.101(b), premium rates proposed to be charged for each qualifying plan will be considered an element in the contract procurement process required under that section.

[Reserves Sections 1508.204-1508.250 for expansion.]

SUBCHAPTER F. HEALTHY TEXAS SMALL EMPLOYER PREMIUM STABILIZATION FUND

Sec. 1508.251. ESTABLISHMENT OF FUND. (a) Requires the commissioner, to the extent that funds appropriated to TDI are available for this purpose, to establish a fund from which issuers are authorized to receive reimbursement for claims paid by the issuers for individuals covered under qualifying plans.

(b) Requires that the fund established under this section be known as the healthy Texas small employer premium stabilization fund.

(c) Requires the commissioner to adopt rules necessary to implement and administer the fund, including rules that set out the procedures for operation of the fund and distribution of money from the fund.

Sec. 1508.252. OPERATION OF FUND; CLAIM ELIGIBILITY. (a) Provides that an issuer is eligible to receive reimbursement in an amount that is equal to 80 percent of the dollar amount of claims paid between $5,000 and $75,000 in a calendar year for an enrollee in a qualifying plan.

(b) Provides that an issuer is eligible for reimbursement from the fund only for the calendar year in which claims are paid.

(c) Prohibits an issuer, once the dollar amount of claims paid on behalf of a covered individual reaches or exceeds $75,000 in a given calendar year, from receiving reimbursement for any other claims paid on behalf of the individual in that calendar year.

Sec. 1508.253. REIMBURSEMENT REQUEST SUBMISSION. (a) Requires an issuer seeking reimbursement from the fund to submit a request for reimbursement in the form prescribed by the commissioner by rule.

(b) Requires an issuer to request reimbursement from the fund annually, not later than the date determined by the commissioner, following the end of the calendar year for which the reimbursement requests are made.

(c) Authorizes the commissioner to require an issuer participating in the program to submit claims data in connection with reimbursement requests as the commissioner determines to be necessary to ensure appropriate distribution of reimbursement funds and oversee the operation of the fund. Authorizes the commissioner to require that the data be submitted on a per covered individual, aggregate, or categorical basis.

Sec. 1508.254. FUND AVAILABILITY. (a) Requires the commissioner to compute the total claims reimbursement amount for all issuers participating in the program for the calendar year for which claims are reported and reimbursement requested.

(b) Requires the commissioner, if the total amount requested by issuers participating in the program for reimbursement for a calendar year exceeds the

amount of funds available for distribution for claims paid during that same calendar year, to provide for the pro rata distribution of any available funds. Provides that an issuer participating in the program is eligible to receive a proportional amount of any available funds that is equal to the proportion of total eligible claims paid by all participating issuers that the requesting issuer paid.

(c) Requires the commissioner, if the amount of funds available for distribution for claims paid by all issuers participating in the program during a calendar year exceeds the total amount requested for reimbursement by all participating issuers during that calendar year, to carry forward any excess funds and make those excess funds available for distribution in the next calendar year. Provides that excess funds carried over under this section are added to the fund in addition to any other money appropriated for the fund for the calendar year into which the funds are carried forward.

Sec. 1508.255. PROGRAM REPORTING. (a) Requires each issuer participating in the program to provide to TDI, in the form prescribed by the commissioner, monthly reports of total enrollment under qualifying plans.

(b) Requires each issuer participating in the program, on the request of the commissioner, to furnish to TDI, in the form prescribed by the commissioner, data other than data described by Subsection (a) that the commissioner determines necessary to oversee the operation of the fund.

Sec. 1508.256. CLAIMS EXPERIENCE DATA. (a) Requires the commissioner, based on available data and appropriate actuarial assumptions, to separately estimate the per covered individual annual cost of total claims reimbursement from the fund for qualifying plans.

(b) Requires an issuer participating in the program, on request, to furnish to TDI claims experience data for use in the estimates described by Subsection (a).

Sec. 1508.257. TOTAL ELIGIBLE ENROLLMENT DETERMINATION. Requires the commissioner to determine total eligible enrollment under qualifying plans by dividing the total funds available for distribution from the fund by the estimated per covered individual annual cost of total claims reimbursement from the fund.

Sec. 1508.258. EVALUATION AND PROTECTION OF FUND; EMPLOYER ENROLLMENT SUSPENSION. (a) Requires the commissioner to suspend the enrollment of new employers in qualifying plans if the commissioner determines that the total enrollment reported by all issuers under qualifying plans exceeds the total eligible enrollment determined under Section 1508.257 and is likely to result in anticipated annual expenditures from the fund in excess of the total funds available for distribution from the fund.

(b) Requires the commissioner to provide an issuer participating in the program with notification of any enrollment suspension under Subsection (a) as soon as practicable after receipt of all enrollment data and determination of the need to suspend enrollment.

(c) Provides that a suspension of issuance of qualifying plans to employers under Subsection (a) does not preclude the addition of new employees of an employer already covered under a qualifying plan or new dependents of employees already covered under a qualifying plan.

Sec. 1508.259. EMPLOYER ENROLLMENT REACTIVATION. Provides that if, at any point during a suspension of enrollment under Section 1508.258, the commissioner determines that funds are sufficient to provide for the addition of new enrollments, the commissioner is authorized to reactivate new enrollments and is required to notify all participating group issuers that enrollment of new employers are authorized to be resumed.

Sec. 1508.260. FUND ADMINISTRATOR. (a) Authorizes the commissioner to obtain the services of an independent organization to administer the fund.

(b) Requires the commissioner to establish guidelines for the submission of proposals by organizations for the purposes of administering the fund and is authorized to approve, disapprove, or recommend modification to the proposal of an applicant to administer the fund.

(c) Requires an organization approved to administer the fund to submit reports to the commissioner, in the form and at the times required by the commissioner, as necessary to facilitate evaluation and ensure orderly operation of the fund, including an annual report of the affairs and operations of the fund. Requires that the annual report be delivered to the governor, the lieutenant governor, and the speaker of the house of representatives.

(d) Requires an organization approved to administer the fund to maintain records in the form prescribed by the commissioner and make those records available for inspection by or at the request of the commissioner.

(e) Requires the commissioner to determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Provides that compensation is payable only from the fund.

(f) Authorizes the commissioner to remove an organization approved to administer the fund from fund administration. Requires an organization removed from fund administration under this subsection to cooperate in the orderly transition of services to another approved organization or to the commissioner.

Sec. 1508.261. STOP-LOSS INSURANCE; REINSURANCE. (a) Authorizes the administrator of the fund, on behalf and with the prior approval of the commissioner, to purchase stop-loss insurance or reinsurance from an insurance company licensed to write that coverage in this state.

(b) Authorizes stop-loss insurance or reinsurance to be purchased to the extent that the commissioner determines funds are available for the purchase of that insurance.

Sec. 1508.262. PUBLIC EDUCATION AND OUTREACH. (a) Authorizes the commissioner to use an amount of the fund, not to exceed eight percent of the annual amount of the fund, for purposes of developing and implementing public education, outreach, and facilitated enrollment strategies targeted to small employers who do not provide health insurance.

(b) Requires the commissioner to solicit and accept recommendations concerning the development and implementation of education, outreach, and enrollment strategies under Subsection (a) from agents licensed under Title 13 (Regulation of Professionals) to write health benefit plans in this state.

(c) Authorizes the commissioner to contract with marketing organizations to perform or provide assistance with education, outreach, and enrollment strategies described by Subsection (a).

SECTION 2. Requires the commissioner to adopt any rules necessary to implement the change in law made by this Act not later than January 4, 2010.

SECTION 3. (a) Requires the commissioner to make an initial determination concerning limitation of issuer participation in the program established under Chapter 1508, Insurance Code, as added by this Act, not later than January 18, 2010. Requires the commissioner, if the commissioner determines that limited participation is necessary to achieve the purposes of

Chapter 1508, Insurance Code, as added by this Act, to issue a request for proposal from issuers to participate in the program not later than May 1, 2010.

(b) Requires the commissioner to ensure that the program is fully operational in a manner that allows issuers participating in the program to make the first annual request for reimbursement on January 1, 2011.

SECTION 4. Effective date: September 1, 2009.