By: Isett H.B. No. 1578

A BILL TO BE ENTITLED

AN ACT

relating to the establishment of a medical reinsurance system and to certain insurance reforms necessary to the efficient operation of that system; providing an administrative penalty.

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

SECTION 1. The heading to Subtitle F, Title 4, Insurance Code, is amended to read as follows:

SUBTITLE F. REINSURANCE; STOP-LOSS INSURANCE

SECTION 2. Subtitle F, Title 4, Insurance Code, is amended by adding Chapter 495 to read as follows:

CHAPTER 495. STOP-LOSS INSURANCE FOR CERTAIN SELF-FUNDED ENTITIES

Sec. 495.001. DEFINITIONS. In this chapter:

(1) "Aggregate stop-loss insurance" means stop-loss insurance in which the issuer responds after a self-funded health benefit plan has covered:

(A) claims that total a specified dollar amount; or

(B) a specified percentage of expected claims, which may be modified to account for any applicable individual stop-loss insurance coverage.

(2) "Health benefit plan" means a plan that provides benefits for hospital, medical, surgical, or other treatment expenses incurred as a result of a health condition, an accident, or sickness, including a group health insurance policy, a group

hospital service contract, a group evidence of coverage, or any other similar coverage document that:

(A) is issued, entered into, or provided by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

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

(iv) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(v) an employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plan, program, or arrangement; and

(B) is not limited in scope to only one or more of the following types of coverage:

(i) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(ii) credit-only insurance coverage;

(iii) disability insurance coverage;

(iv) coverage only for a specified disease or illness;

(v) Medicare services under a federal contract;

(vi) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(vii) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(viii) coverage that provides limited-scope dental or vision benefits;

(ix) coverage for an on-site medical clinic;

(x) liability insurance coverage, including general liability insurance coverage, automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage;

(xi) workers' compensation insurance coverage or similar insurance coverage;

(xii) automobile medical payment insurance coverage, including coverage issued as a supplement to automobile medical payment insurance coverage; or

(xiii) hospital indemnity or other fixed indemnity insurance coverage.

(3) "Individual stop-loss deductible" means the dollar amount of claims that a self-funded health benefit plan must cover before the issuer of an individual stop-loss insurance policy begins to reimburse the health benefit plan for additional covered claims for the remainder of a policy period.

(4) "Individual stop-loss insurance" means stop-loss insurance in which the issuer responds when the self-funded health benefit plan covered by the insurance has covered claims that

exceed the applicable individual stop-loss deductible for one enrollee in the health benefit plan.

(5) "Reinsurance" means a contractual arrangement between a ceding insurer and an assuming insurer in accordance with Chapter 492.

(6) "Self-funded health benefit plan" means a health benefit plan that:

(A) is established as an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) or offered by an entity, agency, or political subdivision of this state under Subtitle H, Title 8;

(B) holds the initial obligation to pay claims under the plan; and

(C) is exempt under state or federal law from the licensing requirements of this code.

(7) "Stop-loss insurance" means an insurance policy covering a self-funded health benefit plan. The term includes aggregate stop-loss insurance and individual stop-loss insurance.

Sec. 495.002. REINSURANCE PROHIBITED; STOP-LOSS INSURANCE REQUIRED. (a) An insurer authorized to write reinsurance in this state may not issue a reinsurance policy covering a self-funded health benefit plan.

(b) Subject to Section 495.003, an insurer authorized to write stop-loss insurance in this state may issue a stop-loss insurance policy covering a self-funded health benefit plan.

Sec. 495.003. PRIOR APPROVAL OF POLICIES. (a) An insurer authorized to write stop-loss insurance in this state may not issue

or issue for delivery a stop-loss insurance policy in this state until the policy has been filed with the department and approved by the commissioner. The commissioner may not approve an individual stop-loss insurance policy filed under this section if the individual stop-loss deductible is less than $5,000 or exceeds $100,000.

(b) The commissioner shall adopt rules under Section 37.001 to govern the approval of policies filed under this section.

(c) If the commissioner disapproves a policy filed under this section, the disapproval is subject to judicial review under Subchapter D, Chapter 36.

(d) In the commissioner's order approving or disapproving a policy filed under this section, the commissioner shall state whether the stop-loss policy is subject to Chapters 1675 and 1676.

Sec. 495.004. REPORTS CONCERNING INDIVIDUAL STOP-LOSS INSURANCE. An insurer that issues individual stop-loss insurance in this state shall annually file with the department a report that contains the annualized gross premium and annual individual stop-loss deductible for each individual stop-loss insurance policy issued in this state.

SECTION 3. Title 8, Insurance Code, is amended by adding Subtitle K to read as follows:

SUBTITLE K. TEXAS MEDICAL REINSURANCE SYSTEM

CHAPTER 1675. TEXAS MEDICAL REINSURANCE SYSTEM

Sec. 1675.001. DEFINITIONS. In this chapter:

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

(2) "Aggregate stop-loss insurance" has the meaning assigned by Section 495.001.

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

(4) "Health benefit plan" has the meaning assigned by Section 495.001.

(5) "Health benefit plan issuer" means an entity that issues a health benefit plan.

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

(7) "Individual stop-loss insurance" has the meaning assigned by Section 495.001.

(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) "Self-funded health benefit plan" has the meaning assigned by Section 495.001.

(11) "Stop-loss insurance" has the meaning assigned by Section 495.001.

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

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

Sec. 1675.002. TEXAS MEDICAL REINSURANCE SYSTEM. The Texas

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 nine members:

(1) one member appointed by the governor, selected from a list of candidates prepared by the lieutenant governor;

(2) one member appointed by the governor, selected from a list of candidates prepared by the speaker of the house of representatives;

(3) one member appointed by the governor who is a small employer, as defined by Section 1501.002;

(4) one member appointed by the governor who is a large employer, as defined by Section 1501.002;

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

(6) one member appointed by the governor who represents the interests of physicians in this state;

(7) one member appointed by the governor who represents the interests of hospitals in this state;

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

(9) one member who is the executive director of the Teacher Retirement System of Texas or that executive director'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 chapter.

(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 the capability to gather, compile, and securely store information received from health benefit plan issuers and health care providers with whom health benefit plan issuers contract in a manner that allows the management company to prepare reports as requested by the board.

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 and underwriting 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 1675.012.

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. An independent audit conducted under this subsection must include a budgetary and accounting analysis of the system's operation.

Sec. 1675.010. REINSURANCE REQUIRED; AMOUNT REQUIRED FOR STOP-LOSS INSURANCE. (a) The following entities shall purchase from the system reinsurance for the following types of health benefit plans:

(1) a health benefit plan issuer, for each health benefit plan issued; and

(2) an insurer that is authorized to write stop-loss

insurance in this state, for each individual stop-loss policy covering a self-funded health benefit plan.

(b) A health benefit plan issuer required to purchase reinsurance under Subsection (a)(1) is not required to and may not purchase reinsurance for a health benefit plan issued that covers exclusively Medicare services or is a Medicare supplement policy, as applicable and as determined by federal law.

(c) An insurer required to purchase reinsurance under Subsection (a)(2) must purchase reinsurance on each health benefit plan and each individual stop-loss insurance policy in a manner and amount consistent with Section 1676.002.

Sec. 1675.011. 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:

(1) allow premium rate variations based on:

(A) demographic and geographic factors; and

(B) the level of benefits provided under a reinsured health benefit plan;

(2) be actuarially justifiable and approved by the commissioner under Section 1675.007 as part of the system plan of operation; and

(3) provide for the sharing, on an equitable and proportionate basis, of system gains or losses among health benefit plan issuers and stop-loss insurers required to purchase reinsurance from the system under Section 1675.010.

Sec. 1675.012. 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 individual stop-loss insurance described by Section 1675.010.

(c) 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.

(d) 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.

(e) 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 chapter.

Sec. 1675.013. EFFECT OF DEFERRAL. A reinsured health benefit plan issuer or stop-loss insurer that receives a deferral under Section 1675.012(d):

(1) remains liable to the system for the amount deferred; and

(2) until the deferred assessment is paid, may not advertise, market, deliver, or issue for delivery:

(A) a health benefit plan or insurance policy of the type for which the deferral is received; or

(B) any other health benefit plan or insurance policy subject to this chapter.

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 AND POLICIES

Sec. 1676.001. DEFINITIONS. (a) In this chapter:

(1) "Health benefit plan claim" means a claim reimbursable under a reinsured plan or policy.

(2) "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 includes a physician.

(3) "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.

(4) "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 or policy.

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

(6) "Policy period" means the period during which a reinsured plan or policy provides coverage.

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

(8) "Qualified health benefit plan claim" means a health benefit plan claim that has been repriced and adjusted by the plan claim administrator under Section 1676.003(b).

(9) "Reinsurance attachment point" means the point at which the system begins to reimburse a reinsured plan or policy under Section 1676.002.

(10) "Reinsurance extension period" means the applicable period in which the system provides reinsurance coverage for a reinsured plan or policy under Section 1676.006.

(11) "Reinsured entity" means:

(A) for a health benefit plan claim under a plan that is insured, the health benefit plan issuer; or

(B) for a health benefit plan claim under a self-funded health benefit plan that is self-insured, the insurer issuing the stop-loss insurance covering the plan.

(12) "Reinsured plan or policy" means a health benefit

plan or individual stop-loss insurance policy that is reinsured under the system as provided by Section 1675.010.

(13) "Repricing schedule" means the schedule established by the system under Section 1676.004 for the purpose of determining whether a health benefit plan claim is a qualified health benefit plan claim and, if applicable, the amount of reimbursement to which a reinsured entity may be entitled.

(b) In this chapter, "board," "management company," and "system" have the meanings assigned by Section 1675.001.

Sec. 1676.002. REINSURANCE ATTACHMENT POINT. (a) The board of the system, after consulting with the management company, shall annually establish the aggregated dollar amount of qualified health benefit claims at which the system begins to reimburse a reinsured entity.

(b) The system shall submit the reinsurance attachment point to the commissioner as an amendment to the system plan of operation for approval under Section 1675.007.

(c) The reinsurance attachment point may not be less than:

(1) $50,000 per enrollee in a policy period, if the reinsured plan or policy is not described by Subdivision (2); and

(2) $50,000 above the individual stop-loss deductible of an individual stop-loss insurance policy in a policy period.

Sec. 1676.003. DETERMINATION THAT CLAIM IS REINSURED; NOTICE TO SYSTEM. (a) A plan claim administrator shall determine, at the time of receipt of a claim under a reinsured plan or policy, whether the claim is potentially a reinsured claim.

(b) On receipt of a potentially reinsured claim, the plan

claim administrator shall adjust the amount of the claim to the lesser of:

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

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

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

(c) At the end of a policy period during which a health benefit plan claim occurs, the plan claim administrator shall calculate the total dollar amount of qualified health benefit plan claims for an individual.

(d) If a plan claim administrator determines that the total dollar amount of qualified health benefit plan claims for an individual exceeds the applicable reinsurance attachment point, the plan claim administrator, not later than the 30th day after the last day of the policy period, shall notify the system in writing of that determination and submit the claim to the system.

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

(b) The repricing schedule established under Subsection (a) must provide for certain reimbursement rates as follows:

(1) for a practitioner, a rate that is not less than 110 percent of Medicare reimbursement rates for the practitioner;

and

(2) for an institutional provider, a rate that is not less than 140 percent of Medicare reimbursement rates for the institutional provider.

Sec. 1676.005. AMOUNT OF REINSURANCE; REINSURANCE REIMBURSEMENT. The system must provide for the reimbursement of aggregated qualified health benefit plan claims that exceed the reinsurance attachment point and that are originally submitted to the system under Section 1676.003(d), or during any applicable reinsurance extension period, as follows:

(1) for a reinsured health benefit plan, an amount that is equal to the lesser of:

(A) 95 percent of the aggregated dollar amount of health benefit plan claims that exceed the reinsurance attachment point for the respective period, before those claims have been repriced and adjusted under Section 1676.003(b); or

(B) the aggregated dollar amount of qualified health benefit plan claims that were submitted to the system under Section 1676.003(d) that exceed the reinsurance attachment point for the respective period; and

(2) for a reinsured stop-loss insurance policy, an amount that is equal to the lesser of:

(A) 95 percent of the aggregated dollar amount of health benefit plan claims that exceed the applicable reinsurance attachment point for the respective period and for which the reinsured entity is responsible under the individual stop-loss insurance policy, before those claims have been repriced and

adjusted under Section 1676.003(b); or

(B) the aggregated dollar amount of qualified health benefit plan claims that were submitted to the system under Section 1676.003(d) for the respective period and for which the insurer issuing the individual stop-loss insurance is responsible.

Sec. 1676.006. PERIOD OF REINSURANCE COVERAGE; CLAIMS BASIS. (a) The reinsurance policy issued by the system shall cover a reinsured plan or policy for:

(1) subject to Subsection (b), a period that is concomitant with the policy period of the reinsured plan or policy; and

(2) a claims basis that is consistent with the claims basis of the reinsured plan or policy, regardless of whether the reinsured plan or policy is an insured plan or a self-funded plan.

(b) A reinsurance policy issued by the system may not provide coverage for an initial period that exceeds 12 months.

Sec. 1676.007. REINSURANCE EXTENSION PERIOD. (a) The policy period that immediately follows the initial policy period during which the aggregated dollar amount of qualified reinsurance claims exceeds the reinsurance attachment point is the first reinsurance extension period. A reinsurance extension period under this subsection is automatic and applies regardless of whether a different health benefit plan issuer is responsible for the reinsured claims or a different stop-loss insurance carrier is responsible for the stop-loss insurance policy.

(b) If, during the first reinsurance extension period described by Subsection (a), the system reimburses a reinsured

entity for qualified health benefit claims that, if submitted during the initial policy period would have exceeded the reinsurance attachment point, the system shall extend reinsurance coverage from the first dollar of claims to the reinsured entity for a second reinsurance extension period.

(c) A reinsured entity may not receive a third or subsequent reinsurance extension period, and the period following the first reinsurance extension period is considered a new initial policy period.

Sec. 1676.008. DATA CALL FOR REIMBURSEMENT SCHEDULE. (a) The commissioner shall provide the system the information required by the system to establish and maintain the repricing 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, 83, and 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.

SECTION 4. Effective September 1, 2012, Subchapter G, Chapter 1501, Insurance Code, is repealed.

SECTION 5. 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 6. (a) The governor shall make the appointments described by Section 1675.003, Insurance Code, as added by this Act, as soon as possible after the effective date of this Act, and in no event later than April 1, 2010.

(b) The lieutenant governor and the speaker of the house of representatives shall submit the lists of candidates described by Sections 1675.003(a)(1) and (2), Insurance Code, as added by this Act, to the governor not later than January 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, 2009.