By: Deuell S.B. No. 901

A BILL TO BE ENTITLED

AN ACT

relating to regulation of health benefit plans.

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

SECTION 1. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1220 to read as follows:

CHAPTER 1220. HEALTH BENEFIT PLAN LEGISLATIVE OVERSIGHT COMMITTEE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1220.001. DEFINITION. In this chapter, "committee" means the health benefit plan legislative oversight committee.

[Sections 1220.002-1220.050 reserved for expansion]

SUBCHAPTER B. LEGISLATIVE OVERSIGHT COMMITTEE

Sec. 1220.051. COMPOSITION OF COMMITTEE. (a) The health benefit plan legislative oversight committee is composed of seven members as follows:

(1) the chair of the Senate State Affairs Committee and the chair of the House Committee on Insurance, who shall serve as joint presiding officers of the committee;

(2) two members of the senate appointed by the lieutenant governor;

(3) two members of the house of representatives appointed by the speaker of the house of representatives; and

(4) the public insurance counsel.

(b) An appointed member of the committee serves at the pleasure of the appointing official.

(c) In making appointments to the committee, the appointing officials shall attempt to appoint persons who represent the gender composition, minority population, and geographic regions of this state.

Sec. 1220.052. MEETINGS. The committee shall meet with the commissioner at least annually.

Sec. 1220.053. POWERS AND DUTIES OF COMMITTEE. (a) The committee shall:

(1) receive information about rules proposed by the department relating to health benefit plans and may submit comments to the commissioner on the proposed rules;

(2) monitor the progress of health benefit plan regulation reform, including:

(A) the fairness of rates, underwriting guidelines, and rating manuals; and

(B) the availability of coverage;

(3) review recommendations for legislation proposed by the department; and

(4) review the necessity of having the department periodically examine the market conduct of a health benefit plan issuer or group of issuers, including the issuer's or group's:

(A) business practices;

(B) performance; and

(C) operations.

(b) The committee may request reports and other information from the department as necessary to implement this chapter.

Sec. 1220.054. REPORT. (a) Not later than November 15 of

each even-numbered year, the committee shall report on the committee's activities under Sections 1220.052 and 1220.053(a) to:

(1) the governor;

(2) the lieutenant governor; and

(3) the speaker of the house of representatives.

(b) The report must include:

(1) an analysis of any problems caused by health benefit plan regulation reform; and

(2) recommendations of any legislative action necessary to address those problems and to foster stability, availability, and competition within the health benefit plan industry.

SECTION 2. Title 8, Insurance Code, is amended by adding Subtitle K to read as follows:

SUBTITLE K. RATEMAKING IN GENERAL

CHAPTER 1670. RATES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1670.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan 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 that is offered by:

(1) an insurance company;

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

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) an exchange operating under Chapter 942;

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

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

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) Notwithstanding any other law, this chapter applies to a health benefit plan issuer with respect to a standard health benefit plan provided under Chapter 1507.

Sec. 1670.002. EXCEPTION. (a) This chapter does not apply with respect to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by

Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy; or

(4) medical payment insurance coverage provided under a motor vehicle insurance policy.

(b) This chapter does not apply to:

(1) coverage provided through the Texas Health Insurance Risk Pool subject to Section 1506.105; or

(2) coverage provided under Subtitle H.

Sec. 1670.003. APPLICABILITY OF OTHER LAWS GOVERNING RATES. The requirements of this chapter are in addition to any other provision of this code governing health benefit plan rates. Except as otherwise provided by this chapter, in the case of a conflict between this chapter and another provision of this code, this chapter controls.

Sec. 1670.004. NOTICE OF RATE INCREASE. (a) In addition to any notice required to be provided under Section 1254.001, a health benefit plan issuer shall notify each person responsible for paying any part of an individual's premium or charge for coverage under the health benefit plan, other than a person who receives notice under Section 1254.001, of a rate increase scheduled to take effect on the renewal of the individual's coverage that will result in a total premium or charge amount for covering that individual that is at least 10 percent greater than the lesser of:

(1) the total premium or charge amount paid for the individual's coverage under the health benefit plan during the 12-month period preceding the coverage's renewal date; or

(2) the total premium or charge amount paid for the

individual's coverage under the health benefit plan during the policy or contract period preceding the coverage's renewal date.

(b) A health benefit plan issuer shall send the notice required by Subsection (a) before the renewal date and not later than the 30th day before the date the rate increase is scheduled to take effect.

(c) The commissioner by rule may exempt a health benefit plan issuer from the notice requirements of this section for a short-term policy, contract, or evidence of coverage, as defined by the commissioner, that is issued by the plan issuer.

Sec. 1670.005. CONSIDERATION OF CERTAIN OTHER LAW. In reviewing rates under this chapter, the commissioner shall consider any state or federal law that may affect rates for health benefit plan coverage included in a policy, contract, or evidence of coverage subject to this chapter.

Sec. 1670.006. ADMINISTRATIVE PROCEDURE ACT APPLICABLE. Chapter 2001, Government Code, applies to all rate hearings under this chapter.

Sec. 1670.007. QUARTERLY REPORT OF PLAN ISSUER; LEGISLATIVE REPORT. (a) The commissioner shall require each health benefit plan issuer subject to this chapter to quarterly file with the commissioner information relating to changes in losses, premiums or other charges for coverage, and market share since January 1, 2010. The commissioner may require a health benefit plan issuer subject to this chapter to report to the commissioner, in the form and in the time required by the commissioner, any other information the commissioner determines is necessary to comply with this

section.

(b) Quarterly, the commissioner shall report to the governor, the lieutenant governor, the speaker of the house of representatives, the legislature, and the public regarding:

(1) the information provided to the commissioner, other than information made confidential by law, in the health benefit plan issuers' reports under Subsection (a); and

(2) market conduct, especially rates and consumer complaints.

(c) The report required by Subsection (b) must:

(1) cover a calendar quarter;

(2) for each health benefit plan issuer that writes a line of health benefit plan coverage subject to this chapter, state:

(A) the plan issuer's market share;

(B) the plan issuer's profits and losses;

(C) the plan issuer's average medical loss ratio; and

(D) whether the plan issuer submitted a rate filing during the quarter covered in the report; and

(3) for each rate filing described by Subdivision (2)(D), indicate any significant impact on holders of policies, contracts, or evidences of coverage, the overall rate change from the rate previously used by the plan issuer stated as a percentage, and any rate changes for the previous 12, 24, and 36 months.

(d) Except as provided by Subsection (e), the quarterly report required by Subsection (b) must be made available to the

governor, lieutenant governor, speaker of the house of representatives, legislature, and public not later than the 90th day after the last day of the calendar quarter covered by the report.

(e) If the commissioner determines that it is not feasible to provide the report required by this section within the period specified by Subsection (d) for all types of health benefit plan coverage subject to this chapter, the department:

(1) shall make the quarterly report, as applicable to individual health benefit plan coverage, available within the period specified by Subsection (d); and

(2) may delay publication of the quarterly report as it relates to other types of health benefit plan coverage subject to this chapter until a date specified by the commissioner.

[Sections 1670.008-1670.050 reserved for expansion]

SUBCHAPTER B. RATE STANDARDS

Sec. 1670.051. EXCESSIVE, INADEQUATE, AND UNFAIRLY DISCRIMINATORY RATES. (a) A rate is excessive, inadequate, or unfairly discriminatory for purposes of this chapter as provided by this section.

(b) A rate is excessive if the rate is likely to produce a long-term profit that is unreasonably high in relation to the health benefit plan coverage provided.

(c) A rate is inadequate if:

(1) the rate is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) continued use of the rate:

(A) endangers the solvency of a health benefit plan issuer using the rate; or

(B) has the effect of substantially lessening competition or creating a monopoly in a market.

(d) A rate is unfairly discriminatory if the rate:

(1) is not based on sound actuarial principles;

(2) does not bear a reasonable relationship to the expected loss and expense experience among risks; or

(3) is based wholly or partly on the race, creed, color, ethnicity, or national origin of an individual or group sponsoring coverage under or covered by the health benefit plan.

Sec. 1670.052. RATE STANDARDS. (a) In setting rates, a health benefit plan issuer shall consider:

(1) past and prospective loss experience:

(A) inside this state; and

(B) outside this state if the data from this state are not credible;

(2) the peculiar hazards and experiences of individual risks, past and prospective, inside and outside this state, except to the extent specifically prohibited by law;

(3) the plan issuer's actuarially credible historical premium or charge, exposure, loss, and expense experience;

(4) catastrophe hazards in this state;

(5) operating expenses, excluding disallowed expenses;

(6) investment income;

(7) a reasonable margin for profit; and

(8) any other factors inside and outside this state:

(A) determined to be relevant by the health benefit plan issuer; and

(B) not disallowed by the commissioner.

(b) A rate may not be excessive, inadequate, or unfairly discriminatory for the risks to which the rate applies.

(c) Except to the extent limited by other law, the health benefit plan issuer may:

(1) group risks by classification to establish rates and minimum premiums or charges for coverage; and

(2) modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (a).

(d) In setting rates that apply only to holders of policies, contracts, or evidences of coverage in this state, a health benefit plan issuer shall use available premium or charge, loss, claim, and exposure information from this state to the full extent of the actuarial credibility of that information. The plan issuer may use experience from outside this state as necessary to supplement information from this state that is not actuarially credible.

(e) In determining rating territories and territorial rates, an insurer shall use methods based on sound actuarial principles.

(f) Rates for a small employer health benefit plan subject to Chapter 1501 must comply with this chapter and Chapter 1501. In the case of a conflict between this chapter and Chapter 1501,

Chapter 1501 controls.

[Sections 1670.053-1670.100 reserved for expansion]

SUBCHAPTER C. RATE FILINGS

Sec. 1670.101. RATE FILINGS AND SUPPORTING INFORMATION. (a) Except as provided by Subchapter D, for risks written in this state, each health benefit plan issuer shall file with the commissioner all rates, applicable rating manuals, supplementary rating information, and additional information as required by the commissioner or another provision of this code.

(b) The commissioner by rule shall determine the information required to be included in the filing, including:

(1) categories of supporting information and supplementary rating information;

(2) statistics or other information to support the rates to be used by the health benefit plan issuer, including information necessary to evidence that the computation of the rate does not include disallowed expenses; and

(3) information concerning policy fees, service fees, and other fees that are charged or collected by the plan issuer under Section 550.001.

Sec. 1670.102. FILING REQUIREMENTS FOR PLAN ISSUERS WITH LESS THAN FIVE PERCENT OF MARKET. In determining filing requirements under Section 1670.101 for a health benefit plan issuer with less than five percent of the market, the commissioner shall consider specific attributes of the plan issuer and the plan issuer's market, as applicable. The commissioner shall determine filing requirements for those plan issuers accordingly to

accommodate premium or charge volume and loss experience, targeted markets, limitations on coverage, and any potential barriers to market entry or growth.

Sec. 1670.103. DISAPPROVAL OF RATE IN RATE FILING; HEARING. (a) The commissioner shall disapprove a rate if the commissioner determines that the rate filing made under this chapter does not meet the standards established under Subchapter B or another provision of this code governing the setting of rates by the health benefit plan issuer.

(b) If the commissioner disapproves a filing, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this chapter or another provision of this code governing the setting of rates by the health benefit plan issuer.

(c) The filer is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order disapproving the rate filing takes effect.

Sec. 1670.104. DISAPPROVAL OF RATE IN EFFECT; HEARING. (a) The commissioner may disapprove a rate that is in effect only after a hearing. The commissioner shall provide the filer at least 20 days' written notice.

(b) The commissioner must issue an order disapproving a rate under Subsection (a) not later than the 15th day after the close of the hearing. The order must:

(1) specify in what respects the rate fails to meet the requirements of this chapter or another provision of this code governing the setting of rates by the health benefit plan issuer;

and

(2) state the date on which further use of the rate is prohibited, which may not be earlier than the 45th day after the close of the hearing under this section.

Sec. 1670.105. GRIEVANCE. (a) An individual or group who sponsors coverage under or is covered by a health benefit plan and who is aggrieved with respect to any filing under this chapter that is in effect, or the public insurance counsel, may apply to the commissioner in writing for a hearing on the filing. The application must specify the grounds for the applicant's grievance.

(b) The commissioner shall hold a hearing on an application filed under Subsection (a) not later than the 30th day after the date the commissioner receives the application if the commissioner determines that:

(1) the application is made in good faith;

(2) the applicant would be aggrieved as alleged if the grounds specified in the application were established; and

(3) the grounds specified in the application otherwise justify holding the hearing.

(c) The commissioner shall provide written notice of a hearing under Subsection (b) to the applicant and each health benefit plan issuer that made the filing not later than the 10th day before the date of the hearing.

(d) If, after the hearing, the commissioner determines that the filing does not meet the requirements of this chapter and other provisions of this code governing the setting of rates by the health benefit plan issuer, the commissioner shall issue an order:

(1) specifying in what respects the filing fails to meet those requirements; and

(2) stating the date on which the filing is no longer in effect, which must be within a reasonable period after the order date.

(e) The commissioner shall send copies of the order issued under Subsection (d) to the applicant and each affected.

Sec. 1670.106. ROLE OF PUBLIC INSURANCE COUNSEL. (a) On request to the commissioner, the public insurance counsel may review all rate filings and additional information provided by a health benefit plan issuer under this chapter. Confidential information reviewed under this subsection remains confidential.

(b) The public insurance counsel, not later than the 30th day after the date of a rate filing under this chapter, may file with the commissioner a written objection to:

(1) a health benefit plan issuer's rate filing; or

(2) the criteria on which the plan issuer relied to determine the rate.

(c) A written objection filed under Subsection (b) must contain the reasons for the objection.

Sec. 1670.107. PUBLIC INSPECTION OF INFORMATION. Each filing made, and any supporting information filed, under this chapter is open to public inspection as of the date of the filing.

[Sections 1670.108-1670.150 reserved for expansion]

SUBCHAPTER D. PRIOR APPROVAL OF RATES UNDER CERTAIN CIRCUMSTANCES

Sec. 1670.151. REQUIREMENT TO FILE RATES FOR PRIOR APPROVAL UNDER CERTAIN CIRCUMSTANCES. (a) The commissioner by order may

require a health benefit plan issuer to file with the department for the commissioner's approval all rates, supplementary rating information, and any supporting information in accordance with this subchapter if the commissioner determines that:

(1) the plan issuer's rates require supervision because of the plan issuer's financial condition or rating practices; or

(2) a statewide health benefit coverage emergency exists.

(b) If a health benefit plan issuer files a petition under Subchapter D, Chapter 36, for judicial review of an order disapproving a rate under this chapter, the plan issuer must use the rates in effect for the plan issuer at the time the petition is filed and may not file and use any higher rate for the same type of health benefit plan coverage subject to this chapter before the matter subject to judicial review is finally resolved unless the health benefit plan issuer, in accordance with this subchapter, files the new rate with the department, along with any applicable supplementary rating information and supporting information, and obtains the commissioner's approval of the rate.

(c) From the date of the filing of the rate with the department to the effective date of the new rate, the health benefit plan issuer's previously filed rate that is in effect on the date of the filing remains in effect.

(d) The commissioner may require a health benefit plan issuer to file the plan issuer's rates under this section until the commissioner determines that the conditions described by

Subsection (a) no longer exist.

(e) For purposes of this section, a rate is filed with the department on the date the department receives the rate filing.

(f) If the commissioner requires a health benefit plan issuer to file the plan issuer's rates under this section, the commissioner shall issue an order specifying the commissioner's reasons for requiring the rate filing. An affected plan issuer is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order is issued.

Sec. 1670.152. RATE APPROVAL REQUIRED; EXCEPTION. (a) A health benefit plan issuer subject to this subchapter may not use a rate until the rate has been filed with the department and approved by the commissioner in accordance with this subchapter.

(b) Notwithstanding Subsection (a), after a rate filing is approved under this subchapter, a health benefit plan issuer, without prior approval of the commissioner, may use any rate subsequently filed by the plan issuer if the subsequently filed rate does not exceed the lesser of:

(1) 107.5 percent of the rate approved by the commissioner; or

(2) 110 percent of any rate used by the plan issuer in the previous 12-month period.

(c) Filed rates under Subsection (b) take effect on the date specified by the insurer.

Sec. 1670.153. COMMISSIONER ACTION. (a) Not later than the 30th day after the date a rate is filed with the department under this subchapter, the commissioner shall:

(1) approve the rate if the commissioner determines that the rate complies with the requirements of this chapter and other provisions of this code governing the setting of rates by the health benefit plan issuer; or

(2) disapprove the rate if the commissioner determines that the rate does not comply with the requirements of this chapter and other provisions of this code governing the setting of rates by the plan issuer.

(b) Except as provided by Subsection (c), if a rate has not been approved or disapproved by the commissioner before the expiration of the 30-day period described by Subsection (a), the rate is considered approved and the health benefit plan issuer may use the rate unless the rate proposed in the filing represents an increase of 12.5 percent or more from the plan issuer's previously filed rate.

(c) For good cause, the commissioner may, on the expiration of the 30-day period described by Subsection (a), extend the period for approval or disapproval of a rate for one additional 30-day period. The commissioner and the health benefit plan issuer may not by agreement extend the 30-day period described by Subsection (a).

Sec. 1670.154. ADDITIONAL INFORMATION. (a) If the department determines that the information filed by a health benefit plan issuer under this chapter is incomplete or otherwise deficient, the department may request additional information from the plan issuer. If the department requests additional information from the plan issuer during the 30-day period provided

by Section 1670.153(a) or under a second 30-day period provided under Section 1670.153(c), the time between the date the department submits the request to the plan issuer and the date the department receives the information requested is not included in the computation of the first 30-day period or the second 30-day period, as applicable.

(b) For purposes of this section, the date of the department's submission of a request for additional information is:

(1) the date of the department's electronic mailing or telephone call relating to the request for additional information; or

(2) the postmarked date on the department's letter relating to the request for additional information.

Sec. 1670.155. NOTICE OF COMMISSIONER APPROVAL; USE OF RATE. If the commissioner approves a rate filing under Section 1670.153, the commissioner shall provide the health benefit plan issuer with a written or electronic notice of the approval. The plan issuer may use the rate on receipt of the approval notice.

Sec. 1670.156. RATE FILING DISAPPROVAL BY COMMISSIONER; HEARING. (a) If the commissioner disapproves a rate filing under Section 1670.153(a)(2), the commissioner shall issue an order disapproving the filing in accordance with Section 1670.103(b).

(b) A health benefit plan issuer whose rate filing is disapproved is entitled to a hearing in accordance with Section 1670.103(c).

SECTION 3. Sections 1507.008 and 1507.058, Insurance Code, are repealed.

SECTION 4. Subtitle K, Title 8, Insurance Code, as added by this Act, applies only to rates for health benefit plan coverage delivered, issued for delivery, or renewed on or after January 1, 2010. Rates for health benefit plan coverage delivered, issued for delivery, or renewed before January 1, 2010, are governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2009.