

By: Davis, Wendy

S.B. No. 1158

A BILL TO BE ENTITLED

AN ACT

relating to regulation of health benefit plan rates.

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

SECTION 1. 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

1 Chapter 843;

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

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

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

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

11 (1) a plan that provides coverage:

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

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

17 (C) for credit insurance;

18 (D) only for dental or vision care;

19 (E) only for hospital expenses; or

20 (F) only for indemnity for hospital confinement;

21 (2) a Medicare supplemental policy as defined by
22 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

23 (3) a workers' compensation insurance policy; or

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

26 (b) This chapter does not apply to:

27 (1) coverage provided through the Texas Health

1 Insurance Risk Pool subject to Section 1506.105; or

2 (2) coverage provided under Subtitle H.

3 Sec. 1670.003. APPLICABILITY OF OTHER LAWS GOVERNING RATES.

4 The requirements of this chapter are in addition to any other
5 provision of this code governing health benefit plan rates. Except
6 as otherwise provided by this chapter, in the case of a conflict
7 between this chapter and another provision of this code, this
8 chapter controls.

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

18 (1) the total premium or charge amount paid for the
19 individual's coverage under the health benefit plan during the
20 12-month period preceding the coverage's renewal date; or

21 (2) the total premium or charge amount paid for the
22 individual's coverage under the health benefit plan during the
23 policy or contract period preceding the coverage's renewal date.

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

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

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

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

13 Sec. 1670.007. QUARTERLY REPORT OF PLAN ISSUER; LEGISLATIVE
14 REPORT. (a) The commissioner shall require each health benefit
15 plan issuer subject to this chapter to quarterly file with the
16 commissioner information relating to changes in losses, premiums or
17 other charges for coverage, and market share since January 1,
18 2010. The commissioner may require a health benefit plan issuer
19 subject to this chapter to report to the commissioner, in the form
20 and in the time required by the commissioner, any other information
21 the commissioner determines is necessary to comply with this
22 section.

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

26 (1) the information provided to the commissioner,
27 other than information made confidential by law, in the health

1 benefit plan issuers' reports under Subsection (a); and
2 (2) market conduct, especially rates and consumer
3 complaints.

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

5 (1) cover a calendar quarter;

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

9 (A) the plan issuer's market share;

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

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

12 and

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

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

20 (d) Except as provided by Subsection (e), the quarterly
21 report required by Subsection (b) must be made available to the
22 governor, lieutenant governor, speaker of the house of
23 representatives, legislature, and public not later than the 90th
24 day after the last day of the calendar quarter covered by the
25 report.

26 (e) If the commissioner determines that it is not feasible
27 to provide the report required by this section within the period

1 specified by Subsection (d) for all types of health benefit plan
2 coverage subject to this chapter, the department:

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

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

9 [Sections 1670.008-1670.050 reserved for expansion]

10 SUBCHAPTER B. RATE STANDARDS

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

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

18 (c) A rate is inadequate if:

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

21 (2) continued use of the rate:

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

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

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

27 (1) is not based on sound actuarial principles;

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

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

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

8 (1) past and prospective loss experience:

9 (A) inside this state; and

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

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

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

17 (4) catastrophe hazards in this state;

18 (5) operating expenses, excluding disallowed
19 expenses;

20 (6) investment income;

21 (7) a reasonable margin for profit; and

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

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

25 (B) not disallowed by the commissioner.

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

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

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

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

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

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

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

23 [Sections 1670.053-1670.100 reserved for expansion]

24 SUBCHAPTER C. RATE FILINGS

25 Sec. 1670.101. RATE FILINGS AND SUPPORTING INFORMATION.

26 (a) Except as provided by Subchapter D, for risks written in this
27 state, each health benefit plan issuer shall file with the

1 commissioner all rates, applicable rating manuals, supplementary
2 rating information, and additional information as required by the
3 commissioner or another provision of this code.

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

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

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

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

15 Sec. 1670.102. FILING REQUIREMENTS FOR PLAN ISSUERS WITH
16 LESS THAN FIVE PERCENT OF MARKET. In determining filing
17 requirements under Section 1670.101 for a health benefit plan
18 issuer with less than five percent of the market, the commissioner
19 shall consider specific attributes of the plan issuer and the plan
20 issuer's market, as applicable. The commissioner shall determine
21 filing requirements for those plan issuers accordingly to
22 accommodate premium or charge volume and loss experience, targeted
23 markets, limitations on coverage, and any potential barriers to
24 market entry or growth.

25 Sec. 1670.103. DISAPPROVAL OF RATE IN RATE FILING; HEARING.

26 (a) The commissioner shall disapprove a rate if the commissioner
27 determines that the rate filing made under this chapter does not

1 meet the standards established under Subchapter B or another
2 provision of this code governing the setting of rates by the health
3 benefit plan issuer.

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

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

12 Sec. 1670.104. DISAPPROVAL OF RATE IN EFFECT; HEARING.

13 (a) The commissioner may disapprove a rate that is in effect only
14 after a hearing. The commissioner shall provide the filer at least
15 20 days' written notice.

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

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

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

26 Sec. 1670.105. GRIEVANCE. (a) An individual or group who
27 sponsors coverage under or is covered by a health benefit plan and

1 who is aggrieved with respect to any filing under this chapter that
2 is in effect, or the public insurance counsel, may apply to the
3 commissioner in writing for a hearing on the filing. The
4 application must specify the grounds for the applicant's grievance.

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

9 (1) the application is made in good faith;

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

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

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

18 (d) If, after the hearing, the commissioner determines that
19 the filing does not meet the requirements of this chapter or another
20 provision of this code governing the setting of rates by the health
21 benefit plan issuer, the commissioner shall issue an order:

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

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

27 (e) The commissioner shall send copies of the order issued

1 under Subsection (d) to the applicant and each affected.

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

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

- 10 (1) a health benefit plan issuer's rate filing; or
11 (2) the criteria on which the plan issuer relied to
12 determine the rate.

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

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

18 [Sections 1670.108-1670.150 reserved for expansion]

19 SUBCHAPTER D. PRIOR APPROVAL OF RATES UNDER CERTAIN CIRCUMSTANCES

20 Sec. 1670.151. REQUIREMENT TO FILE RATES FOR PRIOR APPROVAL
21 UNDER CERTAIN CIRCUMSTANCES. (a) The commissioner by order may
22 require a health benefit plan issuer to file with the department for
23 the commissioner's approval all rates, supplementary rating
24 information, and any supporting information in accordance with this
25 subchapter if the commissioner determines that:

- 26 (1) the plan issuer's rates require supervision
27 because of the plan issuer's financial condition or rating

1 practices; or

2 (2) a statewide health benefit coverage emergency
3 exists.

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

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

19 (d) The commissioner may require a health benefit plan
20 issuer to file the plan issuer's rates under this section until the
21 commissioner determines that the conditions described by
22 Subsection (a) no longer exist.

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

25 (f) If the commissioner requires a health benefit plan
26 issuer to file the plan issuer's rates under this section, the
27 commissioner shall issue an order specifying the commissioner's

1 reasons for requiring the rate filing. An affected plan issuer is
2 entitled to a hearing on written request made to the commissioner
3 not later than the 30th day after the date the order is issued.

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

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

13 (1) 107.5 percent of the rate approved by the
14 commissioner; or

15 (2) 110 percent of any rate used by the plan issuer in
16 the previous 12-month period.

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

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

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

26 (2) disapprove the rate if the commissioner determines
27 that the rate does not comply with the requirements of this chapter

1 and other provisions of this code governing the setting of rates by
2 the plan issuer.

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

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

16 Sec. 1670.154. ADDITIONAL INFORMATION. (a) If the
17 department determines that the information filed by a health
18 benefit plan issuer under this chapter is incomplete or otherwise
19 deficient, the department may request additional information from
20 the plan issuer. If the department requests additional
21 information from the plan issuer during the 30-day period provided
22 by Section 1670.153(a) or under a second 30-day period provided
23 under Section 1670.153(c), the time between the date the department
24 submits the request to the plan issuer and the date the department
25 receives the information requested is not included in the
26 computation of the first 30-day period or the second 30-day period,
27 as applicable.

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

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

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

8 Sec. 1670.155. NOTICE OF COMMISSIONER APPROVAL; USE OF
9 RATE. If the commissioner approves a rate filing under Section
10 1670.153, the commissioner shall provide the health benefit plan
11 issuer with a written or electronic notice of the approval. The
12 plan issuer may use the rate on receipt of the approval notice.

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

17 (b) A health benefit plan issuer whose rate filing is
18 disapproved is entitled to a hearing in accordance with Section
19 1670.103(c).

20 SECTION 2. Sections 1507.008 and 1507.058, Insurance Code,
21 are repealed.

22 SECTION 3. Subtitle K, Title 8, Insurance Code, as added by
23 this Act, applies only to rates for health benefit plan coverage
24 delivered, issued for delivery, or renewed on or after January 1,
25 2010. Rates for health benefit plan coverage delivered, issued for
26 delivery, or renewed before January 1, 2010, are governed by the law
27 in effect immediately before the effective date of this Act, and

1 that law is continued in effect for that purpose.

2 SECTION 4. This Act takes effect September 1, 2009.