BILL ANALYSIS

Senate Research Center

H.B. 2782
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Texas Department of Insurance (TDI) has conducted reviews of certain health benefit plan rate increases, determined whether such increases are reasonable or unreasonable, and posted its findings online. However, under current law, TDI lacks authority to disapprove a rate for a health benefit plan, which could result in consumers paying rates for health benefit plans that TDI finds unreasonable. For many other lines of insurance, such as automobile or homeowners insurance, the commissioner of insurance has the authority to disapprove certain rate changes to help ensure that consumers do not pay rates that are excessive or otherwise unreasonable.

H.B. 2782 amends current law relating to the authority of the commissioner of insurance to disapprove rate changes for certain health benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1671.101, 1671.103, and 1671.104, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Title 8, Insurance Code, by adding Subtitle K, as follows:

SUBTITLE K. RATES

CHAPTER 1671. RATES FOR CERTAIN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1671.001. APPLICABILITY OF CHAPTER. (a) Provides that this chapter applies only to rates for the following health benefit plans:

(1) an individual major medical expense insurance policy to which Chapter 1201 (Accident and Health Insurance) applies;

(2) individual health maintenance organization coverage;

(3) a group accident and health insurance policy issued to an association under Section 1251.052 (Associations);

(4) a blanket accident and health insurance policy issued to an association under Section 1251.358 (Association);

(5) group health maintenance organization coverage issued to an association described by Section 1251.052 or 1251.358; or

(6) a small employer health benefit plan provided under Chapter 1501 (Health Insurance Portability and Availability Act).

(b) Provides that this chapter applies only to rates for a health benefit plan described by Subsection (a) that provides creditable coverage as defined by Section 1205.004(a) (relating to providing that an individual's coverage is creditable coverage for the purposes of Chapter 1205 (Certification of Creditable Coverage) if the coverage is provided under certain health benefit plans).

(c) Provides that this chapter does not apply to rates for coverage provided through the Texas Health Insurance Pool.

Sec. 1671.002. APPLICABILITY OF OTHER LAWS GOVERNING RATES. Provides that the requirements of this chapter are in addition to any other provision of this code governing health benefit plan rates. Provides that, 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.

SUBCHAPTER B. RATE STANDARDS

Sec. 1671.051. EXCESSIVE, INADEQUATE, AND UNFAIRLY DISCRIMINATORY RATES. (a) Provides that a rate is excessive, inadequate, or unfairly discriminatory for purposes of this chapter as provided by this section.

(b) Provides that 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) Provides that 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) Provides that 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 is based on unreasonable administrative expenses; 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.

SUBCHAPTER C. DISAPPROVAL OF RATE CHANGES

Sec. 1671.101. REVIEW OF PREMIUM RATE CHANGES. Requires the commissioner of insurance (commissioner) by rule to establish a process under which the commissioner reviews health benefit plan rate changes for compliance with this chapter and other applicable law, and to disapprove rates that do not comply with this chapter not later than the 60th day after the date the department receives a complete filing.

Sec. 1671.102. DISAPPROVAL OF RATE CHANGE AUTHORIZED. (a) Authorizes the commissioner to disapprove a rate change filed with the Texas Department of

Insurance (TDI) by a health benefit plan issuer not later than the 60th day after the date TDI receives a complete filing if:

(1) the commissioner determines that the proposed rate is excessive, inadequate, or unfairly discriminatory; or

(2) the required rate filing is incomplete.

(b) Requires the commissioner, in making a determination under this section, to consider the following factors:

(1) the reasonableness and soundness of the actuarial assumptions, calculations, projections, and other factors used by the plan issuer to arrive at the proposed rate change;

(2) the historical trends for medical claims experienced by the plan issuer;

(3) the reasonableness of the plan issuer's historical and projected administrative expenses;

(4) the plan issuer's compliance with medical loss ratio standards applicable under state or federal law;

(5) whether the rate change applies to an open or closed block of business;

(6) whether the plan issuer has complied with all requirements for pooling risk and participating in risk adjustment programs in effect under state or federal law;

(7) the financial condition of the plan issuer for at least the previous five years, or for the plan issuer's time in existence, if less than five years, including profitability, surplus, reserves, investment income, reinsurance, dividends, and transfers of funds to affiliates or parent companies;

(8) the financial performance for at least the previous five years of the block of business subject to the proposed rate change, or for the block's time in existence, if less than five years, including past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block;

(9) changes to the covered benefits or health benefit plan design;

(10) the allowable variations for case characteristics, risk classifications, and participation in programs promoting wellness; and

(11) whether the proposed rate change is necessary to maintain the plan issuer's solvency or maintain rate stability and prevent excessive rate increases in the future.

(c) Authorizes the commissioner to consider medical claims trends reported by plan issuers in this state or in a region of this country or the country as a whole, and inflation indexes in making a determination under this section, if the commissioner determines appropriate for comparison purposes.

Sec. 1671.103. DISPUTE RESOLUTION. Requires the commissioner by rule to establish a method for a health benefit plan issuer to dispute the disapproval of a rate change under this subchapter, which is authorized to include an informal method for the plan issuer and the commissioner to reach an agreement about an appropriate rate.

Sec. 1671.104. USE OF DISAPPROVED RATE PENDING DISPUTE RESOLUTION. (a) Authorizes the plan issuer, if the commissioner disapproves a rate change under this subchapter and the plan issuer objects to the disapproval, to use the disapproved rate pending the completion of the dispute resolution process established under this subchapter, and any other appeal of the disapproval authorized by law and pursued by the plan issuer.

(b) Requires the commissioner to adopt rules establishing the conditions under which any excess premiums will be refunded or credited to the persons who paid the premiums if the plan issuer uses a disapproved rate while an appeal is pending and the rate dispute is not resolved in the plan issuer's favor.

Sec. 1671.105. FEDERAL FUNDING. Requires the commissioner to seek all available federal funding to cover the cost to TDI of reviewing rates and resolving rate disputes under this subchapter.

SECTION 2. Makes application of this Act prospective.

SECTION 3. Effective date: September 1, 2013.