By: Smithee H.B. No. 2782

A BILL TO BE ENTITLED

AN ACT

relating to the authority of the commissioner of insurance to disapprove rate changes for certain health benefit plans.

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. RATES

CHAPTER 1671. RATES FOR CERTAIN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

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

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

(2) individual health maintenance organization coverage;

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

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

(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.

(b) This chapter does not apply to rates for coverage provided through the Texas Health Insurance Pool.

(c) This chapter applies only to a health benefit plan rate filed with and reviewed by the commissioner under other law. This chapter does not create a requirement that any health benefit plan issuer file the plan issuer's rates with the department.

Sec. 1671.002. 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.

SUBCHAPTER B. RATE STANDARDS

Sec. 1671.051. 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 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. The commissioner by rule shall establish a process under which the commissioner:

(1) reviews health benefit plan rate changes for compliance with this chapter; and

(2) disapproves rates that do not comply with this chapter.

Sec. 1671.102. DISAPPROVAL OF RATE CHANGE AUTHORIZED. (a) The commissioner may disapprove a rate change filed with the department by a health benefit plan issuer if:

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

(2) the required rate filing is incomplete.

(b) In making a determination under this section, the commissioner shall 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; and

(10) 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) In making a determination under this section, the commissioner may consider the following factors:

(1) if the commissioner determines appropriate for comparison purposes, medical claims trends reported by plan issuers in this state or in a region of this country or the country as a whole; and

(2) inflation indexes.

Sec. 1671.103. DISPUTE RESOLUTION. The commissioner by rule shall establish a method for a health benefit plan issuer to dispute the disapproval of a rate change under this subchapter, which may 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; ESCROW OF EXCESS PREMIUM. (a) If the commissioner disapproves a rate change under this subchapter and the plan issuer objects to the disapproval:

(1) the plan issuer may use the disapproved rate pending the completion of:

(A) the dispute resolution process established under this subchapter; and

(B) any other appeal of the disapproval authorized by law and pursued by the plan issuer; and

(2) if the disapproved rate is an increase, beginning on the date the rate is disapproved and continuing until the completion of the dispute resolution process and any other appeal, the plan issuer shall deposit into an escrow account the portion of the premiums collected by the plan issuer under the increased rate

that exceeds the premium amount charged before the rate change became effective.

(b) The commissioner shall adopt rules governing the escrow of premiums under Subsection (a)(2) and establishing the conditions under which any excess premiums will be refunded or credited to the persons who paid the premiums if the rate dispute is not resolved in the plan issuer's favor.

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

SECTION 2. 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, 2014. Rates for health benefit plan coverage delivered, issued for delivery, or renewed before January 1, 2014, 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 3. This Act takes effect September 1, 2013.