BILL ANALYSIS

Senate Research Center

S.B. 1296
By: Johnson
Business & Commerce
6/8/2021
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Federal law requires that federal regulators review certain health insurance rate increases if states do not do so. After conducting rate review for a couple of years, Texas ceded its authority to federal regulators in 2013. Texas is now one of just three states where federal regulators conduct health insurance rate reviews instead of the state department of insurance.

Through "focused rate review" at the state level, Texas can not only ensure that rate increases are reasonable, but it can also remedy a misalignment in premiums across the different metal tiers of coverage in the health insurance marketplace, resulting in more affordable coverage. Marketplace insurers are obligated by law to give certain low-income individuals "cost-sharing reductions" that lower out-of-pocket costs, like deductibles, in silver-tier plans. But in 2017, the federal government announced it would no longer reimburse for the federally mandated subsidies. Insurers responded by "silver loading," or increasing premiums for silver-tier plans to replace the lost cost-sharing reduction payments. Since premium subsidies in the marketplace are pegged to silver-tier coverage, silver loading has resulted in increased subsidies and increased enrollment, but insurers have not approached silver loading in a uniform manner. The resulting misalignment of premiums has caused Texans to lose out on hundreds of millions of dollars in federal marketplace subsidies, making coverage less affordable.

S.B. 1296 seeks to address this issue by giving the commissioner of insurance (commissioner) the authority to carry out a rate review in a manner that satisfies federal requirements, just as 47 other states have done. Under this bill, the commissioner will be able to review and reject health insurance rates that are excessive, inadequate, or discriminatory. It will also direct the Texas Department of Insurance to focus its rate review in a manner that uniformly maximizes the benefits of silver loading, making coverage more affordable. An analysis of "focused rate review" by Texas 2036 found that it would cover an additional 216,000 Texans at no net cost to the state budget, and result in an additional $1 billion federal marketplace subsidies for Texans.

S.B. 1296 amends the Insurance Code to specify the health insurance plans affected by the provisions of the bill and details the standards that rates should meet, namely that they should not be excessive, inadequate, or unfairly discriminatory. S.B. 1296 also authorizes the commissioner to establish rules for reviewing and rejecting rate changes, requires that proposed rate increases are made available for public comment and that results of the rate review are published, and instructs the commissioner to create a dispute resolution process for insurers.

(Original Author's / Sponsor's Statement of Intent)

S.B. 1296 amends current law relating to the authority of the commissioner of insurance to review rates and rate changes for certain health benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1698.051 and 1698.052, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

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

SUBTITLE N. RATES

CHAPTER 1698. RATES FOR CERTAIN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1698.001. APPLICABILITY OF CHAPTER. Provides that Chapter 1698 applies only to rates for certain health benefit plans.

Sec. 1698.002. APPLICABILITY OF OTHER LAWS GOVERNING RATES. Provides that the requirements of Chapter 1698 are in addition to any other provision of this code governing health benefit plan rates. Provides that Chapter 1698 controls in the case of a conflict between Chapter 1698 and another provision of this code, except as otherwise provided by Chapter 1698.

SUBCHAPTER B. REVIEW OF RATES

Sec. 1698.051. REVIEW OF PREMIUM RATES. (a) Defines "individual health benefit plan" and "small employer health benefit plan."

(b) Requires the commissioner of insurance (commissioner) by rule to establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with this chapter and other applicable state and federal law, including 42 U.S.C. Sections 300gg, 300gg-94, and 18032(c) and those sections' implementing regulations, including rules establishing geographic rating areas.

Sec. 1698.052. ADDITIONAL RULES AND GUIDANCE RELATED TO INDIVIDUAL HEALTH PLAN RATES. (a) Defines "qualified health plan."

(b) Requires the commissioner to adopt rules and provide guidance regarding additional requirements related to individual health benefit plans, including qualified health plans, to address the following factors:

(1) 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;

(2) the covered benefits or health benefit plan design or, for a rate change, any changes to the benefits or design;

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

(4) any other factor listed in 45 C.F.R. Section 154.301(a)(4) to the extent applicable.

(c) Requires the commissioner, in making a determination under this section regarding a proposed rate for a qualified health plan, to consider, in addition to the factors under Subsection (b), the following factors:

(1) the purchasing power of consumers who are eligible for a premium subsidy under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(2) if the plan is in the silver level, as described by 42 U.S.C. Section 18022(d), whether the rate is appropriate for the plan in relation to the rates charged for qualified health plans offering different levels of coverage, taking into account any funding or lack of funding for cost-sharing reductions and the covered benefits for each level of coverage; and

(3) whether the plan issuer utilized the induced demand factors developed by the Centers for Medicare and Medicaid Services for the risk adjustment program established under 42 U.S.C. Section 18063 for the level of

coverage offered by the plan or any state-specific induced demand factors established by the Texas Department of Insurance (TDI) regulations.

(d) Authorizes the commissioner to 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. 1698.053. PLAN DESIGN FLEXIBILITY WITHIN RATING AREAS. Authorizes a health benefit plan issuer, notwithstanding any other provision of this code, to:

(1) offer different plan designs by rating area to individuals and small employers; and

(2) provide network access beyond the geographic rating area.

Sec. 1698.054. FEDERAL ACTUARIAL LEVELS AND PLAN COST-SHARING. Authorizes a health benefit plan issuer, notwithstanding any other provision of this code, to offer plan designs with deductibles, coinsurance, and other cost-sharing mechanisms necessary to comply with federal actuarial values in the individual and small group market in this state.

Sec. 1698.055. 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 Subtitle N, Title 8, Insurance Code, as added by this Act, prospective to January 1, 2023.

SECTION 3. Provides that TDI is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. Provides that, if the legislature does not appropriate money specifically for that purpose, TDI is authorized, but is not required, to implement a provision of this Act using other appropriations that are available for that purpose.

SECTION 4. Effective date: September 1, 2021.