BILL ANALYSIS

S.B. 1296
By: Johnson
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Federal law requires that federal regulators review certain health insurance rate increases if states do not. After conducting rate reviews for a brief period, Texas ceded its authority to federal regulators in 2013. It has been suggested that through focused rate review at the state level, Texas can ensure that rate increases are reasonable and also remedy a misalignment in premiums across the different tiers of coverage in the health insurance marketplace, resulting in more affordable coverage. After the federal government announced it would no longer reimburse for the federally mandated subsidies for cost-sharing reductions given to certain low-income individuals, insurers responded by increasing premiums for certain plans to replace the lost cost-sharing reduction payments. There are concerns that the resulting misalignment of premiums has caused Texans to lose significant federal marketplace subsidies and has made coverage less affordable. S.B. 1296 seeks to address these concerns by requiring the commissioner of insurance by rule to establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with applicable state and federal law and to adopt rules and provide guidance to address certain factors relating to that compliance.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

S.B. 1296 amends the Insurance Code to require the commissioner of insurance by rule to establish a process under which the commissioner reviews health benefit plan rates and rate changes for compliance with the bill's provisions and other applicable state and federal law, and the implementing regulations for specified sections of federal statute, including rules establishing geographic rating areas. The bill 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:

- 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;
- the covered benefits or health benefit plan design or, for a rate change, any changes to the benefits or design;
- the allowable variations for case characteristics, risk classifications, and participation in programs promoting wellness; and
- any other factor listed in specified federal regulations to the extent applicable.

The bill sets out the following additional factors the commissioner is required to consider in making a determination regarding a proposed rate for a qualified health plan:

- the purchasing power of consumers who are eligible for a premium subsidy under the federal Patient Protection and Affordable Care Act;
- whether the rate is appropriate for a silver-level 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
- 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 federal law for the level of coverage offered by the plan or any state-specific induced demand factors established by department regulations.

The commissioner may consider medical claims trends reported by plan issuers in Texas or in a region of this country or the country as a whole, if determined to be appropriate for comparison purposes, and inflation indexes.

S.B. 1296 authorizes a health benefit plan issuer to do the following:

- offer different plan designs by rating area to individuals and small employers;
- provide network access beyond the geographic rating area; and
- 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 Texas.

The bill requires the commissioner to seek all available federal funding to cover the cost to the Texas Department of Insurance (TDI) of reviewing rates under the bill's provisions.

S.B. 1296 applies only to rates for certain individual major medical expense insurance policies, certain individual health maintenance organization coverage, or certain small employer health benefit plans. The bill applies only to rates for health benefit plan coverage delivered, issued for delivery, or renewed on or after January 1, 2023. Implementation of a provision of the bill by TDI is mandatory only if a specific appropriation is made for that purpose. The bill provides for the applicability of other laws governing rates and establishes that its provisions control in case of a conflict between its provisions and another provision of the Insurance Code.

EFFECTIVE DATE

September 1, 2021.