

BILL ANALYSIS

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S.B. 1296
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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.

As proposed, S.B. 1296 amends current law relating to the authority of the commissioner of insurance to review and disapprove 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 1698.101, 1698.103, and 1698.104, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Title 8, Insurance Code, is amended 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. RATE STANDARDS

Sec. 1698.051. **EXCESSIVE, INADEQUATE, AND UNFAIRLY DISCRIMINATORY RATES.** (a) Provides that a rate is excessive, inadequate, or unfairly discriminatory for purposes of Chapter 1698 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 endangers the solvency of a health benefit plan issuer using the rate, or 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 RATES

Sec. 1698.101. **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:

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

(2) disapproves rates that do not comply with this chapter not later than the 60th day after the date the Texas Department of Insurance (TDI) receives a complete filing.

(c) Requires that the rules:

(1) require an individual or small employer health benefit plan issuer to submit to the commissioner a justification for a rate increase that results in an increase equal to or greater than 10 percent and to post information regarding the rate increase on the health benefit plan issuer's Internet website;

- (2) require the commissioner to make available to the public information on rate increases and justifications submitted by health benefit plan issuers under Subdivision (1);
- (3) provide a mechanism for receiving public comment on proposed rate increases; and
- (4) provide for the results of rate reviews to be reported to the Centers for Medicare and Medicaid Services.

Sec. 1698.102. DISAPPROVAL OF RATE CHANGE AUTHORIZED. (a) Defines "qualified health plan."

(b) Authorizes the commissioner to disapprove a rate or rate change filed with 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.

(c) 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 or 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 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) for a rate change, 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) the covered benefits or health benefit plan design or, for a rate change, any changes to the benefits or design;
- (10) the allowable variations for case characteristics, risk classifications, and participation in programs promoting wellness;
- (11) whether the proposed rate is necessary to maintain the plan issuer's solvency or maintain rate stability and prevent excessive rate increases in the future; and
- (12) any other factor listed in 45 C.F.R. Section 154.301(a)(4) to the extent applicable.

(d) 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 (c), 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 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, and, if the plan did not utilize those factors, whether the plan issuer provided objective evidence showing why those factors are inappropriate for the rate.

(e) Authorizes the commissioner to consider the following factors in making a determination under this section:

(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. 1698.103. DISPUTE RESOLUTION. Requires the commissioner by rule to establish a method for a health benefit plan issuer to dispute the disapproval of a rate under Subchapter C, which may include an informal method for the plan issuer and the commissioner to reach an agreement about an appropriate rate.

Sec. 1698.104. USE OF DISAPPROVED RATE PENDING DISPUTE RESOLUTION. (a) Provides that if the commissioner disapproves a rate under Subchapter C and the plan issuer objects to the disapproval, the plan issuer may use the disapproved rate pending the completion of:

(1) the dispute resolution process established under this Subchapter C; and

(2) 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. 1698.105. 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 Subtitle N, Title 8, Insurance Code, as added by this Act, prospective to January 1, 2022.

SECTION 3. Effective date: September 1, 2021.