By: Johnson S.B. No. 745

A BILL TO BE ENTITLED

AN ACT

relating to the creation of a health insurance risk pool for certain health benefit plan enrollees; authorizing an assessment.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1511 to read as follows:

CHAPTER 1511. HEALTH INSURANCE RISK POOL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1511.0001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors appointed under this chapter.

(2) "Pool" means a health insurance risk pool established under this chapter and administered by the board.

Sec. 1511.0002. WAIVER. The commissioner shall:

(1) apply to the United States secretary of health and human services under 42 U.S.C. Section 18052 for a waiver of Section 1312(c)(1) of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and any applicable regulations or guidance beginning with the 2022 plan year;

(2) take any action the commissioner considers appropriate to make an application under Subdivision (1); and

(3) implement a state plan that meets the requirements of a waiver granted in response to an application under Subdivision (1) if the plan is:

(A) consistent with state and federal law; and

(B) approved by the United States secretary of health and human services.

Sec. 1511.0003. EXEMPTION FROM STATE TAXES AND FEES. Notwithstanding any other law, a program created under this chapter is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Sec. 1511.0004. NOTICE AND COMMENT. Following the grant of a waiver under Section 1511.0002 and before the commissioner implements a state plan under that section, the commissioner shall hold a public hearing to solicit stakeholder comments regarding the establishment of a health insurance risk pool under this chapter.

SUBCHAPTER B. ESTABLISHMENT AND PURPOSE

Sec. 1511.0051. ESTABLISHMENT OF HEALTH INSURANCE RISK POOL. To the extent that federal money is available and only if the United States secretary of health and human services grants the waiver application submitted under Section 1511.0002, the commissioner shall:

(1) apply for the federal money;

(2) use the federal money to establish a pool for the purpose of this chapter; and

(3) authorize the board to use the federal money to administer a pool for the purpose of this chapter.

Sec. 1511.0052. PURPOSE OF POOL. The purpose of the pool is to provide a reinsurance mechanism to:

(1) meaningfully reduce health benefit plan premiums in the individual market by mitigating the impact of high-risk

individuals on rates;

(2) maximize available federal money to assist residents of this state to obtain guaranteed issue health benefit coverage without increasing the federal deficit; and

(3) increase enrollment in guaranteed issue, individual market health benefit plans that provide benefits and coverage and cost-sharing protections against out-of-pocket costs comparable to and as comprehensive as health benefit plans that would be available without the pool.

SUBCHAPTER C. ADMINISTRATION

Sec. 1511.0101. BOARD OF DIRECTORS. (a) The pool is governed by a board of directors.

(b) The board consists of nine members appointed by the commissioner as follows:

(1) at least two, but not more than four, members must be individuals who are affiliated with a health benefit plan issuer authorized to write health benefit plans in this state;

(2) at least two members must be:

(A) individuals or the parents of individuals who are covered by the pool or are reasonably expected to qualify for coverage by the pool; or

(B) individuals who work as advocates for individuals described by Paragraph (A); and

(3) the other members may be selected from individuals such as:

(A) a physician licensed to practice in this state by the Texas State Board of Medical Examiners;

(B) a hospital administrator;

(C) an advanced nurse practitioner; or

(D) a representative of the public who is not:

(i) employed by or affiliated with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization;

(ii) related within the first degree of consanguinity or affinity to an individual described by Subparagraph (i); or

(iii) licensed as, employed by, or affiliated with a physician, hospital, or other health care provider.

(c) For purposes of Subsection (b), an individual who is required to register under Chapter 305, Government Code, because of the individual's activities with respect to health benefit plan-related matters is affiliated with a health benefit plan issuer.

(d) An individual is not disqualified under Subsection (b)(3)(D)(i) from representing the public if the individual's only affiliation with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization is as an insured or as an individual who has coverage through a plan provided by the corporation or organization.

Sec. 1511.0102. TERMS; VACANCY. (a) Board members serve staggered six-year terms.

(b) The commissioner shall fill a vacancy on the board by appointing, for the unexpired term, an individual who has the

appropriate qualifications to fill that position.

Sec. 1511.0103. PRESIDING OFFICER. The commissioner shall designate one board member to serve as presiding officer at the pleasure of the commissioner.

Sec. 1511.0104. PER DIEM; REIMBURSEMENT. A board member is not entitled to compensation for service on the board but is entitled to:

(1) a per diem in the amount provided by the General Appropriations Act for state officials for each day the member performs duties as a board member; and

(2) reimbursement of expenses incurred while performing duties as a board member in the amount provided by the General Appropriations Act for state officials.

Sec. 1511.0105. MEMBER'S IMMUNITY. (a) A board member is not liable for an act or omission made in good faith in the performance of powers and duties under this chapter.

(b) A cause of action does not arise against a board member for an act or omission described by Subsection (a).

Sec. 1511.0106. ADDITIONAL POWERS AND DUTIES. The commissioner by rule may establish powers and duties of the board in addition to those provided by this chapter.

Sec. 1511.0107. PLAN OF OPERATION. (a) Operation and management of the pool are governed by a plan of operation adopted by the board and approved by the commissioner. The plan of operation includes the articles, bylaws, and operating rules of the pool.

(b) The plan of operation must ensure the fair, reasonable,

and equitable administration of the pool.

(c) The board shall amend the plan of operation as necessary to carry out this chapter. An amendment to the plan of operation must be approved by the commissioner before the board may adopt the amendment.

SUBCHAPTER D. POWERS AND DUTIES

Sec. 1511.0151. METHODS TO REDUCE PREMIUM IN INDIVIDUAL MARKET. Subject to any requirements to obtain federal money for the pool, the board may use pool money to achieve lower enrollee premium rates by establishing a reinsurance mechanism for health benefit plan issuers writing comprehensive, guaranteed issue coverage in the individual market.

Sec. 1511.0152. INCREASED ACCESS TO GUARANTEED ISSUE COVERAGE. The board shall use pool money to increase enrollment in guaranteed issue coverage in the individual market in a manner that ensures that the benefits and cost-sharing protections available in the individual market are maintained in the same manner the benefits and protections would be maintained without the waiver described by Section 1511.0002.

Sec. 1511.0153. CONTRACTS AND AGREEMENTS. The board may enter into a contract or agreement that the board determines is appropriate to carry out this chapter, including a contract or agreement with:

(1) a similar pool in another state for the joint performance of common administrative functions;

(2) another organization for the performance of administrative functions; or

(3) a federal agency.

Sec. 1511.0154. RULES. The commissioner and board may adopt rules necessary to implement this chapter, including rules to administer the pool and distribute pool money.

Sec. 1511.0155. PROCEDURES, CRITERIA, AND FORMS. The board by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments under Subchapter E.

Sec. 1511.0156. PUBLIC EDUCATION AND OUTREACH. (a) The board may develop and implement public education, outreach, and facilitated enrollment strategies under this chapter.

(b) The board may contract with marketing organizations to perform or provide assistance with the strategies described by Subsection (a).

Sec. 1511.0157. AUTHORITY TO ACT AS REINSURER. In addition to the powers granted to the board under this chapter, the board may exercise any authority that may be exercised under the law of this state by a reinsurer.

SUBCHAPTER E. FUNDING

Sec. 1511.0201. FUNDING. The commissioner may use money appropriated to the department to:

(1) apply for federal money and grants; and

(2) implement this chapter.

Sec. 1511.0202. ASSESSMENTS. (a) The board may assess health benefit plan issuers, including making advance interim assessments, as reasonable and necessary for the pool's organizational and interim operating expenses.

(b) The board shall credit an interim assessment as an

offset against any regular assessment that is due after the end of the fiscal year.

(c) The regular assessment is the amount calculated under Section 1511.0204.

(d) The board shall deposit money from the interim and regular assessments described by this section in an account established outside the treasury and administered by the board. Money in the account may be spent without an appropriation and may be used only for purposes authorized by this chapter.

Sec. 1511.0203. DETERMINATION OF POOL FUNDING REQUIREMENTS. After the end of each fiscal year, the board shall determine for the next calendar year the amount of money required by the pool to reduce enrollee premiums in accordance with this chapter after applying the federal money obtained under this chapter.

Sec. 1511.0204. ASSESSMENTS TO COVER POOL FUNDING REQUIREMENTS. (a) The board shall recover an amount equal to the funding required as determined under Section 1511.0203 by assessing each health benefit plan issuer an amount determined annually by the board based on information in annual statements, the health benefit plan issuer's annual report to the board under Sections 1511.0251 and 1511.0252, and any other reports required by and filed with the board.

(b) The board shall use the total number of enrolled individuals reported by all health benefit plan issuers under Section 1511.0252 as of the preceding December 31 to compute the amount of a health benefit plan issuer's assessment, if any, in

accordance with this subsection. The board shall allocate the total amount to be assessed based on the total number of enrolled individuals covered by excess loss, stop-loss, or reinsurance policies and on the total number of other enrolled individuals as determined under Section 1511.0252. To compute the amount of a health benefit plan issuer's assessment:

(1) for the issuer's enrolled individuals covered by an excess loss, stop-loss, or reinsurance policy, the board shall:

(A) divide the allocated amount to be assessed by the total number of enrolled individuals covered by excess loss, stop-loss, or reinsurance policies, as determined under Section 1511.0252, to determine the per capita amount; and

(B) multiply the number of a health benefit plan issuer's enrolled individuals covered by an excess loss, stop-loss, or reinsurance policy, as determined under Section 1511.0252, by the per capita amount to determine the amount assessed to that health benefit plan issuer; and

(2) for the issuer's enrolled individuals not covered by excess loss, stop-loss, or reinsurance policies, the board, using the gross health benefit plan premiums reported for the preceding calendar year by health benefit plan issuers under Section 1511.0253, shall:

(A) divide the gross premium collected by a health benefit plan issuer by the gross premium collected by all health benefit plan issuers; and

(B) multiply the allocated amount to be assessed by the fraction computed under Paragraph (A) to determine the

amount assessed to that health benefit plan issuer.

(c) A small employer health benefit plan described by Chapter 1501 is not subject to an assessment under this section.

Sec. 1511.0205. ASSESSMENT DUE DATE; INTEREST. (a) An assessment is due on the date specified by the board that is not earlier than the 30th day after the date written notice of the assessment is transmitted to the health benefit plan issuer.

(b) Interest accrues on the unpaid amount of an assessment at a rate equal to the prime lending rate, as published in the most recent issue of the Wall Street Journal and determined as of the first day of each month during which the assessment is delinquent, plus three percent.

Sec. 1511.0206. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A health benefit plan issuer may petition the board for an abatement or deferment of all or part of an assessment imposed by the board. The board may abate or defer all or part of the assessment if the board determines that payment of the assessment would endanger the ability of the health benefit plan issuer to fulfill its contractual obligations.

(b) If all or part of an assessment against a health benefit plan issuer is abated or deferred, the amount of the abatement or deferment shall be assessed against the other health benefit plan issuers in a manner consistent with the method for computing assessments under this chapter.

(c) A health benefit plan issuer receiving an abatement or deferment under this section remains liable to the pool for the deficiency.

Sec. 1511.0207. USE OF EXCESS FROM ASSESSMENTS. If the total amount of the assessments exceeds the pool's actual losses and administrative expenses, the board shall credit each health benefit plan issuer with the excess in an amount proportionate to the amount the health benefit plan issuer paid in assessments. The credit may be paid to the health benefit plan issuer or applied to future assessments under this chapter.

Sec. 1511.0208. COLLECTION OF ASSESSMENTS. The pool may recover or collect assessments made under this subchapter.

SUBCHAPTER F. REPORTING

Sec. 1511.0251. ANNUAL ISSUER REPORT TO BOARD: REQUESTED INFORMATION. Each health benefit plan issuer shall report to the board the information requested by the board, as of December 31 of the preceding year.

Sec. 1511.0252. ANNUAL ISSUER REPORT TO BOARD: ENROLLED INDIVIDUALS. (a) Each health benefit plan issuer shall report to the board the number of residents of this state enrolled, as of December 31 of the preceding year, in the issuer's health benefit plans providing coverage for residents in this state, as:

(1) an employee under a group health benefit plan; or

(2) an individual policyholder or subscriber.

(b) In determining the number of individuals to report under Subsection (a)(1), the health benefit plan issuer shall include each employee for whom a premium is paid and coverage is provided under an excess loss, stop-loss, or reinsurance policy issued by the issuer to an employer or group health benefit plan providing coverage for employees in this state. A health benefit plan issuer

providing excess loss insurance, stop-loss insurance, or reinsurance, as described by this subsection, for a primary health benefit plan issuer may not report individuals reported by the primary health benefit plan issuer.

(c) Ten employees covered by a health benefit plan issuer under a policy of excess loss insurance, stop-loss insurance, or reinsurance count as one employee for purposes of determining that health benefit plan issuer's assessment.

(d) In determining the number of individuals to report under this section, the health benefit plan issuer shall exclude:

(1) the dependents of the employee or an individual policyholder or subscriber; and

(2) individuals who are covered by the health benefit plan issuer under a Medicare supplement benefit plan subject to Chapter 1652.

(e) In determining the number of enrolled individuals to report under this section, the health benefit plan issuer shall exclude individuals who are retired employees 65 years of age or older.

Sec. 1511.0253. ANNUAL ISSUER REPORT TO BOARD: GROSS PREMIUMS. (a) Each health benefit plan issuer shall report to the board the gross premiums collected for the preceding calendar year for health benefit plans.

(b) For purposes of this section, gross health benefit plan premiums do not include premiums collected for:

(1) coverage under a Medicare supplement benefit plan subject to Chapter 1652;

(2) coverage under a small employer health benefit plan subject to Chapter 1501;

(3) coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of accident or disability;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care; or

(E) only for a specified disease or illness;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy;

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides comprehensive health benefit plan coverage;

(7) liability insurance coverage, including general liability insurance and automobile liability insurance;

(8) coverage for on-site medical clinics;

(9) insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; or

(10) other similar insurance coverage, as specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which

benefits for medical care are secondary or incidental to other insurance benefits.

Sec. 1511.0254. ANNUAL BOARD REPORT OF POOL ACTIVITIES. (a) Beginning June 1, 2022, not later than June 1 of each year, the board shall submit a report to the governor, lieutenant governor, and speaker of the house of representatives.

(b) The report submitted under Subsection (a) must include:

(1) a summary of the activities conducted under this chapter in the calendar year preceding the year in which the report is submitted;

(2) the average amount by which health benefit plan premiums were reduced in this state and in each rating region;

(3) the average change in each rating region in the amount of health benefit plan premiums paid by individuals who receive a premium subsidy under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148); and

(4) an estimate of the change in each rating region in enrollment in health benefit plans due to the reduction in premiums.

SECTION 2. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2021.