By: Johnson
(Oliverson) S.B. No. 1296

A BILL TO BE ENTITLED

1 AN ACT

2 relating to the authority of the commissioner of insurance to
3 review rates and rate changes for certain health benefit plans.

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

5 SECTION 1. Title 8, Insurance Code, is amended by adding
6 Subtitle N to read as follows:

7 SUBTITLE N. RATES

8 CHAPTER 1698. RATES FOR CERTAIN COVERAGE

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1698.001. APPLICABILITY OF CHAPTER. This chapter
11 applies only to rates for the following health benefit plans:

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

14 (2) individual health maintenance organization
15 coverage; or

16 (3) a small employer health benefit plan provided
17 under Chapter 1501.

18 Sec. 1698.002. APPLICABILITY OF OTHER LAWS GOVERNING RATES.
19 The requirements of this chapter are in addition to any other
20 provision of this code governing health benefit plan rates. Except
21 as otherwise provided by this chapter, in the case of a conflict
22 between this chapter and another provision of this code, this
23 chapter controls.

SUBCHAPTER B. REVIEW OF RATES

Sec. 1698.051. REVIEW OF PREMIUM RATES. (a) In this section:

(1) "Individual health benefit plan" means:

(A) an individual accident and health insurance policy to which Chapter 1201 applies; or

(B) individual health maintenance organization coverage.

(2) "Small employer health benefit plan" has the meaning assigned by Section 1501.002.

(b) The commissioner by rule shall 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) In this section, "qualified health plan" has the meaning assigned by Section 1301(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18021).

(b) The commissioner shall 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) In making a determination under this section regarding a proposed rate for a qualified health plan, the commissioner shall 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 department regulations.

(d) The commissioner may consider the following factors:

1 (1) if the commissioner determines appropriate for
2 comparison purposes, medical claims trends reported by plan issuers
3 in this state or in a region of this country or the country as a
4 whole; and
5 (2) inflation indexes.
6 Sec. 1698.053. PLAN DESIGN FLEXIBILITY WITHIN RATING AREAS.
7 Notwithstanding any other provision of this code, a health benefit
8 plan issuer may:
9 (1) offer different plan designs by rating area to
10 individuals and small employers; and
11 (2) provide network access beyond the geographic
12 rating area.
13 Sec. 1698.054. FEDERAL ACTUARIAL LEVELS AND PLAN
14 COST-SHARING. Notwithstanding any other provision of this code, a
15 health benefit plan issuer may offer plan designs with deductibles,
16 coinsurance, and other cost-sharing mechanisms necessary to comply
17 with federal actuarial values in the individual and small group
18 market in this state.
19 Sec. 1698.055. FEDERAL FUNDING. The commissioner shall
20 seek all available federal funding to cover the cost to the
21 department of reviewing rates under this subchapter.
22 SECTION 2. Subtitle N, Title 8, Insurance Code, as added by
23 this Act, applies only to rates for health benefit plan coverage
24 delivered, issued for delivery, or renewed on or after January 1,
25 2023. Rates for health benefit plan coverage delivered, issued for
26 delivery, or renewed before January 1, 2023, are governed by the law
27 in effect immediately before the effective date of this Act, and

1 that law is continued in effect for that purpose.
2 SECTION 3. The Texas Department of Insurance is required to
3 implement a provision of this Act only if the legislature
4 appropriates money specifically for that purpose. If the
5 legislature does not appropriate money specifically for that
6 purpose, the department may, but is not required to, implement a
7 provision of this Act using other appropriations that are available
8 for that purpose.
9 SECTION 4. This Act takes effect September 1, 2021.