By: Johnson S.B. No. 1296

A BILL TO BE ENTITLED

AN ACT

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

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

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

SUBTITLE N. RATES

CHAPTER 1698. RATES FOR CERTAIN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

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

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

(2) individual health maintenance organization coverage;

(3) a group accident and health insurance policy issued to an association under Section 1251.052;

(4) a blanket accident and health insurance policy issued to an association under Section 1251.358;

(5) group health maintenance organization coverage issued to an association described by Section 1251.052 or 1251.358; or

(6) a small employer health benefit plan provided

under Chapter 1501.

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

SUBCHAPTER B. RATE STANDARDS

Sec. 1698.051. EXCESSIVE, INADEQUATE, AND UNFAIRLY DISCRIMINATORY RATES. (a) A rate is excessive, inadequate, or unfairly discriminatory for purposes of this chapter as provided by this section.

(b) 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) 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:

(A) endangers the solvency of a health benefit plan issuer using the rate; or

(B) has the effect of substantially lessening competition or creating a monopoly in a market.

(d) 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) 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:

(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 department receives a complete filing.

(c) The rules must:

(1) require an individual or small employer health benefit plan issuer to:

(A) submit to the commissioner a justification for a rate increase that results in an increase equal to or greater than 10 percent; and

(B) 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) 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 may disapprove a rate or rate change filed with the department by a health benefit plan issuer not later than the 60th day after the date the department 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) In making a determination under this section, the commissioner shall 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) 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 (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) In making a determination under this section, the commissioner may 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. 1698.103. DISPUTE RESOLUTION. The commissioner by rule shall establish a method for a health benefit plan issuer to dispute the disapproval of a rate under this subchapter, 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) If the commissioner disapproves a rate under this subchapter 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; and

(2) any other appeal of the disapproval authorized by law and pursued by the plan issuer.

(b) The commissioner shall 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. The commissioner shall seek all available federal funding to cover the cost to the department of reviewing rates and resolving rate disputes under this subchapter.

SECTION 2. Subtitle N, Title 8, Insurance Code, as added by this Act, applies only to rates for health benefit plan coverage

delivered, issued for delivery, or renewed on or after January 1, 2022. Rates for health benefit plan coverage delivered, issued for delivery, or renewed before January 1, 2022, are governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2021.