1-1 By: Johnson S.B. No. 1296
1-2 (In the Senate - Filed March 9, 2021; March 18, 2021, read
1-3 first time and referred to Committee on Business & Commerce;
1-4 April 26, 2021, reported adversely, with favorable Committee
1-5 Substitute by the following vote: Yeas 9, Nays 0; April 26, 2021,
1-6 sent to printer.)

1-7 COMMITTEE VOTE

1-8		Yea	Nay	Absent	PNV
1-9	Hancock	X			
1-10	Nichols	X			
1-11	Campbell	X			
1-12	Creighton	X			
1-13	Johnson	X			
1-14	Menéndez	X			
1-15	Paxton	X			
1-16	Schwertner	X			
1-17	Whitmire	X			

1-18 COMMITTEE SUBSTITUTE FOR S.B. No. 1296 By: Hancock

1-19 A BILL TO BE ENTITLED
1-20 AN ACT

1-21 relating to the authority of the commissioner of insurance to
1-22 review rates and rate changes for certain health benefit plans.
1-23 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-24 SECTION 1. Title 8, Insurance Code, is amended by adding
1-25 Subtitle N to read as follows:
1-26 SUBTITLE N. RATES
1-27 CHAPTER 1698. RATES FOR CERTAIN COVERAGE
1-28 SUBCHAPTER A. GENERAL PROVISIONS
1-29 Sec. 1698.001. APPLICABILITY OF CHAPTER. This chapter
1-30 applies only to rates for the following health benefit plans:
1-31 (1) an individual major medical expense insurance
1-32 policy to which Chapter 1201 applies;
1-33 (2) individual health maintenance organization
1-34 coverage; or
1-35 (3) a small employer health benefit plan provided
1-36 under Chapter 1501.
1-37 Sec. 1698.002. APPLICABILITY OF OTHER LAWS GOVERNING RATES.
1-38 The requirements of this chapter are in addition to any other
1-39 provision of this code governing health benefit plan rates. Except
1-40 as otherwise provided by this chapter, in the case of a conflict
1-41 between this chapter and another provision of this code, this
1-42 chapter controls.
1-43 SUBCHAPTER B. REVIEW OF RATES
1-44 Sec. 1698.051. REVIEW OF PREMIUM RATES. (a) In this
1-45 section:
1-46 (1) "Individual health benefit plan" means:
1-47 (A) an individual accident and health insurance
1-48 policy to which Chapter 1201 applies; or
1-49 (B) individual health maintenance organization
1-50 coverage.
1-51 (2) "Small employer health benefit plan" has the
1-52 meaning assigned by Section 1501.002.
1-53 (b) The commissioner by rule shall establish a process under
1-54 which the commissioner reviews health benefit plan rates and rate
1-55 changes for compliance with this chapter and other applicable state
1-56 and federal law, including 42 U.S.C. Sections 300gg, 300gg-94, and
1-57 18032(c) and those sections' implementing regulations, including
1-58 rules establishing geographic rating areas.
1-59 Sec. 1698.052. ADDITIONAL RULES AND GUIDANCE RELATED TO
1-60 INDIVIDUAL HEALTH PLAN RATES. (a) In this section, "qualified

2-1 health plan" has the meaning assigned by Section 1301(a), Patient
2-2 Protection and Affordable Care Act (42 U.S.C. Section 18021).
2-3 (b) The commissioner shall adopt rules and provide guidance
2-4 regarding additional requirements related to individual health
2-5 benefit plans, including qualified health plans, to address the
2-6 following factors:
2-7 (1) whether the plan issuer has complied with all
2-8 requirements for pooling risk and participating in risk adjustment
2-9 programs in effect under state or federal law;
2-10 (2) the covered benefits or health benefit plan design
2-11 or, for a rate change, any changes to the benefits or design;
2-12 (3) the allowable variations for case
2-13 characteristics, risk classifications, and participation in
2-14 programs promoting wellness; and
2-15 (4) any other factor listed in 45 C.F.R. Section
2-16 154.301(a)(4) to the extent applicable.
2-17 (c) In making a determination under this section regarding a
2-18 proposed rate for a qualified health plan, the commissioner shall
2-19 consider, in addition to the factors under Subsection (b), the
2-20 following factors:
2-21 (1) the purchasing power of consumers who are eligible
2-22 for a premium subsidy under the Patient Protection and Affordable
2-23 Care Act (Pub. L. No. 111-148);
2-24 (2) if the plan is in the silver level, as described by
2-25 42 U.S.C. Section 18022(d), whether the rate is appropriate for the
2-26 plan in relation to the rates charged for qualified health plans
2-27 offering different levels of coverage, taking into account any
2-28 funding or lack of funding for cost-sharing reductions and the
2-29 covered benefits for each level of coverage; and
2-30 (3) whether the plan issuer utilized the induced
2-31 demand factors developed by the Centers for Medicare and Medicaid
2-32 Services for the risk adjustment program established under 42
2-33 U.S.C. Section 18063 for the level of coverage offered by the plan
2-34 or any state-specific induced demand factors established by
2-35 department regulations.
2-36 (d) The commissioner may consider the following factors:
2-37 (1) if the commissioner determines appropriate for
2-38 comparison purposes, medical claims trends reported by plan issuers
2-39 in this state or in a region of this country or the country as a
2-40 whole; and
2-41 (2) inflation indexes.
2-42 Sec. 1698.053. PLAN DESIGN FLEXIBILITY WITHIN RATING AREAS.
2-43 Notwithstanding any other provision of this code, a health benefit
2-44 plan issuer may:
2-45 (1) offer different plan designs by rating area to
2-46 individuals and small employers; and
2-47 (2) provide network access beyond the geographic
2-48 rating area.
2-49 Sec. 1698.054. FEDERAL ACTUARIAL LEVELS AND PLAN
2-50 COST-SHARING. Notwithstanding any other provision of this code, a
2-51 health benefit plan issuer may offer plan designs with deductibles,
2-52 coinsurance, and other cost-sharing mechanisms necessary to comply
2-53 with federal actuarial values in the individual and small group
2-54 market in this state.
2-55 Sec. 1698.055. FEDERAL FUNDING. The commissioner shall
2-56 seek all available federal funding to cover the cost to the
2-57 department of reviewing rates under this subchapter.
2-58 SECTION 2. Subtitle N, Title 8, Insurance Code, as added by
2-59 this Act, applies only to rates for health benefit plan coverage
2-60 delivered, issued for delivery, or renewed on or after January 1,
2-61 2023. Rates for health benefit plan coverage delivered, issued for
2-62 delivery, or renewed before January 1, 2023, are governed by the law
2-63 in effect immediately before the effective date of this Act, and
2-64 that law is continued in effect for that purpose.
2-65 SECTION 3. The Texas Department of Insurance is required to
2-66 implement a provision of this Act only if the legislature
2-67 appropriates money specifically for that purpose. If the
2-68 legislature does not appropriate money specifically for that
2-69 purpose, the department may, but is not required to, implement a

3-1 provision of this Act using other appropriations that are available
3-2 for that purpose.
3-3 SECTION 4. This Act takes effect September 1, 2021.

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