BILL ANALYSIS

Senate Research Center

C.S.H.B. 710
By: Averitt (Sibley)
Economic Development
5-5-97
Committee Report (Substituted)

DIGEST

In August 1996, the 104th Congress enacted the Health Insurance Portability and Accountability Act to provide portability and greater availability to health insurance in the group and individual markets. In order for state regulation of health benefit plans to not be preempted by federal law, the legislature is required to make changes to enact federal health reforms. This bill would amend the Texas Health Insurance Risk Pool in order to meet the federal requirements as an acceptable alternative mechanism for individual market reforms. Additionally, this bill would make other changes to the offering of group and individual health insurance and HMO benefits in order to comply with federal health reforms.

PURPOSE

As proposed, C.S.H.B. 710 amends the Texas Health Insurance Risk Pool in order to meet the federal requirements as an acceptable alternative mechanism for individual market reforms. This bill amends statutes relating to the offering of group and individual health insurance and HMO benefits in order to comply with federal health reforms.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the board of directors of the Texas Health Insurance Risk Pool in SECTION 1.04 (Article 3.77(6)(c), Insurance Code), and to the commissioner of insurance in SECTIONS 1.03, 1.06, 2.01, 3.02, and 4.01 (Articles 3.77(5)(e), 3.77(8), 3.51-6(1)(d)(3)(A)(ii) and (B)(ii), 3.70-1A(c), and 20A.09(k)(B) and (l)(D), Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1.01. Amends Section 2, Article 3.77, Insurance Code, to define "benefits plan," "board," "commissioner," "department," "dependent," "family member," "health insurance," "health maintenance organization," "hospital," "insured," "insurer," "insurance arrangement," "Medicare," "physician," "plan of operation," "pool," and "resident." Deletes existing definitions set forth in Section 2, Article 3.77, Insurance Code.

SECTION 1.02. Amends Section 4, Article 3.77, Insurance Code, by amending Subsections (b)-(e) and (g) and by adding Subsection (h), to require the commissioner of insurance (commissioner), rather than the State Board of Insurance (insurance board), to appoint members of the board of directors (board) of the Texas Health Insurance Risk Pool (pool) for staggered six-year terms. Requires the board to be composed of at least two persons, instead of one, affiliated with an insurer, rather than insurance company, admitted and authorized to write health insurance in this state, but no more than four such persons; at least two persons who are insureds or parents of insureds or who are reasonably expected to qualify for coverage by the pool, rather than one person affiliated with a group hospital service corporation operating under Chapter 20 of this code; and the remaining members of the board may be selected from certain individuals. Provides that a representative of the general public does include a person whose only affiliation with an insurance company or plan, group hospital service corporation, or health maintenance organization is as an insured or person who has coverage through a plan provided by the corporation or organization. Provides that for purposes of this section, an individual required to register with the secretary of state under Chapter 305, Government Code, because of the individual's activities with respect to health insurance-related matters is a person affiliated with an insurer. Provides that a member of the board of directors is not

liable for an action or omission performed in good faith in the performance of powers and duties under this article, and cause of action does not arise against a member for the action or omission. Makes conforming changes.

SECTION 1.03. Amends Section 5, Article 3.77, Insurance Code, to require the plan of operation to include procedures for operation of the pool; selecting an administrator as provided under Section 7 of this article; creating a fund, under management of the board, for administrative expenses; handling, accounting, and auditing of money and other assets of the pool; developing and implementing a program to publicize, rather than to provide public information regarding, the existence of the pool, the eligibility requirements for coverage under the pool, enrollment procedures, and to foster public awareness of the plan; creation of a grievance committee to review complaints presented by applicants for coverage from the pool and insureds who receive coverage from the pool; and other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this article. Requires the commissioner, after notice and hearing, to approve the plan of operation if it is determined that the plan is suitable to assure the fair, reasonable, and equitable administration of the pool. Makes conforming changes.

SECTION 1.04. Amends Section 6, Article 3.77, Insurance Code, as follows:

Sec. 6. AUTHORITY OF THE POOL. (a) Deletes text prohibiting the pool from providing group insurance coverage.

(b) Authorizes the pool to provide health benefits coverage, rather than individual health benefits coverage, to persons who are eligible for that coverage under this article; to sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool; to institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool to recover any amounts erroneously or improperly paid by the pool, to recover any amounts paid by the pool as a mistake of fact or law, and to recover other amounts due the pool; to employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions; to contract for stop-loss insurance for risks incurred by the pool; to recover or collect assessments imposed under Section 13 of this article; to borrow money as necessary to implement the purposes of the pool; to issue additional types of health insurance policies to provide optional coverages which comply with applicable provisions of state and federal law, including Medicare supplemental health insurance; to provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review subject to Article 21.58A of this code, and individual case management for the purpose of making the benefit plans more cost effective; to design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations; and to provide for reinsurance on either a facultative or treaty basis or both.

(c) Requires the board to promulgate a list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance. Requires the list to be effective on the first day of operation of the pool and may be amended from time to time as may be appropriate.

(d) Requires the board, by June 1 of each year, to make an annual report to the governor, the lieutenant governor, the speaker of the house of representatives, and the commissioner. Requires the report to summarize the activities of the pool in the preceding calender year, including information regarding net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

SECTION 1.05. Amends Section 7, Article 3.77, Insurance Code, by amending the heading and by amending Subsections (a), (b), and (e), as follows:

Sec. 7. New heading: ADMINISTRATOR. Authorizes, rather than requires, the board,

after completing a competitive bidding process as provided by the plan of operation, to select one or more insurers or a third party administrator certified by the Department of Insurance (department), rather than the insurance board, to administer the pool. Requires the criteria established by the board for evaluating the bids submitted to include, among other items, the financial condition and stability of the insurer or third party administrator. Requires the administering insurer or third party administrator to perform such functions relating to the pool as may be assigned to it. Makes a conforming change.

SECTION 1.06. Amends Section 8, Article 3.77, Insurance Code, as follows:

Sec. 8. New heading: RULES. Authorizes the commissioner, by rule, to establish additional powers and duties of the board and to adopt other rules as are necessary and proper to implement this article. Requires the commissioner, by rule, to provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments made and collected under Section 13. Deletes text granting rulemaking authority to the board.

SECTION 1.07. Amends Sections 9(b), (d), and (e), Article 3.77, Insurance Code, to authorize, rather than require, the board to consider appropriate risk factors in accordance with established actuarial and underwriting practices in regard to rates and rate schedules. Requires the pool to determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. Requires the standard risk rate to be established using reasonable actuarial techniques, and to reflect anticipated experience and expenses for such coverage. Prohibits the initial pool from being less than 125 percent and from exceeding 150 percent of rates established as applicable for individual standard rates. Requires subsequent rates to be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this section. Deletes text in regard to establishing the standard risk rate. Deletes text granting rulemaking authority to the insurance board. Makes conforming changes.

SECTION 1.08. Amends Section 10, Article 3.77, Insurance Code, to require any individual person who is and continues to be a resident of Texas and a citizen of the United States to be eligible for coverage from the pool if evidence is provided of certain conditions. Deletes text in regard to entitlement to insurance coverage from the pool. Requires each dependent of a person who is eligible for coverage from the pool to also be eligible for coverage from the pool. Requires resident family members, in the instance of a child who is the primary insured, to be eligible for coverage. Authorizes a person to maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy. Provides that a person is not eligible for coverage from the pool if the person, among other conditions, is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation, except for coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person is satisfying any pre-existing condition waiting period under a pool policy; or employer group coverage conditioned by the limitations described by Subsections (a) (1) and (2) of this section; or individual coverage conditioned by the limitations described by Subsections (a) (1)-(3) of this section. Deletes text relating to eligibility for coverage from the pool. Provides that a person is not eligible for coverage from the pool if, among other options, the person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider; or the person has not had prior coverage with the pool terminated for nonpayment of premiums or fraud. Requires pool coverage to cease on a certain date under certain conditions. Deletes existing Subsection (d). Makes conforming changes.

SECTION 1.09. Amends Section 11, Article 3.77, Insurance Code, to require the pool to offer pool coverage consistent with major medical expense coverage to each eligible person who is not eligible for Medicare. Requires the board, with the approval of the commissioner, to establish the coverages to be provided by the pool; the applicable schedules of benefits; and any exclusions to coverage and other limitations. Deletes text relating to pool coverage of individuals eligible for such coverage under Section 10. Requires the benefits provisions of the pool's health benefits coverage to include all required or applicable definitions; a list of any exclusions or limitations to coverage; a description

of covered services required under the pool; and the deductibles, coinsurance options, and copayment options that are required or permitted under the pool. Deletes text setting forth expenses not include under Subsection (a). Deletes existing Subsections (c)-(e). Authorizes the board to adjust deductibles, the amounts of stop-loss coverage, and the time periods governing preexisting conditions under Section 12, rather than Subsection (f), of this article, rather than section, to preserve the financial integrity of the pool. Requires the board, if it makes such an adjustment, to report in writing that adjustment together with its reasons for the adjustment to the commissioner, rather than to the insurance board and the Legislative Budget Board. Deletes existing Subsections (f)-(g). Provides that the pool, rather than the insurer or the pool, has a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Makes conforming changes.

SECTION 1.10. Amends Sections 12 and 13, Article 3.77, Insurance Code, as follows:

Sec. 12. New heading: PREEXISTING CONDITIONS. Requires pool coverage to exclude charges or expenses incurred during the first 12 months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage. Prohibits a preexisting condition provision from applying to an individual who has continuously covered for an aggregate period of 12 months by health insurance that was in effect up to a date not more than 63 days before the effective date of coverage under the pool, excluding any waiting period, provided that the application for pool coverage is made no later than 63 days following the termination of coverage. Requires the pool, in determining whether a preexisting condition provision applies to an individual covered by the pool, to credit the time the individual was previously covered under health insurance if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the pool. Requires any waiting period that applied before the coverage became effective also to be credited against the preexisting condition provision period.

Sec. 13. New heading: ASSESSMENTS. (a) Authorizes the board to assess insurers and make advance interim assessments as reasonable and necessary for the plan's organizational and interim operating expenses. Requires any interim assessment to be credited as offsets against any regular assessments due following the close of the fiscal year. Deletes text relating to shortage of pool funds.

(b) Requires the excess, if assessments exceed the pool's actual losses and administrative expenses, to be held in an interest-bearing account and used by the board to offset future losses or to reduce future assessments. Provides that future losses includes reserves for incurred but not reported claims. Deletes text relating to an assessment imposed by the commissioner.

(c) Requires the board, after the end of each fiscal year, to determine and report to the commissioner the net loss, if any, of the pool for the previous calender year taking into account investment income and other appropriate gains and losses. Requires any net loss for the year to be recouped by assessments on insurers. Requires each insurer's assessment to be determined annually by the board based on annual statements and other reports required by the board and filed with the board. Deletes text relating to collection of assessments by the commissioner.

(d) Provides that the assessment imposed against each insurer to be in an amount that is equal to the ratio of the gross premiums collected by the insurer for health insurance in this state during the preceding calender year, except for Medicare supplement premiums subject to Article 3.74 and small group health insurance premiums subject to Articles 26.01 through 26.76, to the gross premiums collected by all insurers for health insurance, except for Medicare supplement premiums subject to Article 3.74 and small group health insurance premiums subject to Articles 26.01 through 26.76, in this state during the preceding calender year.

(e) Authorizes an insurer to petition the commissioner for an abatement or deferment of

all or part of an assessment imposed by the board. Authorizes the commissioner to abate or defer such assessment if the commissioner determines that the payment of the assessment would endanger the ability of the participating insurer to fulfill its contractual obligation. Requires the amount by which an assessment is abated or deferred, if an assessment against an insurer is abated or deferred in whole or in part, to be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection. Requires the insurer receiving such abatement or deferment to remain liable to the pool for the deficiency. Prohibits the total of all assessments on an insurer from exceeding one-half of one percent of the insurer's collected premiums for health insurance in this state. Provides that this subsection expires January 1, 2000. Deletes text granting certain rulemaking authority to the insurance board. Deletes existing Sections 12(f) and 13.

SECTION 1.11. Amends Article 3.77, Insurance Code, by adding Sections 14 and 15, as follows:

Sec. 14. COMPLAINT PROCEDURES. Provides that an applicant or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board. Requires the grievance committee to report to the board after completion of the review of each complaint. Requires the board to retain all written complaints regarding the pool at least until the third anniversary of the date the pool received the complaint.

Sec. 15. AUDIT. Requires the state auditor to conduct annually a special audit of the pool under Chapter 321, Government Code. Requires the state auditor's report to include a financial audit and an economy and efficiency audit. Requires the state auditor to report the cost of each audit conducted under this article to the board and the comptroller, and the board shall remit that amount to the comptroller for deposit to the general revenue fund.

SECTION 2.01. Amends Section 1(d)(3), Article 3.51-6, Insurance Code, as follows:

(3) Requires any insurer or group hospital service corporation subject to Chapter 20, Insurance Code, who issues policies which provide hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense incurred basis, but not a policy which provides benefits for specified disease or for accident only, to provide a group, rather than a conversion or group, continuation privilege as required by this subsection. Makes conforming changes.

(A) Requires policies subject to this section to provide continuation of group coverage for employees or members and their eligible dependents subject to the eligibility provisions. Deletes existing Subdivisions (A)(i)-(ii) and (B)(i). Requires continuation of group coverage to be requested in writing within 31 days following the later of the date the group coverage would otherwise terminate; or the date the employee, member, or dependent is given notice in a format prescribed by the commissioner of the right of continuation by either the employer or the group policyholder. Deletes existing Subdivision (B)(iii). Prohibits continuation from terminating until the earliest of, among other dates, the date on which failure to make timely payments would terminate coverage; the date on which the covered person is or could be covered under Medicare; the date on which the covered person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical services subscriber contract or medical practice or other prepayment plan or any other plan or program; the date the covered person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group; or similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law. Requires the insurer by a certain date to notify the employee, member, or dependent that he/she may be eligible for coverage under the pool, as provided under Article 3.77 of this code and the insurer shall provide the address for applying to such pool to the employee, member, or dependent. Makes conforming changes.

(B) Authorizes the insurer to offer to each employee, member or dependent a conversion policy. Requires such converted policy to be issued without evidence of insurability if written application for and payment of the first premium is made no later than the 31st after the date of termination. Requires the converted policy to meet the minimum standards for benefits for conversion policies. Prohibits conversion coverage for any insured from termination until the earliest of certain dates. Requires the commissioner to issue rules and regulations to establish minimum standards for benefits under policies issued pursuant to this subsection. Makes conforming changes.

SECTION 3.01. Amends Section 1(H), Article 3.70-1, V.T.C.S., by adding Subdivision (4), to prohibit a preexisting condition provision in an individual health insurance policy from applying to an individual who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date no more than 63 days before the effective date of the individual coverage. Defines "creditable coverage" for purposes of this section. Requires the individual insurance carrier, in determining whether a preexisting condition provision applies to an individual, to credit the time the individual was previously covered under creditable coverage if the previous coverage was in effect at any time during the 18 months preceding the effective date of the individual coverage.

SECTION 3.02. Amends Chapter 3G, Insurance Code, by adding Article 3.70-1A, as follows:

Art. 3.70-1A. GUARANTEED RENEWABILITY OF CERTAIN INDIVIDUAL HEALTH INSURANCE POLICIES. Requires an individual health insurance policy providing benefits for medical care under a hospital, medical, or surgical policy to be renewed or continued in force at the option of the individual. Authorizes an individual health insurance policy providing benefits for medical care under a hospital, medical, or surgical policy to be nonrenewed or discontinued based on certain reasons. Requires the commissioner to adopt rules necessary to implement this article and to meet the minimum requirements of federal law and regulations.

SECTION 4.01. Amends Article 20A.09, Insurance Code (Texas Health Maintenance Organization Act), by adding Subsections (k) and (l), as follows.

(k) Continuation of Coverage and Conversion. Requires a health maintenance organization (HMO) to provide a group continuation privilege as required by this subsection. Requires a certain enrollee to be entitled to such privilege as outlined in this section. Provides that involuntary termination for cause does not include termination for any health-related cause. Requires HMO contracts subject to this section to provide continuation of group coverage for enrollees subject to certain eligibility provisions. Authorizes an HMO to offer to each enrollee a conversion contract. Requires such conversion contract to be issued without evidence of insurability if written application for and payment of the first premium is made no later than the 31st day after the date of termination. Requires the conversion contract to meet the minimum standards for services and benefits for conversion contracts. Requires the commissioner to issue rules and regulations to establish minimum standards for services and benefits under contracts issued pursuant to this subsection. Requires the premium for a conversion contract issued under this Act to be determined in accordance with the HMO's premium rates for coverage that were provided under the group contract or plan. Authorizes the premium to be based on geographic location of each person to be covered and the type of conversion contract and coverage provided. Prohibits the premium for the same coverage under a conversion contract from exceeding 200 percent of the premium determined in accordance with this paragraph. Requires the premium to be based on the type of conversion contract and the coverage provided by contract.

(l) Individual Health Care Plan. Authorizes an HMO to provide an individual health care plan as required by this subsection. Defines "individual health care plan" for purposes of this subsection. Authorizes an HMO to limit its enrollees to those who live, reside, or work within the service area for such network plan. Requires an individual health care plan or a conversion contract providing health care services to be renewable with respect to an enrollee at the option of the enrollee, and may be nonrenewed based on certain reasons. Authorizes

the commissioner to adopt rules necessary to implement this article and to meet the minimum requirements of federal law and regulations.

SECTION 5.01. Makes application of this Act prospective to July 1, 1997.

SECTION 5.02. Requires coverage available under the Texas Health Insurance Risk Pool as provided in Part 1 of this Act to be made available no later than January 1, 1998. Makes application of Section 1(d)(3), Article 3.51-6, Insurance Code, as amended by this Act, prospective to January 1, 1998.

SECTION 5.03. Effective date: July 1, 1997.

SECTION 5.04. Emergency clause.

SUMMARY OF COMMITTEE CHANGES

Amendment 2.

Page 4, lines 8-9, strike Subsection (17), setting forth the proposed definition of "resident" as an individual who is legally domiciled in Texas, and replace with a new proposed Subsection (17), setting forth the proposed definition of "resident" as an individual who has been legally domiciled in Texas for a minimum of 30 days for persons eligible for enrollment in the Texas Health Insurance Risk Pool (Pool) under Section 10(a)(1), (2), (3), or (5) of this article; or an individual who is legally domiciled in Texas for persons eligible for enrollment in the Pool under Section 10(a)(4) of this article.

Amendment 3.

Page 15, line 26, inserts "of which the most recent coverage was through an employer sponsored plan" between "days" and ";".

Amendment 5.

Page 16, lines 25-27, strikes "except for coverage conditioned by the limitations described by Subsections (a) (1)-(3) of this section" and replaces with "including COBRA continuation, except: (A) Coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person is satisfying any pre-existing condition waiting period under a pool policy; or (B) Employer group coverage conditioned by the limitations described by Subsections (a)(1) and (2) of this Section; or (C) Individual coverage conditioned by the limitations described by Subsections (a)(1)-(3) of this Section."

Amendment 6.

Page 17, line 3, strikes "or."

Page 17, line 9, strikes "." and substitutes ";".

Page 17, between lines 7 and 8, insert proposed Sections (10)(d)(5) and (6), providing that a person is not eligible for coverage from the pool if the person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider; or the person has not had prior coverage with the pool terminated for nonpayment of premiums or fraud.

Amendment 7.

Page 26, line 11, inserts after the period the following: "The total of all assessments on an insurer may not exceed one-half of one percent of the insurer's collected premiums for health insurance in this state. This subsection expires January 1, 2000."