# BILL ANALYSIS

Senate Research Center
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C.S.S.B. 1257
By: Averitt
State Affairs
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Committee Report (Substituted)

## AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

C.S.S.B. 1257 addresses a lack of transparency from health benefit plans, as well as certain market conduct in which health benefit plans engage that tends to adversely affect providers/patients.

C.S.S.B. 1257 amends current law relating to the regulation of certain market conduct activities of certain life, accident, and health insurers and health benefit plan issuers; providing civil liability and administrative and criminal penalties.

## RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1.002 (Section 1202.110, Insurance Code), SECTION 2.001 (Section 1301.010, Insurance Code), SECTION 3.004 (Section 1501.652, Insurance Code), and SECTION 4.001 (Section 1460.005, Insurance Code), of this bill.

Rulemaking authority previously granted to the commissioner of insurance is modified in SECTION 1.003 (Section 4202.002, Insurance Code) of this bill.

## SECTION BY SECTION ANALYSIS

ARTICLE 1. CANCELLATION OF HEALTH BENEFIT PLAN

SECTION 1.001. Amends Subchapter B, Chapter 541, Insurance Code, by adding Section 541.062, as follows:

Sec. 541.062. BAD FAITH RESCISSION. (a) Defines "rescission."

(b) Provides that it is an unfair method of competition or an unfair or deceptive act or practice for a health benefit plan issuer to set rescission goals, quotas, or targets; pay compensation of any kind, including a bonus or award, that varies according to the number of rescissions; set, as a condition of employment, a number or volume of rescissions to be achieved; or set a performance standard, for employees or by contract with another entity, based on the number or volume of rescissions.

SECTION 1.002. Amends Chapter 1202, Insurance Code, by adding Subchapter C, as follows:

SUBCHAPTER C. INDEPENDENT REVIEW OF CERTAIN RESCISSION DECISIONS

Sec. 1202.101. DEFINITIONS. Defines "affected individual," "independent review organization," "rescission," and "screening criteria."

Sec. 1202.102. APPLICABILITY. (a) Provides that this subchapter applies only to a health benefit plan, including a small or large employer health benefit plan written under Chapter 1501 (Health Insurance Portability and Availability Act), that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group

evidence of coverage or similar coverage document that is offered by certain insurance organizations.

(b) Sets forth certain plans or policies to which this subchapter does not apply.

Sec. 1202.103. RESCISSION FOR MISREPRESENTATION OR PREEXISTING CONDITION. Prohibits a health benefit plan, notwithstanding any other law, from rescinding a health benefit plan on the basis of a misrepresentation or a preexisting condition, except as provided by this subchapter.

Sec. 1202.104. NOTICE OF INTENT TO RESCIND. (a) Prohibits a health benefit plan issuer from rescinding a health benefit plan on the basis of a misrepresentation or a preexisting condition without first notifying an affected individual in writing of the issuer's intent to rescind the health benefit plan and the individual's entitlement to an independent review.

(b) Requires that the notice required under Subsection (a) include certain information regarding the rescission of a health benefit plan.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) Authorizes an affected individual to appeal a health benefit plan issuer's rescission decision to an independent review organization not later than the 45th day after the date the individual receives notice under Section 1202.104.

(b) Requires a health benefit plan issuer to comply with all requests for information made by the independent review organization and with the independent review organization's determination regarding the appropriateness of the issuer's decision to rescind.

(c) Requires a health benefit plan issuer to pay all otherwise valid medical claims under an individual's plan until the later of the date on which an independent review organization determines that the decision to rescind is appropriate; or the time to appeal to an independent review organization has expired without an affected individual initiating an appeal.

Sec. 1202.106. RESCISSION AUTHORIZED; RECOVERY OF CLAIMS PAID. (a) Authorizes a health benefit plan issuer to rescind a health benefit plan covering an affected individual on the later of the date an independent review organization determines that rescission is appropriate; or the 45th day after the date an affected individual receives notice under Section 1202.104, if the individual has not initiated an appeal.

(b) Authorizes an issuer that rescinds a health benefit plan under this section to seek to recover from an affected individual amounts paid for the individual's medical claims under the rescinded health benefit plan.

(c) Prohibits an issuer that rescinds a health benefit plan under this section from offsetting against or recouping or recovering from a physician or health care provider amounts paid for medical claims under a rescinded health benefit plan. Prohibits this subsection to be waived, voided, or modified by contract.

Sec. 1202.107. RESCISSION RELATED TO PREEXISTING CONDITION; STANDARDS. (a) Provides that for purposes of this subchapter, a rescission for a preexisting condition is appropriate if, within the 18-month period immediately preceding the date on which an application for coverage under a health benefit plan is made, an affected individual received or was advised by a physician or health care provider to seek medical advice, diagnosis, care, or treatment for a physical or mental condition, regardless of the cause, and the individual's failure to disclose the condition affects the risks assumed under the health benefit plan, and is undertaken with the intent to deceive the health benefit plan issuer.

(b) Prohibits a health benefit plan issuer from rescinding a health benefit plan based on a preexisting condition of a newborn delivered after the application for coverage is made or as otherwise authorized to be prohibited by law.

Sec. 1202.108. RESCISSION FOR MISREPRESENTATION; STANDARDS. Provides that for purposes of this subchapter, a rescission for a misrepresentation not related to a preexisting condition is inappropriate unless the misrepresentation is of a material fact; affects the risks assumed under the health benefit plan; and is made with the intent to deceive the health benefit plan issuer.

Sec. 1202.109. REMEDIES NOT EXCLUSIVE. Provides that the remedies provided by this subchapter are not exclusive and are in addition to any other remedy or procedure provided by law or at common law.

Sec. 1202.110. RULES. Requires the commissioner of insurance (commissioner) to adopt rules necessary to implement and administer this subchapter.

Sec. 1202.111. SANCTIONS AND PENALTIES. Provides that a health benefit plan issuer that violates this subchapter commits an unfair practice in violation of Chapter 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices) and is subject to sanctions and penalties under Chapter 82 (Sanctions).

Sec. 1202.112. CONFIDENTIALITY. (a) Provides that a record, report, or other information received or maintained by a health benefit plan issuer, including any material received or developed during a review of a rescission decision under this subchapter, is confidential.

(b) Prohibits a health benefit plan issuer from disclosing the identity of an individual or a decision to rescind an individual's health benefit plan unless an independent review organization determines the decision to rescind is appropriate, or the time to appeal has expired without an affected individual initiating an appeal.

SECTION 1.003. Amends Section 4202.002, Insurance Code, as follows:

Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS. (a) Requires the commissioner to adopt standards and rules for the certification, selection, and operation of independent review organizations to perform independent review described by Subchapter C, Chapter 1202 (Cancellation and Continuation of Policies in General), or Subchapter I (Independent Review of Adverse Determination), Chapter 4201 (Utilization Review Agents); and the suspension and revocation of the certification.

(b) Requires that the standards adopted under this section ensure that certain criteria are met, including that review of a rescission decision based on a preexisting condition be conducted under the direction of a physician. Makes nonsubstantive changes.

SECTION 1.004. Amends Sections 4202.003, 4202.004, and 4202.006, Insurance Code, as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. Requires that the standards adopted under Section 4202.002 (Adoption of Standards For Independent Review Organizations) require each independent review organization to make the organization's determination for certain health conditions, including for a condition other than a life-threatening condition or of the appropriateness of a rescission under Subchapter C, Chapter 1202, not later than the earlier of the 15th day after the date the organization receives the information necessary to make the determination, or the 20th day after the date the organization receives the request that the determination be made.

Sec. 4202.004. CERTIFICATION. Requires an organization, to be certified as an independent review organization under this chapter, to submit to the commissioner an application in the form required by the commissioner. Requires that the application include certain information, including the procedures to be used by the applicant in making independent review determinations under Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201.

Sec. 4202.006. PAYORS FEES. (a) Creates this subsection from existing text. Makes no further changes to this subsection.

(b) Requires a health benefit plan issuer to pay for an independent review of a rescission decision under Subchapter C, Chapter 1202.

SECTION 1.005. Amends Section 4202.009, Insurance Code, as follows:

Sec. 4202.009. CONFIDENTIAL INFORMATION. (a) Creates this subsection from existing text. Makes no further changes to this subsection.

(b) Provides that a record, report, or other information received or maintained by an independent review organization, including any material received or developed during a review of a rescission decision under Subchapter C, Chapter 1202, is confidential.

(c) Prohibits an independent review organization from disclosing the identity of an affected individual or an issuer's decision to rescind a health benefit plan under Subchapter C, Chapter 1202, unless an independent review organization determines the decision to rescind is appropriate, or the time to appeal a rescission under that subchapter has expired without an affected individual initiating an appeal.

SECTION 1.006. Amends Section 4202.010(a), Insurance Code, to make a conforming change.

SECTION 1.007. Makes application of this article prospective to the effective date of this Act.

ARTICLE 2. MEDICAL LOSS RATIOS

SECTION 2.001. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Section 1301.010 as follows:

Sec. 1301.010. MEDICAL LOSS RATIO. (a) Defines "medical loss ratio."

(b) Requires an insurer to report the insurer's medical loss ratio annually or more often as required by the commissioner by rule or order.

(c) Provides that a medical loss ratio reported under this section is public information.

(d) Requires the Texas Department of Insurance (TDI) to include information on the medical loss ratio on TDI's Internet website.

(e) Requires an insurer to report to the master policyholder or sponsor the total dollar amount for health care claims paid under the preferred provider benefit plan for the nine months following the policy effective date or renewal date and the total dollar amount of premiums paid by the master policyholder or the sponsor and insureds.

(f) Requires the commissioner to adopt rules as necessary to implement this section, including rules regarding a specific, uniform definition of "medical loss ratio" for reporting and disclosure purposes; the frequency and form of reporting medical loss ratios; standardizing and regulating the frequency and form of reporting cost-containment expenses separate from the medical loss ratio; and any

disclaimers or explanations that an insurer may include in the report required by Subsection (e).

SECTION 2.002. (a) Requires the commissioner, not later than January 1, 2010, to adopt all rules necessary to implement Section 1301.010, Insurance Code, as added by this article. Prohibits the first reporting period under Section 1301.010(b) from covering any period that begins before January 1, 2010.

(b) Makes application of Section 1301.010(e), Insurance Code, as added by this article, prospective to January 1, 2010.

## ARTICLE 3. PREMIUM RATE INCREASES FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

SECTION 3.001. Amends Subchapter D, Chapter 501, Insurance Code, by amending Sections 501.151 and 501.153, and adding Section 501.160 as follows:

Sec. 501.151. POWERS AND DUTIES OF OFFICE. (a) Provides that the Office of Public Insurance Counsel (OPIC) is authorized to assess the impact of insurance rates, rules, and forms on insurance consumers in this state; is required to advocate in OPIC's own name positions determined by the public counsel to be most advantageous to a substantial number of insurance consumers; and is required to accept from a small employer, an eligible employee, or an eligible employee's dependent and, if appropriate, refer to the commissioner, a complaint described by Section 501.160. Makes nonsubstantive changes.

(b) Provides that the decision to refer a complaint to the commissioner under Subsection (a) is at the public counsel's sole discretion.

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. Authorizes the public counsel to appear or intervene, as a party or otherwise, as a matter of right before the commissioner or TDI on behalf of insurance consumers, as a class, in certain insurance matters, including appearing before the commissioner on behalf of a small employer, eligible employee, or eligible employee's dependent in a complaint OPIC refers to the commissioner under Section 501.160. Makes nonsubstantive changes.

Sec. 501.160. COMPLAINT RESOLUTION FOR CERTAIN PREMIUM RATE INCREASES. (a) Authorizes a small employer, an eligible employee, or an eligible employee's dependent to file a complaint with OPIC alleging that a rate is excessive for the risks to which the rate applies, if the percentage increase in the premium rate charged to a small employer under Subchapter E (Underwriting and Rating of Small Employer Health Benefit Plans), Chapter 1501 (Health Insurance Portability and Availability Act), for a new rating period exceeds 15 percent.

(b) Requires OPIC to refer a complaint received under Subsection (a) to the commissioner if OPIC determines that the complaint substantially attests to a rate charged that is excessive for the risks to which the rate applies.

(c) Authorizes OPIC, with respect to a complaint filed under Subsection (a), to issue a subpoena applicable throughout the state that requires the production of records.

(d) Authorizes a district court, on application of OPIC in the case of disobedience of a subpoena, to issue an order requiring any individual or person, including a small employer health benefit plan issuer described by Section 1501.002 (Definitions), that is subpoenaed to obey the subpoena and produce records, if the individual or person has refused to do so. Requires that an application under this subsection be made in a district court in Travis County.

SECTION 3.002. Amends Section 1501.205, Insurance Code, by adding Subsection (d), to require a small employer health benefit plan issuer, on the request of a small employer, to

disclose the percentage change in the risk load assessed to a smaller employer group to the group, along with the percentage change attributable exclusively to any change in case characteristics.

SECTION 3.003. Amends Subchapter E, Chapter 1501, Insurance Code, by adding Section 1501.2131 and amending Section 1501.214, as follows:

Sec. 1501.2131. COMPLAINT FACILITATION FOR PREMIUM RATE ADJUSTMENTS. Authorizes the small employer, an eligible employee, or an eligible employee's dependent to file a complaint with OPIC as provided by Section 501.160 if the percentage increase in the premium rate charged to a small employer for a new rating period exceeds 15 percent.

Sec. 1501.214. ENFORCEMENT. (a) Creates an exception under Subsection (b).

(b) Requires the commissioner to enter an order under this section if the commissioner makes the finding described by Section 1501.653.

SECTION 3.004. Amends Chapter 1501, Insurance Code, by adding Subchapter N, as follows:

SUBCHAPTER N. RESOLUTION OF CERTAIN COMPLAINTS AGAINST SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUERS

Sec. 1501.651. DEFINITIONS. Defines "honesty-in-premium account" and "office."

Sec. 1501.652. COMPLAINT RESOLUTION PROCEDURE. (a) Requires the commissioner, on the receipt of a referral of a complaint from OPIC under Section 501.160, to request written memoranda from OPIC and the small employer health benefit plan issuer that is the subject of the complaint.

(b) Authorizes the commissioner, after receiving the initial memoranda described by Subsection (a), to request one rebuttal memorandum from OPIC.

(c) Authorizes the commissioner by rule to limit the number of exhibits submitted with or the time frame allowed for the submittal of the memoranda described by Subsection (a) or (b).

Sec. 1501.653. ORDER; FINDINGS. Requires the commissioner to issue an order under Section 1501.214(b) if the commissioner determines that the rate complained of is excessive for the risks to which the rate applies.

Sec. 1501.654. COSTS. Authorizes OPIC to request, and the commissioner to award to OPIC, reasonable costs and fees associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

Sec. 1501.655. ASSESSMENT. (a) Authorizes the commissioner to make an assessment against each small employer health benefit plan issuer in an amount that is sufficient to cover the costs of investigating and resolving a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) Requires the commissioner to deposit assessments collected under this section to the credit of the honesty-in-premium account.

Sec. 1501.656. HONESTY-IN-PREMIUM ACCOUNT. (a) Sets forth that the honesty-in-premium account is an account in the general revenue fund that is authorized to be appropriated only to cover the cost associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) Requires that interest earned on the honesty-in-premium account be credited to the account. Provides that the account is exempt from the application of Section 403.095 (Use of Dedicated Revenue), Government Code.

Sec. 1501.657. RATE CHANGE NOT PROHIBITED. Provides that nothing in this subchapter prohibits a small employer health benefit plan issuer from, at any time, offering a different rate to the group whose rate is the subject of a complaint.

SECTION 3.005. Makes application of Chapter 1501, as amended by this article, prospective to January 1, 2010.

ARTICLE 4. PHYSICIAN RANKING BY HEALTH BENEFIT PLAN ISSUERS

SECTION 4.001. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1460, as follows:

CHAPTER 1460. STANDARDS REQUIRED REGARDING CERTAIN PHYSICIAN RANKINGS BY HEALTH BENEFIT PLANS

Sec. 1460.001. DEFINITIONS. Defines "health benefit plan issuer" and "physician."

Sec. 1460.002. EXEMPTION. Sets forth certain health care programs and benefit plans to which this chapter does not apply.

Sec. 1460.003. PHYSICIAN RANKING REQUIREMENTS. (a) Prohibits a health benefit plan issuer, including a subsidiary or affiliate, from ranking physicians, classifying physicians into tiers based on performance, or publishing physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians, unless the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under Section 1460.005; the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation period used by the health benefit plan issuer; and each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that includes due process protections that conform to protections described by 42 U.S.C. Section 11112.

(b) Provides that this section does not apply to the publication of a list of network physicians and providers if ratings or comparisons are not made.

Sec. 1460.004. DUTIES OF PHYSICIANS. Prohibits a physician from requiring or requesting that a patient of the physician enter into an agreement under which the patient agrees not to rank or otherwise evaluate the physician, participate in surveys regarding the physician, or in any way comment on the patient's opinion of the physician.

Sec. 1460.005. RULES; STANDARDS. (a) Requires the commissioner to adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement this chapter.

(b) Requires the commissioner to adopt rules as necessary to ensure that a health benefit plan issuer that uses a physician ranking system complies with the standards and guidelines described by Subsection (c).

(c) Requires the commissioner, in adopting rules under this section, to consider the standards and guidelines prescribed by nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care, including the National Quality Forum and the AQA Alliance. Requires the commissioner, if neither the National Quality Forum nor the AQA Alliance has established standards or guidelines regarding an issue, to consider the standards and guidelines prescribed by the National Committee on Quality Assurance and other similar national organizations.

Sec. 1460.006. DUTIES OF HEALTH BENEFIT PLAN ISSUER. Requires a health benefit plan issuer to ensure that physicians being measured are actively involved in the development of standards used under this chapter; and the measures and methodology used in the comparison programs described by Section 1460.003 are transparent and valid.

Sec. 1460.007. SANCTIONS; DISCIPLINARY ACTIONS. (a) Provides that a health benefit plan issuer that violates this chapter or a rule adopted under this chapter is subject to sanctions and disciplinary actions under Chapters 82 (Sanctions) and 84 (Administrative Penalties).

(b) Provides that a violation of this chapter by a physician constitutes grounds for disciplinary action by the Texas Medical Board, including imposition of an administrative penalty.

SECTION. 4.002. (a) Requires a health benefit plan issuer to comply with Chapter 1460, Insurance Code, as added by this article, not later than December 31, 2009.

(b) Provides that a health benefit plan issuer is not subject to sanctions or disciplinary actions under Section 1460.007, Insurance Code, as added by this article, before January 1, 2010.

ARTICLE 5. EFFECTIVE DATE

SECTION 5.001. Effective date: upon passage or September 1, 2009.