By: Wu H.B. No. 493

A BILL TO BE ENTITLED

AN ACT

relating to HIV and AIDS tests and to health benefit plan coverage of HIV and AIDS tests.

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

SECTION 1. The heading to Subchapter D, Chapter 85, Health and Safety Code, is amended to read as follows:

SUBCHAPTER D. HIV TESTING, TESTING PROGRAMS, AND COUNSELING

SECTION 2. Subchapter D, Chapter 85, Health and Safety Code, is amended by adding Section 85.0815 to read as follows:

Sec. 85.0815. OPT-OUT HIV TESTING IN CERTAIN ROUTINE MEDICAL SCREENINGS. (a) A health care provider who takes a sample of a person's blood as part of a medical screening may submit the sample for an HIV diagnostic test, regardless of whether an HIV test is part of a primary diagnosis, unless the person opts out of the HIV test.

(b) Before taking a sample of a person's blood as part of a medical screening, a health care provider must obtain the person's written consent for an HIV diagnostic test or verbally inform the person that an HIV diagnostic test will be performed unless the person opts out of the HIV test.

(c) A health care provider who submits a person's blood for an HIV diagnostic test shall provide to each person who receives a positive result of the test information on available HIV health services and referrals to community support programs.

(d) The executive commissioner shall adopt rules to implement this section. In adopting rules, the executive commissioner must consider the most recent recommendations of the Centers for Disease Control and Prevention for HIV testing of adults and adolescents.

SECTION 3. Section 32.024, Human Resources Code, is amended by adding Subsection (ee) to read as follows:

(ee) The executive commissioner shall adopt rules to require the commission to provide an HIV test in accordance with Section 85.0815, Health and Safety Code, to a person who receives medical assistance.

SECTION 4. Chapter 1364, Insurance Code, is amended by adding Subchapter D to read as follows:

SUBCHAPTER D. COVERAGE OF CERTAIN TESTING REQUIRED

Sec. 1364.151. DEFINITIONS. In this subchapter, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

Sec. 1364.152. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan, including a large or small employer health benefit plan written under Chapter 1501, 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:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a Lloyd's plan operating under Chapter 941;

(7) a health maintenance organization operating under Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

Sec. 1364.153. EXCEPTION. This subchapter does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter requires the plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by this subchapter.

Sec. 1364.154. COVERAGE OF CERTAIN TESTING REQUIRED. A health benefit plan issuer may not exclude or deny coverage for the performance of medical tests or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS, regardless of whether the test or medical procedure is related to the primary diagnosis of the health condition, accident, or sickness for which the enrollee seeks medical or surgical treatment.

Sec. 1364.155. RULES. The commissioner may adopt rules necessary to implement this subchapter.

SECTION 5. The heading to Section 1507.004, Insurance Code, is amended to read as follows:

Sec. 1507.004. STANDARD HEALTH BENEFIT PLANS AUTHORIZED; MINIMUM REQUIREMENTS [~~REQUIREMENT~~].

SECTION 6. Section 1507.004, Insurance Code, is amended by adding Subsections (c) and (d) to read as follows:

(c) Any standard health benefit plan must include coverage for tests or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS as required by Subchapter D, Chapter 1364.

(d) Subsection (c) does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) Subsection (c) requires the plan to offer benefits in addition to the essential health benefits required under 42

U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by Subsection (c).

SECTION 7. Section 1507.054, Insurance Code, is amended to read as follows:

Sec. 1507.054. STANDARD HEALTH BENEFIT PLANS AUTHORIZED; MINIMUM REQUIREMENTS. (a) A health maintenance organization authorized to issue an evidence of coverage in this state may offer one or more standard health benefit plans.

(b) Any standard health benefit plan must include coverage for tests or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS as required by Subchapter D, Chapter 1364.

(c) Subsection (b) does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) Subsection (b) requires the plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by Subsection (b).

SECTION 8. If before implementing the change in law made by Section 32.024(ee), Human Resources Code, as added by this Act, a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that change in law, the agency affected by the change in law shall request the waiver or authorization and may delay implementing that change in

law until the waiver or authorization is granted.

SECTION 9. Subchapter D, Chapter 1364, Insurance Code, as added by this Act, and Sections 1507.004 and 1507.054, Insurance Code, as amended by this Act, apply only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2022. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2022, is covered by the law in effect at the time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

SECTION 10. (a) The executive commissioner of the Health and Human Services Commission shall adopt the rules required by Section 85.0815, Health and Safety Code, as added by this Act, and Section 32.024(ee), Human Resources Code, as added by this Act, not later than January 1, 2022.

(b) Notwithstanding Section 85.0815, Health and Safety Code, as added by this Act, a health care provider is not required to comply with that section until January 1, 2022.

SECTION 11. This Act takes effect September 1, 2021.