By: Williams S.B. No. 541

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COMMITTEE SUBSTITUTE FOR S.B. No. 541 By: Duncan

A BILL TO BE ENTITLED
AN ACT

relating to authorizing insurers and health maintenance organizations to issue plans that do not include state-mandated health benefits.

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

SECTION 1. Subchapter G, Chapter 3, Insurance Code, is amended by adding Article 3.80 to read as follows:

Art. 3.80. TEXAS CONSUMER CHOICE OF BENEFITS HEALTH INSURANCE PLAN ACT

Sec. 1. PURPOSE. The legislature recognizes the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. The legislature, therefore, seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in this state to issue accident and sickness policies that, in whole or in part, do not offer or provide state-mandated health benefits.

Sec. 2. DEFINITIONS. In this article:

(1) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 842 of this code, and a stipulated premium company under Chapter 884 of this code.

(2) "Standard health benefit plan" means an accident or sickness insurance policy that, in whole or in part, does not offer or provide state-mandated health benefits, but that provides creditable coverage as defined by Article 26.035(a) of this code or Section 1(H)(4)(b), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

Sec. 3. STATE-MANDATED HEALTH BENEFITS. (a) For purposes of this article, "state-mandated health benefits" means coverage required under this code or other laws of this state to be provided in an individual, blanket, or group policy for accident and health insurance or a contract for a health-related condition that:

(1) includes coverage for specific health care services or benefits;

(2) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

(3) includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

(b) For purposes of this article, "state-mandated health benefits" does not include benefits that are mandated by federal law or standard provisions or rights required under this code or other laws of this state to be provided in an individual, blanket, or group policy for accident and health insurance that are unrelated to specific health illnesses, injuries, or conditions of an insured, including provisions related to:

(1) continuation of coverage under:

(A) Section 1(d)(3) and Section 3B, Article 3.51-6 of this code;

(B) Section 2(C), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code);

(C) Article 3.51-8 of this code; and

(D) Section 3C, Article 3.51-6 of this code, as added by Section 10, Chapter 1041, Acts of the 71st Legislature, Regular Session, 1989;

(2) termination of coverage under Articles 3.70-1A, 26.23, and 26.86 of this code;

(3) preexisting conditions under Section 1(H), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code), and Articles 26.49 and 26.90 of this code;

(4) coverage of children, including newborn or adopted children, under:

(A) Sections 1, 3D, and 3E, Article 3.51-6 of this code;

(B) Sections 2(A), (E), (K), and (M), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code);

(C) Subchapter J, Chapter 3 of this code;

(D) Article 21.24-2 of this code;

(E) Article 26.21(n) of this code;

(F) Article 26.21A of this code; and

(G) Article 26.84 of this code;

(5) supplies and services associated with the treatment of diabetes under Article 21.53G of this code; and

(6) coverage for serious mental illness under Article 3.51-14 of this code if the standard health benefit plan is issued to a large employer as defined by Article 26.02 of this code.

Sec. 4. STANDARD HEALTH BENEFIT PLANS AUTHORIZED. A health carrier may offer one or more standard health benefit plans.

Sec. 5. NOTICE TO POLICYHOLDER. (a) Each written application for participation in a standard health benefit plan must contain the following language at the beginning of the document in bold type:

"You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy."

(b) Each standard health benefit plan must contain the following language at the beginning of the document in bold type:

"This Consumer Choice of Benefits Health Insurance Plan, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy."

Sec. 6. DISCLOSURE STATEMENT. (a) An insurer providing a standard health benefit plan must provide a proposed policyholder or policyholder with a written disclosure statement that:

(1) acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits;

(2) lists those state-mandated health benefits not included under the standard health benefit plan; and

(3) if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan.

(b) Each applicant for initial coverage and each policyholder on renewal of coverage must sign the disclosure statement provided by the insurer under Subsection (a) of this section and return the statement to the insurer. Under a group policy or contract, the term "applicant" means the employer.

(c) An insurer must:

(1) retain the signed disclosure statement in the insurer's records; and

(2) on request from the commissioner, provide the signed disclosure statement to the department.

Sec. 7. RULES. The commissioner shall adopt rules as necessary to implement this article.

Sec. 8. ADDITIONAL POLICIES. An insurer that offers one or more standard health benefit plans under this article must also offer at least one accident or sickness insurance policy with state-mandated health benefits that is otherwise authorized by this code.

Sec. 9. RATES. A health carrier shall file for informational purposes the rates to be used with a standard health benefit plan. Nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any individual accident and sickness insurance policy or policies.

SECTION 2. The Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) is amended by adding Section 9N to read as follows:

Sec. 9N. CHOICE OF BENEFITS PLAN. (a) The legislature recognizes the need for individuals and employers in this state to have the opportunity to choose health maintenance organization plans that are more affordable and flexible than existing market health care plans offered by health maintenance organizations. The legislature, therefore, seeks to increase the availability of health care plans by allowing health maintenance organizations authorized to operate health maintenance organizations in this state to issue group or individual evidences of coverage that, in whole or in part, do not offer or provide mandated health benefits.

(b) In this section, "standard health benefit plan" means a group or individual evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits, but that provides creditable coverage as defined by Article 26.035(a) of this code or Section 1(H)(4)(b), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

(c) For purposes of this section, "state-mandated health benefits" means coverage required under the Insurance Code or other laws of this state to be provided in an evidence of coverage that:

(1) includes coverage for specific health care services or benefits;

(2) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

(3) includes a specific category of licensed health care practitioner from whom an enrollee is entitled to receive care.

(d) For purposes of this section, "state-mandated health benefits" does not include coverage that is mandated by federal law or standard provisions or rights required under the Insurance Code or other law of this state to be provided in an evidence of coverage that are unrelated to specific health illnesses, injuries, or conditions of an insured, including provisions related to:

(1) continuation of coverage under Section 3B, Article 3.51-6, Insurance Code;

(2) termination of coverage under Articles 3.70-1A, 26.23, and 26.86, Insurance Code;

(3) preexisting conditions under Section 1(H), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code), and Articles 26.49 and 26.90, Insurance Code;

(4) coverage of children, including newborn or adopted children, under:

(A) Subchapter J, Chapter 3, Insurance Code;

(B) Article 21.24-2, Insurance Code;

(C) Article 26.21(n), Insurance Code;

(D) Article 26.21A, Insurance Code; and

(E) Article 26.84, Insurance Code; and

(5) coverage for serious mental health illness under Article 3.51-14, Insurance Code, if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code.

(e) A health maintenance organization authorized to issue an evidence of coverage in this state may offer one or more standard health benefit plans.

(f)(1) Each written application for enrollment in a standard health benefit plan must contain the following language at the beginning of the document in bold type:

"You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage."

(2) Each standard health benefit plan must contain the following language at the beginning of the document in bold type:

"This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage."

(g) A health maintenance organization providing a standard health benefit plan must provide a proposed contract holder or a contract holder with a written disclosure statement that:

(1) acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits;

(2) lists those state-mandated health benefits not included in the standard health benefit plan; and

(3) if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan.

(h) Each applicant for initial enrollment and each contract holder on renewal must sign the disclosure statement provided by the health maintenance organization under Subsection (g) of this section and return the statement to the health maintenance organization. Under a group evidence of coverage, the term

"applicant" means the employer.

(i) A health maintenance organization must:

(1) retain the signed disclosure statement in the organization's records; and

(2) on request from the commissioner, provide the signed disclosure statement to the department.

(j) The commissioner shall adopt rules as necessary to implement this section.

(k) A health maintenance organization that offers one or more standard health benefit plans under this section must also offer at least one evidence of coverage that provides state-mandated health benefits and that is otherwise authorized by the Insurance Code.

(l) A health maintenance organization shall file for informational purposes the rates to be used with a standard health benefit plan. Nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any evidence of coverage.

SECTION 3. Subsection (b), Article 26.38, Insurance Code, is amended to read as follows:

(b) A health maintenance organization that participates in a purchasing cooperative that provides employees of small employers a choice of benefit plans, that has established a separate class of business as provided by Article 26.31 of this code, and that has established a separate line of business as provided under Article 26.48(a) of this code [~~and Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.)~~] may use rating methods in accordance with this subchapter that are used by other small employer carriers participating in the same cooperative, including rating by age and gender.

SECTION 4. Article 26.42, Insurance Code, is amended to read as follows:

Art. 26.42. SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) A small employer carrier shall offer a standard health benefit plan as authorized by Article 3.80 of this code and Section 9N, Texas Health Maintenance Organization Act (Article 20A.09N, Vernon's Texas Insurance Code) [~~the following two health benefit plans as adopted by the commissioner:~~

[~~(1) the catastrophic care benefit plan; and~~

[~~(2) the basic coverage benefit plan~~].

(b) A small employer carrier may offer to a small employer additional benefit riders to the standard health benefit plan or may design and offer standard health benefit plans with additional mandatory benefits [~~either of the benefit plans~~].

(c) Subject to the provisions of this chapter, a small employer carrier shall [~~may~~] also offer to small employers at least one [~~any~~] other health benefit plan authorized under this code that provides state-mandated health benefits. Article 26.06(c) does not apply to a health benefit plan offered to a small employer under this subsection.

SECTION 5. Subsection (a), Article 26.43, Insurance Code, is amended to read as follows:

(a) A [~~The commissioner shall promulgate the benefits section of the catastrophic care benefit plan and the basic coverage benefit plan policy forms in accordance with Article 26.44A of this code and shall develop prototype policies for each of the benefit plans. For all other portions of these policy forms, a~~] small employer carrier shall comply with Article 3.42 of this code as it relates to policy form approval and with the Texas Health Maintenance Organization Act (Article 20A.01 et seq., Vernon's Texas Insurance Code) as it relates to approval of an evidence of coverage. A small employer carrier may not offer [~~these~~] benefit plans through a policy form or evidence of coverage that does not comply with this chapter.

SECTION 6. Subsection (a), Article 26.48, Insurance Code, is amended to read as follows:

(a) A health maintenance organization [~~may offer~~]:

(1) shall offer at least one [~~a~~] state-approved basic

health care [~~benefit~~] plan that complies with this chapter, the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and rules adopted under these laws and may offer additional such plans;

(2) shall offer a standard health benefit plan under Section 9N, Texas Health Maintenance Organization Act (Article 20A.09N, Vernon's Texas Insurance Code), and may offer additional benefit riders to the standard health benefit plan or offer standard health benefit plans with additional mandatory benefits [~~developed by the commissioner under Article 26.44A of this code and additional benefit riders to the plan~~]; and [~~or~~]

(3) may offer a point-of-service contract in connection with an insurance carrier that includes optional coverage for out-of-area services, emergency care, or out-of-network care.

SECTION 7. Subdivision (2), Section 843.002, Insurance Code, as effective June 1, 2003, is amended to read as follows:

(2) "Basic health care services" means health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health[~~, including, at a minimum, services designated as basic health services under Section 1302, Title XIII, Public Health Service Act (42 U.S.C. Section 300e-1(1))~~].

SECTION 8. Article 26.44A, Insurance Code, is repealed.

SECTION 9. This Act takes effect September 1, 2003, and applies only to an insurance policy, contract, or evidence of coverage delivered, issued for delivery, or renewed on or after January 1, 2004.

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