By: Averitt S.B. No. 1254

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A BILL TO BE ENTITLED
AN ACT

relating to the Texas Health Insurance Risk Pool.

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

SECTION 1. Section 1506.001, Insurance Code, is amended by adding Subdivisions (1-a) through (1-e) and (8) to read as follows:

(1-a) "Church plan" has the meaning assigned by Section 3(33), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(33)).

(1-b) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) a group health plan;

(B) health insurance coverage;

(C) Part A or Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.);

(D) Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);

(E) 10 U.S.C. Section 1071 et seq.;

(F) a medical care program of the Indian Health Service or a tribal organization;

(G) a state health benefits risk pool;

(H) a health benefits plan offered under 5 U.S.C. Section 8901 et seq.;

(I) a public health plan as defined in federal regulations;

(J) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); or

(K) a state child health plan provided under Title XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.).

(1-c) "Federally defined eligible individual" means an individual:

(A) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is 18 months or more;

(B) whose most recent prior creditable coverage was under:

(i) a group health plan, governmental plan, or church plan; or

(ii) health insurance coverage offered in connection with a plan described by Subparagraph (i);

(C) who is not eligible for coverage under a group health plan, Part A or Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.), or a state plan under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), or any successor program, and who does not have other health benefit plan coverage;

(D) with respect to whom the most recent coverage within the aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(E) who, if offered the option of continuation coverage under a continuation provision required by Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), or under a similar state program, elected that coverage; and

(F) who has exhausted continuation coverage, if elected, under Paragraph (E).

(1-d) "Governmental plan" has the meaning assigned by

Section 3(32), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(32)), and includes any United States governmental plan.

(1-e) "Group health plan" means an employee welfare benefit plan as defined by Section 3(1), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)), to the extent that the plan provides health benefit plan coverage to employees or their dependents as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(8) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have health benefit plan coverage, except that a waiting period or an affiliation period is not considered in determining a significant break in coverage.

SECTION 2. Section 1506.002, Insurance Code, is amended by amending Subsection (b) and adding Subsections (c) and (d) to read as follows:

(b) In this chapter, "health benefit plan" does not include one or more or any combination of the following:

(1) coverage only for accident or disability income insurance or any combination of those coverages;

(2) credit-only [~~a plan providing coverage only for dental or vision care;~~

[~~(3) fixed indemnity insurance, including hospital indemnity insurance;~~

[~~(4) credit~~] insurance;

(3) [~~(5) long-term care insurance;~~

[~~(6) disability income insurance;~~

[~~(7) other limited benefit coverage, including specified disease coverage;~~

[~~(8)~~] coverage issued as a supplement to liability insurance;

(4) liability insurance, including general liability insurance and automobile liability insurance;

(5) [~~(9) insurance arising out of a~~] workers' compensation [~~law~~] or similar insurance [~~law~~];

(6) coverage for on-site medical clinics;

(7) [~~(10)~~] automobile medical payment insurance; [~~or~~]

(8) [~~(11)~~] insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; or

(9) other similar insurance coverage, specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) In this chapter, "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:

(1) limited scope dental or vision benefits;

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; or

(3) other similar, limited benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

(d) In this chapter, "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) coverage only for a specified disease or illness; or

(2) hospital indemnity or other fixed indemnity insurance.

SECTION 3. Subsection (a), Section 1506.151, Insurance Code, is amended to read as follows:

(a) The pool shall offer coverage consistent with major medical expense coverage to each eligible individual [~~who is under the age of 65~~].

SECTION 4. Subsection (a), Section 1506.152, Insurance Code, is amended to read as follows:

(a) An individual who is a legally domiciled resident of this state is eligible for coverage from the pool if the individual:

(1) provides to the pool evidence that the individual is a federally defined eligible individual who has not experienced a significant break in coverage [~~maintained health benefit plan coverage for the preceding 18 months with no gap in coverage longer than 63 days and with the most recent coverage being provided through an employer-sponsored plan, church plan, or government plan~~];

(2) is younger than 65 years of age and provides to the pool evidence that the individual maintained health benefit plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the 63rd day after the date the coverage described by this subdivision was terminated;

(3) is younger than 65 years of age and has been a legally domiciled resident of this state for the preceding 30 days, is a citizen of the United States or has been a permanent resident of the United States for at least three continuous years, and provides to the pool:

(A) a notice of rejection of, or refusal to issue, substantially similar individual health benefit plan coverage from a health benefit plan issuer, other than an insurer that offers only stop-loss, excess loss, or reinsurance coverage, if the rejection or refusal was for health reasons;

(B) certification from an agent or salaried representative of a health benefit plan issuer that states that the agent or salaried representative cannot obtain substantially similar individual coverage for the individual from any health benefit plan issuer that the agent or salaried representative represents because, under the underwriting guidelines of the health benefit plan issuer, the individual will be denied coverage as a result of a medical condition of the individual;

(C) an offer to issue substantially similar individual coverage only with conditional riders;

(D) a diagnosis of the individual with one of the medical or health conditions on the list adopted under Section 1506.154; or

(E) evidence that the individual is covered by substantially similar individual coverage that excludes one or more conditions by rider; or

(4) provides to the pool evidence that, on the date of application to the pool, the individual is certified as eligible for trade adjustment assistance or for pension benefit guaranty corporation assistance, as provided by the Trade Adjustment Assistance Reform Act of 2002 (Pub. L. No. 107-210).

SECTION 5. Section 1506.153, Insurance Code, as amended by Chapters 728 and 824, Acts of the 79th Legislature, Regular Session, 2005, is amended to read as follows:

Sec. 1506.153. INELIGIBILITY FOR COVERAGE. Notwithstanding Section 1506.152 [~~Sections 1506.152(a)-(d)~~], an individual is not eligible for coverage from the pool if:

(1) on the date pool coverage is to take effect, the individual has health benefit plan coverage from a health benefit plan issuer or health benefit arrangement in effect, except as provided by Section 1506.152(a)(3)(E);

(2) at the time the individual applies to the pool, the individual is eligible for other health care benefits, including an

offer of benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.), as amended (COBRA), other than:

(A) coverage, including COBRA or other continuation coverage or conversion coverage, maintained for any preexisting condition waiting period under a pool policy or during any preexisting condition waiting period or other waiting period of the other coverage;

(B) employer group coverage conditioned by a limitation of the kind described by Section 1506.152(a)(3)(A) or (C); or

(C) individual coverage conditioned by a limitation described by Section 1506.152(a)(3)(C) or (D);

(3) within 12 months before the date the individual applies to the pool, the individual terminated coverage in the pool, unless the individual:

(A) demonstrates a good faith reason for the termination; or

(B) is a federally defined eligible individual;

(4) the individual is confined in a county jail or imprisoned in a state or federal prison;

(5) any of the individual's premiums are paid for or reimbursed under a government-sponsored program or by a government agency or health care provider[~~, other than as an otherwise qualifying full-time employee of a government agency or health care provider or as a dependent of such an employee~~];

(6) the individual's prior coverage with the pool was terminated:

(A) during the 12-month period preceding the date of application for nonpayment of premiums; or

(B) for fraud; or

(7) the individual is eligible for health benefit plan coverage provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined.

SECTION 6. Subsection (a), Section 1506.154, Insurance Code, is amended to read as follows:

(a) The board shall adopt a list of medical or health conditions for which an individual is eligible for pool coverage under Section 1506.152(a)(3)(D) [~~1506.152(a)(3)(E)~~] without applying for health benefit plan coverage.

SECTION 7. Subsections (b) and (c), Section 1506.155, Insurance Code, are amended to read as follows:

(b) The exclusion provided by Subsection (a) does not apply to a federally defined eligible individual or an individual who:

(1) was continuously covered for a period of at least 12 months, excluding any waiting period, by creditable [~~health benefit plan~~] coverage that terminated not earlier than the 63rd day before the effective date of coverage under the pool; and

(2) applied for pool coverage not later than the 63rd day after the date the creditable [~~health benefit plan~~] coverage described by Subdivision (1) terminated.

(c) If an individual was covered by creditable [~~health benefit plan~~] coverage that was in effect at any time during the 12-month period preceding the effective date of the individual's coverage under the pool, the pool shall subtract from the exclusion period required under Subsection (a) the period that the individual was covered under that creditable coverage [~~health benefit plan~~] and any waiting period that applied before that creditable [~~health benefit plan~~] coverage became effective.

SECTION 8. Subsection (a), Section 1506.202, Insurance Code, is amended to read as follows:

(a) The board may, on a competitive bid basis, contract with [~~select~~] one or more health benefit plan issuers or [~~a~~] third-party administrators [~~administrator~~] authorized by the department to administer the pool. [~~The selection must be made under a competitive bidding process in accordance with the plan of operation.~~]

SECTION 9. Section 1506.203, Insurance Code, is amended to

read as follows:

Sec. 1506.203. ADMINISTRATOR'S CONTRACT [~~TERM; SUCCEEDING TERM~~]. (a) A person selected as a pool administrator shall serve [~~serves~~] in that capacity for a period specified in the contract between the pool and the pool administrator, subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the pool and the pool administrator. The term of the contract must be at least three years and may be extended, in the board's sole discretion, for up to a total term of six years [~~three-year term beginning on the date the board issues its order making the selection~~].

(b) Not later than one year before the expiration date of a pool administrator's contract, including any board-authorized extensions of that contract [~~term~~], the board shall invite all health benefit plan issuers, including the pool administrator, to submit bids to serve as a pool administrator for the succeeding administration period. The selection of the succeeding pool administrator must be made not later than the sixth calendar month preceding the month in which the pool administrator's contract [~~term~~] expires.

SECTION 10. Subsection (b), Section 1506.254, Insurance Code, is amended to read as follows:

(b) Interest accrues on the unpaid amount of an assessment at a rate equal to the prime lending rate, as published in the most recent issue of the Wall Street Journal and determined as of the first day of each month during which [~~date~~] the assessment is [~~becomes~~] delinquent, plus three percent.

SECTION 11. (a) This Act applies only to an application for initial or renewal coverage through the Texas Health Insurance Risk Pool under Chapter 1506, Insurance Code, as amended by this Act, that is filed with the pool on or after the effective date of this Act. An application filed before the effective date of this Act is governed by the law in effect on the date on which the application was filed, and the former law is continued in effect for that purpose.

(b) The change in law made by this Act to Subsection (b), Section 1506.254, Insurance Code, applies to an assessment under Subchapter F, Chapter 1506, Insurance Code, for a calendar year beginning on or after January 1, 2008. An assessment for a calendar year before January 1, 2008, is governed by the law in effect during the period for which the assessment is made, and the former law is continued in effect for that purpose.

SECTION 12. This Act takes effect January 1, 2008.

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