BILL ANALYSIS

C.S.H.B. 1290
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

C.S.H.B. 1290 provides coverage under certain health benefit plans for specified tests for the early detection of cardiovascular disease. The bill provides coverage for men older than 45 and younger than 76 and women older than 55 and younger than 76 who are diabetic or are at intermediate or higher risk of a heart attack, according to a score using the Framingham Heart Study coronary prediction algorithm. The coverage provides for either computed tomography (CT) scans measuring coronary artery calcification or ultrasonography scans measuring carotid intima-media thickness and plaque once every five years with minimum coverage of up to $200 per test.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 1290 amends the Insurance Code to require a health benefit plan to provide coverage for a noninvasive cardiovascular disease screening test, such as a computed tomography (CT) scan measuring coronary artery calcification or an ultrasonography scan measuring carotid intima-media thickness and plaque, for atherosclerosis and abnormal artery structure and function. The bill requires this coverage be provided to an individual who is a male older than 45 years of age and younger than 76 years of age or a female older than 55 years of age and younger than 76 years of age, and is diabetic or has a risk of developing coronary heart disease based on an intermediate or higher score using the Framingham Heart Study coronary prediction algorithm. The bill provides that the minimum coverage required is up to $200 for one of these tests every five years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this requirement.

C.S.H.B. 1290 provides that this requirement applies only to a health benefit plan, as offered by specified types of insurers, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness. The bill exempts from this requirement a plan that provides coverage only for a specified disease or other limited benefit, only for accidental death or dismemberment, for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury, as a supplement to a liability insurance policy, or only for indemnity for hospital confinement. The bill also exempts a standard health benefit plan issued under a consumer choice of benefits plan, a workers' compensation insurance policy, medical payment insurance coverage provided under a motor vehicle insurance policy, and a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan under the provisions of this bill.

C.S.H.B. 1290 makes its provisions applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010.

EFFECTIVE DATE

September 1, 2009.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 1290 differs from the original by exempting a standard health benefit plan issued under a consumer choice of benefits plan from the bill's provisions, whereas the original makes the provisions applicable to such a plan.