By: Smith of Tarrant H.B. No. 1748

A BILL TO BE ENTITLED

AN ACT

relating to the cancellation of a health benefit plan on the basis of misrepresentation or a preexisting condition; providing penalties.

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

SECTION 1. Subchapter B, Chapter 541, Insurance Code, is amended by adding Section 541.062 to read as follows:

Sec. 541.062. BAD FAITH CANCELLATION. It is an unfair method of competition or an unfair or deceptive act or practice for a health benefit plan issuer to:

(1) set cancellation goals, quotas, or targets;

(2) pay compensation of any kind, including a bonus or award, that varies according to the number of cancellations;

(3) set, as a condition of employment, a number or volume of cancellations to be achieved; or

(4) set a performance standard, for employees or by contract with another entity, based on the number or volume of cancellations.

SECTION 2. Chapter 1202, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. INDEPENDENT REVIEW OF CERTAIN CANCELLATION DECISIONS

Sec. 1202.101. DEFINITIONS. In this subchapter:

(1) "Affected individual" means an individual who is otherwise entitled to benefits under a health benefit plan that is

subject to a decision to cancel.

(2) "Independent review organization" means an organization certified under Chapter 4202.

(3) "Screening criteria" means the elements or factors used in a determination of whether to subject an issued health benefit plan to additional review for possible cancellation, including any applicable dollar amount or number of claims submitted.

Sec. 1202.102. APPLICABILITY. (a) This subchapter applies only to a health benefit plan, including a small or large 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) This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance 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 described by Subsection (a).

Sec. 1202.103. CANCELLATION FOR MISREPRESENTATION OR PREEXISTING CONDITION. Notwithstanding any other law, a health benefit plan issuer may not cancel 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 CANCEL. (a) A health benefit plan issuer may not cancel 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 cancel the health benefit plan and the individual's entitlement to an independent review.

(b) The notice required under Subsection (a) must include, as applicable:

(1) the principal reasons for the decision to cancel the health benefit plan;

(2) the clinical basis for a determination that a preexisting condition exists;

(3) a description of any general screening criteria used to evaluate issued health benefit plans and determine eligibility for a decision to cancel;

(4) a statement that the individual is entitled to appeal a cancellation decision to an independent review organization;

(5) a statement that the individual has at least 45

days in which to appeal the cancellation decision to an independent review organization, and a description of the consequences of failure to appeal within that time limit;

(6) a statement that there is no cost to the individual to appeal the cancellation decision to an independent review organization; and

(7) a description of the independent review process under Chapters 4201 and 4202.

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

(b) A health benefit plan issuer shall 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 cancel.

(c) A health benefit plan issuer shall pay all otherwise valid medical claims under an individual's plan until the later of:

(1) the date on which an independent review organization determines that the decision to cancel is appropriate; or

(2) the time to appeal to an independent review organization has expired without an affected individual initiating an appeal.

Sec. 1202.106. CANCELLATION AUTHORIZED; RECOVERY OF CLAIMS

PAID. (a) A health benefit plan issuer may cancel a health benefit plan covering an affected individual on the later of:

(1) the date an independent review organization determines that cancellation is appropriate; or

(2) the 45th day after the date an affected individual receives notice under Section 1202.104, if the individual has not initiated an appeal.

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

(c) An issuer that cancels a health benefit plan under this section may not offset against or recoup or recover from a physician or health care provider amounts paid for medical claims under a cancelled health benefit plan. This subsection may not be waived, voided, or modified by contract.

Sec. 1202.107. CANCELLATION RELATED TO A PREEXISTING CONDITION; STANDARDS. (a) For purposes of this subchapter, a cancellation 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:

(1) affects the risks assumed under the health benefit plan; and

(2) is undertaken with the intent to deceive the health benefit plan issuer.

(b) A health benefit plan issuer may not cancel a health benefit plan based on a preexisting condition of a newborn delivered after the application for coverage is made or as may otherwise be prohibited by law.

Sec. 1202.108. CANCELLATION FOR MISREPRESENTATION; STANDARDS. For purposes of this subchapter, a cancellation for a misrepresentation not related to a preexisting condition is inappropriate unless the misrepresentation:

(1) is of a material fact;

(2) affects the risks assumed under the health benefit plan; and

(3) is made with the intent to deceive the health benefit plan issuer.

Sec. 1202.109. REMEDIES NOT EXCLUSIVE. 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. The commissioner shall adopt rules necessary to implement and administer this subchapter.

Sec. 1202.111. SANCTIONS AND PENALTIES. A health benefit plan issuer that violates this subchapter commits an unfair practice in violation of Chapter 541 and is subject to sanctions and penalties under Chapter 82.

Sec. 1202.112. CONFIDENTIALITY. (a) 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 cancellation decision under this subchapter, is confidential.

(b) A health benefit plan issuer may not disclose the identity of an individual or a decision to cancel an individual's health benefit plan unless:

(1) an independent review organization determines the decision to cancel is appropriate; or

(2) the time to appeal has expired without an affected individual initiating an appeal.

SECTION 3. Section 4202.002, Insurance Code, is amended to read as follows:

Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall adopt standards and rules for:

(1) the certification, selection, and operation of independent review organizations to perform independent review described by Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201; and

(2) the suspension and revocation of the certification.

(b) The standards adopted under this section must ensure:

(1) the timely response of an independent review organization selected under this chapter;

(2) the confidentiality of medical records transmitted to an independent review organization for use in conducting an independent review;

(3) the qualifications and independence of each

physician or other health care provider making a review determination for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making review determinations; [~~and~~]

(5) the timely notice to an enrollee of the results of an independent review, including the clinical basis for the review determination; and

(6) that review of a cancellation decision based on a preexisting condition be conducted under the direction of a physician.

SECTION 4. Sections 4202.003, 4202.004, and 4202.006, Insurance Code, are amended to read as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. The standards adopted under Section 4202.002 must require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by Section 4201.002, not later than the earlier of:

(A) the fifth day after the date the organization receives the information necessary to make the determination; or

(B) the eighth day after the date the organization receives the request that the determination be made; and

(2) for a condition other than a life-threatening condition or of the appropriateness of a cancellation under Subchapter C, Chapter 1202, not later than the earlier of:

(A) the 15th day after the date the organization receives the information necessary to make the determination; or

(B) the 20th day after the date the organization receives the request that the determination be made.

Sec. 4202.004. CERTIFICATION. To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each shareholder or owner of more than five percent of any of the applicant's stock or options;

(2) the name of any holder of the applicant's bonds or notes that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G);

(5) the percentage of the applicant's revenues that are anticipated to be derived from independent reviews conducted under Subchapter I, Chapter 4201;

(6) a description of the areas of expertise of the physicians or other health care providers making review determinations for the applicant; and

(7) 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) The commissioner shall charge payors fees in accordance with this chapter as necessary to fund the operations of independent review organizations.

(b) A health benefit plan issuer shall pay for an independent review of a cancellation decision under Subchapter C, Chapter 1202.

SECTION 5. Section 4202.009, Insurance Code, is amended to read as follows:

Sec. 4202.009. CONFIDENTIAL INFORMATION. (a) Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential.

(b) 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 cancellation decision under Subchapter C, Chapter 1202, is confidential.

(c) An independent review organization may not disclose the identity of an affected individual or an issuer's decision to cancel a health benefit plan under Subchapter C, Chapter 1202, unless:

(1) an independent review organization determines the decision to cancel is appropriate; or

(2) the time to appeal a cancellation under that subchapter has expired without an affected individual initiating an appeal.

SECTION 6. Section 4202.010(a), Insurance Code, is amended to read as follows:

(a) An independent review organization conducting an independent review under Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201, is not liable for damages arising from the review determination made by the organization.

SECTION 7. The change in law made by this Act applies only to an insurance policy that is delivered, issued for delivery, or renewed on or after the effective date of this Act. An insurance policy that is delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law as it existed before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 8. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.