By: Shapleigh S.B. No. 303

A BILL TO BE ENTITLED

1 AN ACT

2 relating to application for and cancellation or rescission of
3 health benefit plan coverage.

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

5 SECTION 1. Subtitle A, Title 8, Insurance Code, is amended
6 by adding Chapters 1220 and 1221 to read as follows:

7 CHAPTER 1220. APPLICATION FOR AND ISSUANCE OF HEALTH BENEFIT PLAN
8 COVERAGE

9 SUBCHAPTER A. APPLICATION FOR INDIVIDUAL HEALTH BENEFIT PLAN
10 COVERAGE

11 Sec. 1220.001. DEFINITION. In this subchapter, "individual
12 health benefit plan" means:

13 (1) an individual accident and health insurance policy
14 to which Chapter 1201 applies; or

15 (2) individual health maintenance organization
16 coverage.

17 Sec. 1220.002. UNIFORM APPLICATION QUESTIONS. (a) The
18 commissioner by rule shall establish uniform information and health
19 history questions for use in all individual health benefit plan
20 application forms.

21 (b) An application for individual health benefit plan
22 coverage may only contain questions adopted under this section.

23 (c) The standard information and health history questions
24 adopted under this section must:

1 (1) contain clear and unambiguous information and
2 questions designed to ascertain the applicant's health history; and
3 (2) be based on the medical information that is
4 reasonable and necessary for medical underwriting purposes.
5 (d) A question adopted under this section regarding whether
6 an applicant has been diagnosed or treated for a specific health
7 condition must also specify an amount of time before the date of the
8 application during which an occurrence of the diagnosis or
9 treatment must be disclosed and before which an occurrence of the
10 diagnosis or treatment is not required to be disclosed.
11 Sec. 1220.003. FILING AND APPROVAL OF APPLICATION FORM.
12 (a) An individual health benefit plan issuer may not use an
13 application form for individual health benefit plan coverage unless
14 the form has been filed with the department and approved by the
15 commissioner.
16 (b) The commissioner shall, not later than the 30th day
17 after the date an application form is submitted for approval under
18 this section, approve or deny approval for the form. The
19 commissioner shall approve the form if it meets the requirements of
20 this chapter and other applicable provisions of this code.
21 (c) The commissioner by rule shall adopt procedures for
22 filing and approval of application forms under this section.
23 [Sections 1220.004-1220.050 reserved for expansion]
24 SUBCHAPTER B. ISSUANCE AND UNDERWRITING OF INDIVIDUAL AND GROUP
25 HEALTH BENEFIT PLAN COVERAGE
26 Sec. 1220.051. APPLICABILITY OF SUBCHAPTER. (a) This
27 subchapter applies only to a health benefit plan that provides

1 benefits for medical or surgical expenses incurred as a result of a
2 health condition, accident, or sickness, including an individual,
3 group, blanket, or franchise insurance policy or insurance
4 agreement, a group hospital service contract, or an individual or
5 group evidence of coverage or similar coverage document that is
6 offered by:
7 (1) an insurance company;
8 (2) a group hospital service corporation operating
9 under Chapter 842;
10 (3) a fraternal benefit society operating under
11 Chapter 885;
12 (4) a stipulated premium company operating under
13 Chapter 884;
14 (5) an exchange operating under Chapter 942;
15 (6) a health maintenance organization operating under
16 Chapter 843;
17 (7) a multiple employer welfare arrangement that holds
18 a certificate of authority under Chapter 846; or
19 (8) an approved nonprofit health corporation that
20 holds a certificate of authority under Chapter 844.
21 (b) Notwithstanding any provision in Chapter 1551, 1575,
22 1579, or 1601 or any other law, this chapter applies, to the extent
23 the plan or coverage is individually underwritten, to a health
24 benefit plan issuer with respect to:
25 (1) a basic coverage plan under Chapter 1551;
26 (2) a basic plan under Chapter 1575;
27 (3) a primary care coverage plan under Chapter 1579;

1 and

2 (4) basic coverage under Chapter 1601.

3 (c) Notwithstanding any other law, this chapter applies to a
4 health benefit plan issuer with respect to a standard health
5 benefit plan provided under Chapter 1507.

6 Sec. 1220.052. EXCEPTION. This subchapter does not apply
7 with respect to:

8 (1) a plan that provides coverage:

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

12 (B) as a supplement to a liability insurance
13 policy;

14 (C) for credit insurance;

15 (D) only for dental or vision care;

16 (E) only for hospital expenses; or

17 (F) only for indemnity for hospital confinement;

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

20 (3) a workers' compensation insurance policy; or

21 (4) medical payment insurance coverage provided under
22 a motor vehicle insurance policy.

23 Sec. 1220.053. ISSUANCE OF COVERAGE: COMPLETION OF
24 UNDERWRITING REQUIRED. Before issuing a health benefit plan
25 policy, contract, or evidence of coverage, the health benefit plan
26 issuer must complete a reasonable investigation of the applicant's
27 health history information, including:

(1) ensuring that the information submitted on the application form and the material submitted with the application form is complete and accurate; and

(2) resolving all reasonable questions arising from the application form or materials submitted with the application form or any information obtained by the health benefit plan issuer as part of the plan issuer's verification of the accuracy and completeness of the application form.

Sec. 1220.054. DOCUMENTATION OF UNDERWRITING REQUIRED. A health benefit plan issuer shall document all information collected during an underwriting review process.

Sec. 1220.055. WRITTEN UNDERWRITING STANDARDS REQUIRED. A health benefit plan issuer shall adopt and implement written medical underwriting policies and procedures and file those written policies and procedures with the department.

Sec. 1220.056. PROVISION OF APPLICATION INFORMATION REQUIRED; SUPPLEMENTAL UNDERWRITING. (a) Not later than the 10th day after the date a health benefit plan issuer issues a health benefit plan policy, contract, or evidence of coverage to an applicant for coverage under the plan, the plan issuer shall send to the applicant:

(1) a copy of the applicant's application;

(2) a copy of the policy, contract, or evidence of coverage issued to the applicant; and

(3) a notice that states that:

(A) the applicant should review the completed application carefully and notify the plan issuer not later than the

30th day after the date the applicant receives the notice of any inaccuracy in the application;

(B) any intentional material misrepresentation or intentional material omission in the information submitted in the application may result in the cancellation or rescission of the applicant's health benefit plan coverage; and

(C) the applicant should retain a copy of the completed written application for the applicant's records.

(b) If an applicant submits new health history information within the 30-day period prescribed by Subsection (a), the health benefit plan issuer shall complete a reasonable investigation of the applicant's health history information with respect to that new information, including:

(1) ensuring that the new information submitted by the applicant, in conjunction with the material submitted with the application form, is complete and accurate; and

(2) resolving all reasonable questions arising from the new information submitted by the applicant or any information obtained by the plan issuer as part of the plan issuer's verification of the accuracy and completeness of the new information.

CHAPTER 1221. CANCELLATION OR RESCISSION OF INDIVIDUAL HEALTH BENEFIT PLAN COVERAGE

Sec. 1221.001. DEFINITION. In this chapter, "individual health benefit plan" has the meaning assigned by Section 1220.001.

Sec. 1221.002. GROUNDS FOR CANCELLATION OR RESCISSION. An issuer of an individual health benefit plan policy or contract may

1 not cancel or rescind the coverage under the policy or contract
2 unless:
3 (1) there was a material misrepresentation or material
4 omission in the information submitted by the applicant in the
5 written application to the health benefit plan issuer before the
6 issuance of the policy or contract that would prevent the policy or
7 contract from being issued;
8 (2) the health benefit plan issuer completed the
9 investigation of the applicant's health history information in
10 accordance with Sections 1220.053 and 1220.056(b);
11 (3) the health benefit plan issuer demonstrates that
12 the applicant intentionally misrepresented or intentionally
13 omitted material information on the application to obtain health
14 benefit plan coverage;
15 (4) the application form was approved by the
16 commissioner under Section 1220.003; and
17 (5) the health benefit plan issuer sent the applicant
18 a copy of the completed application with a copy of the policy or
19 contract issued in connection with the application with the notice
20 required by Section 1220.056(a).
21 SECTION 2. The change in law made by this Act applies only
22 to a health benefit plan policy, contract, or evidence of coverage
23 delivered or issued for delivery on or after January 1, 2010. A
24 policy, contract, or evidence of coverage delivered or issued for
25 delivery before that date is governed by the law in effect
26 immediately before the effective date of this Act, and that law is
27 continued in effect for that purpose.

1 SECTION 3. This Act takes effect September 1, 2009.