By: Shapleigh S.B. No. 350

(In the Senate - Filed December 9, 2008; February 11, 2009, read first time and referred to Committee on State Affairs; April 20, 2009, reported adversely, with favorable Committee Substitute by the following vote: Yeas 7, Nays 0; April 20, 2009, sent to printer.)

COMMITTEE SUBSTITUTE FOR S.B. No. 350 By: Lucio

A BILL TO BE ENTITLED
AN ACT

relating to the application for and continuation of certain health benefit plan coverage; providing a civil penalty.

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

SECTION 1. Subtitle A, Title 8, Insurance Code, is amended by adding Chapters 1217 and 1218 to read as follows:

CHAPTER 1217. APPLICATION FOR HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1217.001. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means a plan 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) an exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) The term includes:

(1) a small employer health benefit plan subject to Chapter 1501;

(2) a standard health benefit plan provided under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579; and

(6) basic coverage under Chapter 1601.

(c) The term does not include:

(1) disability income insurance coverage; or

(2) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits.

[Sections 1217.002-1217.050 reserved for expansion]

SUBCHAPTER B. APPLICATION FOR COVERAGE

Sec. 1217.051. APPLICATION ASSISTANCE; CIVIL PENALTY. (a) A life, accident, and health agent who assists an applicant in submitting an application to a health benefit plan issuer:

(1) has a duty to assist the applicant in providing answers to health questions accurately and completely; and

(2) shall attest on the written application that:

(A) to the best of the agent's knowledge, the

information on the application is complete and accurate;

(B) the agent explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information; and

(C) the applicant understood the explanation provided under Paragraph (B).

(b) For the purposes of Subsection (a)(2)(C), the agent may request that the applicant attest in writing on the application or a separate document that the applicant understood the explanation provided under Subsection (a)(2)(B).

(c) If, in an attestation required by Subsection (a), an agent wilfully states as true any material fact the agent knows to be false, the agent, in addition to any other penalty or remedy available by law, is liable for a civil penalty in an amount not to exceed $10,000.

(d) The attorney general or a county or district attorney may bring an action to recover a civil penalty under Subsection (c). The penalty shall be deposited in the general revenue fund, except that for a penalty recovered in a suit first instituted by a local government or governments under this subsection, 50 percent of the recovery shall be deposited in the general revenue fund and the other 50 percent shall be equally distributed to the local government or governments that instituted the suit.

(e) An application for health benefit plan coverage shall include a statement advising affiants of the civil penalty authorized under this section.

CHAPTER 1218. RESCISSION OF HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1218.001. DEFINITION. (a) Except as provided by this section, in this chapter, "individual health benefit plan" means:

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

(2) individual health maintenance organization coverage.

(b) The term does not include:

(1) disability income insurance coverage; or

(2) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits.

[Sections 1218.002-1218.050 reserved for expansion]

SUBCHAPTER B. RESCISSION

Sec. 1218.051. INDIVIDUAL HEALTH BENEFIT PLAN: CONTINUATION OF COVERAGE. (a) An individual health benefit plan issuer that intends to rescind an individual health benefit plan policy or contract:

(1) shall offer to each other individual covered under the policy or contract the opportunity to obtain a new individual health benefit plan policy or contract with benefits equal to those of the rescinded policy or contract; and

(2) may permit an individual otherwise entitled to an offer of coverage under Subdivision (1) to remain covered under the policy or contract with a revised premium rate to reflect any reduction in the number of individuals covered by the policy or contract.

(b) An individual health benefit plan issuer is not required to continue existing coverage of or issue new coverage to an individual if the rescission is based on information about that individual.

(c) If a new individual health benefit plan policy or contract is issued under this section, the plan issuer may revise the premium rate only to reflect the number of persons covered by the new policy or contract.

Sec. 1218.052. PREEXISTING CONDITION EXCLUSION; WAITING OR AFFILIATION PERIOD. (a) An individual health benefit plan issuer required to offer coverage under this chapter may not decline to issue the coverage or impose any preexisting condition exclusion on an individual who retains existing coverage or obtains new coverage under this chapter.

(b) Notwithstanding Subsection (a), if an individual was subject to a preexisting condition provision or a waiting or affiliation period under the rescinded health benefit plan policy or contract, the plan issuer may apply the same preexisting condition provision or waiting or affiliation period in a new policy or contract issued under this chapter. The time period in the new policy or contract for the preexisting condition provision period or waiting or affiliation period may not be longer than the applicable period in the rescinded policy or contract. The plan issuer shall credit any time the individual was covered under the rescinded policy or contract to the preexisting condition provision period or waiting or affiliation period in the new policy or contract.

Sec. 1218.053. NOTICE. An individual health benefit plan issuer that rescinds an individual health benefit plan policy or contract shall notify in writing each individual covered under the policy or contract of the offer of coverage required to be made under this chapter.

Sec. 1218.054. MINIMUM TIME TO ACCEPT OFFER. An individual health benefit plan issuer required to offer continuation of coverage under this chapter must allow an individual entitled to the coverage at least 60 days to accept the offered coverage.

Sec. 1218.055. EFFECTIVE DATE OF COVERAGE. A new health benefit plan policy or contract issued under this chapter is effective as of the effective date of the rescinded policy or contract, and there may not be a lapse in coverage.

SECTION 2. (a) The change in law made by Chapter 1217, Insurance Code, as added by this Act, applies only to an application for health benefit plan coverage submitted to a health benefit plan issuer on or after January 1, 2010. An application submitted before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) The change in law made by Chapter 1218, Insurance Code, as added by this Act, applies only to a rescission of an individual health benefit plan policy or contract or health benefit plan coverage on or after the effective date of this Act. A rescission of a policy, contract, or coverage before the effective date of this Act is governed by the law in effect immediately before that date, and that law is continued in effect for that purpose.

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

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