Amend **HB 1951** on third reading (house committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES of the bill accordingly:

ARTICLE ____. RESCISSION OF HEALTH BENEFIT PLAN

SECTION ____.001. Chapter 1202, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. RESCISSION OF HEALTH BENEFIT PLAN

Sec. 1202.101. DEFINITION. In this subchapter, "rescission" means the termination of an insurance agreement, contract, evidence of coverage, insurance policy, or other similar coverage document in which the health benefit plan issuer, as applicable, refunds premium payments or demands the recoupment of any benefit already paid under the plan.

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;

(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);

(6) a Medicaid managed care plan offered under Chapter 533, Government Code;

(7) any policy or contract of insurance with a state agency, department, or board providing health services to eligible individuals under Chapter 32, Human Resources Code; or

(8) a child health plan offered under Chapter 62, Health and Safety Code, or a health benefits plan offered under Chapter 63, Health and Safety Code.

Sec. 1202.103. RESCISSION PROHIBITED; EXCEPTION. (a) Notwithstanding any other law, except as provided by Subsection (b), a health benefit plan issuer may not rescind coverage under a health benefit plan with respect to an enrollee in the plan.

(b) A health benefit plan issuer may rescind coverage under a health benefit plan with respect to an enrollee if the enrollee engages in conduct that constitutes fraud or makes an intentional misrepresentation of a material fact.

Sec. 1202.104. NOTICE OF INTENT TO RESCIND. (a) A health benefit plan issuer may not rescind a health benefit plan without first notifying the affected enrollee in writing at least 30 days in advance of the issuer's intent to rescind the health benefit plan.

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

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

(2) the date on which the rescission is effective and the prior date to which the rescission retroactively reaches;

(3) an itemized list of any pending or paid claims the health benefit plan issuer intends to recoup following the rescission;

(4) an explanation of how the enrollee may obtain any documentation used by the health benefit plan issuer to justify the rescission;

(5) a statement that the enrollee is entitled to appeal a rescission decision to an independent review organization and that the health benefit plan issuer bears the burden of proof on appeal;

(6) an explanation of any time limit with which the enrollee must comply to appeal the rescission decision to an independent review organization, and a description of the consequences of failure to appeal within that time limit; and

(7) a statement that there is no cost to the individual to appeal the rescission decision to an independent review organization.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) An enrollee may appeal a health benefit plan issuer's rescission decision to an independent review organization in the manner prescribed by the commissioner by rule.

(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 rescind.

(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 rescind is appropriate; or

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

(d) The commissioner shall adopt rules necessary to implement and enforce this section, including rules establishing certification standards for independent review organizations for purposes of this chapter.

Sec. 1202.106. BURDEN OF PROOF. In an appeal to an independent review organization under Section 1202.105 or an enforcement action or cause of action based on a violation of this subchapter by a health benefit plan issuer, the health benefit plan issuer must prove that the issuer did not violate this subchapter.

SECTION _____.002. The change in law made by this article applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.