BILL ANALYSIS

C.S.H.B. 2541
By: Zerwas
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Some states have adopted legislation that severely restricts access to cancer treatments for patients based on the severity of the illness. While this guideline allows certain categories of cancer care to be covered, there is concern that the approach means some patients are denied treatment based on life expectancy. The decision to forgo or pursue medical treatment is very personal, and many believe such a decision should be made only by the individual patient and the patient's family and physicians. Interested parties oppose the valuation of a patient's life and want to see protection in Texas to prevent abuses from occurring. C.S.H.B. 2541 seeks to address this issue by preventing the denial of coverage based on a patient's diagnosis.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 2541 amends the Insurance Code to prohibit a health benefit plan from denying coverage, based solely on an enrollee's diagnosis with a terminal illness, for a treatment that is medically accepted as treatment for the terminal illness or another illness or condition with which the enrollee has been diagnosed by a physician, that is prescribed by a physician to treat the terminal illness or other illness or condition, and to which the enrollee or the enrollee's legal guardian or other legal representative consents. The bill prohibits a health benefit plan issuer or third-party administrator from refusing to accept a physician's recommendation of such treatment based solely on the enrollee's diagnosis with a terminal illness or reducing, prohibiting, or denying payment or other forms of reimbursement for the treatment based solely on that diagnosis. The bill classifies a violation of the bill's provisions as an unfair or deceptive act or practice in the business of insurance and as an unfair claim settlement practice. The bill subjects a health benefit plan issuer or third-party administrator that violates the bill's provisions to certain administrative penalties.

C.S.H.B. 2541 requires the state child health plan program, the health benefits plan for certain children who are qualified aliens, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission for the provision of health care services to recipients through a managed care plan to provide coverage to a recipient in accordance with the bill's provisions, to the extent allowed by federal law.

C.S.H.B. 2541 applies to specified health benefit plans and coverages offered by specified

employers, programs, and plans. The bill exempts from its provisions specified health benefit plans, policies, and coverages.

EFFECTIVE DATE

September 1, 2015.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2541 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Subtitle E, Title 8, Insurance Code, is amended by adding Chapter 1372 to read as follows: CHAPTER 1372. ACCESS TO TREATMENT FOR INDIVIDUALS WITH A TERMINAL ILLNESS Sec. 1372.001. DEFINITIONS.	SECTION 1. Subtitle E, Title 8, Insurance Code, is amended by adding Chapter 1372 to read as follows: CHAPTER 1372. ACCESS TO TREATMENT FOR INDIVIDUALS WITH A TERMINAL ILLNESS Sec. 1372.001. DEFINITIONS.
Sec. 1372.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit 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 health maintenance organization operating under Chapter 843; (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; (6) a stipulated premium company operating under Chapter 884; (7) a fraternal benefit society operating under Chapter 885; or (8) an exchange operating under Chapter 942.	Sec. 1372.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit 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 health maintenance organization operating under Chapter 843; (4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; (5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; (6) a stipulated premium company operating under Chapter 884; (7) a fraternal benefit society operating under Chapter 885; or (8) an exchange operating under Chapter 942.
(b) Notwithstanding Section 172.014, Local Government Code, or any other law, this chapter applies to health and accident	

coverage provided by a risk pool created under Chapter 172, Local Government Code.	
(c) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.	(b) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.
(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to health benefit plan coverage provided under: (1) Chapter 1551; (2) Chapter 1575; (3) Chapter 1579; and (4) Chapter 1601.	(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to health benefit plan coverage provided under: (1) Chapter 1551; (2) Chapter 1575; (3) Chapter 1579; and (4) Chapter 1601.
(e) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.	(d) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.
(f) This chapter applies to a consumer choice of benefits plan issued under Chapter 1507.	(e) This chapter applies to a consumer choice of benefits plan issued under Chapter 1507.
(g) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, the health benefits plan for children operated under Chapter 63, Health and Safety Code, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to recipients through a managed care plan shall provide coverage to a recipient in accordance with this chapter.	(f) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, the health benefits plan for children operated under Chapter 63, Health and Safety Code, the state Medicaid program, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to recipients through a managed care plan shall provide coverage to a recipient in accordance with this chapter.
Sec. 1372.003. EXCEPTION TO APPLICABILITY OF CHAPTER.	Sec. 1372.003. EXCEPTION TO APPLICABILITY OF CHAPTER.
Sec. 1372.004. APPLICABILITY TO CERTAIN TREATMENT	Sec. 1372.004. APPLICABILITY TO CERTAIN TREATMENT
Sec. 1372.005. CERTAIN DENIALS OF COVERAGE PROHIBITED.	Sec. 1372.005. CERTAIN DENIALS OF COVERAGE PROHIBITED.
Sec. 1372.006. PROHIBITED CONDUCT.	Sec. 1372.006. PROHIBITED CONDUCT.
Sec. 1372.007. UNFAIR OR DECEPTIVE ACT OR PRACTICE; UNFAIR CLAIM SETTLEMENT PRACTICE.	Sec. 1372.007. UNFAIR OR DECEPTIVE ACT OR PRACTICE; UNFAIR CLAIM SETTLEMENT PRACTICE.
Sec. 1372.008. ADMINISTRATIVE PENALTIES.	Sec. 1372.008. ADMINISTRATIVE PENALTIES.
SECTION 2. Chapter 1372, Insurance Code, as added by this Act, applies only to a	SECTION 2. Same as introduced version.

health benefit plan that is delivered, issued for delivery, or renewed on or after September 1, 2015. A plan delivered, issued for delivery, or renewed before September 1, 2015, 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.	
SECTION 3. This Act takes effect September 1, 2015.	SECTION 3. Same as introduced version.