

By: Coleman

H.B. No. 4218

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan coverage in this state.

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

ARTICLE 1. HEALTH BENEFIT AFFORDABILITY AND ACCESSIBILITY

SECTION 1.01. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1218 to read as follows:

CHAPTER 1218. HEALTH BENEFIT AFFORDABILITY AND ACCESSIBILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1218.001. 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 issued 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;

- 1 (6) a stipulated premium company operating under
2 Chapter 884;
- 3 (7) a fraternal benefit society operating under
4 Chapter 885;
- 5 (8) a Lloyd's plan operating under Chapter 941; or
6 (9) an exchange operating under Chapter 942.
- 7 (b) Notwithstanding any other law, this chapter applies to:
- 8 (1) a small employer health benefit plan subject to
9 Chapter 1501, including coverage provided through a health group
10 cooperative under Subchapter B of that chapter;
- 11 (2) a standard health benefit plan issued under
12 Chapter 1507;
- 13 (3) a basic coverage plan under Chapter 1551;
14 (4) a basic plan under Chapter 1575;
15 (5) a primary care coverage plan under Chapter 1579;
16 (6) a plan providing basic coverage under Chapter
17 1601;
- 18 (7) health benefits provided by or through a church
19 benefits board under Subchapter I, Chapter 22, Business
20 Organizations Code;
- 21 (8) group health coverage made available by a school
22 district in accordance with Section 22.004, Education Code;
- 23 (9) the state Medicaid program, including the Medicaid
24 managed care program operated under Chapter 533, Government Code;
- 25 (10) the child health plan program under Chapter 62,
26 Health and Safety Code;
- 27 (11) a regional or local health care program operated

1 under Section 75.104, Health and Safety Code;

2 (12) a self-funded health benefit plan sponsored by a
3 professional employer organization under Chapter 91, Labor Code;

4 (13) county employee group health benefits provided
5 under Chapter 157, Local Government Code; and

6 (14) health and accident coverage provided by a risk
7 pool created under Chapter 172, Local Government Code.

8 (c) This chapter applies to coverage under a group health
9 benefit plan provided to a resident of this state regardless of
10 whether the group policy, agreement, or contract is delivered,
11 issued for delivery, or renewed in this state.

12 Sec. 1218.002. EXCEPTIONS. (a) This chapter does not apply
13 to:

14 (1) a plan that provides coverage:

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

18 (B) as a supplement to a liability insurance
19 policy;

20 (C) for credit insurance;

21 (D) only for dental or vision care;

22 (E) only for hospital expenses; or

23 (F) only for indemnity for hospital confinement;

24 (2) a Medicare supplemental policy as defined by
25 Section 1882(g)(1), Social Security Act (42 U.S.C. Section
26 1395ss(g)(1));

27 (3) a workers' compensation insurance policy;

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

3 (5) a long-term care policy, including a nursing home
4 fixed indemnity policy, unless the commissioner determines that the
5 policy provides benefit coverage so comprehensive that the policy
6 is a health benefit plan as described by Section 1218.001.

7 (b) This chapter does not apply to an individual health
8 benefit plan issued on or before March 23, 2010, that has not had
9 any significant changes since that date that reduce benefits or
10 increase costs to the individual.

11 Sec. 1218.003. CONFLICT WITH OTHER LAW. If this chapter
12 conflicts with another law relating to lifetime or annual benefit
13 limits or the imposition of a premium, deductible, copayment,
14 coinsurance, or other cost-sharing provision, this chapter
15 controls.

16 SUBCHAPTER B. CERTAIN COST-SHARING AND COVERAGE AMOUNT LIMITS

17 PROHIBITED

18 Sec. 1218.051. CERTAIN COST-SHARING PROVISIONS FOR
19 PREVENTIVE SERVICES PROHIBITED. A health benefit plan issuer may
20 not impose a deductible, copayment, coinsurance, or other
21 cost-sharing provision applicable to benefits for:

22 (1) a preventive item or service that has in effect a
23 rating of "A" or "B" in the most recent recommendations of the
24 United States Preventive Services Task Force;

25 (2) an immunization recommended for routine use in the
26 most recent immunization schedules published by the United States
27 Centers for Disease Control and Prevention of the United States

1 Public Health Service; or

2 (3) preventive care and screenings supported by the
3 most recent comprehensive guidelines adopted by the United States
4 Health Resources and Services Administration.

5 Sec. 1218.052. CERTAIN ANNUAL AND LIFETIME LIMITS
6 PROHIBITED. A health benefit plan issuer may not establish an
7 annual or lifetime benefit amount for an enrollee in relation to
8 essential health benefits listed in 42 U.S.C. Section 18022(b)(1),
9 as that section existed on January 1, 2017, and other benefits
10 identified by the United States secretary of health and human
11 services as essential health benefits as of that date.

12 Sec. 1218.053. LIMITATIONS ON COST-SHARING. A health
13 benefit plan issuer may not impose cost-sharing requirements that
14 exceed the limits established in 42 U.S.C. Section 18022(c)(1) in
15 relation to essential health benefits listed in 42 U.S.C. Section
16 18022(b)(1), as those sections existed on January 1, 2017, and
17 other benefits identified by the United States secretary of health
18 and human services as essential health benefits as of that date.

19 Sec. 1218.054. DISCRIMINATION BASED ON GENDER PROHIBITED.
20 A health benefit plan issuer may not charge an individual a higher
21 premium rate based on the individual's gender.

22 SUBCHAPTER C. COVERAGE OF PREEXISTING CONDITIONS

23 Sec. 1218.101. DEFINITION. In this subchapter,
24 "preexisting condition" means a condition present before the
25 effective date of an individual's coverage under a health benefit
26 plan.

27 Sec. 1218.102. PREEXISTING CONDITION RESTRICTIONS

1 PROHIBITED. Notwithstanding any other law, a health benefit plan
2 issuer may not:

3 (1) deny an individual's application for coverage or
4 refuse to enroll an individual in a health benefit plan due to a
5 preexisting condition;

6 (2) limit or exclude coverage under the health benefit
7 plan for the treatment of a preexisting condition otherwise covered
8 under the plan; or

9 (3) charge the individual more for coverage than the
10 health benefit plan issuer charges an individual who does not have a
11 preexisting condition.

12 SUBCHAPTER D. EXTERNAL REVIEW PROCEDURE

13 Sec. 1218.151. EXTERNAL REVIEW MODEL ACT RULES. (a) The
14 department shall adopt rules as necessary to conform Texas law with
15 the requirements of the NAIC Uniform Health Carrier External Review
16 Model Act (April 2010).

17 (b) To the extent that the rules adopted under this section
18 conflict with Chapter 843 or Title 14, the rules control.

19 ARTICLE 2. HEALTH BENEFIT PLAN COVERAGE FOR MENTAL HEALTH
20 CONDITIONS AND SUBSTANCE USE DISORDERS

21 SECTION 2.01. Chapter 1355, Insurance Code, is amended by
22 adding Subchapter F to read as follows:

23 SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE
24 USE DISORDERS

25 Sec. 1355.251. DEFINITIONS. In this subchapter:

26 (1) "Financial requirement" includes a requirement
27 relating to a deductible, copayment, coinsurance, or other

1 out-of-pocket expense or an annual or lifetime limit.

2 (2) "Mental health benefit" means a benefit relating
3 to an item or service for a mental health condition, as defined
4 under the terms of a health benefit plan and in accordance with
5 applicable federal and state law.

6 (3) "Nonquantitative treatment limitation" includes:

7 (A) a medical management standard limiting or
8 excluding benefits based on medical necessity or medical
9 appropriateness or based on whether a treatment is experimental or
10 investigational;

11 (B) formulary design for prescription drugs;

12 (C) network tier design;

13 (D) a standard for provider participation in a
14 network, including reimbursement rates;

15 (E) a method used by a health benefit plan to
16 determine usual, customary, and reasonable charges;

17 (F) a step therapy protocol;

18 (G) an exclusion based on failure to complete a
19 course of treatment; and

20 (H) a restriction based on geographic location,
21 facility type, provider specialty, and other criteria that limit
22 the scope or duration of a benefit.

23 (4) "Substance use disorder benefit" means a benefit
24 relating to an item or service for a substance use disorder, as
25 defined under the terms of a health benefit plan and in accordance
26 with applicable federal and state law.

27 (5) "Treatment limitation" includes a limit on the

1 frequency of treatment, number of visits, days of coverage, or
2 other similar limit on the scope or duration of treatment. The term
3 includes a nonquantitative treatment limitation.

4 Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This
5 subchapter applies only to a health benefit plan that provides
6 benefits for medical or surgical expenses incurred as a result of a
7 health condition, accident, or sickness, including an individual,
8 group, blanket, or franchise insurance policy or insurance
9 agreement, a group hospital service contract, or an individual or
10 group evidence of coverage or similar coverage document that is
11 issued by:

12 (1) an insurance company;

13 (2) a group hospital service corporation operating
14 under Chapter 842;

15 (3) a health maintenance organization operating under
16 Chapter 843;

17 (4) an approved nonprofit health corporation that
18 holds a certificate of authority under Chapter 844;

19 (5) a multiple employer welfare arrangement that holds
20 a certificate of authority under Chapter 846;

21 (6) a stipulated premium company operating under
22 Chapter 884;

23 (7) a fraternal benefit society operating under
24 Chapter 885;

25 (8) a Lloyd's plan operating under Chapter 941; or

26 (9) an exchange operating under Chapter 942.

27 (b) Notwithstanding any other law, this subchapter applies

1 to:

2 (1) a small employer health benefit plan subject to
3 Chapter 1501, including coverage provided through a health group
4 cooperative under Subchapter B of that chapter;

5 (2) a standard health benefit plan issued under
6 Chapter 1507;

7 (3) a basic coverage plan under Chapter 1551;

8 (4) a basic plan under Chapter 1575;

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

10 (6) a plan providing basic coverage under Chapter
11 1601;

12 (7) health benefits provided by or through a church
13 benefits board under Subchapter I, Chapter 22, Business
14 Organizations Code;

15 (8) group health coverage made available by a school
16 district in accordance with Section 22.004, Education Code;

17 (9) the state Medicaid program, including the Medicaid
18 managed care program operated under Chapter 533, Government Code;

19 (10) the child health plan program under Chapter 62,
20 Health and Safety Code;

21 (11) a regional or local health care program operated
22 under Section 75.104, Health and Safety Code;

23 (12) a self-funded health benefit plan sponsored by a
24 professional employer organization under Chapter 91, Labor Code;

25 (13) county employee group health benefits provided
26 under Chapter 157, Local Government Code; and

27 (14) health and accident coverage provided by a risk

1 pool created under Chapter 172, Local Government Code.

2 (c) This subchapter applies to coverage under a group health
3 benefit plan provided to a resident of this state regardless of
4 whether the group policy, agreement, or contract is delivered,
5 issued for delivery, or renewed in this state.

6 Sec. 1355.253. EXCEPTION. This subchapter does not apply
7 to an individual health benefit plan issued on or before March 23,
8 2010, that has not had any significant changes since that date that
9 reduce benefits or increase costs to the individual.

10 Sec. 1355.254. REQUIRED COVERAGE FOR MENTAL HEALTH
11 CONDITIONS AND SUBSTANCE USE DISORDERS. (a) A health benefit plan
12 must provide benefits for mental health conditions and substance
13 use disorders under the same terms and conditions applicable to
14 benefits for medical or surgical expenses.

15 (b) Coverage under Subsection (a) may not impose treatment
16 limitations or financial requirements on benefits for a mental
17 health condition or substance use disorder that are generally more
18 restrictive than treatment limitations or financial requirements
19 imposed on coverage of benefits for medical or surgical expenses.

20 Sec. 1355.255. DEFINITIONS UNDER PLAN. (a) A health
21 benefit plan must define a condition to be a mental health condition
22 or not a mental health condition in a manner consistent with
23 generally recognized independent standards of medical practice.

24 (b) A health benefit plan must define a condition to be a
25 substance use disorder or not a substance use disorder in a manner
26 consistent with generally recognized independent standards of
27 medical practice.

1 Sec. 1355.256. COORDINATION WITH OTHER LAW; INTENT OF
2 LEGISLATURE. This subchapter supplements Subchapters A and B of
3 this chapter and Chapter 1368 and the department rules adopted
4 under those statutes. It is the intent of the legislature that
5 Subchapter A or B of this chapter or Chapter 1368 or the department
6 rules adopted under those statutes controls in any circumstance in
7 which that other law requires:

8 (1) a benefit that is not required by this subchapter;

9 or

10 (2) a more extensive benefit than is required by this
11 subchapter.

12 Sec. 1355.257. RULES. The commissioner shall adopt rules
13 necessary to implement this subchapter.

14 ARTICLE 3. COVERAGE OF ESSENTIAL HEALTH BENEFITS

15 SECTION 3.01. Subtitle E, Title 8, Insurance Code, is
16 amended by adding Chapter 1380 to read as follows:

17 CHAPTER 1380. COVERAGE OF ESSENTIAL HEALTH BENEFITS

18 Sec. 1380.001. APPLICABILITY OF CHAPTER. (a) This chapter
19 applies only to a health benefit plan that provides benefits for
20 medical or surgical expenses incurred as a result of a health
21 condition, accident, or sickness, including an individual, group,
22 blanket, or franchise insurance policy or insurance agreement, a
23 group hospital service contract, or an individual or group evidence
24 of coverage or similar coverage document that is issued by:

25 (1) an insurance company;

26 (2) a group hospital service corporation operating
27 under Chapter 842;

- 1 (3) a health maintenance organization operating under
2 Chapter 843;
- 3 (4) an approved nonprofit health corporation that
4 holds a certificate of authority under Chapter 844;
- 5 (5) a multiple employer welfare arrangement that holds
6 a certificate of authority under Chapter 846;
- 7 (6) a stipulated premium company operating under
8 Chapter 884;
- 9 (7) a fraternal benefit society operating under
10 Chapter 885;
- 11 (8) a Lloyd's plan operating under Chapter 941; or
12 (9) an exchange operating under Chapter 942.
- 13 (b) Notwithstanding any other law, this chapter applies to:
- 14 (1) a small employer health benefit plan subject to
15 Chapter 1501, including coverage provided through a health group
16 cooperative under Subchapter B of that chapter;
- 17 (2) a standard health benefit plan issued under
18 Chapter 1507;
- 19 (3) a basic coverage plan under Chapter 1551;
20 (4) a basic plan under Chapter 1575;
21 (5) a primary care coverage plan under Chapter 1579;
22 (6) a plan providing basic coverage under Chapter
23 1601;
- 24 (7) health benefits provided by or through a church
25 benefits board under Subchapter I, Chapter 22, Business
26 Organizations Code;
- 27 (8) group health coverage made available by a school

1 district in accordance with Section 22.004, Education Code;

2 (9) the state Medicaid program, including the Medicaid
3 managed care program operated under Chapter 533, Government Code;

4 (10) the child health plan program under Chapter 62,
5 Health and Safety Code;

6 (11) a regional or local health care program operated
7 under Section 75.104, Health and Safety Code;

8 (12) a self-funded health benefit plan sponsored by a
9 professional employer organization under Chapter 91, Labor Code;

10 (13) county employee group health benefits provided
11 under Chapter 157, Local Government Code; and

12 (14) health and accident coverage provided by a risk
13 pool created under Chapter 172, Local Government Code.

14 (c) This chapter applies to coverage under a group health
15 benefit plan provided to a resident of this state regardless of
16 whether the group policy, agreement, or contract is delivered,
17 issued for delivery, or renewed in this state.

18 Sec. 1380.002. EXCEPTION. This chapter does not apply to an
19 individual health benefit plan issued on or before March 23, 2010,
20 that has not had any significant changes since that date that reduce
21 benefits or increase costs to the individual.

22 Sec. 1380.003. REQUIRED COVERAGE FOR ESSENTIAL HEALTH
23 BENEFITS. A health benefit plan must provide coverage for the
24 essential health benefits listed in 42 U.S.C. Section 18022(b)(1),
25 as that section existed on January 1, 2017, and other benefits
26 identified by the United States secretary of health and human
27 services as essential health benefits as of that date.

1 ARTICLE 4. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN YOUNG ADULTS

2 SECTION 4.01. Subchapter A, Chapter 533, Government Code,
3 is amended by adding Section 533.0054 to read as follows:

4 Sec. 533.0054. ELIGIBILITY AGE FOR STAR HEALTH COVERAGE. A
5 child enrolled in the STAR Health Medicaid managed care program is
6 eligible to receive health care services under the program until
7 the child is 26 years of age.

8 SECTION 4.02. Section 846.260, Insurance Code, is amended
9 to read as follows:

10 Sec. 846.260. LIMITING AGE APPLICABLE TO UNMARRIED CHILD.
11 If children are eligible for coverage under the terms of a multiple
12 employer welfare arrangement's plan document, any limiting age
13 applicable to an unmarried child of an enrollee is 26 [~~25~~] years of
14 age.

15 SECTION 4.03. Section 1201.053(b), Insurance Code, as
16 effective until September 1, 2018, is amended to read as follows:

17 (b) On the application of an adult member of a family, an
18 individual accident and health insurance policy may, at the time of
19 original issuance or by subsequent amendment, insure two or more
20 eligible members of the adult's family, including a spouse,
21 unmarried children younger than 26 [~~25~~] years of age, including a
22 grandchild of the adult as described by Section 1201.062(a)(1), a
23 child the adult is required to insure under a medical support order
24 issued under Chapter 154, Family Code, or enforceable by a court in
25 this state, and any other individual dependent on the adult.

26 SECTION 4.04. Section 1201.053(b), Insurance Code, as
27 effective September 1, 2018, is amended to read as follows:

1 (b) On the application of an adult member of a family, an
2 individual accident and health insurance policy may, at the time of
3 original issuance or by subsequent amendment, insure two or more
4 eligible members of the adult's family, including a spouse,
5 unmarried children younger than 26 [~~25~~] years of age, including a
6 grandchild of the adult as described by Section 1201.062(a)(1), a
7 child the adult is required to insure under a medical support order
8 or dental support order, if the policy provides dental coverage,
9 issued under Chapter 154, Family Code, or enforceable by a court in
10 this state, and any other individual dependent on the adult.

11 SECTION 4.05. Section 1201.062(a), Insurance Code, as
12 effective until September 1, 2018, is amended to read as follows:

13 (a) An individual or group accident and health insurance
14 policy that is delivered, issued for delivery, or renewed in this
15 state, including a policy issued by a corporation operating under
16 Chapter 842, or a self-funded or self-insured welfare or benefit
17 plan or program, to the extent that regulation of the plan or
18 program is not preempted by federal law, that provides coverage for
19 a child of an insured or group member, on payment of a premium, must
20 provide coverage for:

21 (1) each grandchild of the insured or group member if
22 the grandchild is:

23 (A) unmarried;

24 (B) younger than 26 [~~25~~] years of age; and

25 (C) a dependent of the insured or group member
26 for federal income tax purposes at the time application for
27 coverage of the grandchild is made; and

1 (2) each child for whom the insured or group member
2 must provide medical support under an order issued under Chapter
3 154, Family Code, or enforceable by a court in this state.

4 SECTION 4.06. Section 1201.062(a), Insurance Code, as
5 effective September 1, 2018, is amended to read as follows:

6 (a) An individual or group accident and health insurance
7 policy that is delivered, issued for delivery, or renewed in this
8 state, including a policy issued by a corporation operating under
9 Chapter 842, or a self-funded or self-insured welfare or benefit
10 plan or program, to the extent that regulation of the plan or
11 program is not preempted by federal law, that provides coverage for
12 a child of an insured or group member, on payment of a premium, must
13 provide coverage for:

14 (1) each grandchild of the insured or group member if
15 the grandchild is:

- 16 (A) unmarried;
- 17 (B) younger than 26 [~~25~~] years of age; and
- 18 (C) a dependent of the insured or group member
19 for federal income tax purposes at the time application for
20 coverage of the grandchild is made; and

21 (2) each child for whom the insured or group member
22 must provide medical support or dental support, if the policy
23 provides dental coverage, under an order issued under Chapter 154,
24 Family Code, or enforceable by a court in this state.

25 SECTION 4.07. Section 1201.065(a), Insurance Code, is
26 amended to read as follows:

27 (a) An individual or group accident and health insurance

1 policy may contain criteria relating to a maximum age or enrollment
2 in school to establish continued eligibility for coverage of a
3 child 26 [~~25~~] years of age or older.

4 SECTION 4.08. Section [1251.151](#)(a), Insurance Code, is
5 amended to read as follows:

6 (a) A group policy or contract of insurance for hospital,
7 surgical, or medical expenses incurred as a result of accident or
8 sickness, including a group contract issued by a group hospital
9 service corporation, that provides coverage under the policy or
10 contract for a child of an insured must, on payment of a premium,
11 provide coverage for any grandchild of the insured if the
12 grandchild is:

- 13 (1) unmarried;
- 14 (2) younger than 26 [~~25~~] years of age; and
- 15 (3) a dependent of the insured for federal income tax
16 purposes at the time the application for coverage of the grandchild
17 is made.

18 SECTION 4.09. Section [1251.152](#)(a), Insurance Code, is
19 amended to read as follows:

- 20 (a) For purposes of this section, "dependent" includes:
- 21 (1) a child of an employee or member who is:
- 22 (A) unmarried; and
- 23 (B) younger than 26 [~~25~~] years of age; and
- 24 (2) a grandchild of an employee or member who is:
- 25 (A) unmarried;
- 26 (B) younger than 26 [~~25~~] years of age; and
- 27 (C) a dependent of the insured for federal income

1 tax purposes at the time the application for coverage of the
2 grandchild is made.

3 SECTION 4.10. Section 1271.006(a), Insurance Code, is
4 amended to read as follows:

5 (a) If children are eligible for coverage under the terms of
6 an evidence of coverage, any limiting age applicable to an
7 unmarried child of an enrollee, including an unmarried grandchild
8 of an enrollee, is 26 [~~25~~] years of age. The limiting age
9 applicable to a child must be stated in the evidence of coverage.

10 SECTION 4.11. Section 1501.002(2), Insurance Code, is
11 amended to read as follows:

- 12 (2) "Dependent" means:
- 13 (A) a spouse;
- 14 (B) a child younger than 26 [~~25~~] years of age,
15 including a newborn child;
- 16 (C) a child of any age who is:
- 17 (i) medically certified as disabled; and
- 18 (ii) dependent on the parent;
- 19 (D) an individual who must be covered under:
- 20 (i) Section 1251.154; or
- 21 (ii) Section 1201.062; and
- 22 (E) any other child eligible under an employer's
23 health benefit plan, including a child described by Section
24 1503.003.

25 SECTION 4.12. Section 1501.609(b), Insurance Code, is
26 amended to read as follows:

27 (b) Any limiting age applicable under a large employer

1 health benefit plan to an unmarried child of an enrollee is 26 [~~25~~]
2 years of age.

3 SECTION 4.13. Sections 1503.003(a) and (b), Insurance Code,
4 are amended to read as follows:

5 (a) A health benefit plan may not condition coverage for a
6 child younger than 26 [~~25~~] years of age on the child's being
7 enrolled at an educational institution.

8 (b) A health benefit plan that requires as a condition of
9 coverage for a child 26 [~~25~~] years of age or older that the child be
10 a full-time student at an educational institution must provide the
11 coverage:

12 (1) for the entire academic term during which the
13 child begins as a full-time student and remains enrolled,
14 regardless of whether the number of hours of instruction for which
15 the child is enrolled is reduced to a level that changes the child's
16 academic status to less than that of a full-time student; and

17 (2) continuously until the 10th day of instruction of
18 the subsequent academic term, on which date the health benefit plan
19 may terminate coverage for the child if the child does not return to
20 full-time student status before that date.

21 SECTION 4.14. Section 1601.004(a), Insurance Code, is
22 amended to read as follows:

23 (a) In this chapter, "dependent," with respect to an
24 individual eligible to participate in the uniform program under
25 Section 1601.101 or 1601.102, means the individual's:

26 (1) spouse;

27 (2) unmarried child younger than 26 [~~25~~] years of age;

1 and

2 (3) child of any age who lives with or has the child's
3 care provided by the individual on a regular basis if the child has
4 a mental disability or is [~~mentally retarded or~~] physically
5 incapacitated to the extent that the child is dependent on the
6 individual for care or support, as determined by the system.

7 ARTICLE 5. TRANSITION; EFFECTIVE DATE

8 SECTION 5.01. The change in law made by this Act applies
9 only to a health benefit plan that is delivered, issued for
10 delivery, or renewed on or after January 1, 2018. A health benefit
11 plan that is delivered, issued for delivery, or renewed before
12 January 1, 2018, is governed by the law as it existed immediately
13 before the effective date of this Act, and that law is continued in
14 effect for that purpose.

15 SECTION 5.02. If before implementing any provision of this
16 Act a state agency determines that a waiver or authorization from a
17 federal agency is necessary for implementation of that provision,
18 the agency affected by the provision shall request the waiver or
19 authorization and may delay implementing that provision until the
20 waiver or authorization is granted.

21 SECTION 5.03. This Act takes effect September 1, 2017.