By: Rodríguez S.B. No. 2224

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;

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

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

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

(2) a standard health benefit plan issued 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;

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

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

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

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

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

(11) a regional or local health care program operated

under Section 75.104, Health and Safety Code;

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

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

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

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

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

(1) a plan that provides coverage:

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

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

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) 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(g)(1));

(3) a workers' compensation insurance policy;

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

(5) a long-term care 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 as described by Section 1218.001.

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

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

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

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

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

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

Public Health Service; or

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

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

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

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

SUBCHAPTER C. COVERAGE OF PREEXISTING CONDITIONS

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

Sec. 1218.102. PREEXISTING CONDITION RESTRICTIONS

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

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

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

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

SUBCHAPTER D. EXTERNAL REVIEW PROCEDURE

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

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

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

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

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

Sec. 1355.251. DEFINITIONS. In this subchapter:

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

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

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

(3) "Nonquantitative treatment limitation" includes:

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

(B) formulary design for prescription drugs;

(C) network tier design;

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

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

(F) a step therapy protocol;

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

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

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

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

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

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter 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;

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

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies

to:

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

(2) a standard health benefit plan issued 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;

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

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

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

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

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

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

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

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

(14) health and accident coverage provided by a risk

pool created under Chapter 172, Local Government Code.

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

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

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

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

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

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

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

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

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

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

ARTICLE 3. COVERAGE OF ESSENTIAL HEALTH BENEFITS

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

CHAPTER 1380. COVERAGE OF ESSENTIAL HEALTH BENEFITS

Sec. 1380.001. 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;

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

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

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

(2) a standard health benefit plan issued 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;

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

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

(8) group health coverage made available by a school

district in accordance with Section 22.004, Education Code;

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

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

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

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

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

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

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

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

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

ARTICLE 4. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN YOUNG ADULTS

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

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

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

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

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

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

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

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

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

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

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

(A) unmarried;

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

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

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

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

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

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

(A) unmarried;

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

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

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

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

(a) An individual or group accident and health insurance

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

SECTION 4.08. Section 1251.151(a), Insurance Code, is amended to read as follows:

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

(1) unmarried;

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

(3) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

SECTION 4.09. Section 1251.152(a), Insurance Code, is amended to read as follows:

(a) For purposes of this section, "dependent" includes:

(1) a child of an employee or member who is:

(A) unmarried; and

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

(2) a grandchild of an employee or member who is:

(A) unmarried;

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

(C) a dependent of the insured for federal income

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

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

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

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

(2) "Dependent" means:

(A) a spouse;

(B) a child younger than 26 [~~25~~] years of age, including a newborn child;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

(i) Section 1251.154; or

(ii) Section 1201.062; and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section 1503.003.

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

(b) Any limiting age applicable under a large employer

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

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

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

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

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

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

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

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

(1) spouse;

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

and

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

ARTICLE 5. TRANSITION; EFFECTIVE DATE

SECTION 5.01. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2018. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2018, 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 5.02. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

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