87R18195 SMT-D

By:  Israel H.B. No. 2761

Substitute the following for H.B. No. 2761:

By:  Oliverson C.S.H.B. No. 2761

A BILL TO BE ENTITLED

AN ACT

relating to disclosure requirements for accident and health coverage and health expense arrangements marketed to individuals.

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

SECTION 1.  Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1223 to read as follows:

CHAPTER 1223. MANDATORY DISCLOSURES FOR ALTERNATIVE HEALTH COVERAGE AND HEALTH EXPENSE ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1223.001.  DEFINITION. In this chapter, "issuer" means a person who markets, sells, issues, or operates an individual health benefit plan or health expense arrangement governed by this chapter.

Sec. 1223.002.  APPLICABILITY. (a) Except as provided by Subsection (b) or Section 1223.003 but notwithstanding any other law, this chapter applies to a health benefit plan or health expense arrangement marketed to an individual to provide health benefit coverage or pay for health care expenses, including:

(1)  a health care sharing ministry operated under Chapter 1681;

(2)  a discount health care program governed by Chapter 7001;

(3)  a direct primary care arrangement governed by Subchapter F, Chapter 162, Occupations Code, but only if sold or marketed by a person other than a physician contracting directly with a patient; or

(4)  any other plan or arrangement the commissioner determines is or could be marketed to an individual as an alternative to major medical coverage.

(b)  Except as provided by Section 1223.003 and notwithstanding any other law, this chapter applies to an individual accident and health insurance policy governed by Chapter 1201 or a group accident and health insurance policy governed by Chapter 1251 and marketed to an individual if the policy is a fixed indemnity, specified disease, or medical indemnity policy and:

(1)  the policy is marketed by the insurer or a third party as an alternative to major medical coverage; or

(2)  the policy:

(A)  has a range of benefits that is similar to the range of benefits in major medical coverage; and

(B)  may be sold as stand-alone coverage because the issuer does not require a purchaser to be covered by major medical coverage.

Sec. 1223.003.  EXCEPTION. This chapter does not apply to a health benefit plan or health expense arrangement if:

(1)  the issuer is required to submit a summary of benefits and coverage for the plan or arrangement to the United States secretary of health and human services under 42 U.S.C. Section 300gg-15; or

(2)  the issuer is required to provide a disclosure form for the plan or arrangement under Section 1509.002.

Sec. 1223.004.  RULES. The commissioner may adopt rules necessary to implement this chapter. Section 2001.0045, Government Code, does not apply to rules adopted under this section.

SUBCHAPTER B. DISCLOSURE REQUIRED

Sec. 1223.051.  DISCLOSURE FORM TEMPLATE. (a) The commissioner by rule shall prescribe a disclosure form template for each type of health benefit plan or health expense arrangement to which this chapter applies.

(b)  The commissioner shall ensure that the disclosure form template is presented in plain language and in a standardized format designed to facilitate consumer understanding.

(c)  The commissioner may prescribe as many disclosure form templates as necessary to account for each type of health benefit plan or health expense arrangement.

(d)  The disclosure form template may include the following information, if applicable, that is tailored to the type of health benefit plan or health expense arrangement described by the template:

(1)  a statement:

(A)  of whether the plan or arrangement is insurance; and

(B)  of what, if any, guarantees are made of payment for or related to health care services;

(2)  the duration of the coverage or the arrangement;

(3)  if the plan or arrangement is subject to renewal, a statement:

(A)  of whether:

(i)  the plan or arrangement may be renewed at the option of the enrollee or participant with no new underwriting;

(ii)  the plan or arrangement is only able to be renewed at the option of the issuer after underwriting; or

(iii)  the plan or arrangement may not be renewed; and

(B)  of whether, on renewal, the issuer is able to:

(i)  increase the premium or assess a direct fee, contribution, or similar cost; or

(ii)  make changes to the plan or arrangement terms, including benefits and limits, based on an individual's health status;

(4)  a statement that the expiration of the plan or arrangement is not a qualifying life event that would make a person eligible for a special enrollment period, if applicable;

(5)  a statement that the plan or arrangement may expire outside of the open enrollment period under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(6)  to the extent the information is available, the dates of the next three open enrollment periods under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(7)  whether the plan or arrangement contains any limitations or exclusions to preexisting conditions;

(8)  the maximum dollar amount payable or shareable under the plan or arrangement;

(9)  the primary cost-sharing features under the plan or arrangement, including a deductible or amount that is not shareable, and the health care services to which the cost-sharing features apply;

(10)  whether the following health care services are covered or shareable and any limits relevant to that coverage or shareability:

(A)  prescription drugs;

(B)  mental health services;

(C)  substance abuse treatment;

(D)  maternity care;

(E)  hospitalization;

(F)  surgery;

(G)  emergency health care; and

(H)  preventive health care;

(11)  for a plan or arrangement other than a traditional, major medical health benefit plan, information on unique aspects of the plan or arrangement and how it differs from traditional, major medical coverage that the commissioner determines is important to facilitate consumer understanding; and

(12)  any other information the commissioner determines is important for a purchaser or participant of a plan or arrangement.

(e)  The commissioner may omit information described by Subsection (d) in a disclosure form template if the information is inapplicable to the type of plan or arrangement for which the template is prescribed.

(f)  The department shall incorporate the content for an outline of coverage required by Section 1201.108 into the disclosure form template for a policy to which that section applies.

Sec. 1223.052.  DISCLOSURE FORM REVIEW. (a) Before an issuer may sell, market, or provide an insurance product that is subject to a determination by the commissioner under Section 1223.002(a)(4) or that is described by Section 1223.002(b), the issuer shall submit to the department for approval in the manner prescribed by commissioner rule a disclosure form on the product.

(b)  Except as provided by Subsection (a), an issuer providing a health benefit plan or health expense arrangement described by Section 1223.002(a) to a consumer shall submit to the department for informational purposes in the manner prescribed by commissioner rule a disclosure form for each plan or arrangement offered by the issuer.

(c)  Except as provided by Subsection (d), the disclosure form must use the disclosure form template prescribed by the commissioner under Section 1223.051 for the health benefit plan or health expense arrangement described by the form.

(d)  An issuer may modify the disclosure form template for a health benefit plan or health expense arrangement that is not able to be accurately represented by the template. If the issuer modifies the template, the issuer shall clearly identify any changes made and explain the reason for those changes when the issuer submits the form under Subsection (a) or (b).

(e)  The department shall approve a disclosure form submitted under Subsection (a) if the form uses the appropriate disclosure form template and accurately describes the health benefit plan or health expense arrangement in a manner that is easily understandable to a consumer.

Sec. 1223.053.  DISCLOSURE TO CONSUMER. (a) An issuer shall provide to a consumer the disclosure form submitted under Section 1223.052 along with an application, if applicable:

(1)  before the earliest of the time that the consumer completes an application, makes an initial premium payment, or makes any other payment in connection with coverage under or participation in the health benefit plan or health expense arrangement; and

(2)  at the time the policy, certificate, or arrangement is issued or entered into.

(b)  An issuer shall ensure that a consumer signs the disclosure form before the issuer accepts an application or payment for or issues or enters into the health benefit plan or health expense arrangement. An electronic signature must comply with Chapter 35 and rules adopted under this chapter.

Sec. 1223.054.  RETENTION. An issuer shall retain a signed disclosure form until the fifth anniversary of the date the issuer receives the form, and the issuer shall make the form available to the department on request.

Sec. 1223.055.  HEALTH CARE SHARING MINISTRIES. The commissioner shall consult with the attorney general in prescribing the disclosure form template applicable to a health care sharing ministry, and the template must incorporate the notice described by Section 1681.002.

Sec. 1223.056.  DIRECT PRIMARY CARE ARRANGEMENTS. The commissioner shall consult with the Texas Medical Board in prescribing the disclosure form template applicable to a direct primary care arrangement, and the template must incorporate the disclosure required by Section 162.256, Occupations Code.

Sec. 1223.057.  ENFORCEMENT. The department may take an enforcement action under Subtitle B, Title 2, against an issuer that violates this chapter.

SECTION 2.  Not later than September 1, 2022, the commissioner of insurance shall adopt rules necessary to implement Chapter 1223, Insurance Code, as added by this Act.

SECTION 3.  Chapter 1223, Insurance Code, as added by this Act, applies only to a health benefit plan or health expense arrangement delivered, issued for delivery, entered into, or renewed on or after September 1, 2022.

SECTION 4.  This Act takes effect September 1, 2021.