

By: Thierry

H.B. No. 3043

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan coverage of individuals with a prior diagnosis of COVID-19.

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

SECTION 1. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1511 to read as follows:

CHAPTER 1511. COVERAGE OF PREEXISTING CONDITIONS

Sec. 1511.001. DEFINITION. In this chapter, "prior diagnosis of COVID-19" means a diagnosis of coronavirus disease (COVID-19) or a related symptom or condition, present before the effective date of an individual's coverage under a health benefit plan.

Sec. 1511.002. 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;

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

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

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

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

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

10 (9) an exchange operating under Chapter 942.

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

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

15 (2) a standard health benefit plan issued under
16 Chapter 1507;

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

18 (4) a basic plan under Chapter 1575;

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

20 (6) a plan providing basic coverage under Chapter
21 1601;

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

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

27 (9) the state Medicaid program, including the Medicaid

1 managed care program operated under Chapter 533, Government Code;

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

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

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

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

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

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

16 (d) Notwithstanding any other law, this chapter applies to a
17 health benefit plan under which coverage is contractually limited
18 to fewer than 12 months in duration.

19 Sec. 1511.003. EXCEPTIONS. This chapter does not apply to:

20 (1) a plan that provides coverage:

21 (A) only for a specified disease or for another
22 limited benefit;

23 (B) only for accidental death or dismemberment;

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

27 (D) as a supplement to a liability insurance

1 policy;

2 (E) for credit insurance;

3 (F) only for dental or vision care; or

4 (G) only for indemnity for hospital confinement;

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

7 (3) a workers' compensation insurance policy;

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

10 (5) a long-term care insurance policy, including a
11 nursing home fixed indemnity policy, unless the commissioner
12 determines that the policy provides benefit coverage so
13 comprehensive that the policy is a health benefit plan as described
14 by Section 1511.002.

15 Sec. 1511.004. RESTRICTIONS BASED ON PRIOR DIAGNOSIS OF
16 COVID-19 PROHIBITED. Notwithstanding any other law, a health
17 benefit plan issuer may not:

18 (1) deny coverage to or refuse to enroll an individual
19 in a health benefit plan on the basis of a prior diagnosis of
20 COVID-19;

21 (2) limit or exclude coverage under the health benefit
22 plan for treatment related to the individual's prior diagnosis of
23 COVID-19 otherwise covered under the plan; or

24 (3) charge the individual more for coverage than the
25 health benefit plan issuer charges an individual who does not have a
26 prior diagnosis of COVID-19.

27 SECTION 2. If before implementing any provision of this Act

1 a state agency determines that a waiver or authorization from a
2 federal agency is necessary for implementation of that provision,
3 the agency affected by the provision shall request the waiver or
4 authorization and may delay implementing that provision until the
5 waiver or authorization is granted.

6 SECTION 3. The change in law made by this Act applies only
7 to a health benefit plan that is delivered, issued for delivery, or
8 renewed on or after January 1, 2022. A health benefit plan that is
9 delivered, issued for delivery, or renewed before January 1, 2022,
10 is governed by the law as it existed immediately before the
11 effective date of this Act, and that law is continued in effect for
12 that purpose.

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