

By: Coleman

H.B. No. 4143

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 COVERAGE AVAILABILITY

SECTION 1.01. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1511 to read as follows:

CHAPTER 1511. HEALTH BENEFIT COVERAGE AVAILABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1511.001. APPLICABILITY OF CHAPTER. (a) Except as otherwise provided by this chapter, 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

1 a certificate of authority under Chapter 846;

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

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

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

7 (9) an exchange operating under Chapter 942.

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

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

12 (2) a standard health benefit plan issued under  
13 Chapter 1507.

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. 1511.002. EXCEPTIONS. (a) This chapter does not apply  
19 to:

20 (1) a plan that provides coverage:

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

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

26 (C) for credit insurance;

27 (D) only for dental or vision care;

1           (E) only for a specified disease or for another  
2 limited benefit; or

3           (F) only for accidental death or dismemberment;  
4           (2) a Medicare supplemental policy as defined by  
5 Section 1882(g)(1), Social Security Act (42 U.S.C. Section  
6 1395ss(g)(1));

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 policy, including a nursing home  
11 fixed indemnity policy, unless the commissioner determines that the  
12 policy provides benefit coverage so comprehensive that the policy  
13 is a health benefit plan as described by Section 1511.001.

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

18           Sec. 1511.003. CONFLICT WITH OTHER LAW. If there is a  
19 conflict between this chapter and other law, this chapter prevails.

20           Sec. 1511.004. RULES. (a) Subject to Subsection (b), the  
21 commissioner may adopt rules as necessary to implement this  
22 chapter.

23           (b) Rules adopted by the commissioner to implement this  
24 chapter must be consistent with the Patient Protection and  
25 Affordable Care Act (Pub. L. No. 111-148), as that Act existed on  
26 January 1, 2017.

1           SUBCHAPTER B. GUARANTEED ISSUE AND RENEWABILITY

2           Sec. 1511.051. GUARANTEED ISSUE. A health benefit plan  
3 issuer shall issue a group or individual health benefit plan chosen  
4 by a group plan sponsor or individual to each group plan sponsor or  
5 individual that elects to be covered under the plan and agrees to  
6 satisfy the requirements of the plan.

7           Sec. 1511.052. RENEWABILITY AND CONTINUATION OF HEALTH  
8 BENEFIT PLANS. (a) Except as provided by Subsection (b), a health  
9 benefit plan issuer shall renew or continue a group or individual  
10 health benefit plan at the option of the group plan sponsor or  
11 individual, as applicable.

12           (b) A health benefit plan issuer may decline to renew or  
13 continue a group or individual health benefit plan:

14           (1) for failure to pay a premium or contribution in  
15 accordance with the terms of the plan;

16           (2) for fraud or intentional misrepresentation;

17           (3) because the issuer is ceasing to offer coverage in  
18 the relevant market in accordance with rules adopted by the  
19 commissioner;

20           (4) with respect to an individual plan, because an  
21 individual no longer resides, lives, or works in an area in which  
22 the issuer is authorized to provide coverage, but only if all plans  
23 are not renewed or not continued under this subdivision uniformly  
24 without regard to any health status related factor of covered  
25 individuals; or

26           (5) in accordance with federal law, including  
27 regulations.

1       Sec. 1511.053. RESCISSION PROHIBITED; EXCEPTION. (a)

2 Notwithstanding any other law, except as provided by Subsection  
3 (b), a health benefit plan issuer may not rescind coverage under a  
4 health benefit plan with respect to an enrollee in the plan.

5       (b) A health benefit plan issuer may rescind coverage under  
6 a health benefit plan with respect to an enrollee if the enrollee  
7 engages in conduct that constitutes fraud or makes an intentional  
8 misrepresentation of a material fact.

9       Sec. 1511.054. EXCESSIVE WAITING PERIODS PROHIBITED. A  
10 health benefit plan issuer issuing a group or individual health  
11 benefit plan may not require a waiting period for coverage that  
12 exceeds 90 days.

13       Sec. 1511.055. OPEN AND SPECIAL ENROLLMENT PERIODS. (a) A  
14 health benefit plan issuer issuing an individual health benefit  
15 plan may restrict enrollment in coverage to an annual open  
16 enrollment period and special enrollment periods.

17       (b) An individual or an individual's dependent qualified to  
18 enroll in an individual health benefit plan may enroll anytime  
19 during the open enrollment period or during a special enrollment  
20 period designated by the commissioner.

21       (c) A health benefit plan issuer issuing a group health  
22 benefit plan may not limit enrollment to an open or special  
23 enrollment period.

24       (d) The commissioner shall adopt rules as necessary to  
25 administer this section, including rules designating enrollment  
26 periods.

1           SUBCHAPTER C. PREEXISTING CONDITIONS AND HEALTH STATUS

2           Sec. 1511.101. DEFINITIONS. In this subchapter:

3                   (1) "Dependent" has the meaning assigned by Section  
4 1501.002.

5                   (2) "Health status related factor" has the meaning  
6 assigned by Section 1501.002.

7                   (3) "Preexisting condition" means a condition present  
8 before the effective date of an individual's coverage under a  
9 health benefit plan.

10           Sec. 1511.102. APPLICABILITY                   OF                   SUBCHAPTER.

11 Notwithstanding any other law, in addition to a health benefit plan  
12 to which this chapter applies under Subchapter A, this subchapter  
13 applies to:

14                   (1) a basic coverage plan under Chapter 1551;

15                   (2) a basic plan under Chapter 1575;

16                   (3) a primary care coverage plan under Chapter 1579;

17                   (4) a plan providing basic coverage under Chapter  
18 1601;

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

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

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

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

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

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

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

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

9           Sec. 1511.103. PREEXISTING CONDITION AND HEALTH STATUS  
10 RESTRICTIONS PROHIBITED. Notwithstanding any other law, a health  
11 benefit plan issuer may not:

12           (1) deny coverage to or refuse to enroll a group, an  
13 individual, or an individual's dependent in a health benefit plan  
14 on the basis of a preexisting condition or health status related  
15 factor;

16           (2) limit or exclude, or require a waiting period for,  
17 coverage under the health benefit plan for treatment of a  
18 preexisting condition otherwise covered under the plan; or

19           (3) charge a group, individual, or dependent more for  
20 coverage than the health benefit plan issuer charges a group,  
21 individual, or dependent who does not have a preexisting condition  
22 or health status related factor.

23           SUBCHAPTER D. PROHIBITED DISCRIMINATION

24           Sec. 1511.151. DISCRIMINATORY BENEFIT DESIGN PROHIBITED.

25           (a) A health benefit plan issuer may not, through the plan's  
26 benefit design, discriminate against an enrollee on the basis of  
27 race, color, national origin, age, sex, expected length of life,

1 present or predicted disability, degree of medical dependency,  
2 quality of life, or other health condition.

3 (b) A health benefit plan issuer may not use a health  
4 benefit design that will have the effect of discouraging the  
5 enrollment of individuals with significant health needs in the  
6 health benefit plan.

7 (c) This section may not be construed to prevent a health  
8 benefit plan issuer from appropriately utilizing reasonable  
9 medical management techniques.

10 Sec. 1511.152. DISCRIMINATORY MARKETING PROHIBITED. A  
11 health benefit plan issuer may not use a marketing practice that  
12 will have the effect of discouraging the enrollment of individuals  
13 with significant health needs in the health benefit plan or that  
14 discriminates on the basis of race, color, national origin, age,  
15 sex, expected length of life, present or predicted disability,  
16 degree of medical dependency, quality of life, or other health  
17 condition.

18 Sec. 1511.153. DISCRIMINATION BASED ON GENDER PROHIBITED.  
19 A health benefit plan issuer may not charge an individual a higher  
20 premium rate based on the individual's gender.

21 SUBCHAPTER E. CHOICE OF HEALTH CARE PROFESSIONAL; EMERGENCY  
22 SERVICES

23 Sec. 1511.201. CHOICE OF PRIMARY CARE PROFESSIONAL. (a)  
24 Notwithstanding any other law, a health benefit plan that requires  
25 or provides for the designation by an enrollee of a participating  
26 primary care provider must allow the enrollee to designate any  
27 available participating primary care provider as the enrollee's



1 primary care provider.

2 (b) For an enrollee who is a child, the health benefit plan  
3 must allow the child's parent or guardian to designate any  
4 available participating primary care provider, including  
5 participating primary care providers specializing in pediatrics,  
6 as the primary care provider for the child.

7 Sec. 1511.202. CHOICE OF HEALTH CARE PROFESSIONAL  
8 SPECIALIZING IN OBSTETRICAL AND GYNECOLOGICAL CARE. (a) A health  
9 benefit plan may not require that a female individual covered by a  
10 health benefit plan obtain authorization or a referral before  
11 seeking obstetrical or gynecological care from a participating  
12 health care professional specializing in obstetrics or gynecology.

13 (b) A health care professional specializing in obstetrics  
14 or gynecology must adhere to the health benefit plan issuer's  
15 policies and procedures.

16 Sec. 1511.203. COVERAGE FOR EMERGENCY SERVICES. (a) In  
17 this section, "emergency services" means bona fide emergency  
18 services provided after the sudden onset of a medical condition  
19 manifesting itself by acute symptoms of sufficient severity,  
20 including severe pain, such that the absence of immediate medical  
21 attention could reasonably be expected to result in:

- 22 (1) placing the patient's health in serious jeopardy;  
23 (2) serious impairment to bodily functions; or  
24 (3) serious dysfunction of any bodily organ or part.

25 (b) A health benefit plan that provides coverage for  
26 emergency services may not:

- 27 (1) require prior authorization for those services;

1           (2) impose requirements or limitations on coverage of  
2 emergency services provided by a health care professional who does  
3 not have a contractual relationship with the health benefit plan  
4 that are more restrictive than the requirements or limitations  
5 imposed on coverage of emergency services provided by health care  
6 professionals who do have a contractual relationship with the  
7 health benefit plan; or

8           (3) apply a different cost-sharing requirement for  
9 emergency services provided by an out-of-network health care  
10 professional.

11       SUBCHAPTER F. COVERAGE AND PREMIUMS FOR INDIVIDUAL AND SMALL  
12                               EMPLOYER HEALTH BENEFIT PLANS

13       Sec. 1511.251. DEFINITIONS. In this subchapter:

14           (1) "Individual health benefit plan" means:

15                       (A) an individual accident and health insurance  
16 policy to which Chapter 1201 applies; or

17                       (B) individual health maintenance organization  
18 coverage.

19           (2) "Small employer health benefit plan" has the  
20 meaning assigned by Section 1501.002.

21       Sec. 1511.252. PREMIUM RATE VARIATION; RATING FACTORS. (a)  
22 Notwithstanding any other law, an individual or small employer  
23 health benefit plan issuer may not vary premium rates for those  
24 plans based on a factor other than:

25           (1) the geographic area in which an individual  
26 resides;

27           (2) the age of an individual;

1           (3) the use of one or more tobacco products by an  
2 individual; and

3           (4) the individual's family size.

4           (b) Premium rates for an individual or small employer health  
5 benefit plan may not vary by a ratio greater than:

6           (1) three to one based on the factor described by  
7 Subsection (a)(2); or

8           (2) 1.5 to one based on the factor described by  
9 Subsection (a)(3).

10           Sec. 1511.253. PREMIUM RATE REVIEW BY COMMISSIONER. (a)  
11 The commissioner by rule shall establish a process to annually  
12 review increases in premium rates charged by individual or small  
13 employer health benefit plan issuers.

14           (b) The rules must require:

15           (1) an individual or small employer health benefit  
16 plan issuer to:

17                   (A) submit to the commissioner a justification  
18 for a premium rate increase that results in an increase equal to or  
19 greater than 10 percent prior to implementing the increase; and

20                   (B) post information regarding the premium rate  
21 increase on the health benefit plan issuer's Internet website; and

22           (2) the commissioner to make available to the public  
23 information on premium increases and justifications submitted by  
24 health benefit plan issuers under Subdivision (1).

25           Sec. 1511.254. SINGLE RISK POOL FOR INDIVIDUAL AND SMALL  
26 EMPLOYER HEALTH BENEFIT PLANS. In establishing premium rates, a  
27 health benefit plan issuer must consider:

1           (1) all individuals enrolled in individual health  
2 benefit plans as members of one risk pool; and

3           (2) all individuals enrolled in small employer health  
4 benefit plans as members of one risk pool.

5           Sec. 1511.255. LEVELS OF COVERAGE. (a) Except as provided  
6 by Subsection (b), an individual or small employer health benefit  
7 plan must provide one of the following levels of coverage:

8           (1) a bronze level of coverage that is designed to  
9 provide benefits that are actuarially equivalent to 60 percent of  
10 the full actuarial value of the benefits provided under the plan;

11           (2) a silver level of coverage that is designed to  
12 provide benefits that are actuarially equivalent to 70 percent of  
13 the full actuarial value of the benefits provided under the plan;

14           (3) a gold level of coverage that is designed to  
15 provide benefits that are actuarially equivalent to 80 percent of  
16 the full actuarial value of the benefits provided under the plan;  
17 and

18           (4) a platinum level of coverage that is designed to  
19 provide benefits that are actuarially equivalent to 90 percent of  
20 the full actuarial value of the benefits provided under the plan.

21           (b) An individual health benefit plan may provide a level of  
22 coverage other than a level of coverage described in Subsection (a)  
23 if:

24           (1) the individual enrolled in the health benefit plan  
25 is:

26           (A) younger than 30 years of age as of the first  
27 day of the plan year; or

1           (B) exempt from the requirement to maintain  
2 minimum essential coverage under 26 U.S.C. Section 5000A(e)(1) or  
3 (5); and

4           (2) the health benefit plan provides coverage for:

5           (A) essential health benefits as required by  
6 Section 1380.003, except that the plan provides no benefits for any  
7 plan year until the individual has incurred cost-sharing expenses  
8 in an amount equal to the annual limitation under Section 1380.005  
9 for the plan year, subject to Section 1380.006; and

10           (B) at least three primary care visits.

11           SUBCHAPTER G. SUMMARY OF BENEFITS AND COVERAGE

12           Sec. 1511.301. SUMMARY OF BENEFITS AND COVERAGE. (a) A  
13 health benefit plan issuer must provide to an individual a summary  
14 of benefits and coverage explanation that accurately describes the  
15 benefits and coverage under the health benefit plan:

16           (1) at the time of the individual's application for  
17 coverage;

18           (2) prior to a period of enrollment or reenrollment;  
19 and

20           (3) at the time the health benefit plan is issued.

21           (b) The commissioner shall adopt rules that establish  
22 standards for the disclosures required in a summary described by  
23 Subsection (a).

24           SUBCHAPTER H. REVIEW AND APPEALS PROCEDURES

25           Sec. 1511.351. EXTERNAL REVIEW MODEL ACT RULES. (a) The  
26 department shall adopt rules as necessary to conform Texas law with  
27 the requirements of the NAIC Uniform Health Carrier External Review

1 Model Act (April 2010).

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

4 Sec. 1511.352. APPEALS. A health benefit plan issuer must  
5 implement an effective appeals process for appeals of coverage  
6 determinations and claims. The appeals process must:

7 (1) include an internal claims appeal process;

8 (2) provide for notice to individuals enrolled in a  
9 health benefit plan, in a culturally and linguistically appropriate  
10 manner, of available internal and external appeals processes and  
11 the availability of any consumer assistance from the department;  
12 and

13 (3) allow an individual enrolled in a health benefit  
14 plan to review the individual's file, present evidence and  
15 testimony as part of the appeals process, and receive continued  
16 coverage pending the outcome of the appeals process.

17 SUBCHAPTER I. REBATE

18 Sec. 1511.401. DEFINITIONS. In this subchapter:

19 (1) "Individual health benefit plan" means:

20 (A) an individual accident and health insurance  
21 policy to which Chapter 1201 applies; or

22 (B) individual health maintenance organization  
23 coverage.

24 (2) "Large employer health benefit plan" and "small  
25 employer health benefit plan" have the meanings assigned by Section  
26 1501.002.

27 Sec. 1511.402. MEDICAL LOSS RATIO. (a) A health benefit

1 plan issuer must calculate, with respect to each plan year:

2 (1) the amount of premium revenue expended on medical  
3 claims, including reimbursement for clinical services provided to  
4 individuals under a health benefit plan;

5 (2) the amount of premium revenue expended on  
6 activities that improve health care quality; and

7 (3) after accounting for payments or receipts for risk  
8 adjustment, risk corridors, and reinsurance, the total amount of  
9 premium revenue received excluding federal and state taxes and  
10 licensing or regulatory fees.

11 (b) A health benefit plan issuer must determine the ratio of  
12 the combined amounts in Subsections (a)(1) and (a)(2) to the amount  
13 in Subsection (a)(3).

14 Sec. 1511.403. REBATE. (a) This section applies only to:

15 (1) an individual or small employer health benefit  
16 plan issuer with a ratio calculated under Section 1511.402(b) that  
17 is greater than 80 percent; or

18 (2) a large group health benefit plan issuer with a  
19 ratio calculated under Section 1511.402(b) that is greater than 85  
20 percent.

21 (b) A health benefit plan issuer must, with respect to each  
22 plan year for which this section applies to the issuer, provide each  
23 enrolled individual a rebate, on a pro rata basis, as provided by  
24 Subsection (c).

25 (c) The total amount of an annual rebate must be equal to the  
26 product of the total amount of premium revenue calculated under  
27 Section 1511.402(a)(3) and:

1           (1) with respect to an individual or small employer  
2 plan, the amount by which the ratio described in Section  
3 1511.402(b) exceeds 80 percent; or

4           (2) with respect to a large group plan, the amount by  
5 which the ratio described in Section 1511.402(b) exceeds 85  
6 percent.

7           ARTICLE 2. COVERAGE OF ESSENTIAL HEALTH BENEFITS

8           SECTION 2.01. Subtitle E, Title 8, Insurance Code, is  
9 amended by adding Chapter 1380 to read as follows:

10           CHAPTER 1380. COVERAGE OF ESSENTIAL HEALTH BENEFITS

11           Sec. 1380.001. APPLICABILITY OF CHAPTER. (a) This chapter  
12 applies only to a health benefit plan that provides benefits for  
13 medical or surgical expenses incurred as a result of a health  
14 condition, accident, or sickness, including an individual, group,  
15 blanket, or franchise insurance policy or insurance agreement, a  
16 group hospital service contract, or an individual or group evidence  
17 of coverage or similar coverage document that is issued by:

18           (1) an insurance company;

19           (2) a group hospital service corporation operating  
20 under Chapter 842;

21           (3) a health maintenance organization operating under  
22 Chapter 843;

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

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

27           (6) a stipulated premium company operating under



1 Chapter 884;

2 (7) a fraternal benefit society operating under

3 Chapter 885;

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

5 (9) an exchange operating under Chapter 942.

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

7 (1) a small employer health benefit plan subject to

8 Chapter 1501, including coverage provided through a health group

9 cooperative under Subchapter B of that chapter;

10 (2) a standard health benefit plan issued under

11 Chapter 1507;

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

13 (4) a basic plan under Chapter 1575;

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

15 (6) a plan providing basic coverage under Chapter

16 1601;

17 (7) health benefits provided by or through a church

18 benefits board under Subchapter I, Chapter 22, Business

19 Organizations Code;

20 (8) group health coverage made available by a school

21 district in accordance with Section 22.004, Education Code;

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

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

24 (10) the child health plan program under Chapter 62,

25 Health and Safety Code;

26 (11) a regional or local health care program operated

27 under Section 75.104, Health and Safety Code;

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

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

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

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

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

15           Sec. 1380.003. REQUIRED COVERAGE FOR ESSENTIAL HEALTH  
16 BENEFITS. (a) In this section:

17                   (1) "Individual health benefit plan" means:

18                           (A) an individual accident and health insurance  
19 policy to which Chapter 1201 applies; or

20                           (B) individual health maintenance organization  
21 coverage.

22                   (2) "Small employer health benefit plan" has the  
23 meaning assigned by Section 1501.002.

24           (b) An individual or small employer health benefit plan must  
25 provide coverage for the essential health benefits listed in 42  
26 U.S.C. Section 18022(b)(1), as that section existed on January 1,  
27 2017, and other benefits identified by the United States secretary

1 of health and human services as essential health benefits as of that  
2 date.

3 Sec. 1380.004. CERTAIN ANNUAL AND LIFETIME LIMITS  
4 PROHIBITED. A health benefit plan issuer may not establish an  
5 annual or lifetime benefit amount for an enrollee in relation to  
6 essential health benefits listed in 42 U.S.C. Section 18022(b)(1),  
7 as that section existed on January 1, 2017, and other benefits  
8 identified by the United States secretary of health and human  
9 services as essential health benefits as of that date.

10 Sec. 1380.005. LIMITATIONS ON COST-SHARING. A health  
11 benefit plan issuer may not impose cost-sharing requirements that  
12 exceed the annual limits established in 42 U.S.C. Section  
13 18022(c)(1) in relation to essential health benefits listed in 42  
14 U.S.C. Section 18022(b)(1), as those sections existed on January 1,  
15 2017, and other benefits identified by the United States secretary  
16 of health and human services as essential health benefits as of that  
17 date.

18 Sec. 1380.006. 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, including additional  
5 preventive care and screenings for women not described in  
6 Subdivision (1).

7 Sec. 1380.007. RULES. (a) Subject to Subsection (b), the  
8 commissioner may adopt rules as necessary to implement this  
9 chapter.

10 (b) Rules adopted by the commissioner to implement this  
11 chapter must be consistent with the Patient Protection and  
12 Affordable Care Act (Pub. L. No. 111-148), as that Act existed on  
13 January 1, 2017.

14 ARTICLE 3. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN YOUNG ADULTS

15 SECTION 3.01. Subchapter A, Chapter 533, Government Code,  
16 is amended by adding Section 533.0057 to read as follows:

17 Sec. 533.0057. ELIGIBILITY AGE FOR STAR HEALTH COVERAGE. A  
18 child enrolled in the STAR Health Medicaid managed care program is  
19 eligible to receive health care services under the program until  
20 the child is 26 years of age.

21 SECTION 3.02. Section 846.260, Insurance Code, is amended  
22 to read as follows:

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

1 SECTION 3.03. Section 1201.053(b), Insurance Code, is  
2 amended to read as follows:

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

13 SECTION 3.04. Section 1201.062(a), Insurance Code, is  
14 amended to read as follows:

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

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

- 25 (A) ~~[unmarried,~~  
26 ~~[(B)]~~ younger than 26 ~~[25]~~ years of age; and  
27 (B) ~~[(C)]~~ a dependent of the insured or group

1 member for federal income tax purposes at the time application for  
2 coverage of the grandchild is made; and

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

7 SECTION 3.05. Section 1201.065(a), Insurance Code, is  
8 amended to read as follows:

9 (a) An individual or group accident and health insurance  
10 policy may contain criteria relating to a maximum age or enrollment  
11 in school to establish continued eligibility for coverage of a  
12 child 26 [~~25~~] years of age or older.

13 SECTION 3.06. Section 1251.151(a), Insurance Code, is  
14 amended to read as follows:

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

22 (1) [~~unmarried,~~  
23 [~~2~~] younger than 26 [~~25~~] years of age; and  
24 (2) [~~3~~] a dependent of the insured for federal  
25 income tax purposes at the time the application for coverage of the  
26 grandchild is made.

27 SECTION 3.07. Section 1251.152(a), Insurance Code, is

1 amended to read as follows:

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

3 (1) a child of an employee or member who is~~+~~

4 [~~(A) unmarried, and~~

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

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

7 (A) [~~unmarried,~~

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

9 (B) [~~(C)~~] a dependent of the insured for federal  
10 income tax purposes at the time the application for coverage of the  
11 grandchild is made.

12 SECTION 3.08. Section [1271.006](#)(a), Insurance Code, is  
13 amended to read as follows:

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

20 SECTION 3.09. Section [1501.002](#)(2), Insurance Code, is  
21 amended to read as follows:

22 (2) "Dependent" means:

23 (A) a spouse;

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

26 (C) a child of any age who is:

27 (i) medically certified as disabled; and

- 1 (ii) dependent on the parent;
- 2 (D) an individual who must be covered under:
- 3 (i) Section 1251.154; or
- 4 (ii) Section 1201.062; and
- 5 (E) any other child eligible under an employer's
- 6 health benefit plan, including a child described by Section
- 7 1503.003.

8 SECTION 3.10. The heading to Section 1501.609, Insurance

9 Code, is amended to read as follows:

10 Sec. 1501.609. COVERAGE FOR ~~[UNMARRIED]~~ CHILDREN.

11 SECTION 3.11. Section 1501.609(b), Insurance Code, is

12 amended to read as follows:

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

14 health benefit plan to a a ~~[an unmarried]~~ child of an enrollee is 26

15 ~~[25]~~ years of age.

16 SECTION 3.12. Sections 1503.003(a) and (b), Insurance Code,

17 are amended to read as follows:

18 (a) A health benefit plan may not condition coverage for a

19 child younger than 26 ~~[25]~~ years of age on the child's being

20 enrolled at an educational institution.

21 (b) A health benefit plan that requires as a condition of

22 coverage for a child 26 ~~[25]~~ years of age or older that the child be

23 a full-time student at an educational institution must provide the

24 coverage:

25 (1) for the entire academic term during which the

26 child begins as a full-time student and remains enrolled,

27 regardless of whether the number of hours of instruction for which



1 the child is enrolled is reduced to a level that changes the child's  
2 academic status to less than that of a full-time student; and

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

7 SECTION 3.13. Section 1551.004(a), Insurance Code, is  
8 amended to read as follows:

9 (a) In this chapter, "dependent" with respect to an  
10 individual eligible to participate in the group benefits program  
11 means the individual's:

12 (1) spouse;

13 (2) ~~unmarried~~ child younger than 26 years of age;

14 (3) child of any age who the board of trustees  
15 determines lives with or has the child's care provided by the  
16 individual on a regular basis if the child is mentally or physically  
17 incapacitated to the extent that the child is dependent on the  
18 individual for care or support, as determined by the board of  
19 trustees;

20 (4) child of any age who is unmarried, for purposes of  
21 health benefit coverage under this chapter, on expiration of the  
22 child's continuation coverage under the Consolidated Omnibus  
23 Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) and its  
24 subsequent amendments; and

25 (5) ward, as that term is defined by Chapter 1002,  
26 Estates Code, who is 26 years of age or younger.

27 SECTION 3.14. Section 1601.004(a), Insurance Code, is

1 amended to read as follows:

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

5 (1) spouse;

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

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

13 ARTICLE 4. CONFORMING AMENDMENTS; REPEALER

14 SECTION 4.01. Section 841.002, Insurance Code, is amended  
15 to read as follows:

16 Sec. 841.002. APPLICABILITY OF CHAPTER AND OTHER  
17 LAW. Except as otherwise expressly provided by this code, each  
18 insurance company incorporated or engaging in business in this  
19 state as a life insurance company, an accident insurance company, a  
20 life and accident insurance company, a health and accident  
21 insurance company, or a life, health, and accident insurance  
22 company is subject to:

23 (1) this chapter;

24 (2) Chapter 3;

25 (3) Chapters 425 and 493;

26 (4) Title 7;

27 (5) Sections [~~1202.051,~~] 1204.151, 1204.153, and

1 1204.154;

2 (6) Subchapter A, Chapter 1202, Subchapters A and F,  
3 Chapter 1204, Subchapter A, Chapter 1273, Subchapters A, B, and D,  
4 Chapter 1355, and Subchapter A, Chapter 1366;

5 (7) Subchapter A, Chapter 1507;

6 (8) Chapters 1203, 1210, 1251-1254, 1301, 1351, 1354,  
7 1359, 1364, 1368, 1505, 1651, 1652, and 1701; and

8 (9) Chapter 177, Local Government Code.

9 SECTION 4.02. Section 1201.005, Insurance Code, is amended  
10 to read as follows:

11 Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a  
12 reference to this chapter includes a reference to:

13 (1) [~~Section 1202.052,~~

14 [~~(2)~~] Section 1271.005(a), to the extent that the  
15 subsection relates to the applicability of Section 1201.105, and  
16 Sections 1271.005(d) and (e);

17 (2) [~~(3)~~] Chapter 1351;

18 (3) [~~(4)~~] Subchapters C and E, Chapter 1355;

19 (4) [~~(5)~~] Chapter 1356;

20 (5) [~~(6)~~] Chapter 1365;

21 (6) [~~(7)~~] Subchapter A, Chapter 1367;

22 (7) Subchapter B, Chapter 1511; and

23 (8) Subchapters A, B, and G, Chapter 1451.

24 SECTION 4.03. Section 1507.003(b), Insurance Code, is  
25 amended to read as follows:

26 (b) For purposes of this subchapter, "state-mandated health  
27 benefits" does not include benefits that are mandated by federal

1 law or standard provisions or rights required under this code or  
2 other laws of this state to be provided in an individual, blanket,  
3 or group policy for accident and health insurance that are  
4 unrelated to a specific health illness, injury, or condition of an  
5 insured, including provisions related to:

6 (1) continuation of coverage under:

7 (A) Subchapters F and G, Chapter 1251;

8 (B) Section 1201.059; and

9 (C) Subchapter B, Chapter 1253;

10 (2) termination of coverage under Sections [~~1202.051~~  
11 ~~and~~] 1501.108 and 1511.052;

12 (3) preexisting conditions under Subchapter D,  
13 Chapter 1201, and Sections 1501.102-1501.105;

14 (4) coverage of children, including newborn or adopted  
15 children, under:

16 (A) Subchapter D, Chapter 1251;

17 (B) Sections 1201.053, 1201.061,  
18 1201.063-1201.065, and Subchapter A, Chapter 1367;

19 (C) Chapter 1504;

20 (D) Chapter 1503;

21 (E) Section 1501.157;

22 (F) Section 1501.158; and

23 (G) Sections 1501.607-1501.609;

24 (5) services of practitioners under:

25 (A) Subchapters A, B, and C, Chapter 1451; or

26 (B) Section 1301.052;

27 (6) supplies and services associated with the

1 treatment of diabetes under Subchapter B, Chapter 1358;

2 (7) coverage for serious mental illness under  
3 Subchapter A, Chapter 1355;

4 (8) coverage for childhood immunizations and hearing  
5 screening as required by Subchapters B and C, Chapter 1367, other  
6 than Section 1367.053(c) and Chapter 1353;

7 (9) coverage for reconstructive surgery for certain  
8 craniofacial abnormalities of children as required by Subchapter D,  
9 Chapter 1367;

10 (10) coverage for the dietary treatment of  
11 phenylketonuria as required by Chapter 1359;

12 (11) coverage for referral to a non-network physician  
13 or provider when medically necessary covered services are not  
14 available through network physicians or providers, as required by  
15 Section 1271.055; and

16 (12) coverage for cancer screenings under:

17 (A) Chapter 1356;

18 (B) Chapter 1362;

19 (C) Chapter 1363; and

20 (D) Chapter 1370.

21 SECTION 4.04. Section 1507.053(b), Insurance Code, is  
22 amended to read as follows:

23 (b) For purposes of this subchapter, "state-mandated health  
24 benefits" does not include coverage that is mandated by federal law  
25 or standard provisions or rights required under this code or other  
26 laws of this state to be provided in an evidence of coverage that  
27 are unrelated to a specific health illness, injury, or condition of

1 an enrollee, including provisions related to:

2 (1) continuation of coverage under Subchapter G,  
3 Chapter 1251;

4 (2) termination of coverage under Sections [~~1202.051~~  
5 ~~and~~] 1501.108 and 1511.052;

6 (3) preexisting conditions under Subchapter D,  
7 Chapter 1201, and Sections 1501.102-1501.105;

8 (4) coverage of children, including newborn or adopted  
9 children, under:

10 (A) Chapter 1504;

11 (B) Chapter 1503;

12 (C) Section 1501.157;

13 (D) Section 1501.158; and

14 (E) Sections 1501.607-1501.609;

15 (5) services of providers under Section 843.304;

16 (6) coverage for serious mental health illness under  
17 Subchapter A, Chapter 1355; and

18 (7) coverage for cancer screenings under:

19 (A) Chapter 1356;

20 (B) Chapter 1362;

21 (C) Chapter 1363; and

22 (D) Chapter 1370.

23 SECTION 4.05. Section 1501.602(a), Insurance Code, is  
24 amended to read as follows:

25 (a) A large employer health benefit plan issuer[+]

26 [~~(1) may refuse to provide coverage to a large~~  
27 ~~employer in accordance with the issuer's underwriting standards and~~

1 ~~criteria;~~

2 ~~(2) shall accept or reject the entire group of~~  
3 ~~individuals who meet the participation criteria and choose~~  
4 ~~coverage; and~~

5 ~~(3)~~ may exclude only those employees or dependents  
6 who decline coverage.

7 SECTION 4.06. Subchapter B, Chapter 1202, Insurance Code,  
8 is repealed.

9 ARTICLE 5. IMPLEMENTATION; TRANSITION; EFFECTIVE DATE

10 SECTION 5.01. If before implementing any provision of this  
11 Act a state agency determines that a waiver or authorization from a  
12 federal agency is necessary for implementation of that provision,  
13 the agency affected by the provision shall request the waiver or  
14 authorization and may delay implementing that provision until the  
15 waiver or authorization is granted.

16 SECTION 5.02. The change in law made by this Act applies  
17 only to a health benefit plan that is delivered, issued for  
18 delivery, or renewed on or after January 1, 2022. A health benefit  
19 plan that is delivered, issued for delivery, or renewed before  
20 January 1, 2022, is governed by the law as it existed immediately  
21 before the effective date of this Act, and that law is continued in  
22 effect for that purpose.

23 SECTION 5.03. This Act takes effect September 1, 2021.