

By: Johnson

S.B. No. 459

A BILL TO BE ENTITLED

AN ACT

relating to availability of and benefits provided under health benefit plan coverage.

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;

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

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

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

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

8 (9) an exchange operating under Chapter 942.

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

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

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

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

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

21 (1) a plan that provides coverage:

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

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

27 (C) for credit insurance;

1 (D) only for dental or vision care;

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

4 (F) only for accidental death or dismemberment;

5 (2) a Medicare supplemental policy as defined by
6 Section 1882(g)(1), Social Security Act (42 U.S.C. Section
7 1395ss(g)(1));

8 (3) a workers' compensation insurance policy;

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

11 (5) a long-term care policy, including a nursing home
12 fixed indemnity policy, unless the commissioner determines that the
13 policy provides benefit coverage so comprehensive that the policy
14 is a health benefit plan as described by Section 1511.001.

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

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

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

24 (b) Rules adopted by the commissioner to implement this
25 chapter must be consistent with the Patient Protection and
26 Affordable Care Act (Pub. L. No. 111-148), as that Act existed on
27 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. OPEN AND SPECIAL ENROLLMENT PERIODS. (a) A
2 health benefit plan issuer issuing an individual health benefit
3 plan may restrict enrollment in coverage to an annual open
4 enrollment period and special enrollment periods.

5 (b) An individual or an individual's dependent qualified to
6 enroll in an individual health benefit plan may enroll anytime
7 during the open enrollment period or during a special enrollment
8 period designated by the commissioner.

9 (c) A health benefit plan issuer issuing a group health
10 benefit plan may not limit enrollment to an open or special
11 enrollment period.

12 (d) The commissioner shall adopt rules as necessary to
13 administer this section, including rules designating enrollment
14 periods.

15 SUBCHAPTER C. PREEXISTING CONDITIONS AND HEALTH STATUS

16 Sec. 1511.101. DEFINITIONS. In this subchapter:

17 (1) "Dependent" has the meaning assigned by Section
18 1501.002.

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

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

24 Sec. 1511.102. APPLICABILITY OF SUBCHAPTER.

25 Notwithstanding any other law, in addition to a health benefit plan
26 to which this chapter applies under Subchapter A, this subchapter
27 applies to:

- 1 (1) a basic coverage plan under Chapter 1551;
- 2 (2) a basic plan under Chapter 1575;
- 3 (3) a primary care coverage plan under Chapter 1579;
- 4 (4) a plan providing basic coverage under Chapter
5 1601;
- 6 (5) health benefits provided by or through a church
7 benefits board under Subchapter I, Chapter 22, Business
8 Organizations Code;
- 9 (6) group health coverage made available by a school
10 district in accordance with Section 22.004, Education Code;
- 11 (7) the state Medicaid program, including the Medicaid
12 managed care program operated under Chapter 533, Government Code;
- 13 (8) the child health plan program under Chapter 62,
14 Health and Safety Code;
- 15 (9) a regional or local health care program operated
16 under Section 75.104, Health and Safety Code;
- 17 (10) a self-funded health benefit plan sponsored by a
18 professional employer organization under Chapter 91, Labor Code;
- 19 (11) county employee group health benefits provided
20 under Chapter 157, Local Government Code; and
- 21 (12) health and accident coverage provided by a risk
22 pool created under Chapter 172, Local Government Code.

23 Sec. 1511.103. PREEXISTING CONDITION AND HEALTH STATUS
24 RESTRICTIONS PROHIBITED. Notwithstanding any other law, a health
25 benefit plan issuer may not:

- 26 (1) deny coverage to or refuse to enroll a group, an
27 individual, or an individual's dependent in a health benefit plan

1 on the basis of a preexisting condition or health status related
2 factor;

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

6 (3) charge a group, individual, or dependent more for
7 coverage than the health benefit plan issuer charges a group,
8 individual, or dependent who does not have a preexisting condition
9 or health status related factor.

10 SUBCHAPTER D. PROHIBITED DISCRIMINATION

11 Sec. 1511.151. DISCRIMINATORY BENEFIT DESIGN PROHIBITED.

12 (a) A health benefit plan issuer may not, through the plan's
13 benefit design, discriminate against an enrollee on the basis of
14 race, color, national origin, age, sex, expected length of life,
15 present or predicted disability, degree of medical dependency,
16 quality of life, or other health condition.

17 (b) A health benefit plan issuer may not use a health
18 benefit design that will have the effect of discouraging the
19 enrollment of individuals with significant health needs in the
20 health benefit plan.

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

24 Sec. 1511.152. DISCRIMINATORY MARKETING PROHIBITED. A
25 health benefit plan issuer may not use a marketing practice that
26 will have the effect of discouraging the enrollment of individuals
27 with significant health needs in the health benefit plan or that

1 discriminates on the basis of race, color, national origin, age,
2 sex, expected length of life, present or predicted disability,
3 degree of medical dependency, quality of life, or other health
4 condition.

5 ARTICLE 2. COVERAGE OF ESSENTIAL HEALTH BENEFITS

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

8 CHAPTER 1380. COVERAGE OF ESSENTIAL HEALTH BENEFITS

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

16 (1) an insurance company;

17 (2) a group hospital service corporation operating
18 under Chapter 842;

19 (3) a health maintenance organization operating under
20 Chapter 843;

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

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

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

27 (7) a fraternal benefit society operating under

1 Chapter 885;

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

3 (9) an exchange operating under Chapter 942.

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

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

8 (2) a standard health benefit plan issued under
9 Chapter 1507;

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

11 (4) a basic plan under Chapter 1575;

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

13 (6) a plan providing basic coverage under Chapter
14 1601;

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (B) individual health maintenance organization
19 coverage.

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

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

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

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

15 Sec. 1380.006. RULES. (a) Subject to Subsection (b), the
16 commissioner may adopt rules as necessary to implement this
17 chapter.

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

22 ARTICLE 3. CONFORMING AMENDMENTS; REPEALER

23 SECTION 3.01. Section 841.002, Insurance Code, is amended
24 to read as follows:

25 Sec. 841.002. APPLICABILITY OF CHAPTER AND OTHER
26 LAW. Except as otherwise expressly provided by this code, each
27 insurance company incorporated or engaging in business in this

1 state as a life insurance company, an accident insurance company, a
2 life and accident insurance company, a health and accident
3 insurance company, or a life, health, and accident insurance
4 company is subject to:

- 5 (1) this chapter;
- 6 (2) Chapter 3;
- 7 (3) Chapters 425 and 493;
- 8 (4) Title 7;
- 9 (5) Sections [~~1202.051~~] 1204.151, 1204.153, and
10 1204.154;
- 11 (6) Subchapter A, Chapter 1202, Subchapters A and F,
12 Chapter 1204, Subchapter A, Chapter 1273, Subchapters A, B, and D,
13 Chapter 1355, and Subchapter A, Chapter 1366;
- 14 (7) Subchapter A, Chapter 1507;
- 15 (8) Chapters 1203, 1210, 1251-1254, 1301, 1351, 1354,
16 1359, 1364, 1368, 1505, 1651, 1652, and 1701; and
- 17 (9) Chapter 177, Local Government Code.

18 SECTION 3.02. Section 1201.005, Insurance Code, is amended
19 to read as follows:

20 Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a
21 reference to this chapter includes a reference to:

- 22 (1) [~~Section 1202.052~~,
23 ~~(2)~~] Section 1271.005(a), to the extent that the
24 subsection relates to the applicability of Section 1201.105, and
25 Sections 1271.005(d) and (e);
- 26 (2) [~~(3)~~] Chapter 1351;
- 27 (3) [~~(4)~~] Subchapters C and E, Chapter 1355;

- 1 (4) [~~(5)~~] Chapter 1356;
- 2 (5) [~~(6)~~] Chapter 1365;
- 3 (6) [~~(7)~~] Subchapter A, Chapter 1367;
- 4 (7) Subchapter B, Chapter 1511; and
- 5 (8) Subchapters A, B, and G, Chapter 1451.

6 SECTION 3.03. Section 1507.003(b), Insurance Code, is
7 amended to read as follows:

8 (b) For purposes of this subchapter, "state-mandated health
9 benefits" does not include benefits that are mandated by federal
10 law or standard provisions or rights required under this code or
11 other laws of this state to be provided in an individual, blanket,
12 or group policy for accident and health insurance that are
13 unrelated to a specific health illness, injury, or condition of an
14 insured, including provisions related to:

- 15 (1) continuation of coverage under:
 - 16 (A) Subchapters F and G, Chapter 1251;
 - 17 (B) Section 1201.059; and
 - 18 (C) Subchapter B, Chapter 1253;
- 19 (2) termination of coverage under Sections [~~1202.051~~
20 ~~and~~] 1501.108 and 1511.052;
- 21 (3) preexisting conditions under Subchapter D,
22 Chapter 1201, and Sections 1501.102-1501.105;
- 23 (4) coverage of children, including newborn or adopted
24 children, under:
 - 25 (A) Subchapter D, Chapter 1251;
 - 26 (B) Sections 1201.053, 1201.061,
27 1201.063-1201.065, and Subchapter A, Chapter 1367;

- 1 (C) Chapter 1504;
- 2 (D) Chapter 1503;
- 3 (E) Section 1501.157;
- 4 (F) Section 1501.158; and
- 5 (G) Sections 1501.607-1501.609;
- 6 (5) services of practitioners under:
- 7 (A) Subchapters A, B, and C, Chapter 1451; or
- 8 (B) Section 1301.052;
- 9 (6) supplies and services associated with the
- 10 treatment of diabetes under Subchapter B, Chapter 1358;
- 11 (7) coverage for serious mental illness under
- 12 Subchapter A, Chapter 1355;
- 13 (8) coverage for childhood immunizations and hearing
- 14 screening as required by Subchapters B and C, Chapter 1367, other
- 15 than Section 1367.053(c) and Chapter 1353;
- 16 (9) coverage for reconstructive surgery for certain
- 17 craniofacial abnormalities of children as required by Subchapter D,
- 18 Chapter 1367;
- 19 (10) coverage for the dietary treatment of
- 20 phenylketonuria as required by Chapter 1359;
- 21 (11) coverage for referral to a non-network physician
- 22 or provider when medically necessary covered services are not
- 23 available through network physicians or providers, as required by
- 24 Section 1271.055; and
- 25 (12) coverage for cancer screenings under:
- 26 (A) Chapter 1356;
- 27 (B) Chapter 1362;

1 (C) Chapter 1363; and

2 (D) Chapter 1370.

3 SECTION 3.04. Section 1507.053(b), Insurance Code, is
4 amended to read as follows:

5 (b) For purposes of this subchapter, "state-mandated health
6 benefits" does not include coverage that is mandated by federal law
7 or standard provisions or rights required under this code or other
8 laws of this state to be provided in an evidence of coverage that
9 are unrelated to a specific health illness, injury, or condition of
10 an enrollee, including provisions related to:

11 (1) continuation of coverage under Subchapter G,
12 Chapter 1251;

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

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

17 (4) coverage of children, including newborn or adopted
18 children, under:

19 (A) Chapter 1504;

20 (B) Chapter 1503;

21 (C) Section 1501.157;

22 (D) Section 1501.158; and

23 (E) Sections 1501.607-1501.609;

24 (5) services of providers under Section 843.304;

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

27 (7) coverage for cancer screenings under:

- 1 (A) Chapter 1356;
- 2 (B) Chapter 1362;
- 3 (C) Chapter 1363; and
- 4 (D) Chapter 1370.

5 SECTION 3.05. Section 1501.602(a), Insurance Code, is
6 amended to read as follows:

- 7 (a) A large employer health benefit plan issuer[+
8 ~~[(1) may refuse to provide coverage to a large~~
9 ~~employer in accordance with the issuer's underwriting standards and~~
10 ~~criteria;~~
11 ~~[(2) shall accept or reject the entire group of~~
12 ~~individuals who meet the participation criteria and choose~~
13 ~~coverage; and~~
14 ~~[(3)]~~ may exclude only those employees or dependents
15 who decline coverage.

16 SECTION 3.06. Subchapter B, Chapter 1202, Insurance Code,
17 is repealed.

18 ARTICLE 4. IMPLEMENTATION; TRANSITION; EFFECTIVE DATE

19 SECTION 4.01. If before implementing any provision of this
20 Act a state agency determines that a waiver or authorization from a
21 federal agency is necessary for implementation of that provision,
22 the agency affected by the provision shall request the waiver or
23 authorization and may delay implementing that provision until the
24 waiver or authorization is granted.

25 SECTION 4.02. The change in law made by this Act applies
26 only to a health benefit plan that is delivered, issued for
27 delivery, or renewed on or after January 1, 2022. A health benefit

1 plan that is delivered, issued for delivery, or renewed before
2 January 1, 2022, is governed by the law as it existed immediately
3 before the effective date of this Act, and that law is continued in
4 effect for that purpose.

5 SECTION 4.03. This Act takes effect September 1, 2021.