By: Hughes S.B. No. 2121

A BILL TO BE ENTITLED

AN ACT

relating to the deductible imposed by a health benefit plan issuer for covered health care services or supplies.

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

SECTION 1. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1219 to read as follows:

CHAPTER 1219. DEDUCTIBLE REQUIREMENTS

Sec. 1219.001. DEFINITIONS. In this chapter:

(1) "Covered health care service or supply" means a health care service or supply, including a prescription drug, for which the costs are payable, wholly or partly, under the terms of a health benefit plan.

(2) "Enrollee" means an individual, including a dependent, entitled to coverage under a health benefit plan.

(3) "Network provider" means any health care provider of a health care service or supply with which a health benefit plan issuer or administrator or a third party for the issuer or administrator has a contract with the terms on which a relevant health care service or supply is provided to an enrollee.

(4) "Out-of-network provider" means a health care provider of any health care service or supply that does not have a contract under an enrollee's health benefit plan.

Sec. 1219.002. 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 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. 1219.003. EXCEPTIONS. 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 1219.002.

Sec. 1219.004. CONFLICT WITH OTHER LAW. If this chapter conflicts with another law relating to the imposition of a deductible, this chapter controls.

Sec. 1219.005. SEPARATE DEDUCTIBLES PROHIBITED. A health benefit plan issuer may not impose separate deductibles for covered health care services and supplies provided by network providers and out-of-network providers.

Sec. 1219.006. COVERED HEALTH CARE SERVICE OR SUPPLY FOR

PURPOSES OF DEDUCTIBLE. A health benefit plan issuer must include as a covered health care service or supply for purposes of an enrollee's deductible any amount the enrollee pays:

(1) for a health care service delivered as a telemedicine medical service or telehealth service, as those terms are defined by Section 111.001, Occupations Code; or

(2) under a direct primary care arrangement governed by Subchapter F, Chapter 162, Occupations Code.

SECTION 2. 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, 2022. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2022, 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 3. 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 4. This Act takes effect September 1, 2021.