BILL ANALYSIS

Senate Research Center

C.S.S.B. 541
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Committee Report (Substituted)

DIGEST AND PURPOSE

Under current Texas law, health insurance carriers are required to include many state-mandated benefits in their accident and sickness policies. C.S.S.B. 541 allows insurers and health maintenance organizations to offer policies that, in whole or in part, do not provide state-mandated health benefits, and requires that documents related to such policies notify the insured or enrollee that the coverage is limited in that way.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 7, Article 3.80, Insurance Code) and SECTION 2 (Section 9N(j), Chapter 20A, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 3G, Insurance Code, by adding Article 3.80, as follows:

Art. 3.80. TEXAS CONSUMER CHOICE OF BENEFITS HEALTH INSURANCE PLAN ACT

Sec. 1. PURPOSE. Expresses the legislature's recognition of the need for individuals, employers, and other purchasers of coverage to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies for accident and sickness insurance coverage. Expresses the legislature's intent to increase the availability of health insurance coverage by allowing certain insurers to issue accident and sickness policies that do not offer or provide state-mandated health benefits.

Sec. 2. DEFINITIONS. Defines "health carrier" and "standard health benefit plan."

Sec. 3. STATE-MANDATED HEALTH BENEFITS. (a) Defines "state-mandated health benefits."

(b) Provides exemptions to the definition of "state-mandated health benefits" for the purposes of this article.

Sec. 4. STANDARD HEALTH BENEFIT PLANS AUTHORIZED. Authorizes a health carrier to offer one or more standard health benefit plans.

Sec. 5. NOTICE TO POLICYHOLDER. (a) Requires a written application for participation in a standard health benefit plan to contain, in bold type at the beginning of the document, certain language declaring that the plan does not provide state-mandated health benefits. Specifies the text to be used in the declaration.

(b) Requires each standard health benefit plan to contain, in bold type at the beginning of the document, certain language declaring that the plan does not provide state-mandated health benefits. Specifies the text to be used in the declaration.

Sec. 6. DISCLOSURE STATEMENT. (a) Requires an insurer providing a standard health benefit plan to provide a policyholder or proposed policyholder with a written disclosure statement that indicates that the plan does not provide state-mandated health benefits, specifies which state-mandated benefits are not included, and notifies an individual policyholder that purchase of the plan may limit future coverage options in the event the policyholder' health changes and needed benefits are not available under the standard health benefit plan.

(b) Requires each applicant for initial coverage and each renewing policyholder to sign the disclosure statement required by Subsection (a) and return it to the insurer. Provides that under a group policy or contract, the term "applicant" means the employer.

(c) Requires an insurer to retain the signed disclosure statement and provide the disclosure statement to the Texas Department of Insurance (TDI) upon request from the commissioner of insurance (commissioner).

Sec. 7. RULES. Requires the commissioner to adopt rules as necessary to implement this article.

Sec. 8. ADDITIONAL POLICIES. Requires an insurer that offers a standard health benefit plan under this article to offer at least one accident or sickness insurance policy with state-mandated health benefits that is otherwise authorized by this code.

Sec. 9. RATES. Requires a health carrier to file for information purposes the rates to be used with a standard health benefit plan. Provides that nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any individual accident and sickness insurance policy or policies.

SECTION 2. Amends Chapter 20A, Insurance Code, by adding Section 9N, as follows:

Sec. 9N. CHOICE OF BENEFITS PLAN. (a) Expresses the legislature's recognition of the need for individuals and employees to have the opportunity to choose health maintenance organization plans that are more affordable and flexible than existing market health care plans offered by health maintenance organizations. Expresses the legislature's intent to increase the availability of health care plans by allowing certain health maintenance organizations to issue group or individual evidences of coverage that do not offer or provide state-mandated health benefits.

(b) Defines "standard health benefit plan."

(c) Defines "state-mandated health benefits" for purposes of this section.

(d) Provides exceptions to the definition of "state-mandated health benefits" for the purposes of this section.

(e) Authorizes a health maintenance organization authorized to issue an evidence of coverage in this state to offer one or more standard health benefit plans.

(f) (1) Requires each written application for enrollment in a standard health benefit plan to contain, in bold type at the beginning of the document, certain language declaring that the plan does not provide state-mandated health benefits normally required in evidences of coverage in Texas. Specifies the language to be used in the declaration.

(2) Requires each standard health benefit plan to contain, in bold type at the beginning of the document, certain language declaring that the plan does not provide state-mandated health benefits normally required in

evidences of coverage in Texas. Specifies the language to be used in the definition.

(g) Requires a health maintenance organization providing a standard health benefit plan to provide a proposed contract holder or a contract holder with a written disclosure statement that indicates that the standard health benefit plan does not provide some or all state-mandated health benefits; lists those benefits not included; and notifies an individual certificate holder that purchase of the plan may limit future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan.

(h) Requires each applicant for initial enrollment and each contract holder on renewal to sign the disclosure statement required by Subsection (g) and return it to the health maintenance organization. Provides that under a group evidence of coverage, the term "applicant" means the employer.

(i) Requires a health maintenance organization to retain the signed disclosure statement and provide the disclosure statement to TDI upon request from the commissioner.

(j) Authorizes the commissioner to adopt rules as necessary to implement this section.

(k) Requires a health maintenance organization that offers one or more standard health benefit plans under this section to offer at least one evidence of coverage that provides state-mandated health benefits and that is otherwise authorized by the Insurance Code.

(l) Requires a health maintenance organization to file for informational purposes the rates to be used with a standard health benefit plan. Provides that nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any evidence of coverage.

SECTION 3. Amends Article 26.38(b), Insurance Code, to delete text regarding Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.).

SECTION 4. Amends Articles 26.42(a), (b), and (c), Insurance Code, as follows:

(a) Requires a small employer carrier to offer a standard health benefit plan as authorized by Article 3.80 of this code and Section 9N, Texas Health Maintenance Organization Act (Article 20A.09N, Insurance Code), rather than the catastrophic care benefit plan and the basic coverage benefit plan.

(b) Authorizes a small employer carrier to offer to a small employer additional benefit riders to the standard health benefit plan, rather than either of the benefit plans, and to design and offer standard health benefit plans with additional mandatory benefits.

(c) Requires, rather than authorizes, a small employer carrier to also offer to small employers at least one, rather than any, other health benefit plan authorized under this code that provides state-mandated health benefits.

SECTION 5. Amends Article 26.43(a), Insurance Code, by removing language requiring the commissioner to develop and approve of certain policies and policy forms for the catastrophic care and basic coverage benefit plans. Makes a nonsubstantive change.

SECTION 6. Amends Article 26.48(a), Insurance Code, by requiring, rather than authorizing, a health maintenance organization to offer at least one state-approved basic health care plan that

complies with this chapter and other laws. It also authorizes a health maintenance organization to offer additional such plans. Requires a health maintenance organization to offer a standard health benefit plan under Article 20A.09N, Insurance Code, and authorizes a health maintenance organization to offer additional benefit riders to the standard health benefit plan or offer standard health benefit plans with additional mandatory benefits. Makes conforming and nonsubstantive changes.

SECTION 7. Amends Section 843.002(2), Insurance Code, to redefine "basic health care services" by removing a minimum requirement.

SECTION 8. Repealer: Article 26.44A (Benefit Plans), Insurance Code.

SECTION 9. Effective date: September 1, 2003. Makes application of this Act prospective to January 1, 2004.

SUMMARY OF COMMITTEE CHANGES

SECTION 1. Differs from the original by:

Sec. 1. Including other purchases of coverage; changes "standard" to "existing" market policies; includes "offer or" provide state-mandated health benefits.

Sec. 2. Including the definition of "health carrier" and "standard health benefit plan" rather than "nonstandard health benefits plan."

Sec. 3. Deleting reference to a contract for a health-related condition. Adding and deleting exemptions to the definition of "state-mandated health benefits" including adding supplies and services associated with the treatment of diabetes to those not included in state-mandated health benefits.

Sec. 4. Changing title and text to conform to "standard health benefit plan" language, rather than "limited" or "nonstandard."

Sec. 5. Separately requiring the policy and the application for the policy to contain the statement using certain language. Making conforming changes.

Sec. 6. Requiring the inclusion of the language regarding limitation of the policyholder's future coverage options in the disclosure statement. Defining "applicant."

Sec. 7. (Makes no changes.)

Sec. 8. Making conforming changes.

Sec. 9. Requiring the health carrier to file the rates, rather than authorizing the commissioner to determine and prescribe rates.

SECTION 2. Differs from the original by making conforming changes.

SECTION 3. Differs from the original by adding a new SECTION 3 to amend Subsection (b), Article 26.38, Chapter 26, Insurance Code.

SECTION 4. Differs from the original SECTION 3 by amending all of Article 26.42, rather than Subsection (a) only.

SECTION 5. Differs from the original SECTION 4 by making a nonsubstantive change.

SECTION 6. Differs from the original by: omitting the original SECTION 5 amending Article

26.44A(a), (b), and (c), Insurance Code; omitting originally proposed Article 26.48(a)(4) and making the changes described in the section-by-section portion of this bill analysis in SECTION 6.

SECTION 7. Not different from the original.

SECTION 8. Differs from the original by adding the repealer.

SECTION 9. Not different from the original.