BILL ANALYSIS

Senate Research Center
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C.S.S.B. 350
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State Affairs
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Because state law does not require the Texas Department of Insurance (TDI) to track health insurance rescission rates, and TDI does not routinely collect information on rescission rates from health insurance companies, there is no way to know the extent of improper health insurance rescissions and cancellations in Texas. TDI's response to a Congressional request for information last fall indicated that the 36 health insurance carriers in Texas that issue more than 250 policies rescinded about 1,700 individual policies in 2007, and 1,544 in 2006. Information regarding the reasons for these policy revocations was not provided; neither was information regarding whether or not these decisions were justified.

Under state law, health insurance policies can be cancelled or rescinded if a policyholder purposefully or accidentally provides false information that affects the medical claims on an application. The application process is complicated and insurance agencies are not required to perform due diligence in investigating the accuracy or completeness of an application before issuing a policy. Individuals and small businesses in particular may struggle to understand available coverage options, find information regarding premium rates, and fill out long technical insurance applications. Most individuals and small businesses rely on insurance agents or brokers to help them navigate the application process to find coverage. Agents or brokers are not required to disclose whether they have a financial incentive to promote certain plans over others or work for specific health plans, though they are required to be licensed by the state. A list of licensed agents is made available on the TDI website.

C.S.S.B. 350 amends current law relating to the application for and continuation of certain health benefit plan coverage; providing a civil penalty.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle A, Title 8, Insurance Code, by adding Chapters 1217 and 1218, as follows:

CHAPTER 1217. APPLICATION FOR HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1217.001. DEFINITION OF HEALTH BENEFIT PLAN. (a) Defines "health benefit plan."

(b) Provides that the term includes a small employer health benefit plan subject to Chapter 1501 (Health Insurance Portability and Availability Act), a standard health benefit plan provided under Chapter 1507 (Consumer Choice of Benefits Plans), a basic coverage plan under 1551 (Texas Employees Group Benefits Act), a basic plan under Chapter 1575 (Texas Public School Employees Group Benefits Program), a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage), and basic coverage under Chapter

1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and The Texas A&M University System).

(c) Provides that the term does not include disability income insurance coverage or long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits.

[Reserves Sections 1217.002-1217.050 for expansion.]

SUBCHAPTER B. APPLICATION FOR COVERAGE

Sec. 1217.051. APPLICATION ASSISTANCE; CIVIL PENALTY. (a) Provides that a life, accident, and health agent (agent) who assists an applicant in submitting an application to a health benefit plan issuer (issuer) has a duty to assist the applicant in providing answers to health questions accurately and completely and is required to attest certain information on the written application.

(b) Authorizes the agent, for the purposes of Subsection (a)(2)(C) (relating to requiring a certain agent to attest on the written application that the applicant understood the explanation provided under Paragraph B), to request the that applicant attest in writing on the application or a separate document that the applicant understood the explanation provided under Subsection (a)(2)(B) (relating to requiring a certain agent to attest on the written application that the agent explained to the applicant the risk to the applicant of providing inaccurate information).

(c) Provides that an agent is liable for a civil penalty in an amount not to exceed $10,000, in addition to any other penalty or remedy available by law, if the agent wilfully states as true any material fact the agent knows to be false in an attestation required by Subsection (a).

(d) Authorizes the attorney general or a county or district attorney to bring an action to recover a civil penalty under Subsection (c). Requires the penalty to be deposited in the general revenue fund, except that for a penalty recovered in a suit first instituted by a local government or governments under this subsection, 50 percent of the recovery is required to be deposited in the general revenue fund and the other 50 percent is required to be equally distributed to the local government or governments that instituted the suit.

(e) Requires that an application for health benefit plan coverage include a statement advising affiants of the civil penalty authorized under this section.

CHAPTER 1218. RESCISSION OF HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1218.001. DEFINITION. (a) Defines "individual health benefit plan" in this chapter, except as provided by this section.

(b) Provides that the term does not include disability income insurance coverage or long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits.

[Reserves Sections 1218.002-1218.050 for expansion.]

SUBCHAPTER B. RESCISSION

Sec. 1218.051. INDIVIDUAL HEALTH BENEFIT PLAN; CONTINUATION OF COVERAGE. (a) Provides that an issuer that intends to rescind an individual health benefit plan policy or contract is:

(1) required to offer to each other individual covered under the policy or contract the opportunity to obtain a new individual health benefit plan policy or contract with benefits equal to those of the canceled or rescinded policy or contract; and

(2) authorized to permit an individual, otherwise entitled to an offer of coverage under Subdivision (1), to remain covered under the policy or contract with a revised premium rate to reflect any reduction in the number of individuals covered by the policy or contract.

(b) Provides that an issuer is not required to continue existing coverage of or issue new coverage to an individual if the rescission is based on information about that individual.

(c) Authorizes the issuer to revise the premium rate only to reflect the number of persons covered by the new policy or contract if a new individual health benefit plan policy or contract is issued under this section.

Sec. 1218.052. PREEXISTING CONDITION EXCLUSION; WAITING OR AFFILIATION PERIOD. (a) Prohibits an issuer required to offer coverage under this chapter from declining to issue the coverage or impose any preexisting condition exclusion on an individual who retains existing coverage or obtains new coverage under this chapter.

(b) Authorizes the issuer, notwithstanding Subsection (a), to apply the same preexisting condition provision or waiting or affiliation period in a new policy or contract issued under this chapter if an individual was subject to one under the rescinded health benefit plan policy or contract. Prohibits the time period in the new policy or contract for the preexisting condition provision period or waiting or affiliation period from being longer than the applicable period in the canceled or rescinded policy or contract. Requires the issuer to credit any time the individual was covered under the canceled or rescinded policy or contract to the preexisting condition provision period or waiting or affiliation period in the new policy or contract.

Sec. 1218.053. NOTICE. Requires an issuer that rescinds an individual health benefit plan policy or contract to notify in writing each individual covered under the policy or contract of the offer of coverage required to be made under this chapter.

Sec. 1218.054. MINIMUM TIME TO ACCEPT OFFER. Requires an issuer required to offer continuation of coverage under this chapter to allow an individual entitled to the coverage at least 60 days to accept the offered coverage.

Sec. 1218.055. EFFECTIVE DATE OF COVERAGE. Provides that a new health benefit plan policy or contract issued under this chapter is effective as of the effective date of the rescinded policy or contract, and prohibits there being a lapse in coverage.

SECTION 2. (a) Provides that the change in law made by Chapter 1217, Insurance Code, as added by this Act, applies only to an application for health benefit plan coverage submitted to a health benefit plan issuer on or after January 1, 2010. Provides that an application submitted before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) Provides that the change in law made by Chapter 1218, Insurance Code, as added by this Act, applies only to a rescission of an individual health benefit plan policy or contract or health benefit plan coverage on or after the effective date of this Act. Provides that a rescission of a policy, contract, or coverage before the effective date of this Act is

governed by the law in effect immediately before that date, and that law is continued in effect for that purpose.

SECTION 3. Effective date: September 1, 2009.