A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,
AND INSURANCE INDUSTRY PROFESSIONALS

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Source Law

Art. 21.35. . . . The provisions of Articles 21.16, 21.17, and 21.19 of this code shall not apply to policies of life insurance in which there is a clause making such policy indisputable after two (2) years or less, provided premiums are duly paid; . . . .

Revisor's Note

V.T.I.C. Article 21.35 refers to a clause making a policy "indisputable." The revised law substitutes "incontestable" for "indisputable" for consistency of terminology in this code and because "incontestable" is the more commonly used modern term.

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CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1201.001. DEFINITIONS. In this chapter:

(1) "Accident and health insurance policy" includes any policy or contract that provides insurance against loss resulting from:

(A) accidental bodily injury;

(B) accidental death; or

(C) sickness.

(2) "Policy" means the entire contract between an insurer and an insured and includes riders, endorsements, and the application, if attached. (V.T.I.C. Art. 3.70-1, Secs. (B)(3), (4).)

Source Law

(B) Definitions. As used in this Act,

(3) "Policy of accident and sickness insurance" as used herein, includes any policy or contract providing insurance against loss resulting from sickness or from bodily injury or death by accident or both.

(4) "Policy" means the entire contract between the insurer and the insured, including the

policy, riders, endorsements, and the application, if attached.

Revisor's Note

(1) Sections (B)(1) and (2), V.T.I.C. Article 3.70-1, define "board" and "commissioner." The revised law omits those definitions as unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately. In addition, Section 31.001 of this code defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance. The omitted law reads:

> (1) "Board" shall mean the State Board of Insurance of the State of Texas.
>
> (2) "Commissioner" shall mean the Commissioner of Insurance of the State of Texas.

(2) Section (B)(3), V.T.I.C. Article 3.70-1, defines "policy of accident and sickness insurance." Throughout this chapter, the revised law substitutes "health" for "sickness" in this context for consistency with modern usage.

Revised Law

Sec. 1201.002. PURPOSE. The purpose of this chapter is to:

(1) provide for reasonable standardization, readability, and simplification of terms and coverages in individual accident and health insurance policies;

(2) promote public understanding of coverages;

(3) eliminate provisions in individual accident and health insurance policies that may be unjust, unfair, misleading, or unreasonably confusing in connection with:

(A) the purchase of coverage; or

(B) the settlement of claims; and

(4) provide for full and fair disclosure in sales of accident and health coverage. (V.T.I.C. Art. 3.70-1, Sec. (A).)

Source Law

Art. 3.70-1. (A) Purpose. The purpose of this Act shall be to provide for reasonable standardization, readability, and simplification of terms and coverages contained in individual accident and sickness insurance policies; to facilitate public understanding of coverages; to eliminate provisions contained in individual accident and sickness insurance policies which may be unjust, unfair, misleading, or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims; and to provide for full and fair disclosure in the sale of accident and sickness coverages.

Revised Law

Sec. 1201.003. APPLICABILITY OF CHAPTER. (a) This chapter applies only to an accident and health insurance policy delivered or issued for delivery in this state.

(b) Except as otherwise provided by this chapter, this chapter applies only to an individual accident and health insurance policy delivered or issued for delivery by:

(1) a life, health, and accident insurance company;

(2) a mutual insurance company, including:

(A) a mutual life insurance company; and

(B) a mutual assessment life insurance company;

(3) a local mutual aid association;

(4) a mutual or natural premium life or casualty insurance company;

(5) a general casualty company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842; or

(9) another insurer required by law to be authorized by the department.

(c) This chapter applies to an accident and health insurance

policy issued by a stipulated premium company subject to Chapter 884.

(d) This chapter does not apply to:

(1) any society, company, or other insurer whose activities are exempt by statute from the control of the department and that is entitled by statute to a certificate from the department that shows the entity's exempt status;

(2) a credit accident and health insurance policy issued under Chapter 1153;

(3) a workers' compensation insurance policy;

(4) a liability insurance policy, with or without supplementary expense coverage;

(5) a reinsurance policy or contract;

(6) a blanket or group insurance policy, except as otherwise provided by this chapter; or

(7) a life insurance endowment or annuity contract or a contract supplemental to a life insurance endowment or annuity contract if the contract or supplemental contract contains only provisions relating to accident and health insurance that:

(A) provide additional benefits in case of accidental death, accidental dismemberment, or accidental loss of sight; or

(B) operate to:

(i) safeguard the contract or supplemental contract against lapse; or

(ii) give a special surrender value, a special benefit, or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(e) Subchapters C and D do not apply to a conversion policy issued under a contractual conversion privilege under a group accident and health insurance policy. (V.T.I.C. Art. 3.70-1, Sec. (C) (part); Art. 3.70-8, Secs. (a) (part), (b).)

Source Law

[Art. 3.70-1]

(C) Scope of Act. This Act shall apply to and govern individual accident and sickness insurance policies delivered, or issued for delivery, in the State of Texas by life, health and accident companies, mutual life insurance companies, mutual assessment life insurance companies, mutual insurance companies, local mutual aid associations, mutual or natural premium life or casualty insurance companies, general casualty companies, Lloyds, reciprocal or inter-insurance exchanges, nonprofit hospital, medical, or dental service corporations including but not limited to companies subject to Chapter 20 of this code, as amended, stipulated premium insurance companies, or any other insurer which by law is required to be licensed by the Board; provided, however, this Act shall not apply to any society, company or other insurer whose activities are by statute exempt from the control of the Board and which are entitled by statute to an exemption certificate from the Board in evidence of their exempt status; nor to credit accident and sickness insurance policies written under Article 3.53 of this code, as amended; . . . . Conversion policies issued pursuant to a contractual conversion privilege under a group accident and sickness insurance policy shall not be subject to Subsections (D) through (H) of this article.

Art. 3.70-8. (a) Nothing in this Act shall apply to or affect (1) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or (2) any policy or contract of reinsurance; or (3) any blanket or group policy of insurance except as provided in Subsections . . . (C) of Section 2 and Subdivision (5) of Subsection (F) of Section 1 and . . . ; or (4) life insurance endowment or annuity contracts or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value, special benefit, or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract, or (5) any policy written under the provisions of Senate Bill No. 208, Acts of the 51st Legislature, 1949.

(b) This Act applies to a health, accident, sickness, and hospitalization policy issued by a stipulated premium insurer subject to Chapter 884 of this code.

Revisor's Note

(1) The provisions of law revised in this chapter apply only to an accident and health insurance policy delivered or issued for delivery in this state. The revised law states this limitation as a limitation on the applicability of the chapter for drafting

convenience and to avoid frequent repetition of the substance of the language in subsequent sections of this chapter. Accordingly, the revised law omits references to "delivered or issued for delivery in this state" in subsequent sections of this chapter.

(2) Section (C), V.T.I.C. Article 3.70-1, provides that the act "shall apply to and govern" certain policies. The revised law omits "govern" because, in this context, "govern" is included in the meaning of "apply to."

(3) Section (C), V.T.I.C. Article 3.70-1, refers to companies, "including but not limited to" certain companies. The revised law omits "but not limited to" and similar language throughout this chapter as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded. Those definitions apply to the revised law.

(4) Section (C), V.T.I.C. Article 3.70-1, refers to "Chapter 20 of this code, as amended" and "Article 3.53 of this code, as amended." Throughout this chapter, the revised law omits the references to "as amended" in this and similar instances because, under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute.

(5) Section (C), V.T.I.C. Article 3.70-1, refers to an insurer required by law to be "licensed" by the board, meaning the Texas Department of

Insurance. The revised law substitutes "authorized" for "licensed" because, under this code, an insurer receives from the department a certificate of authority, instead of a license, to act as an insurer.

(6) Section (C), V.T.I.C. Article 3.70-1, provides that "Subsections (D) through (H) of this article" do not apply to "[c]onversion policies issued pursuant to a contractual conversion privilege under a group accident and sickness insurance policy." The revised law omits the reference to "Subsection (D)" (revised as Section 1201.006), governing rulemaking authority of the commissioner, because conversion policies are subject to other provisions in this chapter and commissioner rules adopted under Subsection (D) implementing those provisions.

(7) Section (a), V.T.I.C. Article 3.70-8, provides that "[n]othing in this Act shall apply to or affect" certain matters. The revised law omits "affect" because, in this context, "affect" is included in the meaning of "apply to."

(8) Section (a), V.T.I.C. Article 3.70-8, provides that the act does not apply to a blanket or group insurance policy "except as provided in Subsections . . . (C) of Section 2 and Subdivision (5) of Subsection (F) of Section 1." The revised law substitutes "except as otherwise provided by this chapter" for the quoted language for clarity and accuracy. The quoted language is misleading because it does not provide a complete list of all provisions in this chapter that apply to a blanket or group policy. For example, Sections (L) and (M), V.T.I.C. Article 3.70-2, revised in relevant part as Sections 1201.062 and 1201.063-1201.065, respectively, apply explicitly to group policies, but a reference to those

provisions is not included in Article 3.70-8.

(9) Section (a), V.T.I.C. Article 3.70-8, provides an exemption from the act for "any policy written under the provisions of Senate Bill No. 208, Acts of the 51st Legislature, 1949." The revised law omits that exemption as unnecessary because it duplicates the exemption provided by Section (C), V.T.I.C. Article 3.70-1, to "credit accident and sickness insurance policies written under Article 3.53," revised as Section 1201.003(d)(2).

(10) Section (b), V.T.I.C. Article 3.70-8, refers to a "health, accident, sickness, and hospitalization policy" issued by a stipulated premium insurer. The revised law substitutes "accident and health insurance policy" for the quoted language because the terms are substantively identical and "accident and health insurance policy" is the defined term used throughout this chapter.

Revised Law

Sec. 1201.004. CONSTRUCTION OF CHAPTER. This chapter does not enlarge the powers of an entity listed in Section 1201.003. (V.T.I.C. Art. 3.70-1, Sec. (C) (part).)

Source Law

(C) . . . provided further, that this Act shall not be construed to enlarge the powers of any of the enumerated companies. . . .

Revised Law

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

(1) Section 1202.052;

(2) Section 1271.005(a), to the extent that the subsection relates to the applicability of Section 1201.105, and Sections 1271.005(d) and (e);

(3) Chapter 1351;

(4) Subchapters C and E, Chapter 1355;

(5) Chapter 1356;

(6) Chapter 1365;

(7) Subchapter A, Chapter 1367; and

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

Revisor's Note

This chapter is derived from a majority of the articles previously contained in Subchapter G, Chapter 3, Insurance Code. Many of those articles were enacted by Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, and references in those articles to "this Act" are revised in this chapter as references to "this chapter." However, the logical organization of this code required various portions of Chapter 397 ("this Act") to be revised in other chapters of this code. As a result, this new section is necessary to ensure the continued applicability of provisions revised in this chapter to the portions of Chapter 397 revised in other chapters.

Revised Law

Sec. 1201.006. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (D).)

Source Law

(D) Rules and Regulations. The Board is authorized to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this article.

Revisor's Note

(1) Section (D), V.T.I.C. Article 3.70-1, refers to "rules and regulations." Throughout this chapter, the revised law omits the reference to "regulations" in this context because, under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section (D), V.T.I.C. Article 3.70-1, refers to the purposes and provisions "of this article" (V.T.I.C. Article 3.70-1). The revised law provides that rulemaking authority applies to the purposes and provisions of the entire chapter because, read in context, including Section (A), Article 3.70-1, revised as Section 1201.002, it is clear that the legislature intended this result.

Revised Law

Sec. 1201.007. NOTICE AND HEARING. The commissioner may adopt a general rule or order relating to a matter covered by this chapter only after a hearing held after the 10th day following the date the department by mail notifies each insurer to which this chapter applies. (V.T.I.C. Art. 3.70-10 (part).)

Source Law

> Art. 3.70-10. No general rule, regulation or order shall be adopted by the Board or the commissioner relating to any matter covered by this Act, except after hearing upon at least ten days prior notice by mail to all insurers to whom this Act applies. . . .

Revised Law

Sec. 1201.008. JUDICIAL REVIEW. An insurer that is dissatisfied with an order, act, rule, administrative ruling, or decision of the commissioner under this chapter may, after failing to get relief from the commissioner, file a petition seeking judicial review of the order, act, rule, ruling, or decision in accordance with Subchapter D, Chapter 36. The action has precedence over all other causes on the docket of a different nature. (V.T.I.C. Art. 3.70-10 (part).)

Source Law

> Art. 3.70-10. . . . If any insurer be dissatisfied with any decision, regulation, order, rule, act, or administrative ruling adopted by the Board or the commissioner under the provisions of this Act, such dissatisfied insurer may file a petition . . . . The action shall have precedence over all other causes on the docket of a different nature. The action shall be tried and determined as provided by Article 1.04, Insurance Code. . . .

Revisor's Note

The revised law omits certain provisions of V.T.I.C. Article 3.70-10 relating to judicial review because the provisions duplicate provisions contained in Subchapter D, Chapter 36. The omitted law reads:

> Art. 3.70-10. . . . [If any insurer be dissatisfied with any decision, regulation, order, rule, act, or administrative ruling adopted by the Board or the commissioner under the provisions of this Act, such dissatisfied insurer may file a petition] setting forth the particular objection to such decision, regulation, order, rule, act or administrative ruling, or to either or all of them, in a District Court of Travis County, Texas, and not elsewhere, against the Board or the commissioner as defendant. . . . Either party to the action may appeal to the Appellate Court having jurisdiction of the cause and the appeal shall be at once returnable to the Appellate Court having jurisdiction of the cause and the action so appealed shall have precedence in the Appellate Court over all causes of a different character therein pending. The Board or the commissioner shall not be required to give any appeal bond in any cause arising hereunder.

Revised Law

Sec. 1201.009. NONCONFORMING POLICY. (a) This chapter governs the rights, duties, and obligations of the insurer, the insured, and the beneficiary of an accident and health insurance policy regardless of a provision in the policy that conflicts with this chapter.

(b) An accident and health insurance policy that violates this chapter is a valid policy, but the policy shall be construed in a manner to make the policy consistent with this chapter. (V.T.I.C. Art. 3.70-4, Sec. (B).)

Source Law

> (B) Policy Conflicting with this Act. A policy delivered or issued for delivery to any person in this state in violation of this Act shall be held valid but shall be construed as provided in this Act. When any provision in a policy subject to this Act is in conflict with any provision of this Act, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this Act.

Revised Law

Sec. 1201.010. THIRD-PARTY OWNERSHIP OF POLICY. The use of "insured" in this chapter does not prevent a person with an insurable interest, other than the insured, from:

(1) applying for and owning an individual accident and health insurance policy covering the insured; or

(2) being entitled to an indemnity, right, or benefit provided for in an individual accident and health insurance policy covering the insured. (V.T.I.C. Art. 3.70-3, Sec. (E).)

Source Law

(E) Third Party Ownership. The word "insured" as used in this Act, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

Revisor's Note

Section (E), V.T.I.C. Article 3.70-3, refers to a "policy." The majority of Subchapter G, V.T.I.C. Chapter 3, including Article 3.70-3, was enacted as Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, and is revised as this chapter. These provisions, as originally enacted, governed individual accident and sickness insurance policies. See, for example, Section (A), V.T.I.C. Article 3.70-1, revised as Section 1201.002, and Section (C), V.T.I.C. Article 3.70-1, and Section (a), V.T.I.C. Article 3.70-8, revised in relevant part as Section 1201.003. Subsequent amendments to Chapter 397 added provisions that also apply to group and franchise accident and health insurance policies. Throughout this chapter, the revised law adds a reference to an "individual" policy where appropriate to clarify the application of the law.

Revised Law

Sec. 1201.011. COVERAGE FOR PREMIUM PERIOD WITH LIMITATIONS

BY AGE OR DATE; MISSTATEMENT OF AGE OF INSURED. (a) Regardless of a provision in an individual accident and health insurance policy that specifies a date, by age limitation or otherwise, after which coverage under the policy is not effective, coverage continues in force, subject to any right of cancellation, until the end of the period for which the insurer accepts a premium if:

(1) the insurer accepts the premium after the specified date; or

(2) the specified date falls before the end of the period for which the insurer accepts the premium.

(b) Notwithstanding Subsection (a), if the age of the insured is misstated and, because of the insured's correct age, coverage of the insured would not have become effective or would have terminated before the insurer's acceptance of a premium, the liability of the insurer is limited to the refund, on request, of the premiums paid for the period not covered by the policy. (V.T.I.C. Art. 3.70-7.)

Source Law

> Art. 3.70-7. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

Revised Law

Sec. 1201.012. DEFENSE OF CLAIM. The following actions by an insurer do not operate as a waiver of the insurer's rights in defense of a claim that arises under an individual accident and health insurance policy:

(1) acknowledgment of the receipt of notice given under the policy;

(2) provision of a form for filing a proof of loss;

(3) acceptance of a proof of loss; or

(4) investigation of a claim under the policy.

(V.T.I.C. Art. 3.70-6.)

Source Law

Art. 3.70-6. The acknowledgment by any insurer of the receipt of notice given under any policy covered by this Act, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Revisor's Note
(End of Subchapter)

Section (I), V.T.I.C. Article 3.70-1, provides that rules adopted under Article 3.70-1 are subject to the notice and hearing requirements of V.T.I.C. Article 3.70-10, revised in relevant part as Section 1201.007. The revised law omits the section as unnecessary because Article 3.70-10 applies on its own terms to rules adopted under Article 3.70-1. The omitted law reads:

(I) Administrative Procedures. Rules and regulations promulgated pursuant to this Article shall be subject to notice and hearing pursuant to Section 10, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-10, Vernon's Texas Insurance Code).

[Sections 1201.013-1201.050 reserved for expansion]

SUBCHAPTER B. POLICY TERMS

Revised Law

Sec. 1201.051. ENTIRE CONSIDERATION. An individual accident and health insurance policy must state the entire monetary and other consideration for the policy in the policy or in the application, if the application is made a part of the policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

Art. 3.70-2. (A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(1) the entire money and other

consideration therefor are expressed therein or in the application, if it is made a part of the policy; and

. . .

Revised Law

Sec. 1201.052. TIME OF EFFECTIVENESS AND TERMINATION. An individual accident and health insurance policy must state the time the insurance takes effect and the time the insurance terminates. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(2) the time at which the insurance takes effect and terminates is expressed therein; and

. . .

Revised Law

Sec. 1201.053. PERSONS INSURED. (a) Except as provided by this section, an individual accident and health insurance policy may not insure more than one individual.

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

(c) The adult who applies for the individual accident and health insurance policy is considered the policyholder. (V.T.I.C. Art. 3.70-2, Sec. (A) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Source Law

(A) [as amended Acts 77th Leg., R.S., Ch. 396] No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(3) it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult

member of a family who shall be deemed the policy holder, any two or more eligible members of that family, including:

(a) the spouse of the policy holder;

(b) a dependent child of the policy holder or any child under a specified age that may not exceed 25 years of age;

(c) a dependent grandchild of the policy holder who is less than 21 years old and living with and in the household of the policy holder; provided that, for purposes of this paragraph, a grandchild of a policy holder is a dependent of the policy holder regardless of whether the policy holder treats the grandchild as a dependent for federal income tax purposes;

(d) a child the policy holder is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state; and

(e) any other person dependent upon the policy holder; and

. . .

(A) [as amended Acts 77th Leg., R.S., Ch. 1027] No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(3) it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policy holder, any two or more eligible members of that family, including husband, wife, unmarried children under 25 years of age, including a grandchild of the policy holder as described by Section (L) of this article, a child the policy holder is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state, and any other person dependent upon the policy holder; and

. . .

Revisor's Note

Section (A)(3), V.T.I.C. Article 3.70-2, was amended twice during the 77th Legislative Session. Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001, amended Section (A)(3) to permit an individual accident and health insurance policy to insure an unmarried child who is younger than 25 years of age and a "grandchild of the policy holder as described by Section (L)." Section (L), V.T.I.C. Article 3.70-2, as amended by Chapter 1027 and revised in relevant part as Section 1201.062(a)(1), provides for coverage of an unmarried grandchild who is younger than 25 years of age and is a dependent of the adult for

federal income tax purposes at the time application for coverage of the grandchild is made.

Chapter 396, Acts of the 77th Legislature, Regular Session, 2001, amended Section (A)(3) to permit an individual accident and health insurance policy to insure a dependent child, any child under a specified age that may not exceed 25 years of age, and a dependent grandchild who is younger than 21 years of age and who lives in the adult's household. In addition, Chapter 396 amended Section (A)(3) to provide that a grandchild of the adult is a dependent regardless of whether the adult treats the grandchild as a dependent for federal income tax purposes.

It is impossible to give effect to both amendments made by Chapters 396 and 1027 regarding coverage for dependent children and other children and regarding the issue of whether a grandchild is required to be a dependent for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Under Sections 311.025 and 312.014, Government Code, the amendment to Section (A)(3), Article 3.70-2, made by Chapter 1027 impliedly repealed the amendment adopted under Chapter 396. The revised law accordingly is drafted to reflect the amendment to Section (A)(3) made by Chapter 1027 and to omit the amendment to Section (A)(3) made by Chapter 396.

Revised Law

Sec. 1201.054. APPEARANCE OF TEXT. (a) In this section, "text" includes all printed matter of an individual accident and health insurance policy except:

(1) the name and address of the insurer;

(2) the name or title of the policy;

(3) the brief description, if any; and

(4) captions and subcaptions.

(b) An individual accident and health insurance policy must have:

(1) a style, arrangement, or overall appearance that does not give undue prominence to any portion of the text; and

(2) every printed portion of its text and of any endorsements or attached papers printed plainly in a lightfaced type:

(A) of a style in general use; and

(B) in a uniform size not less than 10-point with a lowercase unspaced alphabet length not less than 120-point.

(c) Subsection (b)(2) does not apply to a copy of an application or identification card. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

> (A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:
>
> . . .
>
> (4) the style, arrangement and over-all appearance of the policy gives no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers (except copies of applications and identification cards) are plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions); and
>
> . . .

Revised Law

Sec. 1201.055. EXCEPTIONS AND REDUCTIONS OF INDEMNITY. (a)

An individual accident and health insurance policy must state each exception to or reduction of indemnity for the policy.

(b) Except as provided by Subchapter E, each exception to or reduction of indemnity for the policy must be printed, at the insurer's option:

(1) with the benefit provision to which the exception or reduction applies; or

(2) under an appropriate caption such as:

(A) "Exceptions"; or

(B) "Exceptions and Reductions."

(c) Notwithstanding Subsection (b), if an exception or reduction specifically applies only to a particular benefit of an individual accident and health insurance policy, the statement of the exception or reduction must be included with the benefit provision to which the exception or reduction applies. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

> (A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:
>
> . . .
>
> (5) the exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Section 3 of this Act, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions"; provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and
>
> . . .

Revised Law

Sec. 1201.056. FORM NUMBER. Each form that constitutes a part of an individual accident and health insurance policy, including each rider or endorsement, must be identified by a form number placed in the lower left corner of the first page of the form. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

> (A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person

in this state unless:

. . .

(6) each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

. . .

Revised Law

Sec. 1201.057. INCORPORATION OF OR REFERENCE TO OTHER DOCUMENTS. (a) An individual accident and health insurance policy that provides that a portion of the charter, rules, constitution, or bylaws of the insurer are a part of the policy must state that portion fully in the policy.

(b) An individual accident and health insurance policy may incorporate or refer to:

(1) a statement of rates or classification of risks; or

(2) a short-rate table filed with the department. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(7) it contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or shortrate table filed with the Board; and

. . .

Revised Law

Sec. 1201.058. NOTIFICATION THAT POLICY IS RETURNABLE; EFFECT OF RETURN. (a) An individual accident and health insurance policy must include a notice that states in substance that the individual to whom the policy is issued is entitled to have the premium paid refunded if, after the individual examines the policy, the individual is not satisfied with the policy for any reason and returns the policy not later than the 10th day after the date the policy is delivered to the individual.

(b) An individual accident and health insurance policy returned to the insurer at the insurer's home or branch office or to

the agent through whom the policy was purchased within the time provided by the notice is void from the date the policy was issued, and the parties are in the same position as if the policy had not been issued.

(c) The notice required by this section may be printed on the policy or attached to the policy.

(d) This section does not apply to a single premium nonrenewable policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

> (A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:
>
> . . .
>
> (8) it shall have printed thereon or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten (10) days of its delivery to such person and to have the premium paid refunded if, after examination of the policy, such person is not satisfied with it for any reason. If such person pursuant to such notice, returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. This subdivision shall not apply to single premium nonrenewable policies.

Revised Law

Sec. 1201.059. TERMINATION OF COVERAGE BASED ON AGE OF CHILD IN INDIVIDUAL, BLANKET, OR GROUP POLICY. (a) An accident and health insurance policy, including an individual, blanket, or group policy, and including a policy issued by a corporation operating under Chapter 842, that provides that coverage of a child terminates when the child attains a limiting age specified in the policy must provide in substance that the child's attainment of that age does not terminate coverage while the child is:

(1) incapable of self-sustaining employment because of mental retardation or physical disability; and

(2) chiefly dependent on the insured or group member for support and maintenance.

(b) To obtain coverage for a child as described by Subsection (a), the insured or group member must provide to the

insurer proof of the child's incapacity and dependency:

(1) not later than the 31st day after the date the child attains the limiting age; and

(2) subsequently as the insurer requires, except that the insurer may not require proof more frequently than annually after the second anniversary of the date the child attains the limiting age. (V.T.I.C. Art. 3.70-2, Sec. (C); Art. 3.70-8, Sec. (a) (part).)

Source Law

[Art. 3.70-2]

(C) Any policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20, Texas Insurance Code, as amended, delivered or issued for delivery in this state, which provides that coverage of a child shall terminate upon attainment of the limiting age for children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (2) chiefly dependent upon the insured for support and maintenance. Proof of the incapacity and dependency shall be furnished to the insurer by the insured within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Art. 3.70-8. (a) [Nothing in this Act shall apply to . . . any blanket or group policy of insurance] except as provided in Subsections . . . (C) of Section 2 . . . .

Revisor's Note

(1) Section (C), V.T.I.C. Article 3.70-2, refers to physical "handicap." The revised law substitutes "disability" for "handicap" because, in this context, "disability" and "handicap" are synonymous, and "disability" is the term used in most other contexts, including the federal Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.).

(2) Section (C), V.T.I.C. Article 3.70-2, refers to "the insured." The revised law substitutes

"the insured or group member" to provide for consistent use of terminology in this chapter in relation to individual, blanket, and group insurance policies.

Revised Law

Sec. 1201.060. REQUIRED DEFINITION OF "EMERGENCY CARE" IN INDIVIDUAL OR GROUP POLICY. An individual or group accident and health insurance policy that provides an emergency care benefit, including a policy issued by a corporation operating under Chapter 842, must define "emergency care" as follows:

"Emergency care" means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(V.T.I.C. Art. 3.70-2, Sec. (I).)

Source Law

(I) An individual or group policy of accident and sickness insurance that provides any emergency care benefit, including policies issued by companies subject to Chapter 20, Insurance Code, delivered or issued for delivery in this state must define emergency care as follows: "Emergency care" means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

Revised Law

Sec. 1201.061. COVERAGE FOR ADOPTED CHILD. (a) An individual accident and health insurance policy that provides coverage for an insured's immediate family or children may not,

solely because the insured's child is adopted:

(1) exclude the child from coverage; or

(2) limit coverage for the child.

(b) For the purposes of this section, a child is an insured's child if the insured is a party to a suit in which the insured seeks to adopt the child. (V.T.I.C. Art. 3.70-2, Sec. (K).)

Source Law

(K) An accident and sickness insurance policy that provides coverage for the immediate family or children of a person insured under the policy may not exclude from coverage or limit coverage to a child of the insured solely because the child is adopted. For the purposes of this subsection, a child is considered to be the child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought.

Revised Law

Sec. 1201.062. COVERAGE FOR CERTAIN CHILDREN IN INDIVIDUAL OR GROUP POLICY OR IN PLAN OR PROGRAM. (a) An individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide coverage for:

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

(A) unmarried;

(B) younger than 25 years of age; and

(C) a dependent of the insured or group member for federal income tax purposes at the time application for coverage of the grandchild is made; and

(2) each child for whom the insured or group member must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

(b) Coverage for a grandchild of the insured or group member

may not be terminated solely because the grandchild is no longer a dependent of the insured or group member for federal income tax purposes. (V.T.I.C. Art. 3.70-2, Sec. (L) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Source Law

(L) [as amended Acts 77th Leg., R.S., Ch. 396] An individual or group policy of accident and sickness insurance that is delivered, issued for delivery, or renewed in this state, including a policy issued by a company subject to Chapter 20, Insurance Code, . . . and a self-funded or self-insured welfare or benefit plan or program to the extent that regulation of the plan or program is not preempted by federal law that provides coverage for a child of the policyholder, must provide coverage upon payment of a premium for:

(1) any children of the policyholder's child if those children are dependents of the policyholder; provided that, for purposes of this subdivision, a grandchild of a policyholder is a dependent of the policyholder regardless of whether the policyholder treats the grandchild as a dependent for federal income tax purposes; or

(2) a child for whom the group member or insured must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

(L) [as amended Acts 77th Leg., R.S., Ch. 1027] An individual or group policy of accident and sickness insurance that is delivered, issued for delivery, or renewed in this state, including a policy issued by a company subject to Chapter 20, Insurance Code, . . . and a self-funded or self-insured welfare or benefit plan or program to the extent that regulation of the plan or program is not preempted by federal law that provides coverage for a child of the policyholder, must provide coverage upon payment of a premium for any unmarried child of the policyholder's child if the child is younger than 25 years of age and is a dependent of the policyholder for federal income tax purposes at the time application for coverage of the child of the policyholder's child is made or for a child for whom the group member or insured must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state. Coverage for a child of the policyholder's child may not be terminated solely because the covered child is no longer a dependent of the policyholder for federal income tax purposes.

Revisor's Note

(1) Section (L), V.T.I.C. Article 3.70-2, refers to "the policyholder" and "the group member or insured." The revised law omits the reference to "policyholder" and refers only to the "insured or group member" to provide for consistent use of proper

terminology that reflects the application of the section to both group and individual policies.

(2) Section (L), V.T.I.C. Article 3.70-2, was amended twice during the 77th Legislative Session. Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001, amended Section (L) to require coverage of a grandchild of the insured or group member if the grandchild is unmarried, is younger than 25 years of age, and is a dependent of the insured or group member for federal income tax purposes at the time application for coverage of the grandchild is made.

Chapter 396, Acts of the 77th Legislature, Regular Session, 2001, amended Section (L) to require coverage of a grandchild of the insured or group member if the grandchild is a dependent of the insured or group member and to provide that a grandchild of the insured or group member is a dependent regardless of whether the insured or group member treats the grandchild as a dependent for federal income tax purposes.

It is impossible to give effect to both amendments made by Chapters 396 and 1027 regarding coverage for a grandchild. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Under Sections 311.025 and 312.014, Government Code, the amendment to Section (L), Article 3.70-2, made by Chapter 1027 impliedly

repealed the amendment adopted under Chapter 396. The revised law accordingly is drafted to reflect the amendment to Section (L) made by Chapter 1027 and to omit the amendment to Section (L) made by Chapter 396.

Revised Law

Sec. 1201.063. PROHIBITION OF CERTAIN CRITERIA RELATING TO CHILD'S COVERAGE IN INDIVIDUAL OR GROUP POLICY. Regarding a natural or adopted child of an insured or group member or a child for whom the insured or group member must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state, an individual or group accident and health insurance policy that provides coverage for a child of an insured or group member may not set a different premium for the child, exclude the child from coverage, or discontinue coverage of the child because:

(1) the child does not reside with the insured or group member; or

(2) the insured or group member does not claim the child as an exemption for federal income tax purposes under Section 151(c)(1)(B), Internal Revenue Code of 1986. (V.T.I.C. Art. 3.70-2, Sec. (M)(1).)

Source Law

(M)(1) A group or individual accident and sickness insurance policy that provides coverage for children of a group member or a person insured under the policy may not exclude from or discontinue coverage or set a different premium for the natural born or adopted child of the group member or person insured or for a child for whom the group member or insured must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state for either of the following reasons:

(a) the child does not reside with the group member or insured; or

(b) the group member or insured does not claim the child as an exemption for federal income tax purposes under Section 151(c)(1)(B), Internal Revenue Code of 1986 (26 U.S.C. Section 151(c)(1)(B)).

Revisor's Note

Section (M)(1), V.T.I.C. Article 3.70-2, refers to a "person insured." For consistency throughout the

code, the revised law refers to an "insured." Similar changes have been made throughout this chapter.

Revised Law

Sec. 1201.064. COVERAGE FOR CHILD OF SPOUSE IN INDIVIDUAL OR GROUP POLICY. An individual or group accident and health insurance policy that provides coverage for a child of an insured or group member may not:

(1) set a premium for a child that is different from the premium for other children because the child is the natural or adopted child of the spouse of the insured or group member;

(2) exclude a child described by Subdivision (1) from coverage; or

(3) discontinue coverage of a child described by Subdivision (1). (V.T.I.C. Art. 3.70-2, Sec. (M)(2).)

Source Law

(2) A group or individual accident and sickness insurance policy that provides coverage for children of a group member or a person insured under the policy may not exclude from or discontinue coverage or set a different premium for the natural born or adopted child of the spouse of the group member or person insured.

Revised Law

Sec. 1201.065. AGE AND SCHOOL ENROLLMENT ELIGIBILITY CRITERIA FOR DEPENDENT CHILDREN IN INDIVIDUAL OR GROUP POLICY; LATE ENROLLMENT. (a) An individual or group accident and health insurance policy may contain criteria relating to a maximum age or enrollment in school to establish continued eligibility for coverage of a child younger than 25 years of age.

(b) In the case of a late enrollment, an insurer may require evidence of insurability that is satisfactory to the insurer before a child is included for coverage under the policy. (V.T.I.C. Art. 3.70-2, Sec. (M)(3).)

Source Law

(3) Other policy provisions relating to maximum limiting attained age and enrollment in school may be used to establish continued eligibility for coverage of a child less than 25 years of age. In the event of late enrollment, the insurance company may

require evidence of insurability satisfactory to the company before inclusion of the child for coverage under the policy.

[Sections 1201.066-1201.100 reserved for expansion]

SUBCHAPTER C. GENERAL POLICY STANDARDS AND PROVISIONS

Revised Law

Sec. 1201.101. STANDARDS FOR POLICY PROVISIONS. (a) The commissioner shall adopt reasonable rules establishing specific standards for:

(1) the content of an individual accident and health insurance policy; and

(2) the manner of sale of an individual accident and health insurance policy, including disclosures required to be made in connection with the sale.

(b) Rules adopted under this section must establish standards for:

(1) policy readability; and

(2) full and fair policy disclosures.

(c) Standards established under this section may include standards that address:

(1) terms of policy renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) preexisting conditions;

(6) termination of insurance;

(7) probationary periods;

(8) limitations;

(9) exceptions;

(10) reductions;

(11) elimination periods;

(12) requirements for replacement;

(13) recurrent conditions; and

(14) definitions of terms, including definitions of:

(A) "accident";

(B) "accidental means";

(C) "guaranteed renewable and noncancellable";

(D) "hospital";

(E) "injury";

(F) "nervous disorder";

(G) "partial disability";

(H) "physician";

(I) "sickness"; and

(J) "total disability."

(d) A definition of "hospital" adopted under Subsection (c) may not apply to a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (E)(1).)

Source Law

(E) Standards for Policy Provisions. (1) The Board shall issue reasonable rules and regulations to establish specific standards including standards for readability of policies and for full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of accident and sickness insurance which shall be in addition to and in accordance with applicable laws of this state which may cover but shall not be limited to:

(a) terms of renewability;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) pre-existing conditions;

(f) termination of insurance;

(g) probationary periods;

(h) limitations;

(i) exceptions;

(j) reductions;

(k) elimination periods;

(l) requirements for replacement;

(m) recurrent conditions; and

(n) the definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable and noncancellable; provided that any definition of hospital so developed shall not be applicable to companies organized under Chapter 20 of this code, as amended.

Revisor's Note

Section (E)(1), V.T.I.C. Article 3.70-1, provides that rules adopted under that section "shall be in addition to and in accordance with applicable

laws of this state." The revised law omits the quoted language as unnecessary. The phrase "shall be in addition to" is unnecessary because an accepted general principle of statutory construction requires that a statute and rules adopted under a statute be given cumulative effect with other statutes unless the statute provides otherwise or unless the statute or rule conflicts with another statute. The general principle applies to the revised law. The phrase "shall be . . . in accordance with applicable laws of this state" is unnecessary because rules may not conflict with statutes under general legal principles, and a statement to that effect is unnecessary.

Revised Law

Sec. 1201.102. PROHIBITION OF POLICY PROVISIONS. The commissioner may adopt rules prohibiting specific individual accident and health insurance policy provisions not specifically authorized by statute that the commissioner determines are unjust, unfair, or unfairly discriminatory to:

(1) the policyholder;

(2) an insured under the policy; or

(3) a beneficiary. (V.T.I.C. Art. 3.70-1, Sec. (E)(2).)

Source Law

(2) The Board may issue rules and regulations that specify prohibited policy provisions, not otherwise specifically authorized by statute, which in the opinion of the Board are unjust, unfair, or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary.

Revised Law

Sec. 1201.103. COMPLIANCE WITH MINIMUM STANDARDS FOR BENEFITS. (a) An individual accident and health insurance policy must meet the minimum standards for benefits established under Section 1201.104 for each category of coverage provided under the policy.

(b) Subsection (a) does not apply if the commissioner determines that the policy is a supplemental policy or experimental policy or determines that the policy will fulfill a reasonable public need and the policy meets the requirements of Chapter 1701. (V.T.I.C. Art. 3.70-1, Sec. (F)(3).)

Source Law

> (3) No policy shall be issued, or issued for delivery, in the State of Texas which does not meet the prescribed minimum standards for the categories of coverage listed in Paragraphs (a) through (h) of Subsection (1) of this section which are contained within the policy unless the Board finds such policy to be a supplemental policy, a policy experimental in nature or finds such policy will fulfill a reasonable public need and such policy meets the requirements set forth in Article 3.42 of the Insurance Code.

Revised Law

Sec. 1201.104. MINIMUM STANDARDS FOR BENEFITS. (a) For individual accident and health insurance policies, the commissioner shall adopt rules establishing minimum standards for benefits under each of the following categories of coverage:

(1) basic hospital expense;

(2) basic medical-surgical expense;

(3) hospital confinement indemnity;

(4) major medical expense;

(5) disability income protection;

(6) accident only;

(7) specified disease;

(8) specified accident; and

(9) limited benefit.

(b) This section does not prohibit the issuance of an individual accident and health insurance policy that combines categories of coverage listed by this section. (V.T.I.C. Art. 3.70-1, Secs. (F)(1), (2).)

Source Law

> (F) Minimum Standards for Benefits. (1) The Board shall issue rules and regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies of accident and sickness insurance:
>
> (a) basic hospital expense coverage;

(b) basic medical-surgical expense coverage;

(c) hospital confinement indemnity coverage;

(d) major medical expense coverage;

(e) disability income protection coverage;

(f) accident only coverage;

(g) specified disease or specified accident coverage; and

(h) limited benefit coverage.

(2) Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in Paragraphs (a) through (h) of Subsection (1) of this section.

Revised Law

Sec. 1201.105. MINIMUM STANDARDS FOR BENEFITS FOR LONG-TERM CARE IN INDIVIDUAL, GROUP, OR BLANKET POLICY. (a) The commissioner shall adopt rules establishing minimum standards for benefits for long-term care coverage under individual, group, and blanket accident and health insurance policies and certificates delivered or issued for delivery in this state.

(b) Rules adopted under this section apply to group coverages delivered or issued for delivery by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part); Art. 3.70-8, Sec. (a) (part).)

Source Law

[Art. 3.70-1, Sec. (F)]

(5) The Board shall adopt rules and regulations establishing minimum standards for benefits for long-term care coverage under individual and group policies and certificates of accident and sickness insurance delivered or issued for delivery in this state including group coverages delivered or issued for delivery by companies subject to Chapter 20 of this code and . . . .

Art. 3.70-8. (a) [Nothing in this Act shall apply to . . . any blanket or group policy of insurance] except as provided in . . . Subdivision (5) of Subsection (F) of Section 1 and . . . .

Revised Law

Sec. 1201.106. IDENTIFICATION OF POLICIES ACCORDING TO COVERAGE PROVIDED. The commissioner shall prescribe the method to identify an individual accident and health insurance policy according to the coverages the policy provides. (V.T.I.C. Art. 3.70-1, Sec. (F)(4).)

Source Law

(4) The Board shall prescribe the method of identification of policies based on coverages provided.

Revised Law

Sec. 1201.107. OUTLINE OF COVERAGE REQUIRED. (a) An outline of coverage for an individual accident and health insurance policy must be delivered to the applicant at the time application is made, and an acknowledgment of receipt or certificate of delivery of an outline of coverage must be provided to the insurer with the application.

(b) If the policy issued differs from the policy for which the applicant applied, an outline of coverage that properly describes the policy must:

(1) accompany the policy when delivered; and

(2) clearly state that the policy is not the policy for which the applicant applied.

(c) Subsection (a) does not apply to a direct response insurance product.

(d) An outline of coverage under a direct response insurance product must accompany the policy. (V.T.I.C. Art. 3.70-1, Sec. (G)(1).)

Source Law

(G) Outline of Coverage. (1) In order to provide for full and fair disclosure in the sale of individual accident and sickness insurance policies, no such policy shall be delivered, or issued for delivery, in the State of Texas unless: (i) in the case of a direct response insurance product, the outline of coverage described in Subsection (2) of this section accompanies the policy; (ii) in all other cases, the outline of coverage described in Subsection (2) of this section is delivered to the applicant at the time application is made and an acknowledgment of receipt or certificate of delivery of such outline is provided the insurer with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy must accompany the policy when it is delivered and clearly state that it is not the policy for which application was made.

Revisor's Note

Section (G)(1), V.T.I.C. Article 3.70-1, provides restrictions on the delivery or issuance of

insurance policies "[i]n order to provide for full and fair disclosure in the sale of individual accident and sickness insurance policies." The revised law omits the quoted language relating to the purpose of the article as unnecessary because it duplicates language relating to the purpose of the entire act in Section (A), V.T.I.C. Article 3.70-1, revised as Section 1201.002.

Revised Law

Sec. 1201.108. FORMAT AND CONTENT OF OUTLINE OF COVERAGE. (a) In this section, "format" means style, arrangement, and overall appearance, including:

(1) the size, color, and prominence of type; and

(2) the arrangement of text and captions.

(b) The commissioner shall prescribe the format and content of an outline of coverage required by Section 1201.107.

(c) An outline of coverage must include:

(1) a statement that identifies the applicable categories of coverage listed by Section 1201.104 and provided by the policy;

(2) a description of the principal benefits and coverage provided by the policy;

(3) a statement of the exceptions, reductions, and limitations in the policy;

(4) a statement of the renewal provision, including any reservation of the insurer's right to change premiums;

(5) a statement that:

(A) the outline is a summary of the policy issued or applied for; and

(B) the policy should be consulted to determine governing contractual provisions;

(6) as the commissioner determines necessary to carry out the purposes of this chapter, a summary of the provisions required by Subchapter E to be in the policy; and

(7) any other statement, description, or outline that the commissioner determines is reasonably necessary to carry out the purposes of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (G)(2).)

Source Law

(2) The Board shall prescribe the format and content of the outline of coverage required by Subsection (1) of this section. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) a statement identifying the applicable category or categories of coverage provided by the policy as prescribed in Section (F) of this article;

(b) a description of the principal benefits and coverage provided in the policy;

(c) a statement of the exceptions, reductions, and limitations contained in the policy;

(d) a statement of the renewal provision including any reservation by the insurer of a right to change premiums;

(e) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

(f) a summary of such provisions required to be in the policy by Section 3, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, as amended (Article 3.70-3, Vernon's Texas Insurance Code), as the Board may determine to be necessary to carry out the purposes of this Act.

(g) Any other statements, descriptions, or outlines that the Board may determine to be reasonably necessary to carry out the purposes of this Act.

[Sections 1201.109-1201.150 reserved for expansion]

SUBCHAPTER D. PREEXISTING CONDITIONS

Revised Law

Sec. 1201.151. COMPLIANCE WITH SUBCHAPTER; PROHIBITION OF DEFENSE. Except as provided by this subchapter, an individual accident and health insurance policy may not include a provision that permits a defense based on a preexisting condition. (V.T.I.C. Art. 3.70-1, Sec. (H)(3).)

Source Law

(3) Except as so provided, a policy issued under the provisions of this section may not include wording that would permit a defense based on pre-existing conditions.

Revised Law

Sec. 1201.152. COVERAGE UNDER SIMPLIFIED APPLICATION

FORM. (a) Notwithstanding Clause (b) of the provision required by Section 1201.208(a), an individual accident and health insurance policy must cover any loss that occurs after 12 months from a preexisting condition if the insurer uses a simplified application form that does not include a question concerning the applicant's health history or medical treatment history.

(b) This section applies regardless of whether the simplified application form includes a question regarding the applicant's health at the time of application.

(c) This section does not require an insurer to cover a loss from a condition that the policy specifically excludes from coverage. (V.T.I.C. Art. 3.70-1, Sec. (H)(1).)

Source Law

> (H) Pre-existing Conditions. (1) Notwithstanding the provisions of Section 3(A)(2)(b), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, as amended (Article 3.70-3, Vernon's Texas Insurance Code), if an insurer elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy must cover any loss occurring after 12 months from any pre-existing condition not specifically excluded from coverage by terms of the policy.

Revised Law

Sec. 1201.153. COVERAGE FOR INDIVIDUALS AGE 65 OR OLDER. (a) Notwithstanding Section 1201.152 or Clause (b) of the provision required by Section 1201.208(a), an individual accident and health insurance policy delivered or issued for delivery to an individual who is 65 years of age or older may not include a provision that excludes from coverage a loss that occurs from a preexisting condition more than six months after the effective date of coverage under the policy.

(b) Notwithstanding Subsection (a), the commissioner may authorize a policy provision that excludes coverage for a preexisting condition for a period of not more than one year if the commissioner determines that the provision would serve the public interest.

(c) This section does not require an insurer to provide coverage for a loss from a preexisting condition specifically excluded from coverage by name or specific description in an exclusion endorsement or rider that is effective on the date of the loss. (V.T.I.C. Art. 3.70-1, Sec. (H)(2).)

Source Law

> (2) Notwithstanding the provisions of Section 3(A)(2)(b), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, as amended (Article 3.70-3, Vernon's Texas Insurance Code), or of Paragraph (1) of this subsection, no individual policy of accident and sickness insurance delivered or issued for delivery in this state to a person age 65 or over may contain a provision excluding from coverage any loss due to a pre-existing condition, not specifically excluded from coverage by name or specific description in an exclusion endorsement or rider effective on the date of the loss, for a period in excess of six months from the effective date of coverage under the policy; provided, however, that if the Board finds that the public interest would be served thereby, it may authorize a policy provision excluding coverage for pre-existing conditions for a period in excess of six months but in no event shall such period exceed one year.

Revised Law

Sec. 1201.154. COVERAGE FOR CERTAIN PREVIOUSLY COVERED PERSONS. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004.

(b) A preexisting condition provision in an individual accident and health insurance policy may not apply to an individual:

(1) who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage, excluding any waiting period; and

(2) whose most recent creditable coverage was under:

(A) a group health plan;

(B) a governmental plan; or

(C) a church plan.

(c) In determining whether a preexisting condition provision of an individual accident and health insurance policy applies to an individual, an insurer shall credit the time the

individual previously was covered under creditable coverage if the previous coverage was in effect at any time during the 18 months preceding the effective date of the individual coverage. (V.T.I.C. Art. 3.70-1, Sec. (H)(4).)

Source Law

(4)(a) A preexisting condition provision in an individual health insurance policy shall not apply to an individual who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage, excluding any waiting period, and whose most recent creditable coverage was under a group health plan, governmental plan, or church plan.

(b) For purposes of this section, creditable coverage means coverage under any of the following: a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulations; or a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)).

(c) In determining whether a preexisting condition provision applies to an individual, the individual insurance carrier shall credit the time the individual was previously covered under creditable coverage if the previous coverage was in effect at any time during the 18 months preceding the effective date of the individual coverage.

Revisor's Note

(1) Section (H)(4)(a), V.T.I.C. Article 3.70-1, refers to "an individual health insurance policy." The revised law substitutes for the quoted language "an individual accident and health insurance policy" to provide consistency in terminology and because the context of the reference makes it clear that the quoted language refers to an individual accident and health insurance policy.

(2) Section (H)(4)(b), V.T.I.C. Article 3.70-1,

defines "creditable coverage." That definition of "creditable coverage" was adopted by Chapter 837, Acts of the 75th Legislature, Regular Session, 1997. A substantially identical definition, containing exclusions not explicitly made applicable in Article 3.70-1, appeared three times in Chapter 955, Acts of the 75th Legislature, Regular Session, 1997, in sections amending V.T.I.C. Chapter 26, adding V.T.I.C. Article 21.52G, and adding V.T.I.C. Article 3.95-1.5. The intent of the legislature in enacting Chapters 837 and 955 was to implement federal requirements on health insurance portability and availability; the use of similar definitions in four different articles was to ensure compliance with the federal requirements. The relevant portion of the definition contained in V.T.I.C. Article 21.52G is revised in this code in Section 1205.004. Therefore, to avoid unnecessary duplication, the revised law substitutes a cross-reference to Section 1205.004 for the substance of Section (H)(4)(b), Article 3.70-1.

[Sections 1201.155-1201.200 reserved for expansion]

SUBCHAPTER E. REQUIRED POLICY PROVISIONS

Revised Law

Sec. 1201.201. POLICY PROVISIONS REQUIRED. (a) Except as provided by Subsections (b) and (c), an individual accident and health insurance policy must contain the provisions required by this subchapter in the words provided by this subchapter.

(b) An insurer may substitute for a policy provision required by this subchapter a provision with different wording approved by the commissioner in accordance with reasonable rules adopted by the commissioner. A substituted provision may not be less favorable to an insured or a beneficiary of the policy than the provision required by this subchapter.

(c) If a policy provision required by this subchapter is

wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the commissioner's approval, shall:

(1) omit from the policy each inapplicable provision or part of a provision; and

(2) modify each inconsistent provision or part of a provision so that the provision as contained in the policy is consistent with the coverage provided by the policy.

(d) A policy provision required by this subchapter must be preceded by the caption for the provision provided by this subchapter or, at the option of the insurer, by an appropriate individual or group caption or subcaption approved by the commissioner. (V.T.I.C. Art. 3.70-3, Secs. (A) (part), (B) (part), (C).)

Source Law

> Art. 3.70-3. (A) Required Provisions. Except as provided in paragraph (C) of this section each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section; provided, however, that the insurer may, at its option, substitute for one or more of such provisions, provisions of different wording approved by the Board, in accordance with reasonable rules and regulations promulgated by the Board, which are in each instance not less favorable in any respect to the insured or the beneficiary; and . . . . Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Board may approve.
>
> . . .
>
> (B) Other Provisions. Except as provided in paragraph (C) of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; provided, however, that the insurer may, at its option, use in lieu of any such provision a provision of different wording approved by the Board, in accordance with reasonable rules and regulations promulgated by the Board, which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Board may approve.
>
> . . .
>
> (C) Inapplicable or Inconsistent Provisions. If

any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the Board, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Revised Law

Sec. 1201.202. ORDER OF REQUIRED POLICY PROVISIONS. (a) Except as provided by Subsection (b), policy provisions required by this subchapter or corresponding substitute provisions must be printed in the same consecutive order as provided by this subchapter.

(b) An insurer may print a policy provision required by this subchapter or a corresponding substitute provision as a unit in any part of the policy with other provisions to which the provision is logically related.

(c) A policy printed under Subsection (b) may not be wholly or partly unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued. (V.T.I.C. Art. 3.70-3, Sec. (D).)

Source Law

(D) Order of Certain Policy Provisions. The provisions which are the subject of subsections (A) and (B) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

Revised Law

Sec. 1201.203. OTHER POLICY PROVISIONS. A policy provision that is not otherwise subject to this subchapter may not make an individual accident and health insurance policy or any portion of the policy less favorable in any way to the insured or the beneficiary than the policy provisions that are subject to this chapter. (V.T.I.C. Art. 3.70-4, Sec. (A).)

Source Law

Art. 3.70-4. (A) Other Policy Provisions. No policy provision which is not subject to Section 3 of this Act shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this Act.

Revised Law

Sec. 1201.204. POLICY PROVISIONS REQUIRED BY OTHER JURISDICTION. An individual accident and health insurance policy of a foreign or alien insurer may contain any provision that is:

(1) not less favorable to the insured or the beneficiary than the provisions of this chapter; and

(2) prescribed or required by the law of the state under which the insurer is organized. (V.T.I.C. Art. 3.70-3, Sec. (F)(1).)

Source Law

(F) Requirements of other Jurisdictions. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this Act and which is prescribed or required by the law of the state under which the insurer is organized.

Revised Law

Sec. 1201.205. POLICY PROVISIONS FOR POLICY DELIVERED OUTSIDE THIS STATE. An individual accident and health insurance policy issued by a domestic insurer for delivery in another state or country may contain any provision permitted or required by the laws of that state or country. (V.T.I.C. Art. 3.70-3, Sec. (F)(2).)

Source Law

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

Revised Law

Sec. 1201.206. FILING PROCEDURE. (a) The commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to this chapter that are necessary, proper, or advisable for the administration of this chapter.

(b) This section does not limit any authority otherwise

granted by law to the commissioner or department. (V.T.I.C. Art. 3.70-3, Sec. (G).)

Source Law

> (G) Filing Procedure. The Board may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this Act as are necessary, proper or advisable to the administration of this Act. This provision shall not abridge any other authority granted the Board by law.

Revised Law

Sec. 1201.207. POLICY PROVISION: ENTIRETY OF CONTRACT; POLICY CHANGES. An individual accident and health insurance policy must contain the following provision:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this policy is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy. An agent does not have authority to change this policy or to waive any of its provisions." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> (1) A provision as follows:
>
> Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.
>
> . . .

Revisor's Note

Sections (A) and (B), V.T.I.C. Article 3.70-3, provide that certain policies must contain specified provisions "in the words in which the same appear in this section." Consequently, in this subchapter, beginning with this section, the revised law makes only limited nonsubstantive changes to the wording as necessary to accomplish in a minimal way the purposes

of the codification process.

Revised Law

Sec. 1201.208. POLICY PROVISION: INCONTESTABILITY. (a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time Limit on Certain Defenses: (a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.

"(b) A claim for loss incurred or disability (as defined in the policy) beginning after the second anniversary of the date this policy is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy."

(b) Clause (a) of the provision required by Subsection (a) does not:

(1) affect any legal requirement for avoidance of a policy or denial of a claim during the initial two-year period; or

(2) limit the application of Section 1201.219, 1201.220, or 1201.221 in a case of a misstatement regarding age, occupation, or other insurance.

(c) For a policy that provides that the insured is entitled to continue the policy in force by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance, an insurer may use the following clause instead of Clause (a) of the provision required by Subsection (a):

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestible as to

the statements contained in the application."

(d) The provision provided by Subsection (c) must be under the caption "Incontestable." An insurer that uses the provision may omit the parenthetical clause. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> . . .
>
> (2) A provision as follows:
>
> Time Limit on Certain Defenses: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.
>
> (The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of Section 3(B), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance.)
>
> (A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "incontestible":
>
> After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestible as to the statements contained in the application.)
>
> (b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.
>
> . . .

Revisor's Note

Section (A)(2), V.T.I.C. Article 3.70-3, states that the policy provision provided by that section does not limit the application of "Section 3(B), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance" (Sections (B)(1)-(5), V.T.I.C. Article 3.70-3). When

Article 3.70-3 was enacted by Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, those cross-references correctly referred to provisions relating to age, occupation, and other insurance. However, Sections (B)(4) and (5), relating to other insurance, were deleted when Article 3.70-3 was amended by Chapter 703, Acts of the 64th Legislature, Regular Session, 1975. Section (B)(3), also relating to other insurance, was retained. The legislature inadvertently failed at that time to amend Section (A)(2) to reflect the change to Section (B). The revised law corrects the reference in Section (A)(2) by referring only to Sections (B)(1)-(3), revised as Sections 1201.219, 1201.220, and 1201.221.

Revised Law

Sec. 1201.209. POLICY PROVISION: GRACE PERIOD. (a) An individual accident and health insurance policy must contain the following provision:

"Grace Period: A grace period of ____ (insert appropriate number) days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force."

(b) The number of days of the grace period may not be less than:

(1) 7 for a weekly premium policy;

(2) 10 for a monthly premium policy; or

(3) 31 for any other policy.

(c) A policy that contains a cancellation provision may add, at the end of the provision required by Subsection (a): "subject to the right of the insurer to cancel the policy in accordance with the policy's cancellation provision."

(d) A policy in which the insurer reserves the right to refuse any renewal must include the following provision at the beginning of the provision required by Subsection (a):

"Unless, not less than five days before the premium due date, the insurer has delivered to the insured, or has mailed to the insured's last address as shown by the insurer's records, a written notice of the insurer's intention not to renew this policy beyond the period for which the premium has been accepted, ..." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> . . .
>
> (3) A provision as follows:
>
> Grace Period: A grace period of . . . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies, and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.
>
> (A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.
>
> A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision:
>
> Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.)
>
> . . .

Revised Law

Sec. 1201.210. POLICY PROVISION: REINSTATEMENT. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Reinstatement: If a renewal premium is not paid before the expiration of the period granted for the insured to make the payment, a subsequent acceptance of the premium by the insurer or any agent authorized by the insurer to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the policy. However, if the insurer or authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated on approval of the application by the insurer or, if the application is not approved, on the 45th day after the date

of the conditional receipt unless the insurer before that date has notified the insured in writing of the insurer's disapproval of the application. The reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the policy or attached to the policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement."

(b) The insurer may omit the last sentence of the provision required by Subsection (a) in a policy that provides that the insured is entitled to continue the policy in force by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> . . .
>
> (4) A provision as follows:
>
> Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they

had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.)

. . .

Revised Law

Sec. 1201.211. POLICY PROVISION: NOTICE OF CLAIM. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Notice of Claim: A written notice of claim must be given to the insurer before the 21st day after the date of the occurrence or beginning of any loss covered by the policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of any office the insurer designates for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, constitutes notice to the insurer."

(b) In a policy that provides a loss of time benefit that may be payable for at least two years, an insurer may insert, between the first and second sentences of the provision required by Subsection (a), the following provision:

"Subject to the qualifications below, and except in the event of a legal incapacity, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every _____ (insert appropriate number) months after having given notice of claim, give to the insurer notice of continuance of the disability. In applying this provision, the period of _____ (insert appropriate number) months following a filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer shall be

excluded. Delay in giving the notice does not impair the insured's right to any indemnity that would otherwise have accrued during the period of _____ (insert appropriate number) months preceding the date on which the notice is actually given."

(c) The number of months inserted in the clause permitted by Subsection (b) may not be less than one or greater than six. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> . . .
>
> (5) A provision as follows:
>
> Notice of Claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at . . . . . (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.
>
> (In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:
>
> Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every . . . . . (insert a number not less than one nor more than six) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of . . . . . (insert a number not less than one nor more than six) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of . . . . . (insert a number not less than one nor more than six) months preceding the date on which such notice is actually given.)
>
> . . .

Revised Law

Sec. 1201.212. POLICY PROVISION: CLAIM FORMS. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Claim Forms: The insurer, on receipt of a notice of claim,

will provide to the claimant the forms usually provided by the insurer for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made."

(b) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . provided further that Provisions 6 . . . shall not be required provisions under this Subsection A for companies organized under Chapter 20 of this code, as amended. . . .
>
> . . .
>
> (6) A provision as follows:
>
> Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.
>
> . . .

Revised Law

Sec. 1201.213. POLICY PROVISION: PROOF OF LOSS. An individual accident and health insurance policy must contain the following provision:

"Proof of Loss: For a claim for loss for which this policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st day after the termination of the period for which the insurer is liable. For a claim for any other loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st

day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> . . .
>
> (7) A provision as follows:
>
> Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible; and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
>
> . . .

Revised Law

Sec. 1201.214. POLICY PROVISION: TIME OF PAYMENT OF CLAIMS. (a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time of Payment of Claims: Indemnities payable under this policy for any loss, other than a loss for which this policy provides any periodic payment, will be paid immediately on receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for a loss for which this policy provides periodic payment will be paid _____ (insert period for payment) and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written proof of loss."

(b) The period for payment to be inserted in the clause required by Subsection (a) may not be less frequent than monthly.

(c) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . provided further that Provisions . . . 8, and . . . shall not be required provisions under this Subsection A for companies organized under Chapter 20 of this code, as amended. . . .
>
> . . .
>
> (8) A provision as follows:
>
> Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.
>
> . . .

Revised Law

Sec. 1201.215. POLICY PROVISION: PAYMENT OF CLAIMS. (a) Except as provided by Subsection (d), an individual accident and health insurance policy must contain the following provision:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this policy and effective at the time of payment. If such a designation or provision is not then effective, the indemnity will be payable to the insured's estate. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either in accordance with the beneficiary designation or to the insured's estate. All other indemnities will be payable to the insured."

(b) An insurer may include with the provision required by Subsection (a) one or both of the following provisions:

"If any indemnity of this policy is payable to the insured's estate, or to an insured or beneficiary who is a minor or is otherwise not competent to give a valid release, the insurer may pay

the indemnity, up to an amount not exceeding $_____ (insert amount), to any relative by blood or connection by marriage of the insured or beneficiary who is considered by the insurer to be equitably entitled to the indemnity. Any payment made by the insurer in good faith in accordance with this provision fully discharges the insurer to the extent of the payment."

"Subject to any written direction of the insured, in the application or otherwise, all or a portion of any indemnity provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of the loss, be paid directly to the hospital or person providing the services. It is not required that the service be provided by a particular hospital or person."

(c) The amount to be inserted in the clause permitted by Subsection (b) may not exceed $1,000.

(d) The provision required by Subsection (a) is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . provided further that Provisions . . . 9 shall not be required provisions under this Subsection A for companies organized under Chapter 20 of this code, as amended. . . .
>
> . . .
>
> (9) A provision as follows:
>
> Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.
>
> (The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:
>
> If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ . . . . . .

(insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

. . .

Revised Law

Sec. 1201.216. POLICY PROVISION: PHYSICAL EXAMINATIONS AND AUTOPSY. An individual accident and health insurance policy must contain the following provision:

"Physical Examinations and Autopsy: The insurer at its own expense has the right and opportunity to conduct a physical examination of the insured when and as often as the insurer reasonably requires while a claim under the policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(10) A provision as follows:

Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

. . .

Revised Law

Sec. 1201.217. POLICY PROVISION: LEGAL ACTIONS. An individual accident and health insurance policy must contain the following provision:

"Legal Actions: An action at law or in equity may not be brought to recover on this policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this policy. An action at law or in equity may not

be brought after the expiration of three years after the time written proof of loss is required to be provided." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> . . .
>
> (11) A provision as follows:
>
> Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.
>
> . . .

Revised Law

Sec. 1201.218. POLICY PROVISION: CHANGE OF BENEFICIARY. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in this policy."

(b) An insurer may omit the first clause of the provision required by Subsection (a) relating to an irrevocable designation of beneficiary. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

> (A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .
>
> . . .
>
> (12) A provision as follows:
>
> Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.
>
> (The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

Revised Law

Sec. 1201.219. POLICY PROVISION: CHANGE OF OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Change of Occupation: If the insured is injured or contracts a sickness after the insured changes the insured's occupation to one classified by the insurer as more hazardous than the occupation stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only the portion of the indemnity provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than the occupation stated in this policy, the insurer, on receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding the receipt of the proof, whichever date is more recent. In applying this provision, the classification of occupational risk and the premium rates are the classification and rates that, before the occurrence of the loss for which the insurer is liable or before the date of proof of change in occupation, were:

(1) last filed by the insurer with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; or

(2) if filing was not required, last made effective by the insurer in the state where the insured resided at the time this policy was issued." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

> (B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .
>
> (1) A provision as follows:

Change of Occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

. . .

Revised Law

Sec. 1201.220. POLICY PROVISION: MISSTATEMENT OF AGE. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Misstatement of Age: If the age of the insured has been misstated, the amounts payable under this policy are the amounts the premium paid would have purchased at the correct age." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(2) A provision as follows:

Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

. . .

Revised Law

Sec. 1201.221. POLICY PROVISION: EXCESS INSURANCE. An

individual accident and health insurance policy must contain one of the following provisions if the policy addresses the subject matter of the provision:

"Other Insurance With This Insurer: If an accident or health or accident and health policy or policies previously issued by the insurer to the insured is in force concurrently with this policy, making the aggregate indemnity for _____ (insert types of coverages) in excess of $_____ (insert maximum limit of indemnity or indemnities), the excess insurance is void and all premiums paid for the excess shall be returned to the insured or to the insured's estate."

"Other Insurance With This Insurer: Insurance effective at any one time on the insured under the same type of policy or policies with this insurer is limited to the one policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other policies of the same type." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

> (B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .
>
> . . .
>
> (3) A provision as follows:
>
> Other Insurance in This Insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for . . . . . (insert type of coverage or coverages) in excess of $ . . . . . (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate;
>
> or, in lieu thereof:
>
> Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.
>
> . . .

Revised Law

Sec. 1201.222. POLICY PROVISION: RELATION OF EARNINGS TO

INSURANCE. (a) Subject to Subsection (b), an individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage on the insured, regardless of whether the benefits are payable on a weekly or monthly basis, exceeds the amount of monthly earnings of the insured at the time the insured's disability began or the insured's average amount of monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever amount is greater, the insurer will be liable only for the proportionate amount of loss of time benefits under this policy as the amount of the insured's monthly earnings or average monthly earnings bears to the total amount of monthly benefits for the same loss under all loss of time coverage on the insured at the time the disability begins and for the return of the part of the premiums paid during the immediately preceding two years that exceeds the pro rata amount of the premiums for the benefits actually paid under this policy. This provision does not reduce the total monthly amount of benefits payable under all loss of time coverage on the insured to less than $200 or the sum of the monthly benefits specified in the loss of time coverages, whichever amount is less, and does not reduce benefits other than loss of time benefits."

(b) The provision described by Subsection (a) may be included only in a policy that provides that the insured is entitled to continue the policy in force subject to its terms by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance.

(c) An insurer may include in the provision described by Subsection (a) a definition of "valid loss of time coverage." The form of the definition must be approved by the commissioner. The

subject matter of the definition must be limited to:

(1) coverage provided by:

(A) governmental agencies; or

(B) organizations subject to regulation by insurance laws or by insurance authorities of this or any other state or any province of Canada;

(2) any other coverage the inclusion of which is approved by the commissioner; or

(3) any combination of coverages described by Subdivisions (1) and (2).

(d) In the absence of a definition authorized under Subsection (c), "valid loss of time coverage" does not include:

(1) coverage provided for the insured under a compulsory benefit statute, including a workers' compensation or employer's liability statute; or

(2) benefits provided by:

(A) a union welfare plan;

(B) an employer benefit organization; or

(C) an employee benefit organization. (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(4) A provision as follows:

Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly

amount of benefits payable under all such coverage upon the insured below the sum of Two Hundred Dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the Board, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Board or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

. . .

Revised Law

Sec. 1201.223. POLICY PROVISION: UNPAID PREMIUM. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Unpaid Premium: At the time of payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted from the payment." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(5) A provision as follows:

Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

. . .

Revised Law

Sec. 1201.224. POLICY PROVISION: CANCELLATION. An individual accident and health insurance policy must contain the

following provision if the policy addresses the subject matter of the provision:

"Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer, stating when the cancellation is effective, which may not be earlier than five days after the date the notice is delivered or mailed. After this policy has been continued beyond its original term, the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on a later date specified in the notice. In the event of cancellation, the insurer will promptly return the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

> (B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .
>
> . . .
>
> (6) A provision as follows:
>
> Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim

originating prior to the effective date of cancellation.

. . .

Revised Law

Sec. 1201.225. POLICY PROVISION: CONFORMITY WITH STATE STATUTES. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Conformity With State Statutes: Any provision of this policy that, on its effective date, conflicts with the statutes of the state in which the insured resides on the effective date is by this clause effectively amended to conform to the minimum requirements of that state's statutes." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(7) A provision as follows:

Conformity With State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

. . .

Revised Law

Sec. 1201.226. POLICY PROVISION: ILLEGAL OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Illegal Occupation: The insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(8) A provision as follows:

Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

. . .

Revised Law

Sec. 1201.227. POLICY PROVISION: INTOXICANTS AND NARCOTICS. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Intoxicants and Narcotics: The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a physician." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(9) A provision as follows:

Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

[Sections 1201.228-1201.270 reserved for expansion]

SUBCHAPTER F. APPLICATION FOR POLICY

Revised Law

Sec. 1201.271. ALTERATION OF POLICY APPLICATION. (a) A person may not alter a written application for an individual accident and health insurance policy unless the person has the written consent of the applicant.

(b) Notwithstanding Subsection (a), an insurer may make an insertion to an application solely for administrative purposes in a manner that indicates clearly that the insertion is not attributed to the applicant. (V.T.I.C. Art. 3.70-5, Sec. (B).)

Source Law

(B) No alteration of any written application for any such policy shall be made by any person other than

the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Revised Law

Sec. 1201.272. FALSE STATEMENTS. The falsity of a statement in an application for an individual accident and health insurance policy does not bar a right to recovery under the policy unless the statement materially affected the acceptance of the risk or the hazard assumed by the insurer. (V.T.I.C. Art. 3.70-5, Sec. (C).)

Source Law

(C) The falsity of any statement in the application for any policy covered by this Act may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Revised Law

Sec. 1201.273. BINDING STATEMENTS. An insured may not be bound by a statement made in an application for an individual accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy as a part of the policy when issued. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

Source Law

Art. 3.70-5. (A) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. . . .

Revised Law

Sec. 1201.274. INSURER'S EVIDENTIARY USE OF APPLICATION FOR REINSTATEMENT OR RENEWAL. (a) If an individual accident and health insurance policy is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes a written request for a copy of the application for reinstatement or renewal, the insurer shall, not later than the 15th day after the date the insurer receives the request at its home or branch office, deliver or mail a copy of the application to the person who made the request.

(b) An insurer that fails to comply with this section may

not introduce the application for reinstatement or renewal as evidence in any action or proceeding based on or involving the policy or its reinstatement or renewal. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

Source Law

> (A) . . . If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within fifteen days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

[Sections 1201.275-1201.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT

Revised Law

Sec. 1201.701. CIVIL PENALTY. A person, partnership, or corporation that wilfully violates this chapter or an order of the commissioner made under this chapter is liable to the state for a civil penalty in an amount not to exceed $5,000 for each violation. The penalty may be recovered through a civil action. (V.T.I.C. Art. 3.70-9 (part).)

Source Law

> Art. 3.70-9. Any person, partnership, or corporation wilfully violating any provision of this Act or order of the Board made in accordance with this Act, shall forfeit to the people of the state a sum not to exceed Five Thousand Dollars ($5,000.00) for each such violation, which may be recovered by a civil action. . . .

Revised Law

Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY OR LICENSE. The commissioner may suspend or revoke the certificate of authority or license of an insurer or agent who wilfully violates this chapter or an order of the commissioner made under this chapter. (V.T.I.C. Art. 3.70-9 (part).)

Source Law

Art. 3.70-9. . . . The Board may also suspend or revoke the license of an insurer or agent for any such wilful violation.

Revisor's Note

V.T.I.C. Article 3.70-9 refers to a "license of an insurer or agent." The revised law adds a reference to a "certificate of authority" of an insurer for consistency with terminology used throughout this code.

Revisor's Note
(End of Chapter)

The revised law omits V.T.I.C. Article 3.70-11 as executed. That article provided for a five-year period after the effective date of the act containing the article (Chapter 397, Acts of the 54th Legislature, Regular Session, 1955) during which certain other provisions in the act were inapplicable to previously authorized policies, riders, or endorsements. Chapter 397 took effect in 1955, and the five-year period has expired. The omitted law reads:

> Art. 3.70-11. A policy, rider or endorsement, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before the effective date of this Act may be used or delivered or issued for delivery to any such person during five years after the effective date of this Act without being subject to the provisions of Sections 2, 3, or 4 of this Act.

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES IN GENERAL

SUBCHAPTER A. CONTINUOUS POLICIES

Sec. 1202.001. CONTINUOUS POLICIES 632

[Sections 1202.002-1202.050 reserved for expansion]

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL HEALTH INSURANCE POLICIES 633

Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV . . . 634

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES IN GENERAL

SUBCHAPTER A. CONTINUOUS POLICIES

Revised Law

Sec. 1202.001. CONTINUOUS POLICIES. (a) A guaranteed renewable insurance policy or a noncancellable insurance policy is considered to be a continuous policy, subject only to the policy terms and conditions, including payment of the policy premium.

(b) A guaranteed renewable insurance policy or a noncancellable insurance policy:

(1) is continued in effect by the payment of the policy premium in accordance with the policy terms and conditions; and

(2) may not be considered or treated as a renewed policy by the payment of the policy premium.

(c) This section does not apply to a small employer health benefit plan adopted in accordance with Chapter 1501. (V.T.I.C. Art. 3.70-13.)

Source Law

Art. 3.70-13. A guaranteed renewable policy or a noncancellable policy shall be deemed to be a continuous policy, subject only to the terms and conditions thereof, including payment of policy premiums, and such policies shall be considered to be continued in force by the payment of the policy premium in accordance with the policy terms and conditions, and such policies shall not be deemed or treated as renewed policies by the payment of such contracted policy premiums. This article does not apply to a health benefit plan adopted in accordance with Chapter 26 of this code, as added by H.B. No. 2055, Acts of the 73rd Legislature, Regular Session, 1993.

Revisor's Note

V.T.I.C. Article 3.70-13, in the second sentence, refers to a "health benefit plan adopted in accordance with Chapter 26 of this code, as added by H.B. No. 2055, Acts of the 73rd Legislature, Regular Session, 1993." When enacted by that bill, Chapter 26 addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through

enactment of H.B. No. 1212, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the revised law refers to a "small employer health benefit plan" for clarity and to reflect legislative intent.

[Sections 1202.002-1202.050 reserved for expansion]

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Revised Law

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL HEALTH INSURANCE POLICIES. (a) This section applies only to an individual health insurance policy that provides benefits for medical care under a hospital, medical, or surgical policy.

(b) Except as provided by Subsection (c), an insurer shall renew or continue an individual health insurance policy at the option of the individual.

(c) An insurer may decline to renew or continue an individual health insurance policy:

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

(2) for fraud or intentional misrepresentation;

(3) because the insurer is ceasing to offer coverage in the individual market in accordance with rules adopted by the commissioner;

(4) because an individual no longer resides, lives, or works in an area in which the insurer is authorized to provide coverage, but only if all policies are not renewed or not continued under this subdivision uniformly without regard to any health-status related factor of covered individuals; or

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

(d) The commissioner shall adopt rules necessary to:

(1) implement this section; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 3.70-1A.)

Source Law

Art. 3.70-1A. (a) Except as otherwise provided in this article, an individual health insurance policy providing benefits for medical care under a hospital, medical, or surgical policy shall be renewed or continued in force at the option of the individual.

(b) An individual health insurance policy providing benefits for medical care under a hospital, medical, or surgical policy may be nonrenewed or discontinued based only on one or more of the following reasons:

(1) failure to pay premiums or contributions in accordance with the terms of the policy;

(2) fraud or intentional misrepresentation;

(3) the insurance company is ceasing to offer coverage in the individual market in accordance with rules established by the commissioner;

(4) an individual no longer resides, lives, or works in an area in which the insurer is authorized to provide coverage, but only if such coverage is terminated under this subdivision uniformly without regard to any health-status related factor of covered individuals; or

(5) in accordance with applicable federal law and regulations.

(c) The commissioner shall adopt rules necessary to implement this article and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV. (a) In this section, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

(b) Except as provided by Subsection (c), an insurer that delivers or issues for delivery an individual accident and health insurance policy in this state may not cancel that policy during its term because the insured:

(1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(c) The insurer may cancel the policy for:

(1) failure to pay a premium when due; or

(2) fraud or misrepresentation in obtaining coverage by not disclosing a diagnosis of an AIDS or HIV-related condition.

(d) The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking

under that chapter, and definitions of terms applicable in that chapter, apply to this section. (V.T.I.C. Art. 3.70-3A; New.)

Source Law

Art. 3.70-3A. (a) Except as provided by Subsection (b) of this section, an insurer that delivers or issues for delivery an accident and sickness insurance policy in this state may not cancel that policy during its term because the insured has been diagnosed as having or has been or is being treated for HIV or AIDS as defined by Section 81.101, Health and Safety Code.

(b) An insurer may cancel an insurance policy covered by Subsection (a) of this section for fraud or misrepresentation in obtaining coverage by not disclosing a diagnosis of AIDS or HIV-related conditions or for failure to pay premiums when due.

Revisor's Note

(1) Section (a), V.T.I.C. Article 3.70-3A, refers to an "accident and sickness insurance policy." The revised law substitutes "individual accident and health insurance policy" for the quoted language. The revised law adds "individual" for clarity because it is clear from the placement of Article 3.70-3A in Subchapter G, Chapter 3, Insurance Code, that the article is intended to address individual policies only. Section (C), V.T.I.C. Article 3.70-1, states that Subchapter G applies only to "individual accident and sickness insurance policies." The revised law substitutes "health" for "sickness" for consistency with modern usage.

(2) Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to V.T.I.C. Article 3.70-3A, revised as this section. The majority of these articles are revised in this code as Chapter 1201. Section 1202.052(d) is added to indicate the applicability of those general provisions to this section. For the convenience of the reader,

the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

Sec. 1203.001. APPLICABILITY OF CHAPTER 636
Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED 637
Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID 638

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

Revised Law

Sec. 1203.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to:

(1) a policy of group accident and health insurance as described by Chapter 1251;

(2) a policy of blanket accident and health insurance as described by Chapter 1251;

(3) a policy of individual accident and health insurance as defined by Section 1201.001; or

(4) an evidence of coverage as defined by Section 843.002.

(b) This chapter does not apply to an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible. (V.T.I.C. Art. 3.51-6B, Sec. 1(a) (part).)

Source Law

Art. 3.51-6B

Sec. 1. (a) A policy of group accident and health insurance or blanket accident and health insurance as defined by Sections 1 and 2, Article 3.51-6, Insurance Code, an individual policy of accident and sickness insurance as defined by Section 1(B)(3), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code), except an individual policy designed to fully integrate with other policies through a variable deductible, or an evidence of coverage as defined by the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), [may not be delivered, issued for delivery, or renewed in this state if the terms of the policy or evidence of coverage exclude or reduce the payment of benefits to or on behalf of an insured or enrollee because benefits

are also payable or have been paid under a supplemental policy of accident and health insurance that is individually underwritten and individually issued as a hospital confinement indemnity, specified disease or limited benefit plan of coverage.]

Revisor's Note

Section 1(a), V.T.I.C. Article 3.51-6B, refers to "an individual policy of accident and sickness insurance." For consistency with modern usage, the revised law substitutes "health" for "sickness" throughout this chapter.

Revised Law

Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED. (a) An accident and health insurance policy or evidence of coverage may not be delivered, issued for delivery, or renewed in this state if:

(1) a provision of the policy or evidence of coverage excludes or reduces the payment of benefits to or on behalf of an insured or enrollee;

(2) the reason for the exclusion or reduction is that benefits are also payable or have been paid to or on behalf of the insured or enrollee under a supplemental policy of accident and health insurance; and

(3) the supplemental policy is individually underwritten and individually issued as a plan of coverage for:

(A) hospital confinement indemnity;

(B) a specified disease; or

(C) a limited benefit.

(b) Application of Subsection (a) to a provision of an accident and health insurance policy or evidence of coverage is not affected by:

(1) the mode or channel by which the premium for a supplemental policy of accident and health insurance is paid to the insurer; or

(2) a reduction in the premium for a supplemental policy of accident and health insurance because of the insured's

membership in an organization or status as an employee. (V.T.I.C. Art. 3.51-6B, Secs. 1(a) (part), (b).)

Source Law

(a) [A policy of group accident and health insurance or blanket accident and health insurance as defined by Sections 1 and 2, Article 3.51-6, Insurance Code, an individual policy of accident and sickness insurance as defined by Section 1(B)(3), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code), except an individual policy designed to fully integrate with other policies through a variable deductible, or an evidence of coverage as defined by the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code),] may not be delivered, issued for delivery, or renewed in this state if the terms of the policy or evidence of coverage exclude or reduce the payment of benefits to or on behalf of an insured or enrollee because benefits are also payable or have been paid under a supplemental policy of accident and health insurance that is individually underwritten and individually issued as a hospital confinement indemnity, specified disease or limited benefit plan of coverage.

(b) Subsection (a) of this section applies to such supplemental policies irrespective of the mode or channel of premium payment to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of his status as an employee.

Revised Law

Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID. A provision of an accident and health insurance policy or evidence of coverage that violates Section 1203.002 is void. (V.T.I.C. Art. 3.51-6B, Sec. 2.)

Source Law

Sec. 2. A provision in a group accident and health insurance or blanket accident and health insurance policy, an individual accident and sickness insurance policy, or an evidence of coverage that violates Section 1 of this article is void.

CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES 640

Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT 641

[Sections 1204.003-1204.050 reserved for expansion]

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS
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CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Revised Law

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES. This subchapter does not apply to indigent care or chronic disease care provided in or by an eleemosynary institution, sanitarium, sanitorium, mental health treatment facility, tuberculosis treatment facility, or cancer treatment facility that is owned or controlled by the state or by a unit of local government. (V.T.I.C. Art. 3.42B (part).)

Source Law

> Art. 3.42B. . . .
>
> The provisions of this article shall not apply to indigent care nor to chronic disease care, in an eleemosynary institution, sanitarium, sanitorium, mental treatment facility of every type, tuberculosis treatment facility of every type, and cancer treatment facility of every type, where any such care is provided in or by any such facility (regardless of the type or name) owned or controlled by the state government or by any unit of local government.

Revisor's Note

V.T.I.C. Article 3.42B refers to a "mental treatment facility of every type, tuberculosis treatment facility of every type, and cancer treatment facility of every type . . . (regardless of the type or name)." The revised law substitutes "mental health treatment facility" for "mental treatment facility" for consistency of terminology with the Health and Safety Code. The revised law omits the references to "of every type" and "regardless of the type or name" because, for each category of facility listed, absent an express limitation in the phrase describing the category, the phrase describing the category of facility includes a facility of any type or name in that category.

Revised Law

Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT. An insurance policy providing hospital, nursing, medical, or surgical coverage that is issued or delivered in this state after August 27, 1973, may not include a provision that prevents the payment of benefits for expenses of a nonindigent patient incurred in a hospital facility that:

(1) is owned or controlled by the state or by a unit of local government; and

(2) regularly and customarily demands and collects from nonindigent persons payment for those expenses. (V.T.I.C. Art. 3.42B (part).)

Source Law

> Art. 3.42B. After the effective date of this Act, no insurance policy issued or delivered in this state providing hospital, nursing, medical, or surgical coverage may include a provision which would prevent payment of benefits for expenses of a person who is a non-indigent patient incurred in a hospital facility owned or controlled by the state government or by any unit of local government, provided charges for such expenses are regularly and customarily charged to and collected from non-indigent persons by such hospital facility.
>
> . . .

Revisor's Note

V.T.I.C. Article 3.42B refers to "the effective date of this Act." The revised law substitutes for the quoted language "August 27, 1973," the effective date of the referenced act, which is Chapter 402, Acts of the 63rd Legislature, Regular Session, 1973.

[Sections 1204.003-1204.050 reserved for expansion]

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

Revised Law

Sec. 1204.051. DEFINITIONS. In this subchapter:

(1) "Covered person" means a person who is insured or covered by a health insurance policy or is a participant in an employee benefit plan. The term includes:

(A) a person covered by a health insurance policy because the person is an eligible dependent; and

(B) an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that it provides, through the purchase of insurance or otherwise, health care services to employees, participants, or the dependents of employees or participants.

(3) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United States.

(4) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to a covered person by a physician or other health care provider.

(5) "Health insurance policy" means an individual, group, blanket, or franchise insurance policy, or an insurance agreement, that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

(6) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(7) "Person" means an individual, association, partnership, corporation, or other legal entity.

(8) "Physician" means an individual licensed to practice medicine in this or another state of the United States. (V.T.I.C. Art. 21.24-1, Sec. 1; New.)

Source Law

Art. 21.24-1
Sec. 1. In this article:
(1) "Covered person" means a person

insured or covered by a health insurance policy or a participant in an employee benefit plan. The term includes a person covered by a health insurance policy because the person is an eligible dependent or an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that the plan, fund, or program is established or maintained to provide health care services to its employees, participants, or their dependents through the purchase of insurance or otherwise.

(3) "Health care provider" means a person who furnishes health care services under a license, certificate, registration, or other similar evidence of regulation issued by this state or another state of the United States.

(4) "Health care service" means a service furnished to a covered person by a physician or other health care provider to diagnose, prevent, alleviate, cure, or heal a human illness or injury.

(5) "Health insurance policy" or "policy" means an individual, group, blanket, or franchise insurance policy, or insurance agreement that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

(6) "Insurer" means an insurance company, association, or organization authorized to do business in this state under Chapter 3, 8, 10, 11, 12, 13, 14, 15, 18, 19, or 22 of this code.

(7) "Physician" means an individual licensed to practice medicine in this state or another state of the United States.

(8) "Person" means an individual, association, partnership, corporation, or other legal entity.

Revisor's Note

Section 1(6), V.T.I.C. Article 21.24-1, refers to Chapter 3 of the Insurance Code. The pertinent portions of Chapter 3, relating to authorization of domestic, foreign, and alien life, health, and accident insurance companies, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS. This subchapter applies to:

(1) an employee benefit plan, to the extent not preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) benefit programs under Chapters 1551 and 1601, to

the extent that the benefit programs are self-insuring; and

(3) insurance coverage provided under Chapter 1575. (V.T.I.C. Art. 21.24-1, Sec. 2.)

Source Law

Sec. 2. (a) This article applies to employee benefit plans to the extent the application of this article to those plans is not preempted by the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

(b) This article applies to the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code) and the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code) to the extent that benefit programs under those Acts are self-insuring.

(c) This article applies to insurance coverage provided under the Texas Public School Retired Employees Group Insurance Act (Article 3.50-4, Insurance Code).

Revised Law

Sec. 1204.053. ASSIGNMENT OF BENEFITS. (a) An insurer may not deliver, renew, or issue for delivery in this state a health insurance policy that prohibits or restricts a covered person from making a written assignment of benefits to a physician or other health care provider who provides health care services to the person.

(b) This section does not:

(1) provide a coverage or benefit that is not otherwise available under the health insurance policy;

(2) allow assignment of a benefit to:

(A) a person who is not legally entitled to receive such a direct payment; or

(B) another person if, under the health insurance policy or plan, the benefit must be provided to the covered person by a physician or other health care provider who is a contractor or preferred provider under the policy; or

(3) prohibit an insurer from verifying, through the insurer's normal process, the health care services the physician or other health care provider provides to the covered person. (V.T.I.C. Art. 21.24-1, Sec. 3.)

Source Law

Sec. 3. (a) An insurer may not deliver, renew, or issue for delivery a health insurance policy in this state that prohibits or restricts the written assignment by a covered person of benefits provided by the policy for health care services to the physician or other health care provider that furnishes those health care services to the covered person.

(b) This section may not be construed to:

(1) provide a coverage or benefit not otherwise available under the health insurance policy;

(2) allow assignment of a benefit to another party if that benefit must be provided to the covered person under the policy or plan by a physician or a health care provider who is a contractor or preferred provider under the policy;

(3) allow assignment of a benefit payment to a person who is not legally entitled to receive such a direct payment; or

(4) prohibit an insurer from verifying through the insurer's normal process the health care services provided to the covered person by the physician or health care provider.

Revised Law

Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT. An insurer shall pay benefits directly to a physician or other health care provider, and the insurer is relieved of the obligation to pay, and of any liability for paying, those benefits to the covered person if:

(1) the covered person makes a written assignment of those benefits payable to the physician or other health care provider; and

(2) the assignment is obtained by or delivered to the insurer with the claim for benefits. (V.T.I.C. Art. 21.24-1, Secs. 4(a), (b).)

Source Law

Sec. 4. (a) If a written assignment of benefits payable for health care services is made by a covered person and is obtained by or delivered to the insurer with the claim for benefits, the benefit payment shall be made by the insurer directly to the physician or other health care provider.

(b) If a written assignment of benefits is made and delivered or obtained as provided by this section, the insurer is relieved of the obligation to pay and of any liability for paying the benefits for the health care services to the covered person.

Revised Law

Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES AND COPAYMENTS. (a) The payment of benefits under an assignment

does not relieve a covered person of a contractual obligation to pay a deductible or copayment.

(b) A physician or other health care provider may not waive a deductible or copayment by the acceptance of an assignment. (V.T.I.C. Art. 21.24-1, Sec. 4(c).)

Source Law

(c) The payment of benefits under an assignment does not relieve the covered person of any contractual responsibility for the payment of deductibles and copayments. A physician or other health care provider may not waive copayments or deductibles by acceptance of an assignment.

[Sections 1204.056-1204.100 reserved for expansion]

SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

Revised Law

Sec. 1204.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan" means a group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization, that provides benefits for health care services.

(2) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(3) "Provider" means a person who provides health care under a license issued by this state. The term includes a health care practitioner listed in Section 1451.001 and a nurse first assistant, as defined by Section 1451.101. (V.T.I.C. Art. 21.52C,

Sec. (a).)

Source Law

Art. 21.52C. (a) In this article:

(1) "Health benefit plan" means a group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

(2) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 20 of this code, a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and a stipulated premium company authorized under Chapter 22 of this code.

(3) "Provider" means a person who provides health care under a license issued by this state, including a person listed in Section 2(B), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), or in Article 21.52 of this code.

Revisor's Note

Section (a), V.T.I.C. Article 21.52C, defines "health carrier." "Carrier" is a term used in conjunction with traditional insurance. Included in the definition of "health carrier" are entities such as health maintenance organizations that are not insurers. Consequently, "benefit plan issuer" is a more accurate term than "carrier," and the revised law substitutes "health benefit plan issuer" for "health carrier."

Revised Law

Sec. 1204.102. REQUIRED CLAIM BILLING FORMS. A provider who seeks payment or reimbursement under a health benefit plan and the health benefit plan issuer that issued the plan shall use uniform claim billing form UB-82/HCFA or HCFA 1500, or a successor to one of those forms, as developed by the National Uniform Billing Committee or its successor. (V.T.I.C. Art. 21.52C, Sec. (b).)

Source Law

(b) A provider seeking payment or reimbursement under a health benefit plan and the health carrier that issued that plan must use uniform claim billing form

UB-82/HCFA or HCFA 1500, or their successors, as developed by the National Uniform Billing Committee or its successor.

[Sections 1204.103-1204.150 reserved for expansion]

SUBCHAPTER D. PAYMENTS FOR CERTAIN PUBLICLY PROVIDED SERVICES

Revised Law

Sec. 1204.151. DEFINITION. In this subchapter, "policy" means an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.76, Sec. 1 (part); Art. 21.49-10 (part).)

Source Law

Art. 3.76

Sec. 1. Each individual or group policy of accident and sickness insurance, including a policy issued by a company subject to Chapter 20 of this code . . . .

Art. 21.49-10. Each individual policy or group policy of accident or sickness insurance, including policies issued by companies subject to Chapter 20 of this Code . . . .

Revisor's Note

(1) The definition of "policy" is derived from Section 1, V.T.I.C. Article 3.76, and V.T.I.C. Article 21.49-10. The relevant portions of those laws have been revised as a definition for drafting convenience and to avoid unnecessary repetition of the substance of the definition.

(2) Section 1, V.T.I.C. Article 3.76, refers to "accident and sickness insurance" and V.T.I.C. Article 21.49-10 refers to "accident or sickness insurance." Throughout this chapter, the revised law substitutes for those terms "accident and health insurance" for consistency with modern usage.

(3) Section 1, V.T.I.C. Article 3.76, refers to a "company subject to Chapter 20 of this code," and V.T.I.C. Article 21.49-10 refers to "companies subject to Chapter 20 of this Code." In each instance, the quoted language refers to a corporation operating

under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes for the quoted language "group hospital service corporation" to provide for consistent use of terminology throughout this code. Similar changes are made throughout this chapter.

Revised Law

Sec. 1204.152. PAYMENT FOR CERTAIN EXPENSES INCURRED BY TEXAS DEPARTMENT OF HUMAN SERVICES. Each policy delivered or issued for delivery in this state must provide for the repayment of the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for an insured person if, under the policy, the insured person is entitled to payment for the medical expenses. (V.T.I.C. Art. 21.49-10 (part).)

Source Law

Art. 21.49-10. [Each individual policy or group policy of accident or sickness insurance, including policies issued by companies subject to Chapter 20 of this Code], delivered or issued for delivery to any person in this state shall provide for payment to the Texas Department of Human Resources for the actual cost of medical expenses the department pays through medical assistance for a person insured by the contract if the insured is entitled to payment for the medical expenses by the insurance contract.

Revisor's Note

V.T.I.C. Article 21.49-10 refers to the "Texas Department of Human Resources." Section 1, Chapter 264, Acts of the 69th Legislature, Regular Session, 1985, changed the name of that agency to the Texas Department of Human Services. The revised law is drafted accordingly.

Revised Law

Sec. 1204.153. PAYMENTS TO TEXAS DEPARTMENT OF HUMAN SERVICES FOR CERTAIN CHILDREN. (a) This section applies only to a policy that is delivered, issued for delivery, or renewed in this

state and that provides coverage for a child whose parent:

(1) purchased the policy; or

(2) is a member of the group covered under the policy.

(b) Each policy must include a requirement that, after written notice to the insurer or group hospital service corporation at the insurer's or group hospital service corporation's home office, benefits payable on behalf of a child must be paid to the Texas Department of Human Services if:

(1) the parent who purchased the policy or who is a group member is required to pay child support by a court order or court-approved agreement and:

(A) is a possessory conservator of the child under a court order issued in this state; or

(B) is not entitled to possession of or access to the child;

(2) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and

(3) the insurer or group hospital service corporation is notified, through an attachment to the claim for benefits at the time the claim is first submitted to the insurer or group hospital service corporation, that the benefits must be paid directly to the Texas Department of Human Services.

(c) The commissioner and the Texas Department of Human Services may consult regarding implementation of this section. (V.T.I.C. Art. 3.76, Secs. 1 (part), 2.)

Source Law

Sec. 1. [Each individual or group policy of accident and sickness insurance, including a policy issued by a company subject to Chapter 20 of this code], that is delivered, issued for delivery, or renewed in this state and that provides coverage for one or more children whose parent purchased the policy or whose parent is a member of the group shall include a requirement that benefits paid on behalf of the child or children under the policy must be paid to the Texas Department of Human Services after written notice to the insurer at the insurer's home office, if:

(1) the parent who purchased the policy or who is a member of the group is:

(A) a possessory conservator of the child under an order issued by a court in this state or is not entitled to possession of or access to the child; and

(B) is required by court order or court-approved agreement to pay child support;

(2) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or Chapter 32, Human Resources Code; and

(3) the insurer or group hospital service company is notified through an attachment to the claim for insurance benefits when the claim is first submitted to the insurer or company that the benefits must be paid directly to the Texas Department of Human Services.

Sec. 2. The State Board of Insurance and the Texas Department of Human Services may consult with regard to the implementation of this article.

Revisor's Note

Section 2, V.T.I.C. Article 3.76, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 1204.154. UNIFORM PROVISIONS. (a) The commissioner shall adopt uniform policy provisions, riders, and endorsements for the policy requirement of Section 1204.153.

(b) Before the commissioner adopts or makes a change to a provision, rider, or endorsement under Subsection (a), the commissioner shall present each provision, rider, or endorsement, and any amendment to a provision, rider, or endorsement, to the Texas Department of Human Services for comment. (V.T.I.C. Art. 3.76, Sec. 3.)

Source Law

Sec. 3. The State Board of Insurance shall prescribe uniform policy provisions, riders, and endorsements for the policy requirement provided by Section 1 of this article. Before the board prescribes any provisions, riders, or endorsements or any changes in provisions, riders, or endorsements, the State Board of Insurance shall submit the provisions, riders, or endorsements or amendments to them to the Texas Department of Human Services for comment.

[Sections 1204.155-1204.200 reserved for expansion]

SUBCHAPTER E. EXCLUSIONARY CLAUSES

Revised Law

Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN MEDICAL ASSISTANCE BENEFITS. An individual or group accident and health insurance policy delivered or issued for delivery in this state, including a policy issued by a group hospital service corporation operating under Chapter 842, may not include a provision that excludes or limits the insurer's or group hospital service corporation's coverage from paying benefits covered by Chapter 32, Human Resources Code. (V.T.I.C. Art. 21.49-9.)

Source Law

> Art. 21.49-9. No individual policy or group policy of accident or sickness insurance, including policies issued by companies subject to Chapter 20 of this code, delivered or issued for delivery to any person in this state, may include a provision that excludes or limits coverage of the insurer from paying benefits covered by The Medical Assistance Act of 1967, as amended (Article 695j-1, Vernon's Texas Civil Statutes).

Revisor's Note

V.T.I.C. Article 21.49-9 refers to "The Medical Assistance Act of 1967, as amended (Article 695j-1, Vernon's Texas Civil Statutes)." The revised law substitutes for that reference a reference to Chapter 32, Human Resources Code, which contains the substance of that article.

[Sections 1204.202-1204.250 reserved for expansion]

SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

Revised Law

Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN GROUP MEMBER. (a) An insurer or group hospital service corporation operating under Chapter 842 that delivers, issues for delivery, or renews in this state a group accident and health insurance policy that provides coverage for a minor child who qualifies as a dependent of a group member may pay benefits on the child's behalf to a person who is not a group member if an order providing for the appointment of a possessory or managing conservator of the child

has been issued by a court in this or another state.

(b) A person who is not a group member is entitled to be paid benefits under this section only if the person presents to the insurer or group hospital service corporation, with the claim application:

(1) written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides. (V.T.I.C. Art. 3.51-13, Secs. 1, 3.)

Source Law

Art. 3.51-13

Sec. 1. An insurer or group hospital service company that delivers, issues for delivery, or renews a group accident and sickness insurance policy in this state, including a policy issued by a company subject to Chapter 20 of this code, that provides coverage for a minor child who otherwise qualifies as a dependent of a person who is a member of the group may pay benefits on behalf of the child to the person who is not a member of the group if a court order providing for the appointment of a possessory or managing conservator of the child has been issued by a court of competent jurisdiction in this or any other state.

Sec. 3. Before a person who is not a member of a group is entitled to be paid benefits under Section 1 of this article, the person must submit to the insurer or company with the claim application written notice that the person:

(1) is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) submit a certified copy of a court order establishing the person as possessory or managing conservator or other evidence designated by rule of the State Board of Insurance that the person qualifies to be paid the benefits as provided by this article.

Revisor's Note

Section 1, V.T.I.C. Article 3.51-13, refers to an order for conservatorship of a child issued by a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because the

constitutions and general laws of civil jurisdiction of this state and other states determine which courts have jurisdiction over such matters.

Revised Law

Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS. (a) In accordance with the terms of the policy and this subchapter, an insurer or group hospital service corporation may be required to pay benefits under a group accident and health insurance policy to a person who is not a group member and who complies with:

(1) Section 1204.251;

(2) the insurer's or group hospital service corporation's claim application procedures; and

(3) department rules.

(b) Any requirement imposed on a possessory or managing conservator of a child under this subchapter does not apply with regard to:

(1) an unpaid medical bill for which an assignment of benefits has been exercised, whether in accordance with policy provisions or otherwise; or

(2) a claim presented by a group member for which the group member paid any portion of a medical bill that is covered under the policy's terms. (V.T.I.C. Art. 3.51-13, Sec. 2.)

Source Law

Sec. 2. A group accident and sickness insurance policy issued by an insurer or group hospital service company may be required to pay benefits pursuant to the terms of the policy and as provided by this article on compliance by the person who is not a member of the group with the requirements of this article, claim application procedures of the insurer or company, and rules of the State Board of Insurance. However, any requirements imposed on a possessory or managing conservator of the child shall not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised in accordance with policy provisions or otherwise, nor to claims submitted by the group member where the group member has paid any portion of a medical bill that would be covered under the terms of the policy.

Revisor's Note

Section 2, V.T.I.C. Article 3.51-13, refers to a

"valid assignment of benefits." The revised law omits "valid" as unnecessary because the word does not add to the clear meaning of the law. A forged assignment or an attempted assignment that does not meet the legal requirements of an enforceable assignment is not considered an assignment.

Revised Law

Sec. 1204.253. RULES. The commissioner may adopt rules to ensure the effective implementation of this subchapter. (V.T.I.C. Art. 3.51-13, Sec. 4.)

Source Law

Sec. 4. The State Board of Insurance may adopt rules to assure the effective implementation of this article.

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

Sec. 1205.001. APPLICABILITY OF CHAPTER 655
Sec. 1205.002. CERTIFICATION OF COVERAGE 658
Sec. 1205.003. RULES 658
Sec. 1205.004. CREDITABLE COVERAGE 658

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

Revised Law

Sec. 1205.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act and operating under Chapter 846; or

(ii) an analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) is offered by any other entity that:

(A) is not authorized under this code or another insurance law of this state; and

(B) contracts directly for health care services on a risk-sharing basis, including a capitation basis. (V.T.I.C. Art. 21.52G, Sec. 2, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 2. This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), and operating under Article 3.95-1 et seq. of this code; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code; or

(3) is offered by any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis.

Revisor's Note

(1) Section 2(2), V.T.I.C. Article 21.52G, as added by Chapter 955, Acts of the 75th Legislature, Regular Session, 1997, refers to a health benefit plan offered by a nonprofit corporation "certified under Section 5.01(a), Medical Practice Act," and holding a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Article 21.52F, as revised, requires the commissioner to issue the certificate of authority.

(2) Section 2(3), V.T.I.C. Article 21.52G, as added by Chapter 955, Acts of the 75th Legislature, Regular Session, 1997, refers to a health benefit plan offered by an entity not "licensed" under this code or

another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

Revised Law

Sec. 1205.002. CERTIFICATION OF COVERAGE. (a) A health benefit plan issuer shall provide a certification of coverage as necessary to determine the period of applicable creditable coverage under that health benefit plan.

(b) The certification required under this section must be provided in accordance with the standards adopted by rule by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 4. Each issuer of a health benefit plan shall provide a certification of coverage, in accordance with the standards the commissioner adopts by rule, as necessary to determine the period of applicable creditable coverage of health benefit plans.

Revised Law

Sec. 1205.003. RULES. The commissioner shall adopt rules as necessary to:

(1) implement this chapter and related provisions of this code; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.52G, Sec. 5, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 5. The commissioner shall adopt rules as necessary to implement this article and related provisions of this code and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 1205.004. CREDITABLE COVERAGE. (a) An individual's coverage is creditable coverage for purposes of this chapter if the coverage is provided under:

(1) a self-funded or self-insured employee welfare

benefit plan that:

(A) provides health benefits; and

(B) is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurer or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that act (42 U.S.C. Section 1396s);

(6) 10 U.S.C. Section 1071 et seq.;

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under 5 U.S.C. Section 8901 et seq.;

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) For purposes of this chapter, creditable coverage does not include:

(1) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability insurance and automobile liability insurance;

(4) workers' compensation insurance or other similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified by federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

(10) long-term care, nursing home care, home health care, or community-based care coverage or benefits or any combination of those coverages or benefits;

(11) coverage that provides other limited benefits specified by federal regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance; or

(14) Medicare supplemental health insurance, as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under 10 U.S.C. Section 1071 et seq., or other similar supplemental coverage provided under a group plan. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 3. (a) An individual's coverage is creditable for purposes of this article if the coverage is provided under:

(1) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurance carrier or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage

consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);

(6) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) Creditable coverage does not include:

(1) accident-only or disability income insurance, or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability insurance and automobile liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described in this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified in federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

(10) 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;

(11) coverage that provides other limited benefits specified by federal regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance; or

(14) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.52G, as added by Chapter 955, Acts of the 75th Legislature, Regular Session, 1997, defines "creditable coverage" and "health benefit plan." The revised law omits those definitions as unnecessary because Section 3 of that

article, revised as Section 1205.004, specifies the type of coverage that is creditable coverage for purposes of the chapter, and Section 2 of that article, revised as Section 1205.001, specifies the types of health benefit plans to which the chapter applies. The defined terms are thus not helpful to the reader. The omitted law reads:

Art. 21.52G
Sec. 1. In this article:
(1) "Creditable coverage" means creditable coverage described by Section 3 of this article.
(2) "Health benefit plan" means a plan subject to this article under Section 2 of this article.

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED ON EXISTING COVERAGE PROHIBITED

Sec. 1206.001. APPLICABILITY OF CHAPTER 662
Sec. 1206.002. EXCEPTION. 663
Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED 665
Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR DISCRIMINATION 665

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED ON EXISTING COVERAGE PROHIBITED

Revised Law

Sec. 1206.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, 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 offered by:

(1) an insurance company;

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

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52L, Secs. 1(a), (b), as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

Art. 21.52L

Sec. 1. (a) This article 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 offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) This article applies to a small employer health benefit plan written under Chapter 26 of this code.

Revised Law

Sec. 1206.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

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

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses;

(H) only for indemnity for hospital confinement; or

(I) in accordance with Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.);

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

(3) a workers' compensation insurance policy;

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

(5) a long-term care insurance 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 1206.001. (V.T.I.C. Art. 21.52L, Sec. 1(c), as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for benefits for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

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

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;
(F) only for dental or vision care;
(G) only for hospital expenses;
(H) only for indemnity for hospital confinement; or
(I) pursuant to Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.);
(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;
(3) a workers' compensation insurance policy;
(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or
(5) a long-term care insurance 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 Subsection (a) of this section.

Revised Law

Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED. A health benefit plan issuer may not refuse to enroll an individual in the plan solely because the individual is enrolled in another health benefit plan at the time the individual applies for coverage under the plan. (V.T.I.C. Art. 21.52L, Sec. 2, as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

Sec. 2. The issuer of a health benefit plan may not refuse to enroll a person in the plan solely because the person is enrolled in another health benefit plan at the time the person applies for the coverage.

Revised Law

Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR DISCRIMINATION. A health benefit plan issuer who violates this chapter engages in unfair discrimination under Subchapter B, Chapter 544. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

Sec. 3. An issuer of a health benefit plan who violates the article engages in unfair discrimination under Article 21.21-8 of this code.

CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

Sec. 1207.001. APPLICABILITY OF CHAPTER 666

Sec. 1207.002. ENROLLMENT REQUIRED 667
Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT 668
Sec. 1207.004. TERMINATION OF ENROLLMENT 669

CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

Revised Law

Sec. 1207.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan, including a small employer health benefit plan written under Chapter 1501 or a plan provided under Chapter 1551, 1575, or 1601, or a successor to a plan provided under one of those chapters, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(1) an insurance company;

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

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52K, Sec. 1.)

Source Law

Art. 21.52K

Sec. 1. (a) In this article, "group health benefit plan" means a plan that provides benefits for

medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) The term "group health benefit plan" includes:

(1) a small employer health benefit plan written under Chapter 26 of this code; and

(2) a plan provided under the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code), the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code), the Texas Public School Employees Group Insurance Act (Article 3.50-4, Vernon's Texas Insurance Code), or a successor of any of those plans.

Revised Law

Sec. 1207.002. ENROLLMENT REQUIRED. (a) A group health benefit plan issuer shall permit an individual who is otherwise eligible for enrollment in the plan to enroll in the plan, without regard to any enrollment period restriction, on receipt of written notice from the Texas Department of Health or a designee of that department stating that the individual is:

(1) a recipient of medical assistance under the state Medicaid program and is a participant in the health insurance premium payment reimbursement program under Section 32.0422, Human Resources Code; or

(2) a child enrolled in the state child health plan under Chapter 62, Health and Safety Code, and is a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code.

(b) If an individual described by Subsection (a)(1) or (2) is not eligible to enroll in the group health benefit plan unless a family member of the individual is also enrolled in the plan, the plan issuer, on receipt of written notice under Subsection (a), shall enroll both the individual and the family member in the plan. (V.T.I.C. Art. 21.52K, Secs. 2(a), (b), (c).)

Source Law

> Sec. 2. (a) The issuer of a group health benefit plan, on receipt of written notice from the Texas Department of Health or a designee of the Texas Department of Health that states that an individual who is otherwise eligible for enrollment in the plan is a recipient of medical assistance under the state Medicaid program and is a participant in the health insurance premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code, shall permit the individual to enroll in the plan without regard to any enrollment period restriction.
>
> (b) The issuer of a group health benefit plan, on receipt of written notice from the Texas Department of Health or a designee of the Texas Department of Health that states that a child who is otherwise eligible for enrollment in the plan is enrolled in the state child health plan under Chapter 62, Health and Safety Code, and is a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code, provided for children eligible for the state child health plan shall permit the child to enroll in the group health benefit plan without regard to any enrollment period restriction.
>
> (c) If an individual described by Subsection (a) or (b) of this section is not eligible to enroll in the plan unless a family member of the individual is also enrolled in the plan, the issuer, on receipt of the written notice under Subsection (a) or (b) of this section, shall enroll both the individual and the family member in the plan.

Revised Law

Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT. Unless enrollment occurs during an established enrollment period, enrollment in a group health benefit plan under Section 1207.002 takes effect on the first day of the calendar month that begins at least 30 days after the date written notice is received by the plan issuer under Section 1207.002(a). (V.T.I.C. Art. 21.52K, Sec. 2(d).)

Source Law

> (d) Unless enrollment occurs during an established enrollment period, enrollment under this

article takes effect on the first day of the calendar month that begins at least 30 days after the date written notice is received by the issuer under Subsection (a) or (b) of this section.

Revised Law

Sec. 1207.004. TERMINATION OF ENROLLMENT. (a) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in the plan under Section 1207.002(a)(1), and any family member of the individual enrolled under Section 1207.002(b), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the individual is no longer:

(1) a recipient of medical assistance under the state Medicaid program; or

(2) a participant in the health insurance premium payment reimbursement program under Section 32.0422, Human Resources Code.

(b) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in the plan under Section 1207.002(a)(2), and any family member of the individual enrolled under Section 1207.002(b), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the child is no longer a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code. (V.T.I.C. Art. 21.52K, Secs. 2(e), (f).)

Source Law

(e) Notwithstanding any other requirement of the group health benefit plan, the issuer of the plan shall permit an individual who is enrolled in a group health benefit plan under Subsection (a) of this section, and any family member of the individual enrolled under Subsection (c) of this section, to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the individual is no longer:

(1) a recipient of medical assistance under the state Medicaid program; or

(2) a participant in the health insurance

premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code.

(f) Notwithstanding any other requirement of the group health benefit plan, the issuer of the plan shall permit an individual who is enrolled in a group health benefit plan under Subsection (b) of this section, and any family member of the individual enrolled under Subsection (c) of this section, to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the child is no longer a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code, provided for children eligible for the state child health plan.

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH BENEFIT PLAN ISSUER

Sec. 1208.001. APPLICABILITY OF CHAPTER 670

Sec. 1208.002. DISCLOSURE REQUIRED 671

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH BENEFIT PLAN ISSUER

Revised Law

Sec. 1208.001. APPLICABILITY OF 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 offered by:

(1) an insurance company;

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

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.24-3, Sec. 1.)

Source Law

Art. 21.24-3

Sec. 1. In this article, "health benefit plan" means a 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 offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

Revised Law

Sec. 1208.002. DISCLOSURE REQUIRED. After an oral or written request by an insured or enrollee of a health benefit plan, the plan issuer shall provide to the insured or enrollee the name or employee identifier of the issuer's employee who is available to respond to questions or other communication from the insured or enrollee relating to coverage and benefits provided under the plan to the insured or enrollee. The issuer shall also provide:

(1) the employee's mailing address;

(2) the municipality and state of the employee's business location; and

(3) the employee's job title. (V.T.I.C. Art. 21.24-3, Sec. 2.)

Source Law

Sec. 2. After an oral or written request by an

insured or enrollee of a health benefit plan for the information, the issuer of the health benefit plan shall provide to the insured or enrollee the name or employee identifier, mailing address, business city and state location, and job title of the employee of the issuer of the health benefit plan who is available to the enrollee or insured to respond to communications and questions from the insured or enrollee relating to coverage and benefits provided by the health benefit plan to the insured or enrollee.

Revisor's Note

Section 2, V.T.I.C. Article 21.24-3, refers to "city." The revised law substitutes the term "municipality" for "city" because that is the term used in the Local Government Code.

CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION REQUIRED TO BE PROVIDED TO EMPLOYER

Sec. 1209.001. APPLICABILITY OF CHAPTER 672
Sec. 1209.002. CLAIMS COST INFORMATION. 673
Sec. 1209.003. CONFIDENTIALITY 674

CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION REQUIRED TO BE PROVIDED TO EMPLOYER

Revised Law

Sec. 1209.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan, including a small employer health benefit plan written under Chapter 1501, that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a reciprocal exchange operating under Chapter 942;

(F) a health maintenance organization operating under Chapter 843;

(G) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(H) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; and

(2) provides health benefits to the employees of one or more employers that sponsor the plan. (V.T.I.C. Art. 21.49-19, Secs. 1, 2.)

Source Law

Art. 21.49-19

Sec. 1. (a) In this article, "group health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) The term "group health benefit plan" includes a small employer health benefit plan written under Chapter 26 of this code.

Sec. 2. This article applies only to a group health benefit plan issued to provide health benefits to the employees of one or more employers that sponsor the plan.

Revised Law

Sec. 1209.002. CLAIMS COST INFORMATION. (a) On the request of an employer sponsoring a group health benefit plan, the plan issuer shall provide to the employer the claims cost

information for employees covered by the plan during the preceding calendar year.

(b) Claims cost information provided under this section:

(1) may be provided in the aggregate or on a detailed basis;

(2) must be provided separately for each month during which the group health benefit plan was in effect; and

(3) may not include information, including diagnosis code information, that may be used to identify a specific individual enrolled in the plan or a diagnosis of that individual. (V.T.I.C. Art. 21.49-19, Secs. 3(a), (b).)

Source Law

> Sec. 3. (a) On the request of an employer sponsoring a group health benefit plan, the issuer of the plan shall provide to the employer the claims cost information for employees covered by the plan during the preceding calendar year. The information must be reported separately for each month during which the plan was in effect.
>
> (b) Claims cost information provided under this section may be provided either in the aggregate or on a detailed basis, but may not include:
>
> (1) any information through which a specific individual enrolled in the group health benefit plan may be identified; or
>
> (2) diagnosis codes or other information through which a diagnosis of a specific individual enrolled in the group health benefit plan may be identified.

Revised Law

Sec. 1209.003. CONFIDENTIALITY. Information obtained by an employer under this chapter is confidential and may be used by the employer only for purposes relating to obtaining or maintaining group health benefit plan coverage for the employer's employees. (V.T.I.C. Art. 21.49-19, Sec. 3(c).)

Source Law

> (c) Information obtained by the employer under this section is confidential and may be used by the employer only for purposes relating to obtaining and maintaining group health benefit plan coverage for the employer's employees.

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

Sec. 1210.001. NOTICE REQUIRED 675

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

Revised Law

Sec. 1210.001. NOTICE REQUIRED. A policy, contract, or certificate of insurance that insures against loss resulting from sickness or accidental bodily injury and that is subject to an increase in the premium at time of renewal or to nonrenewal on the insured attaining a certain age may not be delivered, issued, or used in this state unless the document contains on the first page above the policy provisions a printed notice in 10-point type that states that the policy, contract, or certificate is subject to either or both conditions. (V.T.I.C. Art. 3.42-1, Secs. (a), (b).)

Source Law

> Art. 3.42-1. (a) As used in this article, "health insurance policy" means a policy, contract, or certificate of insurance which insures against loss resulting from sickness or accidental bodily injury.
>
> (b) No health insurance policy which is subject to an increase in the premium at time of renewal, which is subject to nonrenewal on the insured attaining a certain age, or which is subject to both of these conditions and limitations, may be delivered, issued, or used in this state unless there is printed, above the first of the policy provisions on the first page in 10-point type, notice that the policy is subject to any or all of the conditions stated in this section.

Revisor's Note

Section (c), V.T.I.C. Article 3.42-1, refers to the notice required of certain policy forms used before June 1, 1974. That part of the law is executed and therefore is omitted from the revised law. The omitted law reads:

> (c) Until June 1, 1974, any company may continue to use any policy form heretofore approved for issuance by the State Board of Insurance by either (i) stamping or affixing such language at the top of the first policy page or (ii) affixing an endorsement containing such required language at the top of the first page of each such policy form, either of which shall be at least in 10-point type.

[Chapters 1211-1250 reserved for expansion]

SUBTITLE B. GROUP HEALTH COVERAGE

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CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1251.001. DEFINITIONS. In this chapter:

(1) "Blanket accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter H.

(2) "Group accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter B.

(3) "Group hospital service corporation" means a corporation operating under Chapter 842. (V.T.I.C. Art. 3.51-6, Secs. 1(a) (part), 2(a) (part).)

Source Law

Art. 3.51-6

Sec. 1. (a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:

. . .

Sec. 2. (a) Blanket accident and health insurance is hereby defined to be that form of

accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:

. . .

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.51-6, defines group accident and health insurance as "accident, sickness, or accident and sickness insurance." For consistency throughout this chapter, the revised law substitutes "health insurance" for "sickness insurance."

(2) The definition of "group hospital service corporation" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition. Throughout this chapter, the revised law substitutes the defined term for the substance of the definition.

Revised Law

Sec. 1251.002. CERTAIN GROUP HEALTH INSURANCE AUTHORIZED. A group policy of accident, health, or accident and health insurance, including a group contract issued by a group hospital service corporation, may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter B; and

(2) meets the requirements adopted under this chapter for a group policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(1).)

Source Law

(d)(1) No group policy of accident, health, or accident and health insurance, including group contracts issued by companies subject to Chapter 20, Insurance Code, as amended, shall be delivered or issued for delivery in this state which does not conform to the requirements and definitions set forth in Subdivisions (a)(1) through (a)(6) of this section.

Revisor's Note

Section 1(d)(1), V.T.I.C. Article 3.51-6, refers to "Chapter 20, Insurance Code, as amended." The revised law omits the reference to "as amended" because Section 311.027, Government Code (Code

Construction Act), applicable to the revised law, provides that unless expressly provided otherwise, a reference to any portion of a statute applies to all reenactments, revisions, or amendments of the statute.

Revised Law

Sec. 1251.003. CERTAIN BLANKET HEALTH INSURANCE AUTHORIZED. A blanket policy of accident, health, or accident and health insurance may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter H; and

(2) meets the requirements adopted under this chapter for a blanket policy. (V.T.I.C. Art. 3.51-6, Sec. 2(d).)

Source Law

(d) No blanket policy shall be delivered or issued for delivery in this state which does not conform to the requirements and definitions set forth in Subdivisions (a)(1) through (a)(9) of this section.

Revised Law

Sec. 1251.004. CERTAIN PAYMENTS BY INSURERS PROHIBITED. (a) Except as reimbursement for the cost of services that otherwise would have been provided by the insurer, an insurer may not pay to any individual, firm, corporation, or group entity a fee or allowance for services related to:

(1) a group accident and health insurance policy; or

(2) a blanket accident and health insurance policy.

(b) Subsection (a) does not limit an insurer's right to:

(1) pay dividends;

(2) return a premium to a group or a combination of groups;

(3) provide for a rate stabilization fund with combinations of groups; or

(4) pay compensation, including a commission, to a licensed agent. (V.T.I.C. Art. 3.51-6, Secs. 1(e), 2(e).)

Source Law

[Sec. 1]

(e) No insurer shall pay to any individual,

firm, corporation, or group entity any fees or allowances for services related to group policies except as reimbursement for the cost of such services which would otherwise have been provided by the insurer, provided that this provision shall not limit the right of the insurer to pay dividends or make returns of premium to any group or to any combination of groups or make provision for rate stabilization funds with combinations of groups, nor shall it prohibit payment of commissions or compensation to a duly licensed agent.

[Sec. 2]

(e) No insurer shall pay to any individual, firm, or corporation any fees or allowances for services related to blanket policies except as reimbursement for the cost of such services which would otherwise have been provided by the insurer provided that this provision shall not limit the right of the insurer to pay dividends or make return of premium to any group or any combination of groups or make provision for rate stabilization funds with combinations of groups, nor shall it prohibit the payment of commissions or compensation to a duly licensed agent.

Revised Law

Sec. 1251.005. PAYMENT OF BENEFITS. (a) Except as otherwise provided by this section or Section 1251.113, benefits under a group accident and health insurance policy or blanket accident and health insurance policy must be paid to:

(1) the insured;

(2) the insured's designated beneficiary;

(3) the insured's estate; or

(4) if the insured is a minor or is otherwise not competent to give a valid release, the insured's parent, guardian, or other person actually supporting the insured.

(b) A group accident and health insurance policy or blanket accident and health insurance policy may provide that all or a portion of any indemnity provided by the policy because of hospital, nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing a proof of the loss, be paid directly to the hospital or person providing the services. A payment made as provided by this subsection discharges the obligation of the insurer with respect to the amount paid.

(c) A group accident and health insurance policy or blanket

accident and health insurance policy must provide that all or a portion of any benefits provided by the policy for dental care services may, at the option of the insured, be assigned to the dentist providing the services. In the case of an assignment under this subsection, payment must be made directly to the dentist designated. A payment made pursuant to an assignment under this subsection discharges the obligation of the insurer with respect to the amount paid. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

Source Law

> Sec. 3. Except as otherwise provided in this section, all benefits under any group or blanket accident and sickness policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his parent, guardian, or other person actually supporting him. The policy may provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid. The policy shall provide that all or a portion of any benefits provided by any such policy for dental care services may, at the option of the insured, be assigned to the dentist providing such services. In the case of such assignment, payment shall be made directly to the dentist designated. A payment made pursuant to such assignment shall discharge the obligation of the insurer with respect to the amount of insurance so paid. . . .

Revisor's Note

(1) Section 3, V.T.I.C. Article 3.51-6, was enacted in 1975 as part of the original enactment of Article 3.51-6. See Chapter 419, Acts of the 64th Legislature, Regular Session, 1975. In 1985, Article 3.51-6 was amended by the addition of Section 1(d)(2), which prescribes provisions that must be included in a group accident and health insurance policy. See Chapter 673, Acts of the 69th Legislature, Regular Session, 1985. Among those provisions is Section 1(d)(2)(xi) (revised as Section 1251.114), relating to

payment of benefits under a group policy. The later addition of Section 1(d)(2)(xi) superseded Section 3 to the extent of any conflict. The revised law is drafted accordingly.

(2) Section 3, V.T.I.C. Article 3.51-6, refers both to a "person insured" and an "insured." For consistency throughout the code, the revised law refers to an "insured." Similar changes have been made throughout this chapter.

Revised Law

Sec. 1251.006. POLICY MAY NOT SPECIFY SERVICE PROVIDER. A group accident and health insurance policy or blanket accident and health insurance policy may not require that a covered service be provided by a particular hospital or person. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

Source Law

> Sec. 3. . . . The policy may not require that a covered service be rendered by a particular hospital or person.

Revised Law

Sec. 1251.007. EXCEPTIONS. This subchapter and Subchapters B-I do not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Source Law

Sec. 4. The provisions of this article shall not be applicable to:

(1) credit accident and health insurance policies subject to Article 3.53 of the Insurance Code, as amended;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance prior to April 1, 1975;

(3) accident and health coverages that are incidental to any form of group automobile, casualty, property, or workmen's compensation--employers' liability policies promulgated or approved by the State Board of Insurance;

(4) any policy or contract of insurance with a state agency, department, or board providing health services to all eligible persons under Chapter 32, Human Resources Code, or in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended, under a state plan.

Revisor's Note

(1) Section 4(1), V.T.I.C. Article 3.51-6, refers to "Article 3.53 of the Insurance Code, as amended." The revised law omits "as amended" for the reason stated in the revisor's note to Section 1251.002.

(2) Section 4(3), V.T.I.C. Article 3.51-6, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 1251.008. RULES. The commissioner may adopt rules necessary to administer this chapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

Source Law

Sec. 5. The State Board of Insurance is authorized to issue such rules and regulations as may be necessary to carry out the various provisions of this article. Rules and regulations promulgated pursuant to this article shall be subject to notice and hearing pursuant to Section 10, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-10, Vernon's Texas Insurance Code).

Revisor's Note

Section 5, V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 1251.009-1251.050 reserved for expansion]

SUBCHAPTER B. GROUP ACCIDENT AND HEALTH INSURANCE: ELIGIBLE POLICYHOLDERS

Revised Law

Sec. 1251.051. EMPLOYERS. (a) For purposes of this section, "employee" includes:

(1) an officer, manager, or employee of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership;

(3) an officer, manager, or employee of a subsidiary or affiliated corporation; and

(4) an individual proprietor, partner, or employee of an individual or firm, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise.

(b) A policy issued to insure employees of a public body may provide that the term "employee" includes an elected or appointed officer of the body.

(c) A policy issued to the trustees of a fund established by an employer may provide that the term "employee" includes a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(d) A group accident and health insurance policy may be issued to an employer or trustees of a fund established by an employer to insure the employer's active and retired employees for the benefit of persons other than the employer.

(e) The employer or the trustees of a fund established by an employer are the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

> [(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]
>
> (1) under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. The term "employees" as used herein shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor, or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners, and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise, and retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;
>
> . . .

Revised Law

Sec. 1251.052. ASSOCIATIONS. (a) A group accident and health insurance policy may be issued to an association, including a labor union or an organization of labor unions, a membership corporation organized or holding a certificate of authority under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), and a cooperative or corporation subject to the supervision and control of the Farm Credit Administration, to insure the association's active and retired members, employees, or employees of members for the benefit of persons other than the association or its officers or trustees.

(b) To be eligible to obtain a group accident and health

insurance policy, an association must:

(1) have a constitution and bylaws;

(2) have been organized and have actively existed for at least two years; and

(3) be maintained in good faith for purposes other than that of obtaining insurance. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

> [(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]
>
> . . .
>
> (2) under a policy issued to an association, including but not limited to a labor union or organizations of such unions, membership corporations organized or holding a certificate of authority under the Texas Non-Profit Corporation Act, and cooperatives and corporations subject to the supervision and control of the Farm Credit Administration of the United States of America, and which association shall have a constitution and bylaws, which has been organized and has had an active existence for at least two years, and which is maintained in good faith for purposes other than that of obtaining insurance, to insure members, employees, or employees of members (active and retired for the benefit of persons other than the association or its officers or trustees);
>
> . . .

Revisor's Note

Section 1(a)(2), V.T.I.C. Article 3.51-6, refers to associations, "including but not limited to" labor unions and other specified organizations. The revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, provides that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 1251.053. FUNDS ESTABLISHED BY EMPLOYERS, LABOR UNIONS, OR ASSOCIATIONS. (a) A group accident and health insurance

policy may be issued to the trustees of a fund established by two or more employers in the same or related industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association described by Section 1251.052 to insure the active and retired employees of the employers, members of the union or association, or employees of the association for the benefit of persons other than the employers, union, or association.

(b) A policy issued to the trustees of a fund established by employers or a labor union or association may provide that the term "employee" includes:

(1) an officer or manager of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership; or

(3) a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(c) The trustees of a fund established by employers or a labor union or association are the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

[(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]

. . .

(3) under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in (2) above, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or such association, or employees or members of such association for the benefit of persons other than the employers or the unions or such association. The term "employees" as used herein may include the officers, managers, and employees of the employer, retired employees, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

. . .

Revised Law

Sec. 1251.054. ELIGIBILITY FOR GROUP LIFE INSURANCE. A group accident and health insurance policy may be issued to any individual or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under the group life policy. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

> [(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]
>
> . . .
>
> (4) under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under such group life policy;
>
> . . .

Revised Law

Sec. 1251.055. FUND FOR FORMER EMPLOYEES AND MEMBERS. (a) An insurer may issue a group accident and health insurance policy to a trustee of a fund to insure former employees, former members, and the spouses, former spouses, and dependents of former employees and members who were previously insured by the insurer under a policy issued to any entity described by this subchapter.

(b) The trustee of a fund is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

> [(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]
>
> . . .
>
> (5) under a policy issued by an insurer to a trustee of a fund, which shall be deemed to be the policyholder, to insure former employees, former members, their spouses, former spouses, and their dependents, who were previously insured by such insurer under a policy issued to any of the groups provided for in this article;
>
> . . .

Revised Law

Sec. 1251.056. OTHER GROUPS. (a) Under the requirements prescribed by this section, a group accident and health insurance policy may be issued to cover a group other than a group described by Sections 1251.051-1251.055 if the commissioner determines that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits are reasonable in relation to the premiums charged.

(b) Group accident and health insurance coverage may not be offered to a group in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those prescribed by Subsections (a)(1)-(3) has determined that those requirements have been met.

(c) The premium for the policy must be paid from the policyholder's funds, funds contributed by the covered persons, or both. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

[(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]

. . .

(6) under a policy issued to cover any other group subject to the following requirements:

(A) No such group health insurance policy shall be delivered in this state unless the Commissioner of Insurance finds that:

(i) the issuance of such group policy is not contrary to the best interest of the public;

(ii) the issuance of the group policy would result in economies of acquisition or administration; and

(iii) the benefits are reasonable in relation to the premiums charged.

(B) No such group health insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in Subparagraphs (i), (ii), and (iii) of Paragraph (A) of

this subdivision has made a determination that such requirements have been met.

(C) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

[Sections 1251.057-1251.100 reserved for expansion]

SUBCHAPTER C. GROUP ACCIDENT AND HEALTH INSURANCE: REQUIRED PROVISIONS

Revised Law

Sec. 1251.101. REQUIRED PROVISIONS. (a) A group accident and health insurance policy, including a group contract issued by a group hospital service corporation, may not be delivered in this state unless the policy contains in substance the provisions prescribed by this subchapter or provisions in relation to provisions prescribed by this subchapter that, in the opinion of the commissioner, are:

(1) more favorable to the insureds under the policy; or

(2) at least as favorable to the insureds under the policy and more favorable to the policyholder.

(b) The standard provisions required for individual health insurance policies do not apply to group health insurance policies.

(c) If any provision of this subchapter is wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall:

(1) omit the inapplicable provision or part from the policy; or

(2) modify the inconsistent provision in a manner that makes the provision as contained in the policy consistent with the coverage provided by the policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

(2) No group policy of accident, health, or accident and health insurance, including group contracts issued by companies subject to Chapter 20, Insurance Code, as amended, shall be delivered in this state unless it contains in substance the following

provisions or provisions which in the opinion of the commissioner are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; provided, however, that . . . (C) the standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and (D) if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy an inapplicable provision or part of a provision and shall modify an inconsistent provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

. . .

Revisor's Note

(1) Section 1(d)(2), V.T.I.C. Article 3.51-6, refers to a "group policy of accident, health, or accident and health insurance." Throughout this subchapter, the revised law substitutes "group accident and health insurance" for "group . . . accident, health, or accident and health insurance" because that is the term defined by Section 1251.001.

(2) Section 1(d)(2), V.T.I.C. Article 3.51-6, refers to Chapter 20, Insurance Code, "as amended." The revised law omits "as amended" for the reason stated in the revisor's note to Section 1251.002.

Revised Law

Sec. 1251.102. PAYMENT OF PREMIUMS. A group accident and health insurance policy must provide that premiums due under the policy must be remitted by the premium payor as designated in the policy:

(1) on or before the due date; or

(2) within any grace period specified in the policy.

(V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

(i) a provision that premiums due under the policy shall be remitted on or before the due date by the premium payors as designated in the policy and within such period of grace as may be specified

therein;

. . .

Revised Law

Sec. 1251.103. INCONTESTABILITY OF POLICY. (a) A group accident and health insurance policy must provide that:

(1) the validity of the policy may not be contested after the policy has been in force for two years after its date of issue; and

(2) in the absence of fraud, a statement made by any individual covered by the policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made:

(A) after the insurance has been in force before the contest for two years during the individual's lifetime; and

(B) unless the statement is contained in a written instrument signed by the individual making the statement.

(b) Subsection (a)(1) does not apply to a contest based on nonpayment of premiums.

(c) The provisions required by this section do not preclude the assertion at any time of a defense based on:

(1) a provision in the policy that relates to eligibility for coverage;

(2) a provision in a group accident and health insurance policy or disability insurance policy that relates to overinsurance;

(3) a provision in a disability policy that relates to the relation of earnings to insurance; or

(4) another similar provision in a group accident and health insurance policy or disability insurance policy that limits the amounts of recovery from all sources to not more than 100 percent of the total actual losses or expenses incurred. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the

following provisions . . . :]

. . .

(ii) a provision that the validity of the policy shall not be contested except for nonpayment of premiums after it has been in force for two years from its date of issue and that in the absence of fraud no statement made by any person covered by the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him or her; provided, however, that no such provision shall preclude the assertion at any time of defenses based upon: (aa) provisions in the policy which relate to eligibility for coverage; (bb) provisions in group accident and health insurance or disability insurance policies which relate to overinsurance; (cc) provisions of disability policies which relate to the relation of earnings to insurance; or (dd) other similar provisions in such policies that limit the amounts of recovery from all sources to no more than 100 percent of the total actual losses or expenses incurred;

. . .

Revised Law

Sec. 1251.104. ENTIRE CONTRACT. A group accident and health insurance policy must provide that the policy and any application attached to the policy constitute the entire contract between the parties. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(iii) a provision that the policy and any application attached shall constitute the entire contract between the parties and . . . ;

. . .

Revised Law

Sec. 1251.105. STATEMENT MADE BY POLICYHOLDER OR INSURED. A group accident and health insurance policy must provide that:

(1) in the absence of fraud, a statement made by the policyholder or an insured is considered a representation and not a warranty; and

(2) a statement made by the policyholder or an insured may not be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been provided

to:

(A) the person making the statement; or

(B) if the statement was made by the insured and the insured has died or become incapacitated, the insured's beneficiary or personal representative. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]
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> . . .
>
> (iii) a provision . . . that in the absence of fraud all statements made by the policyholder or person insured shall be deemed representations and not warranties, and that no such statement shall be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been furnished to such person or in the event of death or incapacity of the insured person to the individual's beneficiary or personal representative;
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> . . .

Revised Law

Sec. 1251.106. DISTINCTION BASED ON MARITAL STATUS PROHIBITED. A group accident and health insurance policy must include a provision that prohibits a distinction on the basis of the marital status or lack of marital status between an insured and the other parent in the determination of the dependents or the beneficiaries of the insured, or both. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]
>
> . . .
>
> (xv) a provision that, in determining the dependents or the beneficiaries of an insured, or both, prohibits a distinction on the basis of the marital status or the lack of marital status between the insured and the other parent.

Revised Law

Sec. 1251.107. EVIDENCE OF INSURABILITY. A group accident and health insurance policy must state the conditions, if any, under which the insurer reserves the right to require an individual

eligible for insurance to provide evidence of individual insurability satisfactory to the insurer as a condition of obtaining part or all of the coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]
>
> . . .
>
> (iv) a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the coverage;
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> . . .

Revised Law

Sec. 1251.108. EXCLUSION OR LIMITATION OF COVERAGE FOR PREEXISTING CONDITIONS. (a) A group accident and health insurance policy must specify the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of an insured, not otherwise excluded from the insured's coverage by name or specific description effective on the date of the insured's loss, that existed before the effective date of the insured's coverage under the policy.

(b) An exclusion or limitation described by Subsection (a) may apply only to a disease or physical condition for which the insured received medical advice or treatment during the 12 months before the effective date of the insured's coverage.

(c) An exclusion or limitation described by Subsection (a) may not apply to a loss incurred or disability beginning after the earlier of:

(1) the end of 12 consecutive months, beginning on or after the effective date of the insured's coverage, during which the insured has not received medical advice or treatment in connection with the disease or physical condition; or

(2) the second anniversary of the effective date of the insured's coverage.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group accident and health insurance policy subject to Chapter 1501. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . provided, however, that] (A) provisions (v), . . . shall not apply to policies issued to a creditor to insure debtors of such creditor; . . . :

. . .

(v) a provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the 12 months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of: (aa) the end of a continuous period of 12 months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and (bb) the end of the two-year period commencing on the effective date of the person's coverage;

. . .

Revisor's Note

Section 1(d)(2), V.T.I.C. Article 3.51-6, prescribes certain requirements applicable to exclusions or limitations on preexisting conditions under a group accident and health insurance policy. The revised law clarifies that these requirements do not apply to group accident and health insurance policies subject to V.T.I.C. Chapter 26, revised in this code as Chapter 1501, because the later-enacted preexisting condition requirements in Chapter 26 supersede the preexisting condition requirements in Article 3.51-6 with respect to group policies subject

to Chapter 26.

Revised Law

Sec. 1251.109. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF INSURED IS MISSTATED. (a) A group accident and health insurance policy under which the premiums or benefits vary by age must specify an equitable adjustment of premiums or benefits, or both, to be made if the age of an insured has been misstated.

(b) The provision required by Subsection (a) must contain a clear statement of the method of adjustment to be used. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]
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> . . .
>
> (vi) if the premiums or benefits vary by age, a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;
>
> . . .

Revised Law

Sec. 1251.110. DEADLINE FOR NOTICE OF CLAIM. (a) A group accident and health insurance policy must provide that written notice of a claim must be given to the insurer not later than the 20th day after the date of the occurrence or beginning of any loss covered by the policy.

(b) Failure to give notice within the time prescribed by Subsection (a) does not invalidate or reduce any claim if it is shown that:

(1) it was not reasonably possible to give the notice within that time; and

(2) notice was given as soon as was reasonably possible. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(vii) a provision that written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

. . .

Revised Law

Sec. 1251.111. CLAIM FORMS. (a) A group accident and health insurance policy must provide that the insurer will furnish to the person making a claim or to the policyholder for delivery to a person making a claim the forms usually provided by the insurer for filing a proof of loss.

(b) If the forms for a proof of loss are not provided before the 16th day after the date the insurer received notice of a claim under the policy, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss on submitting, within the time set in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(viii) a provision that the insurer will furnish to the person making claim or to the policy holder for delivery to such person such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the insurer received notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

. . .

Revised Law

Sec. 1251.112. DEADLINE FOR CLAIM. (a) A group accident and health insurance policy must provide that:

(1) in the case of a claim for a loss other than a claim

for a loss of time for disability, written proof of the loss must be provided to the insurer not later than the 90th day after the date of the loss; and

(2) in the case of a claim for loss of time for disability:

(A) written proof of the loss must be provided to the insurer not later than the 90th day after the beginning of the period for which the insurer is liable; and

(B) subsequent written proofs of the continuance of the disability must be provided to the insurer at intervals as reasonably required by the insurer.

(b) Failure to provide written proof of a loss within the time prescribed by Subsection (a) does not invalidate or reduce a claim if:

(1) it was not reasonably possible to provide written proof of the loss within that time;

(2) written proof of the loss is provided as soon as reasonably possible; and

(3) unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(ix) a provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within the 90 days after the commencement of the period for which the insurer is liable, that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the

claimant, later than one year from the time proof is otherwise required;

. . .

Revised Law

Sec. 1251.113. PROMPT PAYMENT OF BENEFITS REQUIRED. A group accident and health insurance policy must provide that:

(1) all benefits payable under the policy, other than benefits for loss of time, must be paid not later than the 60th day after the date the proof of loss is received; and

(2) subject to written proof of loss, all accrued benefits payable under the policy for loss of time must be paid at least monthly during the period for which the insurer is liable, and that any balance remaining unpaid at the end of that period must be paid as soon as possible after the proof of loss is received. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(x) a provision that all benefits payable under the policy other than benefits for loss of time shall be payable not more than 60 days after receipt of proof, that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof;

. . .

Revised Law

Sec. 1251.114. PAYMENT OF BENEFITS. (a) A group accident and health insurance policy must provide that all benefits of the policy, other than benefits for loss of life, must be paid to the insured or the insured's assignee.

(b) A group accident and health insurance policy must provide that, subject to the provisions of the policy, benefits for loss of life of an insured must be paid to:

(1) the beneficiary designated by the insured or the beneficiary's assignee;

(2) the family member specified by the policy terms,

if the policy contains conditions relating to family status; or

(3) the estate of the insured, if the designated or specified beneficiary is not living at the time the insured dies.

(c) A group accident and health insurance policy may provide that if any benefits are payable to the estate of an individual or to an individual who is a minor or is otherwise not competent to give a valid release, the insurer may pay the benefits, up to an amount established by the commissioner, to any individual related by consanguinity or affinity to the individual who is considered by the insurer to be equitably entitled to the benefits.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group contract issued by a group hospital service corporation. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . provided, however, that (A) provisions . . .] (xi), and . . . shall not apply to policies issued to a creditor to insure debtors of such creditor; (B) provision (xi) shall not apply to Chapter 20 companies; . . . :
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> . . .
>
> (xi) a provision that benefits for loss of life of the person insured shall be payable to the beneficiary designated by the person insured or the assignee. However, if the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy. In the event no such designated or specified beneficiary is living at the death of the person insured, the benefits shall be payable to the estate of the insured. All other benefits of the policy shall be payable to the person insured or the assignee. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount established by the board, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;
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> . . .

Revised Law

Sec. 1251.115. RIGHT TO CONDUCT PHYSICAL EXAMINATION OR AUTOPSY. A group accident and health insurance policy must provide

that the insurer has the right and opportunity to:

(1) conduct a physical examination of an individual for whom a claim is made when and as often as the insurer reasonably requires during the pendency of the claim under the policy; and

(2) in the case of a death, require that an autopsy be conducted, unless the autopsy is prohibited by law. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]
>
> . . .
>
> (xii) a provision that the insurer shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law;
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> . . .

Revised Law

Sec. 1251.116. LEGAL OR EQUITABLE ACTIONS; LIMITATIONS. A group accident and health insurance policy must provide that an action at law or in equity may not be brought to recover on the policy:

(1) before the 61st day after the date written proof of loss is filed as required under the policy; or

(2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]
>
> . . .
>
> (xiii) a provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy;
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> . . .

Revised Law

Sec. 1251.117. CONTINUATION OR CONVERSION OF COVERAGE. (a) A group accident and health insurance policy must describe the continuation of group coverage and any conversion coverage provided in accordance with Subchapter F.

(b) Subsection (a) does not apply to a credit accident and health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

> [(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . provided, however, that (A) provisions . . .] (xiv) shall not apply to policies issued to a creditor to insure debtors of such creditor; . . . :
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> . . .
>
> (xiv) a provision describing the conversion or extension of coverage option elected by the insurer in accordance with Subdivision (3) of Subsection (d) of this section; and
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> . . .

Revisor's Note

Section 1(d)(2)(xiv), V.T.I.C. Article 3.51-6, refers to "the conversion or extension of coverage option elected by the insurer in accordance with Subdivision (3) of Subsection (d)" (revised as Subchapter F). Article 3.51-6 was amended by Chapter 673, Acts of the 69th Legislature, Regular Session, 1985; those amendments included the addition of Sections 1(d)(2) and (3). As enacted in 1985, Section 1(d)(3) required an insurer to provide either a "conversion or group continuation privilege." Section 1(d)(3) was amended by Chapter 837, Acts of the 75th Legislature, Regular Session, 1997. Under the 1997 amendments, an insurer must provide a continuation privilege and may provide conversion coverage. The later amendment of Section 1(d)(3) supersedes Section 1(d)(2)(xiv). The revised law is drafted accordingly.

[Sections 1251.118-1251.150 reserved for expansion]

SUBCHAPTER D. GROUP ACCIDENT AND HEALTH INSURANCE: COVERAGE FOR DEPENDENTS

Revised Law

Sec. 1251.151. COVERAGE FOR CERTAIN GRANDCHILDREN. (a) A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage under the policy or contract for a child of an insured must, on payment of a premium, provide coverage for any grandchild of the insured if the grandchild is:

(1) unmarried;

(2) younger than 25 years of age; and

(3) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

(b) Coverage for a grandchild of the insured under this section may not be terminated solely because the covered grandchild is no longer a dependent of the insured for federal income tax purposes. (V.T.I.C. Art. 3.51-6, Sec. 3E, as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Source Law

Sec. 3E. (a) In this section, "health insurance policy" means a group policy or contract, including a group contract issued by a company subject to Chapter 20 of this code that provides coverage for hospital, surgical, or medical expenses incurred as a result of accident or sickness.

(b) [as amended Acts 77th Leg., R.S., Ch. 396] A health insurance policy that provides coverage for a child of the policyholder must upon payment of a premium provide coverage for any children of the policyholder's child if those children are dependents of the policyholder. For purposes of this subsection, a child of the policyholder's child is a dependent of the policyholder regardless of whether the policyholder treats the child as a dependent for federal income tax purposes.

(b) [as amended Acts 77th Leg., R.S., Ch. 1027] A health insurance policy that provides coverage for a child of the policyholder must upon payment of a premium provide coverage for any unmarried child of the policyholder's child if the child is younger than 25 years of age and is a dependent of the policyholder for federal income tax purposes at the time

application for coverage of the child is made. Coverage for a child of the policyholder's child under this subsection may not be terminated solely because the covered child is no longer a dependent of the policyholder for federal income tax purposes.

Revisor's Note

(1) Section 3E(b), V.T.I.C. Article 3.51-6, refers to a "child of the policyholder." The revised law substitutes "child of an insured" for "child of the policyholder" because under a group policy of accident and health insurance, the employer, association, or trustees of a fund that obtains the policy is considered to be the policyholder. See Sections 1(a)(1), (3), and (5), Article 3.51-6 (revised as Sections 1251.051, 1251.053, and 1251.055, respectively).

(2) Before September 1, 2001, Section 3E(b), V.T.I.C. Article 3.51-6, provided that a health insurance policy that provides coverage for a policyholder's child must provide coverage for any grandchild of the policyholder if the grandchild is a dependent of the policyholder for federal income tax purposes. Section 3E(b) was amended twice during the 77th Legislative Session. Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001, amended Section 3E(b) by limiting the required coverage for grandchildren to any unmarried grandchild younger than 25 years of age who is a dependent of the policyholder for federal income tax purposes at the time application for coverage is made and by prohibiting the termination of the required coverage solely because the covered grandchild ceases to be a dependent of the policyholder for federal income tax purposes. Chapter 396, Acts of the 77th Legislature, Regular Session, 2001, amended Section 3E(b) by requiring coverage of a dependent grandchild

regardless of whether the grandchild is a dependent of the policyholder for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Under Sections 311.025 and 312.014, Government Code, the amendment to Section 3E(b), Article 3.51-6, made by Chapter 1027 that requires a grandchild to be a dependent of the policyholder for federal income tax purposes impliedly repealed the amendment adopted under Chapter 396 that requires coverage of a dependent grandchild regardless of whether the grandchild is a dependent of the policyholder for federal income tax purposes. The revised law accordingly is drafted to reflect the amendment to Section 3E(b) made by Chapter 1027.

Revised Law

Sec. 1251.152. OPTIONAL COVERAGE FOR SPOUSES AND DEPENDENTS. (a) For purposes of this section, "dependent" includes:

(1) a child of an employee or member who is:

(A) unmarried; and

(B) younger than 25 years of age; and

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

(A) unmarried;

(B) younger than 25 years of age; and

(C) a dependent of the insured for federal income tax purposes at the time the application for coverage of the

grandchild is made.

(b) A group accident and health insurance policy may provide coverage for the spouse or a dependent of an employee or member. (V.T.I.C. Art. 3.51-6, Sec. 1(b), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Source Law

> (b) [as amended Acts 77th Leg., R.S., Ch. 396] The spouse and dependents of employees or members, including a dependent grandchild of an employee or member who is less than 21 years old and living with and in the household of the employee or member, referred to in Subdivisions (a)(1) through (a)(6) of this section may be included within the coverage provided in a group policy. For purposes of this subsection, a grandchild of an employee or member is a dependent of the employee or member, regardless of whether the employee or member treats the grandchild as a dependent for federal income tax purposes.
>
> (b) [as amended Acts 77th Leg., R.S., Ch. 1027] The spouse and dependents of employees or members described by Subsections (a)(1)-(6) of this section, including an unmarried child less than 25 years old and a grandchild described by Section 3E of this article, may be included within the coverage provided in a group policy.

Revisor's Note

Before September 1, 2001, Section 1(b), V.T.I.C. Article 3.51-6, included a dependent grandchild as a dependent of an employee or member if the grandchild is younger than 21 years of age and living with and in the household of the employee or member. Section 1(b) was amended twice during the 77th Legislative Session. Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001, amended Section 1(b) by including as a dependent of the employee or member an unmarried child who is younger than 25 years of age and an unmarried grandchild described by Section 3E, V.T.I.C. Article 3.51-6. Section 3E describes an unmarried grandchild who is younger than 25 years of age and is a dependent of the insured for federal income tax purposes. Chapter 396, Acts of the 77th Legislature, Regular Session, 2001, amended Section 1(b) by providing that

a grandchild is a dependent of the employee or member, regardless of whether the employee or member treats the grandchild as a dependent for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Under Sections 311.025 and 312.014, Government Code, the amendment to Section 1(b) made by Chapter 1027 that includes as a dependent of the employee or member a grandchild who is a dependent of the employee or member for federal income tax purposes impliedly repealed the amendment adopted under Chapter 396 that provides that a grandchild is a dependent of the employee or member regardless of whether the grandchild is treated as a dependent for federal income tax purposes. The revised law accordingly is drafted to reflect the amendment to Section 1(b) made by Chapter 1027.

Revised Law

Sec. 1251.153. OPTIONAL CONTINUATION OF DEPENDENTS' BENEFITS ON DEATH OF INSURED. (a) A group accident and health insurance policy that provides for the payment by the insurer of benefits for members of the family or dependents of an insured may provide for a continuation of all or part of those benefits after the death of the insured.

(b) Insurance provided by benefits described by Subsection (a) is not life insurance under Title 7.

(c) Coverage described by Subsection (a) may continue for any period subject to any other policy provisions relating to the

termination of a dependent's coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(f).)

Source Law

(f) Any group accident and health insurance policy which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group may provide for a continuation of such benefits or any part thereof after the death of the person in the insured group and provided further that any amounts of insurance so provided by such benefits shall not be construed as life insurance under this chapter. Such coverage may continue for any period subject to any other policy provisions relating to termination of dependent's coverage.

Revisor's Note

Section 1(f), V.T.I.C. Article 3.51-6, refers to "life insurance under this chapter," meaning V.T.I.C. Chapter 3. The provisions of Chapter 3 relating to life insurance are revised as Title 7 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1251.154. COVERAGE FOR ADOPTED CHILDREN. A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage for the immediate family or a child of an insured may not exclude from coverage or limit coverage of a child of the insured solely because the child is adopted. A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child. (V.T.I.C. Art. 3.51-6, Sec. 3D.)

Source Law

Sec. 3D. (a) In this section, "health insurance" means a group policy or contract, including group contracts issued by companies subject to Chapter 20, Insurance Code, that provides insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness.

(b) A health insurance policy that provides coverage for the immediate family or children of a person insured under the policy may not exclude from coverage or limit coverage to a child of the insured solely because the child is adopted.

(c) For the purposes of this section, a child is

considered to be the child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought.

[Sections 1251.155-1251.200 reserved for expansion]

SUBCHAPTER E. GROUP ACCIDENT AND HEALTH INSURANCE: GENERAL PROVISIONS

Revised Law

Sec. 1251.201. CERTIFICATE OF INSURANCE. (a) An insurer issuing a group policy under this chapter shall provide to the policyholder for delivery to each employee or member of the insured group a certificate of insurance that:

(1) summarizes the essential features of the insurance coverage of the employee or member; and

(2) states the person to whom benefits are payable.

(b) If dependents are included in the coverage, an insurer is not required to provide more than one certificate for each family unit. (V.T.I.C. Art. 3.51-6, Sec. 1(c).)

Source Law

(c) An insurer issuing a group policy under this article shall furnish to the policyholder for delivery to each employee or member of the insured group a certificate of insurance which shall contain a statement, in summary form, of the essential features of the insurance coverage of such employee or member and to whom benefits are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

[Sections 1251.202-1251.250 reserved for expansion]

SUBCHAPTER F. CONTINUATION OR CONVERSION PRIVILEGE ON TERMINATION OF COVERAGE UNDER GROUP POLICY

Revised Law

Sec. 1251.251. CONTINUATION OF GROUP COVERAGE REQUIRED; EXCEPTION. (a) An insurer or group hospital service corporation that issues policies that provide hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense incurred basis shall, as required by this subchapter, provide continuation of group coverage for employees or members and their eligible dependents, subject to the eligibility provisions prescribed by Section 1251.252.

(b) This subchapter does not apply to an insurance policy that provides benefits only for expenses incurred because of a specified disease or an accident. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3) (part), (3)(A)(i).)

Source Law

> (3) Any insurer or group hospital service corporation subject to Chapter 20, Insurance Code, who issues policies which provide hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense incurred basis, but not a policy which provides benefits for specified disease or for accident only, shall provide a group continuation privilege as required by this subsection. . . .
>
> (A)(i) Policies subject to this section shall provide continuation of group coverage for employees or members and their eligible dependents subject to the eligibility provisions.

Revised Law

Sec. 1251.252. ELIGIBILITY FOR CONTINUATION OF GROUP COVERAGE. (a) An employee, member, or dependent is entitled to continuation of group coverage if:

(1) the individual's coverage under the group policy is terminated for any reason other than involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class; and

(2) the individual has been continuously insured under the group policy, or under any group policy providing similar benefits that the policy replaces, for at least three consecutive months immediately before termination.

(b) For purposes of Subsection (a), involuntary termination for cause does not include termination for any health-related cause. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

Source Law

> (3) . . . Any employee, member, or dependent whose insurance under the group policy has been terminated for any reason except involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy and under any group policy providing similar benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to such privilege as outlined in Paragraph (A) below. Involuntary

termination for cause does not include termination for any health-related cause.

Revised Law

Sec. 1251.253. REQUEST FOR CONTINUATION OF GROUP COVERAGE. An employee, member, or dependent must request in writing the continuation of group coverage not later than the 31st day after the later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the individual is given, in a format prescribed by the commissioner, notice by either the employer or the group policyholder of the right to continuation of group coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(A)(ii).)

Source Law

(ii) Continuation of group coverage must be requested in writing within 31 days following the later of: (aa) the date the group coverage would otherwise terminate; or (bb) the date the employee, member, or dependent is given notice in a format prescribed by the commissioner of the right of continuation by either the employer or the group policyholder.

Revised Law

Sec. 1251.254. PAYMENT OF CONTRIBUTIONS. (a) An employee, member, or dependent who elects to continue group coverage under this subchapter must pay to the employer or group policyholder, each month in advance, the amount of contribution required by the employer or policyholder, plus two percent of the group rate for the coverage being continued under the group policy on the due date of each payment.

(b) The employee's, member's, or dependent's written election for continuation of group coverage, together with the first contribution required to establish advance monthly contributions, must be given to the employer or policyholder not later than the later of:

(1) the 31st day after the date coverage would otherwise terminate; or

(2) the date the individual is given notice by either

the employer or the group policyholder of the right to continuation of group coverage. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(iii), (iv).)

Source Law

> (iii) An employee, member, or dependent electing continuation must pay to the group policyholder or employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, plus two percent of the group rate for the insurance being continued under the group policy on the due date of each payment.
>
> (iv) The employee's, member's, or dependent's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within the later of: (aa) 31 days of the date coverage would otherwise terminate, or (bb) the date the employee is given notice of the right of continuation by either the employer or the group policyholder.

Revised Law

Sec. 1251.255. TERMINATION OF CONTINUED COVERAGE. (a) Group coverage continued under this subchapter may not terminate until the earliest of:

(1) six months after the date the employee, member, or dependent elects to continue the group coverage;

(2) the date failure to make timely payments would terminate the group coverage;

(3) the date the group coverage terminates in its entirety;

(4) the date the insured is or could be covered under Medicare;

(5) the date the insured is covered for similar benefits by another plan or program, including:

(A) a hospital, surgical, medical, or major medical expense insurance policy;

(B) a hospital or medical service subscriber contract; or

(C) a medical practice or other prepayment plan;

(6) the date the insured is eligible for similar benefits, whether or not covered for those benefits, under any

arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(7) the date similar benefits are provided or available to the insured under any state or federal law.

(b) Not later than the 30th day before the end of the six months after the date the employee, member, or dependent elects to continue group coverage under the policy, the insurer shall:

(1) notify the individual that the individual may be eligible for coverage under the Texas Health Insurance Risk Pool as provided by Chapter 1506; and

(2) provide to the individual the address for applying to that pool. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(v), (vi).)

Source Law

> (v) Continuation may not terminate until the earliest of: (aa) six months after the date the election is made; (bb) the date on which failure to make timely payments would terminate coverage; (cc) the date on which the group coverage terminates in its entirety; (dd) the date on which the covered person is or could be covered under Medicare; (ee) the date on which the covered person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program; (ff) the date the covered person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or (gg) similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law.
>
> (vi) Not less than 30 days before the end of the six months after the date the employee, member, or dependent elects continuation of the policy, the insurer shall notify the employee, member, or dependent that he/she may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under Article 3.77 of this code, and the insurer shall provide the address for applying to such pool to the employee, member, or dependent.

Revised Law

Sec. 1251.256. CONVERSION OF GROUP POLICY. (a) An insurer may offer a conversion policy to each employee, member, or dependent who is covered under a group accident and health insurance policy that is terminating.

(b) If offered, an issuer shall issue a conversion policy

without evidence of insurability if a written application for the policy and payment of the first premium are made not later than the 31st day after the date of termination.

(c) Any conversion policy must meet the minimum standards for benefits for conversion policies.

(d) The insurer may provide the conversion coverage on an individual or group basis. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(B)(i), (iii).)

Source Law

> (B)(i) An insurer may offer to each employee, member, or dependent a conversion policy. Such a conversion policy shall be issued without evidence of insurability if a written application for the policy and payment of the first premium are made not later than the 31st day after the date of termination. The conversion policy shall meet the minimum standards for benefits for conversion policies.
>
> (iii) The insurer may elect to provide the conversion coverage on an individual or group basis.

Revised Law

Sec. 1251.257. PREMIUM FOR CONVERTED POLICY. (a) An insurer shall determine the premium for a converted policy issued under this subchapter in accordance with the insurer's table of premium rates for coverage that was provided under the group policy. The premium:

(1) must be based on the type of converted policy and the coverage provided by the policy; and

(2) may be based on the age and geographic location of each individual to be covered.

(b) The premium for the same coverage and benefits under a converted policy may not exceed 200 percent of the premium determined for the group policy in accordance with Subsection (a). (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

Source Law

> (3) . . .
>
> The premium for the converted policy issued under Paragraph (B) of this subdivision shall be determined in accordance with the insurer's table of premium rates for coverage that was provided under the

group policy or plan. The premium may be based on the age and geographic location of each person to be covered and the type of converted policy. The premium for the same coverage and benefits under a converted policy may not exceed 200 percent of the premium determined in accordance with this paragraph. The premium must be based on the type of converted policy and the coverage provided by the policy.

Revised Law

Sec. 1251.258. BENEFITS UNDER CONVERTED POLICY. The commissioner by rule shall establish minimum standards for benefits under converted policies issued under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Source Law

(ii) . . . The commissioner shall issue rules and regulations to establish minimum standards for benefits under policies issued pursuant to this paragraph.

Revisor's Note

Section 1(d)(3)(B)(ii), V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" for the reason stated in the revisor's note to Section 1251.008.

Revised Law

Sec. 1251.259. TERMINATION OF CONVERTED POLICY. Conversion coverage under this subchapter for an insured may not terminate until the earlier of:

(1) the date failure to make timely payments would terminate coverage; or

(2) the date of an event specified by Section 1251.255(a)(4), (5), (6), or (7) for termination of continued group coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Source Law

(ii) Conversion coverage for any insured person may not terminate until the earliest of: (aa) the date on which failure to make timely payments would terminate coverage; or (bb) one of the conditions specified in items (dd) through (gg) of Subparagraph (v), Paragraph (A), of this subdivision. . . .

Revised Law

Sec. 1251.260. NOTICE OF CONTINUATION AND CONVERSION

PRIVILEGES. (a) An employer that provides to its employees group accident and health insurance coverage that includes a group continuation or conversion privilege on termination of coverage shall give written notice of the continuation or conversion privileges under the policy to each employee or dependent insured under the group and affected by the termination.

(b) The commissioner by rule shall establish minimum standards for the notice required by this section. (V.T.I.C. Art. 3.51-6, Sec. 3C, as added Acts 71st Leg., R.S., Ch. 1041, Sec. 10.)

Source Law

> Sec. 3C. (a) An employer that provides to its employees group accident and health insurance coverage that includes a conversion or group continuation privilege on termination of coverage shall give written notice to each employee, member, or dependent insured under the group and affected by the termination of this conversion or group continuation privileges under the policy.
>
> (b) The State Board of Insurance by rule shall establish minimum standards for the notice required by this section.

Revisor's Note

Section 3C, V.T.I.C. Article 3.51-6, as added by Chapter 1041, Acts of the 71st Legislature, Regular Session, 1989, requires an employer that provides group accident and health insurance to its employees to give written notice of any continuation or conversion privileges under the policy to "each employee, member, or dependent." The revised law omits as unnecessary the reference to each "member" because under a policy issued to an employer, the only individuals covered are employees and their dependents.

[Sections 1251.261-1251.300 reserved for expansion]

SUBCHAPTER G. CONTINUATION OF GROUP COVERAGE FOR CERTAIN FAMILY MEMBERS AND DEPENDENTS

Revised Law

Sec. 1251.301. CONTINUATION OF GROUP COVERAGE. A group policy or contract delivered, issued for delivery, renewed,

amended, or extended in this state, including a group contract issued by a group hospital service corporation, that provides insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness must include an option for each individual covered by the policy or contract because of a family or dependent relationship to an individual who is a member of the group for which the policy or contract is provided to continue coverage with the group if the individual's eligibility for coverage under the policy or contract ends because of:

(1) the severance of the family relationship; or

(2) the retirement or death of the group member.

(V.T.I.C. Art. 3.51-6, Secs. 3B(a), (b) (part).)

Source Law

> Sec. 3B. (a) In this section, "health insurance policy" means a group policy or contract, including group contracts issued by companies subject to Chapter 20 of this code and the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), providing insurance for hospital, surgical, or medical expenses incurred as a result of an accident or sickness.
>
> (b) Each health insurance policy delivered, issued for delivery, renewed, amended, or extended in this state shall include an option for each person covered by the policy by virtue of family or dependent relationship to a person who is a member of the group for which the health insurance policy is provided to continue coverage with the group if:
>
> (1) previous eligibility for coverage under the health insurance policy ceases because of the severance of the family relationship or the retirement or death of the member of the group; and
>
> . . .

Revisor's Note

(1) Section 3B(a), V.T.I.C. Article 3.51-6, refers to "companies subject to . . . the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code)." The revised law omits the reference as unnecessary because it duplicates the substance of Section 843.051(b)(1) of this code.

(2) Section 3B(b), V.T.I.C. Article 3.51-6, refers to a "health insurance policy." Throughout this subchapter, the revised law substitutes "health

insurance policy or contract" because Section 3B applies to contracts for nonprofit hospital service plans. See Section 3B(a) (revised as this section).

Revised Law

Sec. 1251.302. ELIGIBILITY FOR CONTINUED COVERAGE. A family member or dependent of an insured is eligible for continued coverage under this subchapter if the family member or dependent:

(1) has been a member of the group for a period of at least one year; or

(2) is an infant under one year of age. (V.T.I.C. Art. 3.51-6, Sec. 3B(b) (part).)

Source Law

> [(b) Each health insurance policy delivered, issued for delivery, renewed, amended, or extended in this state shall include an option for each person covered by the policy by virtue of family or dependent relationship to a person who is a member of the group for which the health insurance policy is provided to continue coverage with the group if:]
>
> . . .
>
> (2) the family member or dependent has been a member of the group for a period of at least one year or is an infant under one year of age.

Revised Law

Sec. 1251.303. PHYSICAL EXAMINATION NOT REQUIRED. An individual who exercises the option to continue group coverage under this subchapter may not be required to take and pass a physical examination as a condition to continuing coverage. (V.T.I.C. Art. 3.51-6, Sec. 3B(c).)

Source Law

> (c) A person who exercises the option provided by Subsection (b) of this section may not be required to take and pass a physical examination as a condition for continuing coverage.

Revised Law

Sec. 1251.304. SCOPE OF COVERAGE. (a) An individual covered under group continuation coverage under this subchapter is entitled to coverage that is identical in scope to the coverage provided under the group health insurance policy or contract. An exclusion that was not included in the health insurance policy or

contract may not be included in the group continuation coverage.

(b) If the group policyholder or contract holder replaces the health insurance policy or contract within the period prescribed by Section 1251.310(3), an individual covered under group continuation coverage may obtain coverage identical in scope to the coverage under the replacement group policy as provided by this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(d).)

Source Law

> (d) If a person exercises the option provided by Subsection (b) of this section, that person is entitled to coverage that is identical in scope to the coverage provided under the health insurance policy, and exclusions that were not included in the health insurance policy may not be included in the group continuation coverage. However, if the group policyholder replaces the health insurance policy within the one-year period provided by Subdivision (4) of Subsection (l) of this section, the person may obtain coverage identical in scope to the coverage under the replacement group policy as provided by this article.

Revisor's Note

Section 3B(d), V.T.I.C. Article 3.51-6, refers to "the one-year period provided by Subdivision (4) of Subsection (l) of this section." As originally enacted by Chapter 673, Acts of the 69th Legislature, Regular Session, 1985, Section 3B(l)(4) provided that continued coverage could not terminate until "a period of one year has elapsed since the severance of the family relationship or the retirement or death of the member of the group." Chapter 377, Acts of the 71st Legislature, Regular Session, 1989, amended Section 3B(l) by deleting the existing Subdivision (2), renumbering existing Subdivisions (3) and (4) as (2) and (3), respectively, and changing "one year" in existing Subdivision (4) to "three years." Section 3B(l)(3) is revised as Section 1251.310(3), and the revised law is drafted accordingly.

Revised Law

Sec. 1251.305. AMOUNT OF PREMIUM. Except as provided by

Section 1551.064, the premium for continuation of a spouse or dependent on the group health insurance policy or contract may not be more than the premium charged under the group policy or contract for the individual had the family relationship not been severed. (V.T.I.C. Art. 3.51-6, Sec. 3B(f).)

Source Law

> (f) Except as provided in Subsection (m) of this section, a premium for continuation of the spouse or dependent on the group policy shall be no more than the premium charged under the group contract for the spouse or dependent had the family relationship not been severed.

Revised Law

Sec. 1251.306. PAYMENT OF PREMIUMS. (a) An individual covered under group continuation coverage under this subchapter shall pay premiums for the coverage directly to the group policyholder or contract holder.

(b) The coverage must provide the individual with the option of paying the premiums in monthly installments.

(c) The group policyholder or contract holder may require the individual to pay a monthly fee of not more than $5 for administrative costs. (V.T.I.C. Art. 3.51-6, Sec. 3B(e).)

Source Law

> (e) A person covered under group continuation coverage shall pay premiums for the coverage directly to the group policyholder, and the coverage shall provide the person with the option of paying the premiums in monthly installments. The group policyholder may require the person to pay a fee of not more than $5 a month for administrative costs.

Revised Law

Sec. 1251.307. NOTICE OF CONTINUATION OPTION. Except as provided by Section 1551.064, at the time a health insurance policy or contract is issued, the group policyholder or contract holder shall give written notice to each group member and each dependent of a group member covered by the policy or contract of the continuation option under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(g).)

Source Law

> (g) Except as provided in Subsection (m) of this section, at the time the health insurance policy is

issued, the group policyholder shall give written notice to each member of the group and each dependent of a member of the group covered by a health insurance policy of the continuation option.

Revised Law

Sec. 1251.308. NOTICE OF SEVERANCE OF FAMILY RELATIONSHIP; NOTICE OF DESIRE TO EXERCISE OPTION. (a) Except as provided by Section 1551.064, each group health insurance policy or contract must require a group member to give written notice to the group policyholder or contract holder not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option under this subchapter. Written notice under this subsection may be given by the group member's dependent.

(b) On receipt of notice under Subsection (a), the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter to each affected dependent of the group member.

(c) On receipt of notice of the death or retirement of a group member, the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter to each dependent of the group member. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

(d) Not later than the 60th day after the date of the severance of the family relationship or the retirement or death of the group member, a dependent must give written notice to the group policyholder or contract holder of the individual's desire to exercise the continuation option under this subchapter. Coverage under the health insurance policy or contract remains in effect during the period prescribed by this subsection if the policy or contract premiums are paid.

(e) If a dependent does not give written notice of the individual's desire to exercise the continuation option under this subchapter within the time prescribed by Subsection (d), the option expires. (V.T.I.C. Art. 3.51-6, Secs. 3B(h), (i).)

Source Law

(h) Except as provided in Subsection (m) of this section, each health insurance policy shall require a member of the group to give written notice to the group policyholder within 15 days of any severance of the family relationship that might activate the continuation option under Subsection (b) of this section, and the group policyholder on receiving this notice shall immediately give written notice to each affected dependent of the continuation option; however, such written notice may be given by the group member's dependent. On receipt of notice of the death or retirement of a group member, the group policyholder shall immediately give written notice to the group member's dependents of the continuation option under Subsection (b) of this section. Such notice shall include a statement of the amount of the premium to be charged and shall be accompanied by any necessary enrollment forms.

(i) Within 60 days from the severance of the family relationship or the retirement or death of the member of the group, the dependent must give written notice to the group policyholder of the desire to exercise the option under Subsection (b) of this section or the option expires. Coverage under the health insurance policy remains in effect during this 60-day period provided the policy premiums are paid.

Revised Law

Sec. 1251.309. CONTINUATION OF CERTAIN COVERAGES. (a) Any period of previous coverage under the health insurance policy or contract, including a policy or contract executed under Chapter 1551, must be used in full or partial satisfaction of any required probationary or waiting periods provided in the contract for dependent coverage.

(b) If a health insurance policy or contract provides to a group member continuation rights to cover the period between the time the member retires and the time the member is eligible for coverage by Medicare, those same continuation rights must be made available to the group member's dependents. (V.T.I.C. Art. 3.51-6, Secs. 3B(j), (k).)

Source Law

(j) Any period of previous coverage under the health insurance policy is to be used in full or partial satisfaction of any required probationary or waiting periods provided in the contract for dependent coverage.

(k) If a health insurance policy provides to a group member continuation rights to cover the period between the time that the member retires and the time of eligibility for coverage by Medicare, those same continuation rights shall be made available to the

group member's dependents.

Revisor's Note

The revised law adds "including a policy or contract executed under Chapter 1551" to Section 1251.309(a) for the convenience of the reader and to maintain the textual linkage between this provision and Chapter 1551 of this code. Section 3B(m), V.T.I.C. Article 3.51-6, revised as Section 1551.064 of this code, contained an explicit reference to the Texas Employees Group Benefits Act (V.T.I.C. Article 3.50-2), revised as Chapter 1551 of this code. The addition of the referenced language to Section 1251.309(a) maintains that explicit reference in the context in which it appeared.

Revised Law

Sec. 1251.310. TERMINATION OF CONTINUED COVERAGE. The coverage of an individual who exercises the continuation option under this subchapter continues without interruption and may not be canceled or otherwise terminated until:

(1) the insured fails to make a premium payment within the time required to make the payment;

(2) the insured becomes eligible for substantially similar coverage under another plan or program, including a group health insurance policy or contract, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(3) the third anniversary of:

(A) the severance of the family relationship; or

(B) the retirement or death of the group member.

(V.T.I.C. Art. 3.51-6, Sec. 3B(l).)

Source Law

(l) If a person exercises the continuation option under Subsection (b) of this section, coverage of that person continues without interruption and may not be cancelled or otherwise terminated until:

(1) the insured fails to make a premium payment in the time required to make that payment;

(2) the insured becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or

(3) a period of three years has elapsed since the severance of the family relationship or the retirement or death of the member of the group.

[Sections 1251.311-1251.350 reserved for expansion]

SUBCHAPTER H. BLANKET ACCIDENT AND HEALTH INSURANCE: ELIGIBLE POLICYHOLDERS

Revised Law

Sec. 1251.351. COMMON CARRIER OR MOTOR VEHICLE RENTAL OR LEASING COMPANY. (a) A blanket accident and health insurance policy may be issued to:

(1) a common carrier or the operator, owner, or lessor of a means of transportation to cover a group of individuals who may become passengers defined by reference to their travel status on the common carrier or means of transportation; or

(2) an automobile or truck rental or leasing company to cover a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles.

(b) The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

(1) under a policy issued to any common carrier or to any operator, owner, or lessor of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation; or, under a policy issued to any automobile and/or truck leasing company, which shall be deemed the policyholder, covering a group of persons who may become either renters, lessees, or passengers defined by their travel status on such rented or leased vehicles;

. . .

Revisor's Note

Section 2(a)(1), V.T.I.C. Article 3.51-6, provides that a blanket accident and health insurance policy may be issued to an "automobile and/or truck leasing company" to cover "renters, lessees, or passengers." The revised law substitutes "automobile or truck rental or leasing company" for "automobile and/or truck leasing company" because it is clear from the reference to "renters" that a company that rents automobiles or trucks may obtain a blanket accident and health insurance policy.

Revised Law

Sec. 1251.352. EMPLOYERS. (a) A blanket accident and health insurance policy may be issued to an employer to cover any group of employees, dependents, or guests defined by reference to specified hazards incident to an activity or operation of the employer.

(b) The employer is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(2) under a policy issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents, or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder;

. . .

Revised Law

Sec. 1251.353. EDUCATIONAL INSTITUTIONS. (a) A blanket accident and health insurance policy may be issued to a college, school, or other institution of learning, to a school district or school jurisdictional unit, or to the head, principal, or governing board of such an educational unit to cover students, teachers, or employees.

(b) The institution, head, principal, or governing board is

the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

> [(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]
>
> . . .
>
> (3) under a policy issued to a college, school, or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal, or governing board of any such education unit, who or which shall be deemed the policyholder, covering students, teachers, or employees;
>
> . . .

Revised Law

Sec. 1251.354. RELIGIOUS, CHARITABLE, RECREATIONAL, EDUCATIONAL, OR CIVIC ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a religious, charitable, recreational, educational, or civic organization, or a branch of the organization, to cover any group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the organization or branch.

(b) The organization or branch is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

> [(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]
>
> . . .
>
> (4) under a policy issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by such policyholder;
>
> . . .

Revised Law

Sec. 1251.355. SPORTS TEAM OR CAMP. (a) A blanket accident and health insurance policy may be issued to a sports team or camp or the sponsor of a sports team or camp to cover members,

campers, employees, officials, or supervisors.

(b) The sports team, camp, or sponsor is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

> [(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]
>
> . . .
>
> (5) under a policy issued to a sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials, or supervisors;
>
> . . .

Revised Law

Sec. 1251.356. GOVERNMENTAL OR VOLUNTEER EMERGENCY SERVICES ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a governmental or volunteer fire department or fire company, first aid or civil defense organization, or similar governmental or volunteer organization to cover a group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the organization.

(b) The governmental or volunteer organization is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

> [(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]
>
> . . .
>
> (6) under a policy issued to any governmental or volunteer fire department or fire company, first aid, civil defense, or other such governmental or volunteer organization, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder;
>
> . . .

Revised Law

Sec. 1251.357. NEWSPAPER OR OTHER PUBLISHER. (a) A

blanket accident and health insurance policy may be issued to a newspaper or other publisher to cover the publisher's carriers.

(b) The publisher is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

> [(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]
>
> . . .
>
> (7) under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers;
>
> . . .

Revised Law

Sec. 1251.358. ASSOCIATION. (a) A blanket accident and health insurance policy may be issued to an association, including a labor union, to cover any group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the association.

(b) To be eligible to obtain a blanket accident and health insurance policy, an association must:

(1) have a constitution and bylaws; and

(2) have been organized and be maintained in good faith for purposes other than that of obtaining insurance.

(c) The association is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

> [(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]
>
> . . .
>
> (8) under a policy issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder;
>
> . . .

Revised Law

Sec. 1251.359. COVERAGE FOR OTHER RISKS. (a) A blanket accident and health insurance policy may be issued to cover any risk or class of risks other than a risk described by this subchapter that, as determined by the commissioner, is eligible for blanket accident and health insurance.

(b) The commissioner may make a determination under Subsection (a) based on an individual risk, a class of risks, or both. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

> [(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]
>
> . . .
>
> (9) under a policy issued to cover any other risk or class of risks which, in the discretion of the commissioner of insurance, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner of insurance may be exercised on an individual risk basis or class of risks, or both.

[Sections 1251.360-1251.400 reserved for expansion]

SUBCHAPTER I. BLANKET ACCIDENT AND HEALTH INSURANCE: GENERAL PROVISIONS

Revised Law

Sec. 1251.401. INDIVIDUAL APPLICATION AND CERTIFICATE NOT REQUIRED. (a) An individual application from an insured under a blanket accident and health insurance policy is not required.

(b) An insurer is not required to provide a certificate to each insured under a blanket accident and health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 2(b).)

Source Law

> (b) An individual application need not be required from a person covered under a blanket accident and sickness policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

Revisor's Note

Section 2(b), V.T.I.C. Article 3.51-6, refers to a blanket accident and sickness "policy or contract."

The revised law omits the reference to a "contract" for consistency with the remaining provisions of Section 2, V.T.I.C. Article 3.51-6 (revised as this subchapter), which use the term "policy."

Revised Law

Sec. 1251.402. LIABILITY OF POLICYHOLDER NOT AFFECTED. Subchapter H and this subchapter do not affect the legal liability of a policyholder for the death of or injury to a member of a group. (V.T.I.C. Art. 3.51-6, Sec. 2(c).)

Source Law

(c) Nothing in this section shall be deemed to affect the legal liability of any policyholder for the death of or injury to any member of a group.

[Sections 1251.403-1251.450 reserved for expansion]

SUBCHAPTER J. REGULATION OF OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE

Revised Law

Sec. 1251.451. APPLICABILITY OF CERTAIN LAWS TO OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE. (a) Chapters 1365 and 1368 and Subchapters A and C, Chapter 1451, apply to:

(1) a certificate of insurance issued to a resident of this state under a group accident and health insurance policy delivered, issued for delivery, or renewed outside this state; or

(2) a certificate issued to a resident of this state under a policy delivered, issued for delivery, or renewed outside this state by a group hospital service corporation.

(b) Subsection (a) does not apply to a specified disease or limited benefit policy. (V.T.I.C. Art. 3.51-12.)

Source Law

Art. 3.51-12. Articles 3.51-9, 21.35A, and 21.52 of this code and Section 2(G), Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), apply to:

(1) a certificate of insurance issued to a resident of this state under a group accident and health insurance policy delivered, issued for delivery, or renewed outside this state; or

(2) a certificate issued to a resident of

this state under a policy delivered, issued for delivery, or renewed outside this state by a nonprofit hospital and medical service plan corporation. This article shall not apply to specified disease or limited benefit policies.

Revisor's Note

V.T.I.C. Article 3.51-12 provides in part that V.T.I.C. Article 21.35A applies to coverage under certain out-of-state group accident and health insurance policies. Article 3.51-12 was enacted by Chapter 824, Acts of the 69th Legislature, Regular Session, 1985, as Article 3.51-10. It was renumbered as Article 3.51-12 by Section 5.01(a)(30), Chapter 167, Acts of the 70th Legislature, Regular Session, 1987. At the time the article was enacted, Vernon's Texas Insurance Code included an Article 21.35A that was enacted by Chapter 556, Acts of the 65th Legislature, Regular Session, 1977, that provided that if a group insurance policy covered psychological services, an insured was entitled to obtain those services from a medical doctor or psychologist. That Article 21.35A was repealed by Section 11.91, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991. (A second Article 21.35A was enacted by Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, but it relates to charges imposed by a local recording agent for obtaining certain records or photographs in connection with an insured or an applicant for insurance.) Accordingly, the revised law omits the reference to Article 21.35A.

CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

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CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1252.001. DEFINITIONS. In this chapter:

(1) "Carrier" means:

(A) an insurer; or

(B) a group hospital service corporation operating under Chapter 842.

(2) "Health benefit plan" means:

(A) any accident and health insurance policy;

(B) a subscriber contract of a group hospital service corporation; or

(C) an accident and health benefits package of a multiple employer trust that is not exempt from regulation by this

state as an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), as amended.

(3) "Previous carrier" means a carrier whose health benefit plan coverage has been replaced with health benefit plan coverage provided by a succeeding carrier.

(4) "Succeeding carrier" means a carrier that replaces the health benefit plan coverage provided by another carrier with its own health benefit plan coverage.

(5) "Total disability" or "totally disabled" means:

(A) with respect to an employee or other primary insured covered under a health benefit plan, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability; and

(B) with respect to any other individual covered under a health benefit plan, confinement as a bed patient in a hospital. (V.T.I.C. Art. 3.51-6A, Secs. 1 (part); 2(b); 5(f); 6(b)(1), (3); New.)

Source Law

Art. 3.51-6A
Sec. 1. [This article is applicable to:]
(1) all accident and health insurance policies, including subscriber contracts of a nonprofit service corporation subject to Chapter 20 of this code; and
(2) benefit packages of multiple employer trusts which are not exempt from regulation by the State of Texas as employee welfare benefit plans under the Employee Retirement Income Security Act of 1974, as amended (Public Law 93-406), ...

[Sec. 2]
(b) "Carrier" means any insurer, including a nonprofit service corporation subject to Chapter 20 of this code as specified in Section 1 of this article.

[Sec. 5]
(f) For the purposes of this section, the terms "total disability" and "totally disabled" mean (1) with respect to an employee or other primary insured under the policy, the complete inability of the person to perform all of the substantial and material duties and functions of his or her occupation and any other gainful occupation in which such person earns

substantially the same compensation earned prior to disability, and (2) with respect to any other person under the policy, confinement as a bed patient in a hospital.

[Sec. 6]

(b) In this section:

(1) "Prior carrier" means an insurer including a group hospital service corporation subject to Chapter 20 of this code, whose coverage has been replaced by a succeeding carrier.

(3) "Succeeding carrier" means an insurer including a group hospital service corporation subject to Chapter 20 of this code that has replaced the coverage of a prior carrier with its coverage.

Revisor's Note

(1) Sections 1, 2(a)(3), and 2(b), V.T.I.C. Article 3.51-6A, refer to a "nonprofit service corporation" or "a nonprofit service corporation subject to Chapter 20 of this code." The term most frequently used to refer to such a corporation in Chapter 20, revised as Chapter 842 of this code, is "group hospital service corporation." Consequently, throughout this chapter the revised law refers to Chapter 842 and substitutes "group hospital service corporation" for "nonprofit service corporation" to provide for consistent use of terminology in this code.

(2) The definition of "health benefit plan" is added to the revised law for clarity and drafting convenience. Although V.T.I.C. Article 3.51-6A refers to "policies" and "policies or contracts," it is clear from the context of Section 1 of that article that in addition to insurance policies, the article applies to subscriber contracts of group hospital service corporations and benefit packages of certain multiple employer trusts when referring to a plan of health benefits. Consequently, for purposes of this chapter, "health benefit plan" is a more accurate term than "policy" and "policy or contract," and throughout this chapter, the revised law substitutes "health

benefit plan" for "policy" and "policy or contract."

(3) Section 1, V.T.I.C. Article 3.51-6A, refers to the applicability of this chapter to benefit packages of certain multiple employer trusts. When referring to those trusts in the definition of "health benefit plan," the revised law adds "accident and health" before the term "benefits packages" because it is clear from the context of the source law that those are the type of benefits packages to which this chapter applies.

(4) Section 6(b)(2), V.T.I.C. Article 3.51-6A, defines a "prior plan" and Section 6(b)(4), V.T.I.C. Article 3.51-6A, defines a "succeeding carrier's plan." The revised law omits the definitions as unnecessary because the meaning of those terms is clear in the context in which the terms appear. The omitted law reads:

> (2) "Prior plan" means the plan of benefits of a prior carrier.
>
> (4) "Succeeding carrier's plan" means the plan of benefits of the succeeding carrier.

Revised Law

Sec. 1252.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that:

(1) provides coverage on a group or group-type basis to an individual eligible for that coverage because of the individual's status as:

(A) an employee of an employer; or

(B) a member of a labor union or a member of an association; and

(2) is delivered or issued for delivery in this state.

(b) This chapter does not apply to an entity that is not engaged in the business of insurance in this state. (V.T.I.C. Art. 3.51-6A, Sec. 1.)

Source Law

Sec. 1. This article is applicable to:

(1) all accident and health insurance policies, including subscriber contracts of a nonprofit service corporation subject to Chapter 20 of this code; and

(2) benefit packages of multiple employer trusts which are not exempt from regulation by the State of Texas as employee welfare benefit plans under the Employee Retirement Income Security Act of 1974, as amended (Public Law 93-406), that are delivered or issued for delivery in this state on a group or group-type basis covering a person who is eligible for insurance because of the person's status as an employee of an employer or as a member of a labor union or as a member of an association. This article does not apply to or otherwise regulate any entity not engaged in the business of insurance in this state.

Revisor's Note

(1) Section 1, V.T.I.C. Article 3.51-6A, refers to the type of health and accident coverage to which this chapter applies. Although it may appear that the article applies to all accident and health insurance policies and subscriber contracts of group hospital service corporations and to group or group-type coverage issued under benefit packages of certain multiple employer trusts, it is clear from the context of the source law and the legislative history of that provision that the legislature intended the application of this article to be limited to group and group-type health and accident coverage. The revised law reflects the legislature's intent and limits the application of this chapter to certain group and group-type health and accident coverage issued under insurance policies, subscriber contracts of group hospital service corporations, and benefits packages of certain multiple employer trusts that are delivered or issued for delivery in this state.

(2) Section 1(2), V.T.I.C. Article 3.51-6A, states that this chapter does not apply to "or otherwise regulate" any entity not engaged in the business of insurance in this state. The revised law

omits the quoted language as unnecessary because if a law does not apply to an entity, it cannot provide the legal basis for a regulation arising from that law.

Revised Law

Sec. 1252.003. COVERAGE ISSUED ON GROUP-TYPE BASIS. (a) For purposes of this chapter, health benefit plan coverage is provided on a group-type basis if:

(1) the plan provides coverage under an insurance policy or subscriber contract to a class of employees or a class of members of a labor union or members of an association and the class is determined by conditions relating to their employment or to their membership in the union or association;

(2) coverage under the plan is not available to the general public and can be obtained and maintained only because of the covered individual's employment status or membership in a labor union or an association;

(3) premiums or subscription charges for the plan are paid to the carrier on an aggregate or bulk-payment basis; and

(4) the plan is sponsored by:

(A) the employer of the class of employees covered by the plan; or

(B) the labor union or an association to which the class of members covered by the plan belongs.

(b) Health benefit plan coverage is not provided on a group-type basis if it is a salary-budget plan using individual insurance policies or subscriber contracts that do not meet the conditions for group-type coverage specified by Subsection (a). (V.T.I.C. Art. 3.51-6A, Sec. 2(a).)

Source Law

Sec. 2. (a) "Group-type basis" means an accident and health benefit plan that meets the following conditions:

(1) insurance coverage is provided through insurance policies or subscriber contracts to classes of employees or members of a labor union or members of an association, in which the classes are defined in terms of conditions pertaining to employment or membership;

(2) coverage is not available to the general public and can be obtained and maintained only because of the covered person's employment status or membership in a labor union or an association;

(3) payment of premiums or subscription charges is arranged on an aggregate or bulk-payment basis to the insurer or nonprofit service corporation; and

(4) the employer, union, or association sponsors the plan. The term does not refer to a salary-budget plan utilizing either individual insurance policies or subscriber contracts that do not meet the conditions specified in this subsection.

[Sections 1252.004-1252.100 reserved for expansion]

SUBCHAPTER B. DISCONTINUATION OF COVERAGE

Revised Law

Sec. 1252.101. NOTICE OF DISCONTINUATION OF COVERAGE. A notice of discontinuation of a health benefit plan must include a request to the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier to notify employees or members covered by the plan of the discontinuation and the date of the discontinuation. (V.T.I.C. Art. 3.51-6A, Sec. 4.)

Source Law

Sec. 4. A notice of discontinuance of the policy or contract must include a request to the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier for notification of employees covered under the policy or contract of the date on which the policy or contract will discontinue.

Revisor's Note

Section 4, V.T.I.C. Article 3.51-6A, refers to "employees" covered under the policy or contract. The revised law substitutes "employees or members" for "employees" for consistency of terminology in this chapter and because it is clear that members of a labor union or association may be covered under a policy or contract subject to this chapter. See Section 1252.002.

Revised Law

Sec. 1252.102. EXTENSION OF BENEFITS PROVISION; EXEMPTION. (a) A health benefit plan must contain, subject to

this section and Section 1252.103, a reasonable provision providing for an extension of benefits for a total disability that exists on the date of the plan's discontinuation.

(b) A health benefit plan must contain a reasonable extension of benefits provision for coverage for hospital or medical expenses other than dental expenses. A provision is considered reasonable if it provides to an individual who is covered under the plan and who is totally disabled on the date of the plan's discontinuation an extension of benefits for expenses incurred in treating the condition causing the total disability and the extension is provided for at least the lesser of:

(1) 90 days; or

(2) the duration of the total disability.

(c) An extension of benefits provision required under this section may provide for an exclusion from coverage for an individual whose coverage is being discontinued and replaced with coverage that:

(1) is provided by a succeeding carrier; and

(2) provides a level of benefits that is at least substantially equal to the level of benefits provided under the replaced health benefit plan.

(d) An applicable extension of benefits provision must be described in the policy or contract and the group insurance certificate.

(e) Benefits payable during an extension period may be subject to the regular benefit limits of the health benefit plan.

(f) This section does not apply to a health benefit plan that was delivered or issued for delivery in this state before January 1, 1982, and whose level of benefits has not been modified after December 31, 1981. (V.T.I.C. Art. 3.51-6A, Secs. 5(a), (c), (d), (e).)

Source Law

Sec. 5. (a) Every policy or other contract subject to this article delivered or issued for delivery in this state or under which the level of

benefits is altered, modified, or amended, on or after the date this article takes effect, must contain a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract. The provision must at a minimum comply with this section.

(c) In the case of hospital or medical expense coverages other than dental expense coverages, a reasonable extension of benefits provision must be included. The provision is considered reasonable if it provides an extension of benefits for any person under the policy who is totally disabled at the date of discontinuance of the group policy or contract at least for the period of such total disability or for 90 days, whichever is less, for expenses for treatment of the condition causing such total disability.

(d) Any applicable extension of benefits must be described in the policies, contracts, and group insurance certificates. The benefits payable during any period of extension may be subject to the regular benefit limits of the policy or contract.

(e) Any extension of benefits provision under this Section 5 may provide that the extension of benefits are not applicable to any person whose coverage under the group policy or contract being discontinued is replaced by coverage with a succeeding carrier as defined in Section 6 of this article providing substantially equivalent or greater benefits than those provided by the discontinued policy or contract.

Revisor's Note

(1) Section 5(a), V.T.I.C. Article 3.51-6A, refers to a "policy that is altered, modified, or amended." The revised law omits the references to "altered" and "amended" because those terms are included within the meaning of "modified."

(2) Section 5(a), V.T.I.C. Article 3.51-6A, refers to "on or after the date this article takes effect." The effective date of Article 3.51-6A was January 1, 1982. For clarity, the revised law refers to "January 1, 1982" and "after December 31, 1981."

Revised Law

Sec. 1252.103. INDEMNITY OR BENEFITS PAYABLE FOR DISABILITY. A discontinuation of health benefit plan coverage occurring during a period of disability does not affect:

(1) any benefits payable under the plan for loss of time from work because of the disability; or

(2) any specific indemnity required to be provided

under the plan during a period of hospital confinement. (V.T.I.C. Art. 3.51-6A, Sec. 5(b).)

Source Law

> (b) In a group or group-type basis coverage providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability does not discontinue or otherwise affect the benefits payable for that disability or confinement.

Revised Law

Sec. 1252.104. LIABILITY FOR LOSS UNDER AUTOMATICALLY DISCONTINUED COVERAGE. (a) If a health benefit plan provides for automatic discontinuation of coverage when a premium or subscription charge due under the plan is not paid before the expiration of a grace period specified in the plan for that payment, the carrier or other entity responsible for making premium payments or for submitting premiums or subscription charges to the carrier is liable, on the submission of a valid claim, for a loss that is:

(1) covered by the plan; and

(2) incurred before the expiration of the grace period.

(b) The commissioner may adopt reasonable rules necessary to implement this section. (V.T.I.C. Art. 3.51-6A, Sec. 3.)

Source Law

> Sec. 3. If a policy or contract subject to this article provides a grace period for payment of premiums or subscription charges and for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for that payment, the carrier or other entity responsible for making payments or submitting subscription charges or premiums to the carrier is liable for valid claims for covered losses incurred before the end of the grace period. The State Board of Insurance may adopt reasonable rules that are necessary to implement this section.

Revisor's Note

Section 3, V.T.I.C. Article 3.51-6A, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions

to the commissioner of insurance and the Texas Department of Insurance. Consequently, the reference to the board has been changed appropriately.

[Sections 1252.105-1252.200 reserved for expansion]

SUBCHAPTER C. REPLACEMENT OF COVERAGE

Revised Law

Sec. 1252.201. TOTAL DISABILITY STATUS. In this subchapter, a reference to the total disability status of an individual means the individual's disability status immediately preceding the date on which the succeeding carrier's coverage takes effect. (V.T.I.C. Art. 3.51-6A, Sec. 6(c).)

Source Law

(c) In this section, any reference to an individual who was or was not totally disabled means the individual's status immediately before the date the succeeding carrier's coverage becomes effective.

Revised Law

Sec. 1252.202. EFFECTIVE DATE OF COVERAGE UNDER REPLACEMENT PLAN. (a) An individual who was covered by a previous carrier's health benefit plan on the date on which that plan was discontinued shall be provided coverage under the succeeding carrier's health benefit plan as of the replacement plan's effective date if the individual:

(1) is eligible for coverage because the individual is a member of a class eligible for coverage under the replacement plan and satisfies the replacement plan's actively at work and nonconfinement requirements; and

(2) elects to be covered under the replacement plan.

(b) An individual who would be covered by the succeeding carrier under Subsection (a) but who does not satisfy the replacement plan's actively at work and nonconfinement requirements shall be covered under the replacement plan when the individual satisfies those requirements. (V.T.I.C. Art. 3.51-6A, Sec. 6(e).)

Source Law

(e) Any person covered under the prior plan on its date of discontinuance who is eligible for coverage in accordance with the succeeding carrier's plan of benefits, in respect of classes eligible and actively at work and nonconfinement rules and who elects such coverage shall be covered under the succeeding carrier's plan on its effective date; provided that any person who would have been covered under the succeeding provisions of this subsection but for the actively at work or nonconfinement rules shall become covered under the succeeding carrier's plan when such person satisfied such actively at work and nonconfinement rules.

Revised Law

Sec. 1252.203. EXTENSION OF BENEFITS FOR TOTAL DISABILITY. (a) With respect to providing a type of coverage for which Section 1252.102 requires an extension of benefits for an individual with a total disability, a succeeding carrier replacing a previous carrier's plan that is not subject to that section must provide, subject to Subsection (b), the lesser of:

(1) extended benefit coverage that the previous carrier would have been required to provide under Section 1252.102 if the previous carrier had been subject to that section; or

(2) extended benefit coverage that the succeeding carrier is required to provide under Section 1252.102.

(b) The extended benefit coverage may be reduced by any benefits actually payable under the previous carrier's health benefit plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(f).)

Source Law

(f) When replacing a prior carrier's plan which is not subject to Section 5 of this article, the succeeding carrier's plan, in the case of a type of coverage for which Section 5 of this article requires an extension of benefits for a person who is totally disabled shall provide the lesser of (1) the extension of benefits which would have been required by the prior carrier's plan under Section 5, or (2) the extension of benefits required for the succeeding carrier's plan; provided, any such benefits may be reduced by any benefits actually payable under the prior carrier's plan.

Revised Law

Sec. 1252.204. COVERAGE FOR PREEXISTING CONDITIONS. (a) A succeeding carrier's health benefit plan that limits coverage in accordance with a preexisting conditions provision, other than a

waiting period, must provide, during the period the limitation on coverage is in effect, the level of benefits prescribed by this section to an individual covered by the succeeding carrier who:

(1) has a preexisting condition; and

(2) was covered by the previous carrier's plan on the date on which that plan was discontinued.

(b) The health benefit plan must provide a level of benefits equal to the lesser of:

(1) the level of benefits available under the succeeding carrier's plan as determined without applying the preexisting conditions provision; or

(2) the level of benefits that would have been available under the previous carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(g).)

Source Law

> (g) If there is a preexisting conditions limitation, other than a waiting period, included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered in accordance with this subsection by the succeeding carrier's plan and who were covered under the prior plan on the date of discontinuance of the prior plan during the period of time the limitation applies under the succeeding carrier's plan shall be the lesser of:
>
> (1) the benefits of the succeeding carrier's plan determined without application of the preexisting conditions limitation; or
>
> (2) the benefits of the prior plan.

Revised Law

Sec. 1252.205. WAITING PERIOD. If the benefits that were available under a previous carrier's health benefit plan are similar to the benefits available under a succeeding carrier's health benefit plan, the succeeding carrier shall give credit for the satisfaction or partial satisfaction of any waiting period or similar provision that has been satisfied under the previous carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(h) (part).)

Source Law

> (h) The succeeding carrier, in applying any waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of same or similar provisions under a prior plan providing

similar benefits.

. . . .

Revised Law

Sec. 1252.206. DETERMINATION OF BENEFITS AVAILABLE UNDER REPLACED PLAN. (a) If a succeeding carrier requires a determination of the benefits available under the previous carrier's health benefit plan, the previous carrier shall provide at the request of the succeeding carrier:

(1) a statement of the benefits available under the previous carrier's plan; or

(2) pertinent information sufficient either to allow verification of those benefits or to allow the succeeding carrier to make a determination of those benefits.

(b) A determination of benefits under this section must be made using the definitions of, and in accordance with all of the conditions and covered expense provisions of, the previous carrier's plan as if that plan had not been replaced. (V.T.I.C. Art. 3.51-6A, Sec. 6(h) (part).)

Source Law

(h) . . .

If a determination of the benefits of the prior plan is required by the succeeding carrier, the prior carrier shall, at the succeeding carrier's request, furnish a statement of the benefits available or pertinent information sufficient either to permit verification of the benefits available under the prior plan or to permit the determination of the benefits by the succeeding carrier. For the purposes of this subsection, benefits of the prior plan are determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan and not the succeeding carrier's plan. The benefit determination is made as if the prior plan had not been replaced by the succeeding carrier.

Revised Law

Sec. 1252.207. LIABILITY OF PREVIOUS CARRIER. A carrier of a health benefit plan that is being discontinued is liable only for any accrued liabilities regarding the plan and for any extension of benefits provided under the plan, regardless of whether the group policyholder or any other entity responsible for making payments or for submitting subscription charges to the carrier:

(1) replaces the coverage provided under the

discontinued plan with health benefit plan coverage provided by another carrier;

(2) self-insures a health benefit plan; or

(3) does not provide health benefit plan coverage. (V.T.I.C. Art. 3.51-6A, Sec. 6(d).)

Source Law

(d) The prior carrier is liable only to the extent of its accrued liabilities and extensions of benefits, regardless of whether the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

Revisor's Note
(End of Subchapter)

The revised law omits as unnecessary Section 6(a), V.T.I.C. Article 3.51-6A, which states that Section 6 governs determination of carrier liability when a carrier's health benefit plan replaces another health benefit plan providing similar benefits. Provisions relating to carrier liability requirements to which Section 6 refers are revised in this subchapter and establish those requirements without an additional reference to them in this subchapter. The omitted law reads:

Sec. 6. (a) This section applies to determination of the carrier responsible for liability in those instances in which one carrier's plan of benefits replaces a plan of similar benefits of another.

CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN CIRCUMSTANCES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON CONTRACT RENEGOTIATION 750

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CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN CIRCUMSTANCES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON CONTRACT RENEGOTIATION. (a) In this section, "health benefit contract" means a contract providing group health care coverage for employees that is delivered, issued for delivery, or renewed in this state by:

(1) an insurance company;

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

(3) a health maintenance organization operating under Chapter 843.

(b) Subject to Subsection (c), if an employer in this state agrees to renegotiate a health benefit contract, a change in the renegotiated contract may not operate solely to terminate eligibility with respect to any member of the group who, before the contract was renegotiated:

(1) was covered under the contract; and

(2) had a sickness or injury for which a service was

being provided or a benefit was being paid under the contract.

(c) A renegotiated health benefit contract may include a different durational or dollar limit or a different deductible amount or amount of coinsurance applicable to a sickness or injury for which a service was being provided or benefit was being paid before the contract was renegotiated if that same or a similar limit or amount applies to a service provided or benefit paid for a similar sickness or a related condition or injury covered by the contract. (V.T.I.C. Art. 3.51-6C.)

Source Law

> Art. 3.51-6C. (a) In this article, "health insurance contract" means a group health insurance contract providing health care coverage for employees delivered, issued for delivery, or renewed in this state by an insurance company, including a group hospital service corporation under Chapter 20 of this code and a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).
>
> (b) If an employer in this state agrees to renegotiate a health insurance contract through which coverage is provided to his employees, subject to Subsection (c) of this article, any changes in the renegotiated contract may not operate solely to terminate eligibility as to any member of the group with coverage under the contract before the renegotiation for a sickness or injury for which services were being provided or benefits were being paid before renegotiation.
>
> (c) A renegotiated health insurance contract may include any amended or renegotiated durational limits, dollar limits, deductibles, or coinsurance covering services or benefits under Subsection (b) of this article if those same or similar limits apply to similar sicknesses or related conditions and injuries covered by the health insurance contract.

Revisor's Note

Section (a), V.T.I.C. Article 3.51-6C, defines "health insurance contract." "Insurance contract" is a term used in conjunction with traditional insurance. Included within the definition of "health insurance contract" are group contracts issued by health maintenance organizations. The coverage provided by this type of document is not insurance coverage, and this type of coverage document is not typically described as an "insurance contract." Therefore,

"health benefit contract" is a more accurate term than "health insurance contract," and the revised law substitutes "health benefit contract" for "health insurance contract."

[Sections 1253.002-1253.050 reserved for expansion]

SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE POLICIES DURING LABOR DISPUTE

Revised Law

Sec. 1253.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group accident and health insurance policy that is delivered or issued for delivery in this state and as to which any part of the premium is paid or is to be paid by an employer under the terms of a collective bargaining agreement. (V.T.I.C. Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

Source Law

> Art. 3.51-8. [No] group accident and health insurance policy shall be delivered or issued for delivery in this state where the premiums or any part thereof is paid or is to be paid in whole or in part by an employer pursuant to the terms of a collective bargaining agreement . . . .

Revised Law

Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE DURING LABOR DISPUTE REQUIRED FOR CERTAIN POLICIES. An insurer may not deliver or issue for delivery a policy subject to this subchapter unless the policy provides that if the employees covered by the policy stop work because of a labor dispute, coverage continues under the policy, on timely payment of the premium, for each employee who:

(1) is covered under the policy on the date the work stoppage begins;

(2) continues to pay the employee's individual contribution, subject to the conditions provided by this subchapter; and

(3) assumes and pays during the work stoppage the contribution due from the employer, subject to the conditions

provided by this subchapter. (V.T.I.C. Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

Source Law

> Art. 3.51-8. No group accident and health insurance policy shall be delivered or issued for delivery . . . unless the policy provides that in the event of a cessation of work by the employees covered by the policy as the result of a labor dispute, the policy upon timely payment of the premium shall continue in effect with respect to all employees insured by the policy on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer for the period of cessation of work, under the following conditions:
>
> . . .

Revised Law

Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE. (a) An employee's contribution for purposes of a policy as to which the policyholder is a trustee or the trustees of a fund established or maintained wholly or partly by the employer is the amount the employee and employer would have been required to contribute to the fund for the employee if:

(1) the work stoppage had not occurred; and

(2) the agreement requiring the employer to make contributions to the fund were in effect.

(b) The policy may provide that continuation of coverage is contingent on the collection of individual contributions by the policyholder or the policyholder's agent. (V.T.I.C. Art. 3.51-8, Subdivs. (b), (c) (part).)

Source Law

> (b) If the policyholder is a trustee or the trustees of a fund established or maintained in whole or in part by the employer, the employee's contribution shall be the amount which he and his employer would have been required to contribute to the trust for such employee if (1) the cessation of work had not occurred and (2) the agreement requiring the employer to make contributions to the trust were in full force.
>
> (c) The policy may provide that the continuation of insurance is contingent upon the collection of individual contributions . . . by the policyholder or the policyholder's agent with respect to policies referred to in Subdivision (b) above.

Revised Law

Sec. 1253.054. CONTRIBUTIONS IF POLICYHOLDER IS NOT

TRUSTEE. (a) A policy as to which the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer must provide that the employee's individual contribution:

(1) is the policy rate applicable:

(A) on the date the work stoppage begins; and

(B) to an individual in the class to which the employee belongs as provided by the policy; or

(2) if the policy does not provide for a rate applicable to an individual, is an amount equal to the amount determined by dividing:

(A) the total monthly premium in effect under the policy on the date the work stoppage begins; by

(B) the total number of insureds under the policy on that date.

(b) The policy may provide that continuation of coverage under this subchapter is contingent on the collection of individual contributions by the union or unions representing the employees. (V.T.I.C. Art. 3.51-8, Subdivs. (a), (c) (part).)

Source Law

> (a) If the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer, the policy shall provide that the employee's individual contribution shall be the rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in the policy. If the policy does not provide for a rate applicable to individuals, the policy shall provide that the employee's individual contribution shall be an amount equal to the amount determined by dividing (1) the total monthly premium in effect under the policy at the date of cessation of work by (2) the total number of persons insured under the policy at such date.
>
> (c) The policy may provide that the continuation of insurance is contingent upon the collection of individual contributions by the union or unions representing the employees for policies referred to in Subdivision (a) above and . . . .

Revised Law

Sec. 1253.055. PAYMENT OF CONTRIBUTION AND PREMIUM. A policy may provide that continuation of coverage for an employee

under the policy is contingent on timely payment of:

(1) contributions by the employee; and

(2) the premium by the entity responsible for collecting the individual employee contributions. (V.T.I.C. Art. 3.51-8, Subdiv. (d).)

Source Law

> (d) The policy may provide that the continuation of insurance on each employee is contingent upon timely payment of contributions by the individual and timely payment of the premium by the entity responsible for collecting the individual contributions.

Revised Law

Sec. 1253.056. PAST DUE PREMIUM. (a) A policy may provide that the continuation of coverage is contingent on payment of any premium that:

(1) is unpaid on the date the work stoppage begins; and

(2) became due before the date the work stoppage begins.

(b) A premium described by Subsection (a) must be paid before the date the next premium becomes due under the policy. (V.T.I.C. Art. 3.51-8, Subdiv. (h).)

Source Law

> (h) The policy may provide that, if a premium is unpaid at the date of cessation of work and such premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of such premium prior to the date the next premium becomes due under the terms of the policy.

Revised Law

Sec. 1253.057. INDIVIDUAL PREMIUM RATE INCREASE. (a) A policy may provide that, during the period of a work stoppage, each individual premium rate shall be increased by an amount not to exceed 20 percent of the amount shown in the policy, or a greater percentage as approved by the commissioner, to provide sufficient compensation to the insurer to cover increased:

(1) administrative costs; and

(2) mortality and morbidity.

(b) If a policy provides for a premium rate increase in

accordance with this section, the amount of an employee's contribution must be increased by the same percentage. (V.T.I.C. Art. 3.51-8, Subdiv. (e).)

Source Law

> (e) The policy may provide that each individual premium rate shall be increased by any amount up to 20 percent, or any higher percent which may be approved by the commissioner, of that otherwise shown in the policy during the period of cessation of work in order to provide sufficient compensation to the insurer to cover increased administrative costs and increased mortality and morbidity. If the policy does provide for such an increase, this shall have the effect of increasing the employee's contribution by a like percent.

Revised Law

Sec. 1253.058. PREMIUM RATE CHANGE NOT LIMITED. (a) This subchapter does not limit any right of the insurer under a policy to increase or decrease a premium rate before, during, or after a work stoppage if the insurer would be entitled to increase the premium rate had a work stoppage not occurred.

(b) A change in a premium rate made in accordance with this section takes effect on a date that is determined by the insurer in accordance with the terms of the policy. (V.T.I.C. Art. 3.51-8, Subdiv. (f).)

Source Law

> (f) Nothing in this article shall be deemed to limit any right which the insurer may have in accordance with the terms of the policy to increase or decrease the premium rates before, during, or after such cessation of work if in fact the insurer would have had the right to increase the premium rate had the cessation of work not occurred. If such a premium rate change is made, it shall be effective, notwithstanding any other provisions of this article, on such date as the insurer shall determine in accordance with the terms of the policy.

Revised Law

Sec. 1253.059. LIMITATIONS ON CONTINUATION OF COVERAGE. This subchapter does not require the continuation of coverage under a policy for any loss of time benefits included in the policy or the continuation of other coverage for a period:

(1) longer than six months after a work stoppage occurs;

(2) beyond the time that 75 percent of the covered employees continue the coverage; or

(3) as to an individual covered employee, beyond the time that the employee takes a full-time job with another employer. (V.T.I.C. Art. 3.51-8, Subdiv. (i).)

Source Law

> (i) Nothing herein shall be deemed to require the continuation of any loss of time payments included in any such group accident and health insurance policy, nor of any other coverages beyond the time that 75 percent of the employees continue such coverage or as to any individual employee beyond the time that he takes full-time employment with another employer; nor shall anything herein be deemed to require continuation of coverage more than six months after the cessation of work.

Revised Law

Sec. 1253.060. OTHER PROVISIONS; COMMISSIONER APPROVAL REQUIRED. A policy may contain any other provision relating to continuation of policy coverage during a work stoppage that the commissioner approves. (V.T.I.C. Art. 3.51-8, Subdiv. (g).)

Source Law

> (g) The policy may contain such other provisions with respect to such continuation of insurance as the Commissioner of Insurance may approve.

CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND ACCIDENT COVERAGE

Sec. 1254.001. NOTICE OF RATE INCREASE 757

CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND ACCIDENT COVERAGE

Revised Law

Sec. 1254.001. NOTICE OF RATE INCREASE. (a) In this section, "insurer" means:

(1) a life insurance company;

(2) a health insurance company;

(3) an accident insurance company;

(4) a general casualty company;

(5) a mutual life insurance company or other mutual insurance company;

(6) a mutual or natural premium life insurance company;

(7) a Lloyd's plan;

(8) a reciprocal or interinsurance exchange;

(9) a fraternal benefit society;

(10) a local mutual aid association; or

(11) a group hospital service corporation.

(b) Not later than the 31st day before the date on which a premium rate increase takes effect on a group policy of health insurance, accident and health insurance, or life, health, and accident insurance delivered or issued for delivery in this state by an insurer, the insurer shall give written notice to the policyholder of:

(1) the amount of the increase; and

(2) the date on which the increase is to take effect.

(c) A health maintenance organization shall give notice of an increase in subscriber charges and service fees under a group contract or coverage in the same manner as is required of an insurer under Subsection (b).

(d) An insurer that issues a group policy described by Subsection (b) to a multiple employer trust shall give the notice required by that subsection to the trustee or group policyholder.

(e) The notice required by this section must be based on coverage in effect on the date of the notice.

(f) This section may not be construed to prevent an insurer or health maintenance organization, at the request of a policyholder or contract holder, from negotiating a change in benefits or rates after delivery of the notice required by this section. (V.T.I.C. Art. 3.51-10, as amended Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 3.51-10. Not less than 30 days before the date on which a premium rate increase takes effect on a group policy of health, accident and health, or life, health, and accident insurance delivered or issued for delivery in this state by a life, accident, health or

casualty insurance company, mutual life insurance company, mutual insurance company other than life, mutual or natural premium life insurance company, general casualty company, Lloyds, reciprocal or interinsurance exchange, fraternal benefit society, group hospitalization service insurer, or local mutual aid association, the insurer shall give written notice of the premium rate increase to the policyholder or in the instance of a multiple employer trust to the trustee or group policyholder of the amount of such increase and the date on which the increase is to take effect. Such notice is also required for increases in subscriber charges and service fees under group policies or contracts or coverage provided by health maintenance organizations. Notice shall be based upon coverages in effect on the date of the notice and nothing contained herein shall be construed to prevent the insurer or health maintenance organization from negotiating changes in benefits and/or rates at the request of the policyholder after the required notice has been delivered.

Revisor's Note

(1) V.T.I.C. Article 3.51-10 refers to a "group hospitalization service insurer." The term most frequently used to refer to such an entity is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "group hospitalization service insurer" to provide for consistent use of terminology throughout this code.

(2) V.T.I.C. Article 3.51-10 refers in the second sentence to "group policies or contracts or coverage provided by health maintenance organizations." The revised law omits the reference to "policies" because that term is not necessary and is not appropriately used in connection with coverage provided by a health maintenance organization. Similarly, the third sentence of V.T.I.C. Article 3.51-10 refers to the authority of an insurer or health maintenance organization to negotiate changes in benefits or rates at the request of "the policyholder." The revised law adds a reference to "contract holder" to reflect the appropriate term used in connection with coverage provided by a health

maintenance organization.

[Chapters 1255-1270 reserved for expansion]

SUBTITLE C. MANAGED CARE

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CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS; EVIDENCE OF COVERAGE; CHARGES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1271.001. APPLICABILITY OF DEFINITIONS. In this chapter, terms defined by Section 843.002 have the meanings assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 20A.01B. In this Act, terms defined by Section 843.002, Insurance Code, have the meanings assigned by that section.

Revised Law

Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE. (a) Each enrollee residing in this state is entitled to evidence of coverage under a health care plan.

(b) The health maintenance organization shall issue the evidence of coverage, except as provided by Subsection (c).

(c) If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. (V.T.I.C. Art. 20A.09, Secs. (a), as amended Acts 75th Leg., R.S., Ch. 905; (a)(1), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

Art. 20A.09. (a) [as amended Acts 75th Leg., R.S., Ch. 905] Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

Art. 20A.09. (a)(1) [as amended Acts 75th Leg., R.S., Ch. 1026] Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

Revised Law

Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE POLICY. An evidence of coverage is not a health insurance policy as that term is defined by this code. (V.T.I.C. Art. 20A.09, Secs. (o), as amended Acts 75th Leg., R.S., Ch. 905; (g), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(o) [as amended Acts 75th Leg., R.S., Ch. 905] Evidence of coverage does not constitute a health insurance policy as that term is defined by the Insurance Code.

(g) [as amended Acts 75th Leg., R.S., Ch. 1026] Evidence of coverage does not constitute a health insurance policy as that term is defined by the Insurance Code.

Revised Law

Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN. (a) In this section, "individual health care plan" means a health care plan:

(1) that provides health care services for individuals and their dependents;

(2) under which an enrollee:

(A) pays the premium; and

(B) is not covered under the contract in accordance with a continuation of services or continuation of benefits requirement applicable under federal or state law; and

(3) in which the evidence of coverage meets the requirements of the definition of "basic health care services" provided by Section 843.002.

(b) A health maintenance organization may provide an individual health care plan in accordance with this section and Section 1271.307.

(c) A health maintenance organization may limit enrollment in an individual health care plan to individuals who reside or work within the service area for the plan's network.

(d) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 20A.09, Sec. (l) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

> (l) Individual Health Care Plan. A health maintenance organization may provide an individual health care plan as required by this subsection.
>
> (A) For purposes of this subsection, an "individual health care plan" means:
>
> (1) a health care plan providing health care services for individuals and their dependents;
>
> (2) a health care plan in which an enrollee pays the premium and is not being covered under the contract pursuant to continuation of services and benefits provisions applicable under federal or state law; and
>
> (3) a plan in which the evidence of coverage meets the requirements of Section 2(a) of this Act.
>
> (B) A health maintenance organization may limit its enrollees to those who live, reside, or work within the service area for such network plan.
>
> . . .
>
> (D) The commissioner may adopt rules necessary to implement this subsection and to meet the minimum requirements of federal law and regulations.

Revisor's Note

(1) Section (l)(A)(3), V.T.I.C. Article 20A.09, as added by Chapter 837, Acts of the 75th Legislature, Regular Session, 1997, refers to "a plan in which the evidence of coverage meets the requirements of Section 2(a) of this Act," meaning Section 2(a) of the Texas Health Maintenance Organization Act (Section (a), V.T.I.C. Article 20A.02). At the time of revision in 1999, Section 2(a), revised as Section 843.002(1) of this code, defined the term "adverse determination." However, at the time Chapter 837 was enacted, Section 2(a) defined the term "basic health care services." In context, it is clear that the legislature intended to refer to the definition of "basic health care

services." The revised law accordingly references that definition.

(2) Section (l)(B), V.T.I.C. Article 20A.09, as added by Chapter 837, Acts of the 75th Legislature, Regular Session, 1997, refers to enrollees who "live, reside, or work within the service area." Throughout this chapter, the revised law omits "live" because in this context it is included within the meaning of "reside."

Revised Law

Sec. 1271.005. APPLICABILITY OF OTHER LAW. (a) Chapters 1368 and 1652 apply to a health maintenance organization other than a health maintenance organization that offers only a single health care service plan.

(b) Subchapter B, Chapter 1355, applies to a health maintenance organization providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that:

(1) Subchapter B, Chapter 1355, does not conflict with this chapter, Chapter 843, or Subchapter A, Chapter 1452; and

(2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the service area of the health maintenance organization and is subject to inspection and review as required by this chapter, Chapter 843, or Subchapter A, Chapter 1452, or rules adopted under this chapter, Chapter 843, or Subchapter A, Chapter 1452.

(c) A health maintenance organization shall comply with Subchapter B, Chapter 542, with respect to prompt payment to an enrollee.

(d) Notwithstanding any other law, Subchapter C, Chapter 1355, applies to a group contract issued by a health maintenance organization.

(e) Notwithstanding any other law, Section 1201.062 applies to an evidence of coverage issued by a health maintenance

organization. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part); Art. 3.70-2, Secs. (F) (part), (L) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027; Art. 20A.09, Secs. (n), (p), (q), as amended Acts 75th Leg., R.S., Ch. 905; (e), (f), (h), (i), as amended Acts 75th Leg., R.S., Ch. 1026; Art. 20A.09Z.)

Source Law

[Art. 3.70-1]

(5) [The Board shall adopt rules and regulations establishing minimum standards for benefits for long-term care coverage under . . .] under policies and evidences of coverages delivered or issued for delivery in this state by health maintenance organizations under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

[Art. 3.70-2]

(F) A . . . group policy issued by a company subject to . . . Chapter 20A, Texas Insurance Code, that provides coverage . . . [if such coverage is offered by or negotiated with such] . . . health maintenance organization; . . . .

(L) [as amended Acts 77th Leg., R.S., Ch. 396] An . . . evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), ...

(L) [as amended Acts 77th Leg., R.S., Ch. 1027] An . . . evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), ...

[Art. 20A.09, as amended Acts 75th Leg., R.S., Ch. 905]

(n) Articles 3.51-9 and 3.74, Insurance Code, and Section 1(F)(5), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1(F)(5), Vernon's Texas Insurance Code), apply to health maintenance organizations other than those health maintenance organizations offering only a single health care service plan.

(p) Article 3.72 of the Insurance Code applies to health maintenance organizations to the extent that such article is not in conflict with this Act and to the extent that the residential treatment center or crisis stabilization unit is located within the service area of the health maintenance organization and subject to such inspection and review as required by this Act or the rules hereunder.

(q) Article 21.55, Insurance Code, applies to out-of-area or emergency claims for which benefits are not assigned or payment is not made directly to the physician or provider.

[Art. 20A.09, as amended Acts 75th Leg., R.S., Ch. 1026]

(e) Article 3.74 of the Texas Insurance Code applies to health maintenance organizations other than

those health maintenance organizations offering only a single health care service plan.

(f) Article 3.51-9 of the Texas Insurance Code applies to health maintenance organizations other than those health maintenance organizations offering only a single health care service plan.

(h) Article 3.70-1(F)(5) of the Insurance Code applies to health maintenance organizations other than those health maintenance organizations offering only a single health care service plan.

(i) Article 3.72 of the Insurance Code applies to health maintenance organizations to the extent that such article is not in conflict with this Act and to the extent that the residential treatment center or crisis stabilization unit is located within the service area of the health maintenance organization and subject to such inspection and review as required by this Act or the rules hereunder.

Art. 20A.09Z. A health maintenance organization shall comply with Article 21.55 of the Insurance Code with respect to prompt payment to enrollees.

Revisor's Note

(1) Section (q), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, states that Article 21.55, Insurance Code, applies to certain claims for which benefits are not assigned and for which payment is not made directly to the physician or provider. V.T.I.C. Article 20A.09Z (formerly Section (j), V.T.I.C. Article 20A.09, as amended by Section 7, Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997), states that Article 21.55, Insurance Code, applies with respect to prompt payment to enrollees.

The amendment to Section (q) made by Chapter 905 only corrected a deficient citation without changing the substantive language of the section. Section 7, Chapter 1026, amended the substantive language of the same provision by substituting a requirement that Article 21.55, Insurance Code, apply with respect to prompt payment to enrollees.

Section 312.014, Government Code, provides that in this circumstance the amendment to the statute that substantively changed the language of the statute

prevails over the amendment that only reenacted existing language without substantive change. The revised law accordingly gives effect to the Chapter 1026 substantive amendment.

(2) Section (p), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (i), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, provide that V.T.I.C. Article 3.72 (revised as Subchapter B, Chapter 1355, of this code), which requires a group policy of accident and health insurance to provide coverage for mental health treatment in a residential treatment center or crisis stabilization unit, applies to a health maintenance organization to the extent that it does not conflict with the Texas Health Maintenance Organization Act (V.T.I.C. Chapter 20A) and to the extent that the residential treatment center or crisis stabilization unit is subject to inspection and review as required by that act. A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1272, which deals with delegated networks; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Because the issues of taxes, delegated networks, and childhood immunization coverage are

irrelevant to whether a requirement to provide coverage for certain mental health treatment applies to a health maintenance organization, and because the chapters dealing with those issues do not impose requirements relating to the inspection and review of treatment facilities, the revised law refers only to this chapter, Chapter 843, and Subchapter A, Chapter 1452, of this code.

Revised Law

Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND GRANDCHILD. (a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, is 25 years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

(b) A health maintenance organization may provide benefits under a health care plan to an enrollee's dependent grandchild who is living with and in the household of the enrollee. (V.T.I.C. Art. 20A.09H, Sec. (a), as redesignated and amended Acts 77th Leg., R.S., Ch. 396; Art. 20A.09H, as redesignated and amended Acts 77th Leg., R.S., Ch. 1027.)

Source Law

Art. 20A.09H. [as redesignated and amended Acts 77th Leg., R.S., Ch. 396] (a) A health maintenance organization may provide benefits under a health care plan to a dependent grandchild of an enrollee when the dependent grandchild is less than 21 years old and living with and in the household of the enrollee.

Art. 20A.09H. [as redesignated and amended Acts 77th Leg., R.S., Ch. 1027] (a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, is 25 years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

(b) A health maintenance organization may provide benefits under a health care plan to a dependent grandchild of an enrollee who is living with and in the household of the enrollee.

Revisor's Note

V.T.I.C. Article 20A.09H was amended by Chapters

396 and 1027, Acts of the 77th Legislature, Regular Session, 2001.

Chapter 396 amended the article to provide that a grandchild of an enrollee is a dependent, regardless of whether the enrollee treats the grandchild as a dependent for federal income tax purposes. Chapter 1027 amended the article to increase the age of an eligible grandchild from 21 to 25 years, and the revised law reflects that change. Chapter 1027 also, however, amended Section (L), V.T.I.C. Article 3.70-2, which applies to an evidence of coverage issued by a health maintenance organization and which must be read in conjunction with Article 20A.09H. Section (L), as amended by Chapter 1027, provides that a grandchild may receive coverage only if the grandchild is a dependent of the enrollee for federal income tax purposes at the time application for coverage is made.

It is impossible to give effect to both amendments made by Chapters 396 and 1027 regarding the issue of whether a grandchild is required to be a dependent for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, which apply to this revision, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Therefore, the amendment made by Chapter 1027 requiring a grandchild to be a dependent for federal income tax purposes impliedly repealed the amendment adopted under Chapter 396 providing that a grandchild

is a dependent, regardless of whether the grandchild is treated as a dependent for federal income tax purposes. The revised law accordingly omits the amendment adopted under Chapter 396. The omitted law reads:

> (b) For purposes of this section, a grandchild of an enrollee is a dependent, regardless of whether the enrollee treats the grandchild as a dependent for federal income tax purposes.

Revised Law

Sec. 1271.007. RELIGIOUS CONVICTIONS. (a) This chapter, Chapters 843, 1272, and 1367, and Subchapter A, Chapter 1452, do not require a health maintenance organization, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates the religious convictions of the health maintenance organization, physician, or provider.

(b) A health maintenance organization that limits or denies health care services under this section shall state the limitations in the evidence of coverage as required by Section 1271.052. (V.T.I.C. Art. 20A.09, Sec. (m), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (m) Nothing in this Act shall require a health maintenance organization, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates its religious convictions. A health maintenance organization that limits or denies health care services under this subsection shall set forth such limitations in the evidence of coverage as required by Section 9(a)(3) of this Act.

Revisor's Note

Section (m), V.T.I.C. Article 20A.09, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, provides that the Texas Health Maintenance Organization Act (V.T.I.C. Chapter 20A) does not require a health maintenance organization,

physician, or provider to engage in certain activities that violate the religious convictions of the organization, physician, or provider. A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1272, which deals with delegated networks; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Because the issue of taxes is irrelevant to whether an activity violates the religious convictions of a health maintenance organization, physician, or provider, the revised law does not refer to Chapter 222 or 258 of this code.

[Sections 1271.008-1271.050 reserved for expansion]

SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

Revised Law

Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND CERTIFICATE REQUIREMENTS. (a) An evidence of coverage that is a contract must contain a clear and complete statement of the information required by Sections 1271.052, 1271.053, and 1271.054.

(b) An evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by Sections 1271.052, 1271.053, and 1271.054. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably

complete facsimile, if a certificate, of:

. . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026]

. . .

(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:

. . .

Revised Law

Sec. 1271.052. INFORMATION ABOUT BENEFITS AND LIMITATIONS. An evidence of coverage must state:

(1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan; and

(3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] [Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

(1) the medical, health care services, limited health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or co-payment feature;

. . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026]

. . .

[(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

(i) the medical, health care services, limited health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(ii) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or co-payment feature;

. . .

Revisor's Note

Section (e)(1), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (a)(3)(B)(i), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refer to "medical [and] health care services." Throughout this chapter, the revised law omits references to "medical" or "medical care" in this context as unnecessary because Section 843.002 of this code includes medical care within the definition of "health care services."

Revised Law

Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES. An evidence of coverage must indicate where and in what manner information is available about how to obtain services. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] [Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(3) where and in what manner information is available as to how services may be obtained; and

. . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . .

[(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(iii) where and in what manner information is available as to how services may be obtained; and

. . .

Revised Law

Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) An evidence of coverage must contain a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including:

(1) the enrollee's right to appeal denial of an adverse determination to an independent review organization; and

(2) the procedures for appealing to an independent review organization.

(b) A health maintenance organization may indicate a subsequent change to the methods for resolving enrollee complaints in a separate document issued to the enrollee. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] [Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(4) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to appeal denials of an adverse determination, as that term is defined by Section 12A of this Act, to an independent review organization and the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . .

[(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(iv) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to appeal denials of an adverse determination, as that term is defined by Section 12A of this Act, to an independent review organization and

the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee;

. . .

Revisor's Note

Section (e)(4), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (a)(3), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refer to an adverse determination, "as that term is defined by Section 12A of this Act." The revised law omits the reference to the definition in Section 12A, Texas Health Maintenance Organization Act, because the relevant part of that section is revised in Section 843.002 of this code, and Section 1271.001 states that in this chapter, terms defined by Section 843.002 have the meanings assigned by that section.

Revised Law

Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence of coverage must contain a provision regarding non-network physicians and providers in accordance with the requirements of this section.

(b) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider and within a reasonable period, shall:

(1) allow referral to a non-network physician or provider; and

(2) fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

(c) Before denying a request for a referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested. (V.T.I.C. Art. 20A.09, Secs. (d), (f), as

amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

[Art. 20A.09, as amended Acts 75th Leg., R.S., Ch. 905]

(d) Each evidence of coverage must contain provisions regarding the requirements adopted under Subsections (e)-(i) of this section.

(f) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the usual and customary or an agreed rate. The evidence of coverage must provide for a review by a specialist of the same specialty or a similar specialty as the type of physician or provider to whom a referral is requested before the health maintenance organization may deny a referral.

[Art. 20A.09, Sec. (a), as amended Acts 75th Leg., R.S., Ch. 1026]

[(3) An evidence of coverage shall contain:]

. . .

(C) a provision that, if medically necessary covered services are not available through network physicians or providers, the health maintenance organization must, on the request of a network physician or provider, within a reasonable time period allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the usual and customary or an agreed rate; each contract must further provide for a review by a specialist of the same, or a similar, specialty as the physician or provider to whom a referral is requested before the health maintenance organization may deny a referral;

. . .

Revised Law

Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS AND STATEMENTS PROHIBITED. An evidence of coverage may not contain a provision or statement that:

(1) is unjust, unfair, inequitable, misleading, or deceptive;

(2) encourages misrepresentation; or

(3) is untrue, misleading, or deceptive within the meaning of Section 843.204. (V.T.I.C. Art. 20A.09, Secs. (c), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(c) [as amended Acts 75th Leg., R.S., Ch. 905] An evidence of coverage may not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026]

. . .

(3) An evidence of coverage shall contain:

(A) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act;

. . .

[Sections 1271.057-1271.100 reserved for expansion]

SUBCHAPTER C. COMMISSIONER APPROVAL

Revised Law

Sec. 1271.101. APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT. (a) An evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner.

(b) Except as provided by Subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of Section 1271.102.

(c) If the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. However, Subchapters B and E apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E. (V.T.I.C. Art. 20A.09, Secs. (b), (j), as amended Acts 75th Leg., R.S., Ch. 905; (a)(2), (5), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

[Art. 20A.09, as amended Acts 75th Leg., R.S., Ch. 905]

(b) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(j) Any form of the evidence of coverage or group contract to be used in this state, and any amendments thereto, are subject to the filing and approval requirements of Subsection (l) of this section, unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or group hospital service corporations, in which event the filing and approval provisions of such law shall apply. To the extent, however, that such provisions do not apply to the requirements of Subsections (c)-(i) of this section, the requirements of those subsections apply.

[Art. 20A.09, Sec. (a), as amended Acts 75th Leg., R.S., Ch. 1026]

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(5) Any form of the evidence of coverage or group contract to be used in this state, and any amendments thereto, are subject to the filing and approval requirements of Subsection (c) of this section, unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or group hospital service corporations, in which event the filing and approval provisions of such law shall apply. To the extent, however, that such provisions do not apply to the requirements of Subdivision (3) of this subsection, the requirements of Subdivision (3) shall be applicable.

Revised Law

Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL OF APPROVAL. (a) The commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of this chapter.

(b) If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The commissioner may, by written notice, extend the period for approval or disapproval as necessary for proper consideration of the filing for not more than an additional 30 days.

(c) If the commissioner disapproves a form, the commissioner shall notify the person who filed the form of the

reason for the disapproval.

(d) A hearing on the disapproval of a form shall be granted not later than the 30th day after the date the person filing the form makes a written request for a hearing. (V.T.I.C. Art. 20A.09, Secs. (l) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (l) [as amended Acts 75th Leg., R.S., Ch. 905] The commissioner shall, within a reasonable period, approve any form of the evidence of coverage or group contract, or amendment thereto, if the requirements of this section are met. . . . If the commissioner disapproves such form, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reason for the disapproval. A hearing shall be granted within 30 days after a request in writing by the person filing. If the commissioner does not disapprove any form within 30 days after the filing of such form it shall be considered approved; provided that the commissioner may by written notice extend the period for approval or disapproval of any filing for such further time, not exceeding an additional 30 days, as necessary for proper consideration of the filing.

> (c) [as amended Acts 75th Leg., R.S., Ch. 1026] The commissioner shall, within a reasonable period, approve any form of the evidence of coverage or group contract, or amendment thereto, if the requirements of this section are met. . . . If the commissioner disapproves such form, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reason for the disapproval. A hearing shall be granted within 30 days after a request in writing by the person filing. If the commissioner does not disapprove any form within 30 days after the filing of such form it shall be considered approved; provided that the commissioner may by written notice extend the period for approval or disapproval of any filing for such further time, not exceeding an additional 30 days, as necessary for proper consideration of the filing.

Revised Law

Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM. (a) After notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates this chapter, Chapter 843, 1272, or 1367, or Subchapter A, Chapter 1452, or a rule adopted by the commissioner.

(b) If the commissioner withdraws approval of a form under this section, the form may not be issued until it is approved.

(V.T.I.C. Art. 20A.09, Secs. (l) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (l) [as amended Acts 75th Leg., R.S., Ch. 905] . . . After notice and hearing, the commissioner may withdraw previous approval of any form, if the commissioner determines that it violates or does not comply with this Act or a rule adopted by the commissioner. It shall be unlawful to issue such form until approved. . . .
>
> (c) [as amended Acts 75th Leg., R.S., Ch. 1026] . . . After notice and opportunity for hearing, the commissioner may withdraw previous approval of any form, if the commissioner determines that it violates or does not comply with this Act or a rule adopted by the commissioner. It shall be unlawful to issue such form until approved. . . .

Revisor's Note

(1) In 1997, Section (c), V.T.I.C. Article 20A.09, was amended by Chapters 905 and 1026, Acts of the 75th Legislature, Regular Session. Chapter 905 relettered Section (c) as Section (l) and corrected a reference to the State Board of Insurance without changing the substantive language of the section. Chapter 1026 also corrected the State Board of Insurance reference and, in addition, amended the substantive language of the section by requiring an "opportunity for hearing" instead of a "hearing" before the commissioner of insurance may withdraw certain approvals. Section 312.014, Government Code, provides that in this circumstance the amendment to the statute that substantively changed the language of the statute prevails over the amendment that only reenacted existing language without substantive change. The revised law accordingly gives effect to the Chapter 1026 substantive amendment.

(2) Section (l), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (c), V.T.I.C.

Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refer to a form that "violates or does not comply with this Act." The revised law omits the references to "does not comply with" as unnecessary because "does not comply with" is included within the meaning of "violates."

(3) Section (l), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (c), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, provide that the commissioner of insurance may withdraw the commissioner's approval of the form of certain documents if the commissioner determines that the form violates the Texas Health Maintenance Organization Act (V.T.I.C. Chapter 20A). A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1272, which deals with delegated networks; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Because the issue of taxes is irrelevant to the commissioner's determination regarding the form of a document, the revised law does not refer to Chapter 222 or 258 of this code.

Revised Law

Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information

the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter. (V.T.I.C. Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905; (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(m) [as amended Acts 75th Leg., R.S., Ch. 905] The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(d) [as amended Acts 75th Leg., R.S., Ch. 1026] The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

[Sections 1271.105-1271.150 reserved for expansion]

SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

Revised Law

Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES. A health maintenance organization that offers a basic health care plan shall provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner. (V.T.I.C. Art. 20A.09, Sec. (l), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(l) A health maintenance organization that offers a basic health care plan shall provide or arrange for the provision of basic health care services to its enrollees as needed and without limitations as to time and cost other than limitations prescribed by rule of the commissioner.

Revised Law

Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE SERVICES. The commissioner may adopt minimum standards relating to basic health care services. (V.T.I.C. Art. 20A.09, Sec. (n), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(n) The commissioner may adopt minimum standards relating to basic health care services.

Revised Law

Sec. 1271.153. PERIODIC HEALTH EVALUATIONS. (a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.

(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Subchapter F, Chapter 1451.

(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan. (V.T.I.C. Art. 20A.09B.)

Source Law

Art. 20A.09B. (a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.

(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Article 21.53D of this code, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997.

(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Revised Law

Sec. 1271.154. WELL-CHILD CARE FROM BIRTH. (a) In this section, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments. The term includes newborn screening required by the Texas Department of Health.

(b) A health maintenance organization shall ensure that each health care plan provided by the health maintenance organization includes well-child care from birth that complies with:

(1) federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments; and

(2) the rules adopted by the Texas Department of Health to implement those requirements. (V.T.I.C. Art. 20A.09E.)

Source Law

Art. 20A.09E. (a) In this Act, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments, and includes newborn screening required by the Texas Department of Health.

(b) Each health maintenance organization shall ensure that each health care plan provided by the organization includes well-child care from birth that complies with the federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and the rules adopted by the Texas Department of Health to implement those requirements.

Revised Law

Sec. 1271.155. EMERGENCY CARE. (a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate.

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and

(3) services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d).

(c) A health maintenance organization shall approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

(d) A health maintenance organization shall respond to inquiries from a treating physician or provider in compliance with this provision in the health care plan of the health maintenance organization.

(e) A health care plan of a health maintenance organization shall comply with this section regardless of whether the physician or provider furnishing the emergency care has a contractual or other arrangement with the health maintenance organization to provide items or services to covered enrollees. (V.T.I.C. Art. 20A.09Y, as added Acts 77th Leg., R.S., Ch. 1419.)

Source Law

> Art. 20A.09Y. A health maintenance organization shall pay for emergency care services performed by non-network physicians or providers at the negotiated or usual and customary rate and that the health care plan contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement with the entity to provide items or services to covered individuals, the following provisions and procedures for coverage of emergency care services:
>
> (1) any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists will be provided to covered enrollees in a hospital emergency facility or comparable facility;
>
> (2) necessary emergency care services will be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and
>
> (3) services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition will be provided to covered enrollees as approved by the health maintenance organization, provided that the health maintenance organization is required to approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from the time of the request; the health maintenance organization must respond to inquiries from the treating physician or provider in compliance with this provision in the health maintenance organization's plan.

Revised Law

Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND THERAPIES. (a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision

of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

(b) For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration. (V.T.I.C. Art. 20A.09, Sec. (a)(4), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (4) If an evidence of coverage provides benefits for rehabilitation services and therapies, the provision of those services and therapies that, in the opinion of a physician, are medically necessary may not be denied, limited, or terminated if they meet or exceed treatment goals for the enrollee. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

[Sections 1271.157-1271.200 reserved for expansion]

SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN FOR CERTAIN ENROLLEES

Revised Law

Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY CARE PHYSICIAN. (a) An evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

(b) The application must:

(1) include information specified by the health maintenance organization, including certification of the medical need; and

(2) be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's primary care physician.

(c) To be eligible to serve as the enrollee's primary care physician, a physician specialist must:

(1) meet the health maintenance organization's

requirements for primary care physician participation; and

(2) agree to accept the responsibility to coordinate all of the enrollee's health care needs. (V.T.I.C. Art. 20A.09, Secs. (d), (g), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

[Art. 20A.09, as amended Acts 75th Leg., R.S., Ch. 905]

(d) Each evidence of coverage must contain provisions regarding the requirements adopted under Subsections (e)-(i) of this section.

(g) An enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician. An application made by an enrollee under this subsection must include information specified by the health maintenance organization, including certification of the medical need, and must be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's primary care physician. To be eligible to serve as the enrollee's primary care physician, the specialist must:

(1) meet the health maintenance organization's requirements for primary care physician participation; and

(2) be willing to accept the coordination of all of the enrollee's health care needs.

[Art. 20A.09, Sec. (a), as amended Acts 75th Leg., R.S., Ch. 1026]

[(3) An evidence of coverage shall contain:]

. . .

(D) a provision to allow enrollees with chronic, disabling, or life-threatening illnesses to apply to the health maintenance organization's medical director to utilize a nonprimary care physician specialist as a primary care physician, provided that:

(i) the request includes information specified by the health maintenance organization, including certification of medical need, and is signed by the enrollee and the nonprimary care physician specialist interested in serving as the primary care physician;

(ii) the nonprimary care physician specialist meets the health maintenance organization's requirements for primary care physician participation; and

(iii) the nonprimary care physician specialist is willing to accept the coordination of all of the enrollee's health care needs;

. . .

Revised Law

Sec. 1271.202. APPEAL. If a health maintenance

organization denies a request under Section 1271.201, the enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process. (V.T.I.C. Art. 20A.09, Secs. (h), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(h) [as amended Acts 75th Leg., R.S., Ch. 905] If the request for special consideration described by Subsection (g) is denied, an enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . .

(3) . . .

(E) a provision that if the request for special consideration specified in Paragraph (D) of this subdivision is denied, an enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process; and

. . .

Revised Law

Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION. (a) The effective date of the designation of a nonprimary care physician specialist as an enrollee's primary care physician under Section 1271.201 may not be applied retroactively.

(b) A health maintenance organization may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation. (V.T.I.C. Art. 20A.09, Secs. (i), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(i) [as amended Acts 75th Leg., R.S., Ch. 905] The effective date of the designation of a nonprimary care physician specialist as an enrollee's primary care physician, as provided by Subsection (g) of this section, may not be applied retroactively. The health maintenance organization may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . .

(3) . . .

(F) a provision that the effective date of the new designation of a nonprimary care physician specialist as set out in Paragraph (D) of

this subdivision shall not be retroactive; the health maintenance organization may not reduce the amount of compensation owed to the original primary care physician prior to the date of the new designation.

[Sections 1271.204-1271.250 reserved for expansion]

SUBCHAPTER F. SCHEDULE OF CHARGES

Revised Law

Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR COMPUTING SCHEDULE OF CHARGES. (a) The formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan.

(b) The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. The filing of the method or formula must contain:

(1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and

(2) supporting information that the commissioner considers adequate.

(c) The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory. Benefits must be reasonable with respect to the rates produced by the formula or method. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(k) [as amended Acts 75th Leg., R.S., Ch. 905] The formula or method for calculating the schedule of charges for enrollee coverage for medical services or health care services must be filed with the commissioner before it is used in conjunction with any health care plan. The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. . . . The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and benefits must be reasonable with respect to the rates produced by the formula or method. A statement by a qualified actuary that certifies the appropriateness of the formula or method must accompany the filing together with supporting information considered adequate by the commissioner.

(b) [as amended Acts 75th Leg., R.S., Ch. 1026] The formula or method for calculating the schedule of

charges for enrollee coverage for medical services or health care services must be filed with the commissioner before it is used in conjunction with any health care plan. The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. . . . The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and benefits must be reasonable with respect to the rates produced by the formula or method. A statement by a qualified actuary that certifies the appropriateness of the formula or method must accompany the filing together with supporting information considered adequate by the commissioner.

Revised Law

Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH STATUS PROHIBITED. The charges resulting from the application of a formula or method described by Section 1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(k) [as amended Acts 75th Leg., R.S., Ch. 905] . . . The charges resulting from the application of the formula or method may not be altered for an individual enrollee based on the status of that enrollee's health. . . .

(b) [as amended Acts 75th Leg., R.S., Ch. 1026] . . . The charges resulting from the application of the formula or method may not be altered for an individual enrollee based on the status of that enrollee's health. . . .

Revised Law

Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter. (V.T.I.C. Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905; (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(m) [as amended Acts 75th Leg., R.S., Ch. 905] The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(d) [as amended Acts 75th Leg., R.S., Ch. 1026]

The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

[Sections 1271.254-1271.300 reserved for expansion]

SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION CONTRACTS, AND RENEWAL

Revised Law

Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP COVERAGE. (a) In this section, "involuntary termination for cause" does not include termination for any health-related reason.

(b) A health maintenance organization shall provide a group coverage continuation privilege as required by and subject to the eligibility provisions of this subchapter.

(c) An enrollee is entitled to continue group coverage as provided by this subchapter if:

(1) the enrollee's coverage under a group contract is terminated for any reason except involuntary termination for cause; and

(2) the enrollee for at least three consecutive months immediately before the termination of coverage has been continuously covered under the group contract and under any previous group contract providing similar services and benefits that the current group contract replaced. (V.T.I.C. Art. 20A.09, Sec. (k)(A) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(k) Continuation of Coverage and Conversion. (A) A health maintenance organization shall provide a group continuation privilege as required by this subsection. Any enrollee whose coverage under the group contract has been terminated for any reason except involuntary termination for cause, and who has been continuously insured under the group contract and under any group contract providing similar services and benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to such privilege as outlined below. Involuntary termination for cause does not include termination for any health-related cause. Health maintenance organization contracts subject to this section shall provide continuation of group coverage for enrollees subject to the eligibility provisions below:

. . .

Revised Law

Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE; DEADLINE. An enrollee must make a written election to continue group coverage under this subchapter and pay the first contribution required to establish contributions on an advance monthly basis to the employer or group contract holder not later than the 31st day after the later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the enrollee is given notice of the right of continuation by the employer or group contract holder. (V.T.I.C. Art. 20A.09, Secs. (k)(A)(1), (3), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(1) Continuation of group coverage must be requested in writing within 31 days following the later of: (aa) the date the group coverage would otherwise terminate; or (bb) the date the enrollee is given notice of the right of continuation by either the employer or the group contract holder.

(3) The enrollee's written election of continuation, together with the first contribution required to establish contributions on a monthly basis, in advance, must be given to the contract holder or employer within 31 days following the later of: (aa) the date the group coverage would otherwise terminate; or (bb) the date the enrollee is given notice of the right of continuation by either the employer or the group contract holder.

Revised Law

Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE. (a) An enrollee electing continuation of group coverage must pay to the employer or group contract holder the amount of contribution required by the employer or group contract holder, plus an amount equal to two percent of the group rate for the coverage being continued under the group contract.

(b) The enrollee must make the payment in advance on a monthly basis on the due date of each payment. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(2), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(2) An enrollee electing continuation must pay to the group contract holder or employer on a monthly basis, in advance, the amount of contribution required by the contract holder or employer, plus two percent of the group rate for the coverage being continued under the group contract, on the due date of each payment.

Revised Law

Sec. 1271.304. TERMINATION OF CONTINUED COVERAGE. Group continued coverage under this subchapter may not terminate until the earliest of:

(1) the end of the six-month period after the date the election to continue coverage is made;

(2) the date on which failure to make timely payments terminates coverage;

(3) the date on which the enrollee is covered for similar services and benefits by any other plan or program, including a hospital, surgical, medical, or major medical expense insurance policy, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(4) the date on which the group coverage terminates in its entirety. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(4), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(4) Continuation may not terminate until the earliest of: (aa) six months after the date the election is made; (bb) the date on which failure to make timely payments would terminate coverage; (cc) the date on which the covered person is covered for similar services and benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program; or (dd) the date on which the group coverage terminates in its entirety.

Revised Law

Sec. 1271.305. NOTIFICATION OF RISK POOL ELIGIBILITY. (a) At least 30 days before the end of the six-month period after the date an enrollee elects to continue group coverage, the health maintenance organization shall notify the enrollee that the enrollee may be eligible for coverage under the Texas Health

Insurance Risk Pool as provided by Chapter 1506.

(b) The health maintenance organization shall provide to the enrollee the address for applying to the pool for coverage. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(5), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

> (5) Not less than 30 days before the end of the six months after the date the enrollee elects continuation of the contract, the health maintenance organization shall notify the enrollee that he/she may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under Article 3.77, Insurance Code, and the health maintenance organization shall provide the address for applying to such pool to the enrollee.

Revised Law

Sec. 1271.306. CONVERSION CONTRACTS. (a) A health maintenance organization may offer to each enrollee a conversion contract.

(b) A health maintenance organization shall issue the conversion contract without evidence of insurability if written application for the contract and payment of the first premium are made not later than the 31st day after the date of termination of coverage.

(c) A conversion contract must meet the minimum standards for services and benefits for conversion contracts. The commissioner shall adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

(d) The premium for a conversion contract shall be determined in accordance with the health maintenance organization's premium rates for coverage provided under the group contract or plan. The premium may be based on the geographic location of each person to be covered and must be based on the type of conversion contract and the coverage provided by the contract. The premium may not exceed 200 percent of the premium rates for the same coverage provided under a group contract or plan. (V.T.I.C. Art. 20A.09, Secs. (k)(B), (C), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(B) A health maintenance organization may offer to each enrollee a conversion contract. Such conversion contract shall be issued without evidence of insurability if written application for and payment of the first premium is made not later than the 31st day after the date of termination. The conversion contract shall meet the minimum standards for services and benefits for conversion contracts. The commissioner shall issue rules and regulations to establish minimum standards for services and benefits under contracts issued pursuant to this subdivision.

(C) The premium for a conversion contract issued under this Act shall be determined in accordance with the health maintenance organization's premium rates for coverage that were provided under the group contract or plan. The premium may be based on geographic location of each person to be covered and the type of conversion contract and coverage provided. The premium for the same coverage under a conversion contract may not exceed 200 percent of the premium determined in accordance with this subdivision. The premium must be based on the type of conversion contract and the coverage provided by contract.

Revisor's Note

Section (k)(B), V.T.I.C. Article 20A.09, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL HEALTH CARE PLANS AND CONVERSION CONTRACTS. (a) In this section, "individual health care plan" has the meaning assigned by Section 1271.004.

(b) An individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee. A health maintenance organization may decline to renew an individual health care plan or conversion contract only:

(1) for failure to pay premiums or contributions in accordance with the terms of the plan or because the issuer of the plan has not received timely premium payments;

(2) for fraud or intentional misrepresentation;

(3) because the health maintenance organization ceases to offer coverage in the individual market in accordance with rules established by the commissioner;

(4) because the enrollee no longer resides or works in the area in which the health maintenance organization is authorized to provide coverage, if coverage under the plan is terminated uniformly for this reason without regard to any factor related to the health status of a covered enrollee; or

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

(c) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 20A.09, Sec. (l) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(l) . . .

(A) For purposes of this subsection, an "individual health care plan" means:

(1) a health care plan providing health care services for individuals and their dependents;

(2) a health care plan in which an enrollee pays the premium and is not being covered under the contract pursuant to continuation of services and benefits provisions applicable under federal or state law; and

(3) a plan in which the evidence of coverage meets the requirements of Section 2(a) of this Act.

. . .

(C) Renewability of Coverage. An individual health care plan or a conversion contract providing health care services shall be renewable with respect to an enrollee at the option of the enrollee, and may be nonrenewed based only on one or more of the following reasons:

(1) failure to pay premiums or contributions in accordance with the terms of the plan or the issuer has not received timely premium payments;

(2) fraud or intentional misrepresentation;

(3) the health maintenance organization is ceasing to offer coverage in the individual market in accordance with rules established by the commissioner;

(4) enrollee no longer resides, lives, or works in the area in which the health maintenance organization is authorized to provide coverage, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered enrollees; or

(5) in accordance with applicable federal law and regulations.

(D) The commissioner may adopt rules necessary to implement this subsection and to meet the minimum requirements of federal law and regulations.

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CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH MAINTENANCE ORGANIZATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1272.001. DEFINITIONS. (a) In this chapter:

(1) "Delegated entity" means an entity, other than a health maintenance organization authorized to engage in business under Chapter 843, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452. The term does not include:

(A) an individual physician; or

(B) a group of employed physicians, practicing medicine under one federal tax identification number, whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis.

(2) "Delegated network" means a delegated entity that assumes total financial risk for more than one of the following

categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with a health maintenance organization.

(3) "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility for performing a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration is directly or indirectly related to a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(4) "Delegation agreement" means an agreement by which a health maintenance organization assigns the responsibility for a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(5) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits an enrollee's access to physicians and providers to those physicians and providers in the subnetwork.

(b) In this chapter, terms defined by Section 843.002 have the meanings assigned by that section. (V.T.I.C. Art. 20A.02, Secs. (dd), (ee), (ff), (gg), (hh); New.)

Source Law

(dd) "Delegation agreement" means an agreement by which a health maintenance organization assigns the responsibility for a function regulated under this Act.

(ee) "Delegated entity" means an entity, other than a health maintenance organization authorized to do business under this Act, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide

medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the health maintenance organization any function regulated by this Act. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to providers not employed by the group is less than 20 percent of the total collected revenue of the group calculated on a calendar year basis.

(ff) "Delegated network" means any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with a health maintenance organization.

(gg) "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(1) accept responsibility to perform any function regulated by this Act; or

(2) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by this Act.

(hh) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits the physicians and providers to which the enrollees have access to physicians and providers in the subnetwork.

Revisor's Note

(1) This chapter is derived from V.T.I.C. Articles 20A.02, 20A.18C, 20A.18D, 20A.18E, 20A.18F, and 20A.18G, which are parts of the Texas Health Maintenance Organization Act. Most provisions of the Texas Health Maintenance Organization Act, including the definitional provisions that apply throughout the act, are revised in Chapter 843 of this code. Accordingly, this chapter includes a reference to the applicability of the definitions provided by Section 843.002 of this code.

(2) Sections (dd), (ee), and (gg), V.T.I.C. Article 20A.02, refer to any "function regulated under this Act" or any "function regulated by this Act," meaning any function regulated under the Texas Health

Maintenance Organization Act (V.T.I.C. Chapter 20A). A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1271, which deals with various benefits provided by health maintenance organizations; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Accordingly, throughout this chapter the revised law substitutes references to the specified chapters for references to "this Act." However, because the issue of taxes is irrelevant to the delegation of a function under this chapter, the revised law throughout this chapter does not refer to Chapter 222 or 258 of this code.

Revised Law

Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK OR DELEGATED ENTITY WITH CERTAIN LEGAL REQUIREMENTS. A limited provider network or delegated entity shall comply with each statutory or regulatory requirement that relates to a function assumed by or carried out by the network or entity under this chapter. (V.T.I.C. Art. 20A.18G.)

Source Law

Art. 20A.18G. A limited provider network or delegated entity shall comply with all statutory and regulatory requirements relating to any function, duty, responsibility, or delegation assumed by or carried out by the limited provider network or delegated entity under this Act.

Revisor's Note

V.T.I.C. Article 20A.18G refers to a "function, duty, responsibility, or delegation" assumed by or carried out by a limited provider network or delegated entity under "this Act," meaning the Texas Health Maintenance Organization Act. Throughout this chapter, the revised law omits as unnecessary references to a "duty, responsibility, or delegation" because, in this context, a "function" assumed by or carried out by a limited provider network or delegated entity under that act includes a duty, responsibility, or delegation assumed by or carried out by the network or entity. The revised law also substitutes a reference to "this chapter" for the reference to the Texas Health Maintenance Organization Act because the law revised in this chapter is the relevant part of that act under which a limited provider or delegated entity may assume or carry out a function of a health maintenance organization.

[Sections 1272.003-1272.050 reserved for expansion]

SUBCHAPTER B. DELEGATION AGREEMENTS

Revised Law

Sec. 1272.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Source Law

(q) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.052. DELEGATION AGREEMENT REQUIRED. (a) A health maintenance organization that delegates a function required by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452, shall execute a written delegation agreement with the

entity to which the function is delegated.

(b) The health maintenance organization shall file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

(c) The parties to the delegation agreement shall determine which party bears the expense of complying with a requirement of this subchapter, including the cost of an examination required by the department under Article 1.15, if applicable. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

> Art. 20A.18C. (a) A health maintenance organization that delegates any function required by this Act shall execute a written agreement with each delegated entity. The health maintenance organization shall file the written agreement with the Texas Department of Insurance not later than the 30th day after the date the agreement is executed. The parties to each agreement shall determine the party that will bear the expense of compliance with any requirement of this subsection, including the cost of any examinations required by the department under Article 1.15, Insurance Code, if applicable. . . .

Revisor's Note

> Section (a), V.T.I.C. Article 20A.18C, requires a health maintenance organization that delegates certain functions to execute a "written agreement" with each delegated entity. The revised law substitutes a reference to "delegation agreement" for the reference to "agreement" because "delegation agreement" is the defined term used throughout this chapter to describe the contract between a health maintenance organization and a delegated entity or other entity or party to whom the health maintenance organization delegates certain functions. Similar changes have been made throughout this chapter.

Revised Law

Sec. 1272.053. MONITORING PLAN. A delegation agreement required by Section 1272.052 must establish a monitoring plan that:

(1) allows the health maintenance organization to

monitor compliance with the minimum solvency requirements established under Subchapter D, if applicable; and

(2) includes:

(A) a description of financial practices that will ensure that the delegated entity tracks and reports liabilities that have been incurred but not reported;

(B) a summary of the total amount paid by the entity to physicians and providers on a monthly basis; and

(C) a summary of complaints from physicians, providers, and enrollees regarding delays in payment or nonpayment of claims, including the status of each complaint, on a monthly basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

(1) a monitoring plan that allows the health maintenance organization to monitor compliance with the minimum solvency requirements established under Section 18D of this Act, if applicable, and that includes:

(A) a description of financial practices that will ensure that the delegated entity tracks and reports liabilities that have been incurred but not reported;

(B) a summary of the total amount paid by the delegated entity to physicians and providers on a monthly basis; and

(C) a summary of complaints from physicians, enrollees, and providers regarding delays in payments of claims or nonpayment of claims, including the status of each complaint, on a monthly basis;

. . .

Revised Law

Sec. 1272.054. REQUIREMENTS FOR TERMINATION WITHOUT CAUSE. A delegation agreement required by Section 1272.052 must provide that the agreement cannot be terminated without cause by the delegated entity or the health maintenance organization unless the party terminating the agreement provides written notice before the 90th day before the termination date. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(2) A provision that the agreement cannot

be terminated without cause by the delegated entity or the health maintenance organization without written notice provided before the 90th day preceding the termination date;

. . .

Revised Law

Sec. 1272.055. COLLECTION OF PAYMENTS. A delegation agreement required by Section 1272.052 must prohibit the delegated entity and the physicians and providers with whom the entity has contracted from billing or attempting to collect from an enrollee under any circumstance, including the insolvency of the health maintenance organization or entity, payments for covered services other than authorized copayments and deductibles. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(3) a provision that prohibits the delegated entity and the physicians and providers with whom it has contracted from billing or attempting to collect from an enrollee under any circumstance, including the insolvency of the health maintenance organization or delegated entity, payments for covered services other than authorized copayments and deductibles;

. . .

Revised Law

Sec. 1272.056. COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS. A delegation agreement required by Section 1272.052 must provide that:

(1) the agreement does not limit in any way the health maintenance organization's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and

(2) the delegated entity shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(4) a provision that the delegation agreement may not be construed to limit in any way the

health maintenance organization's authority or responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(5) a provision that requires the delegated entity to comply with all statutory and regulatory requirements relating to any function, duty, responsibility, or delegation assumed by or carried out by the delegated entity;

. . .

Revised Law

Sec. 1272.057. EXAMINATION BY COMMISSIONER. A delegation agreement required by Section 1272.052 must require the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to:

(1) the financial solvency of the entity; or

(2) the ability of the entity to meet the entity's responsibilities in connection with any function delegated to the entity by the health maintenance organization. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(6) a provision that requires the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to:

(A) the financial solvency of the delegated entity; or

(B) the ability of the delegated entity to meet the entity's responsibilities in connection with any function delegated to the entity by the health maintenance organization;

. . .

Revised Law

Sec. 1272.058. INFORMATION RELATING TO DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires:

(1) a license as a third-party administrator under Chapter 4151 or utilization review agent under Article 21.58A; or

(2) another license under this code or another insurance law of this state. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(7) a provision that requires the delegated entity to provide the license number of any delegated third party performing any function that requires a license as a third party administrator under Article 21.07-6, Insurance Code, or a license as a utilization review agent under Article 21.58A, Insurance Code, or that requires any other license under the Insurance Code or another insurance law of this state;

. . .

Revised Law

Sec. 1272.059. CONTRACTS WITH DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must provide that:

(1) any agreement under which the delegated entity directly or indirectly delegates a function required by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452, including the handling of funds, if applicable, to a delegated third party must be in writing; and

(2) the delegated entity, in contracting with a delegated third party directly or through a third party, shall require the delegated third party to comply with the requirements of Section 1272.057 and any rules adopted by the commissioner implementing that section. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(9) a provision that requires that any agreement in which the delegated entity directly or indirectly delegates any function required by this Act, including the handling of funds, if applicable, to a delegated third party be in writing;

(10) a provision that requires the delegated entity, in contracting with a delegated third party directly or through a third party, to require the delegated third party to comply with the requirements of Subdivision (6) of this subsection and any rules adopted by the commissioner implementing that subdivision;

. . .

Revised Law

Sec. 1272.060. UTILIZATION REVIEW. A delegation agreement required by Section 1272.052 must provide that:

(1) enrollees shall receive notification at the time of enrollment of which entity is responsible for performing utilization review;

(2) the delegated entity or third party performing utilization review shall perform that review in accordance with Article 21.58A; and

(3) the delegated entity or third party shall forward utilization review decisions made by the entity or third party to the health maintenance organization on a monthly basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(8) a provision that requires that:

(A) enrollees will receive notification at the time of enrollment which entity has responsibility for performing utilization review;

(B) the delegated entity or third party performing utilization review shall do so in accordance with Article 21.58A, Insurance Code; and

(C) utilization review decisions made by the delegated entity or a third party shall be forwarded to the health maintenance organization on a monthly basis;

. . .

Revised Law

Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY AND HEALTH MAINTENANCE ORGANIZATION. A delegation agreement required by Section 1272.052 must provide that the delegated entity acknowledges and agrees that:

(1) the health maintenance organization:

(A) is required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards;

(B) is directly accountable for compliance with those standards; and

(C) is not precluded from contractually requesting that the delegated entity provide proof of financial viability;

(2) the role of another delegated entity with which the delegated entity subcontracts through a delegated third party is limited to performing certain delegated functions of the health maintenance organization, using standards that are approved by the health maintenance organization and that are in compliance with applicable statutes and rules and subject to the health maintenance organization's oversight and monitoring of the entity's performance; and

(3) if the delegated entity fails to meet monitoring standards established to ensure that functions delegated or assigned to the entity under the delegation agreement are in full compliance with all statutory and regulatory requirements, the health maintenance organization may cancel delegation of any or all delegated functions. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(11) an acknowledgment and agreement by the delegated entity that:

(A) the health maintenance organization is:

(i) required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards;

(ii) directly accountable for compliance with those standards; and

(iii) not precluded from contractually requesting that the delegated entity provide proof of financial viability;

(B) the role of any delegated entity with which it subcontracts through a delegated third party is limited to performing certain delegated functions of the health maintenance organization, using standards that are approved by the health maintenance organization and that are in compliance with applicable statutes and rules and subject to the health maintenance organization's oversight and monitoring of the delegated entity's performance; and

(C) if the delegated entity fails to meet monitoring standards established to ensure that functions delegated or assigned to the entity under the delegation contract are in full compliance with all statutory and regulatory requirements, the health maintenance organization may cancel delegation of any or all delegated functions;

. . .

Revised Law

Sec. 1272.062. INFORMATION TO BE PROVIDED BY DELEGATED

ENTITY TO HEALTH MAINTENANCE ORGANIZATION. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) except as provided by Subsection (b), the delegated entity shall make available to the health maintenance organization samples of contracts with physicians and providers to ensure compliance with the contractual requirements described by Sections 1272.054 and 1272.055; and

(2) the delegated entity shall provide to the health maintenance organization, in a format usable for audit purposes and not more frequently than quarterly unless otherwise specified in the delegation agreement, the data necessary for the health maintenance organization to comply with the department's reporting requirements with respect to any delegated functions performed under the delegation agreement, including:

(A) a summary describing the methods, including capitation, fee-for-service, or other risk arrangements, that the delegated entity used to pay the entity's physicians and providers, and including the percentage of physicians and providers paid for each payment category;

(B) the period that claims and debts for medical services owed by the delegated entity have been pending and the aggregate dollar amount of those claims and debts;

(C) information to enable the health maintenance organization to file claims for reinsurance, coordination of benefits, and subrogation, if required by the delegation agreement; and

(D) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Subchapter A, Chapter 160, Occupations Code, that relates to:

(i) a regulatory agency's inquiry or investigation of the delegated entity or an individual physician or provider with whom the entity contracts that relates to an enrollee of the health maintenance organization; and

(ii) the final resolution of a regulatory agency's inquiry or investigation.

(b) A delegation agreement may not require a delegated entity to make available to the health maintenance organization contractual provisions relating to financial arrangements with the entity's physicians and providers. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(12) a provision that requires the delegated entity to make available to the health maintenance organization samples of contracts with physicians and providers to ensure compliance with the contractual requirements described by Subdivisions (2) and (3) of this subsection, except that the agreement may not require that the delegated entity make available to the health maintenance organization contractual provisions relating to financial arrangements with the delegated entity's physicians and providers;

(13) a provision that requires the delegated entity to provide the health maintenance organization, in a usable format necessary for audit purposes and at most quarterly unless otherwise specified in the agreement, the data necessary for the health maintenance organization to comply with the department's reporting requirements with respect to any delegated functions performed under the delegation agreement, including:

(A) a summary:

(i) describing the methods, including capitation, fee-for-service, or other risk arrangements, that the delegated entity used to pay its physicians and providers; and

(ii) including the percentage of physicians and providers paid for each payment category;

(B) the period that claims and debts for medical services owed by the delegated entity have been pending and the aggregate dollar amount of those claims and debts;

(C) information that will enable the health maintenance organization to file claims for reinsurance, coordination of benefits, and subrogation, if required by the health maintenance organization's contract with the delegated entity; and

(D) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Subchapter A, Chapter 160, Occupations Code, that relates to:

(i) a regulatory agency's inquiry or investigation of the delegated entity or of an individual physician or provider with whom the delegated entity contracts that relates to an enrollee of the health maintenance organization; and

(ii) the final resolution of a regulatory agency's inquiry or investigation; and

. . .

Revised Law

Sec. 1272.063. ENROLLEE COMPLAINTS. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) if the delegated entity receives a complaint that does not involve emergency care, the entity shall report the complaint to the health maintenance organization not later than the second business day after the date the entity receives the complaint; and

(2) if the delegated entity receives a complaint involving emergency care, the entity shall immediately forward the complaint to the health maintenance organization.

(b) Subsection (a) does not prohibit a delegated entity from attempting to resolve a complaint. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(14) a provision relating to enrollee complaints that requires the delegated entity to ensure that upon receipt of a complaint, as defined by this Act, the delegated entity shall report the complaint to the health maintenance organization within two business days, except that in a case in which a complaint involves emergency care, as defined in this Act, the delegated entity shall forward the complaint immediately to the health maintenance organization, and provided that nothing in this subdivision prohibits the delegated entity from attempting to resolve a complaint.

Revisor's Note

Section (a)(14), V.T.I.C. Article 20A.18C, refers to the definitions of "complaint" and "emergency care" in the Texas Health Maintenance Organization Act. The revised law omits the references to those definitions as unnecessary because the relevant part of that act was codified as Section 843.002, which applies to this chapter. See Section 1272.001(b) and Revisor's Note (1) to that section.

Revised Law

Sec. 1272.064. RULES. The commissioner may adopt rules as

necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

Source Law

(r) The commissioner may adopt rules as necessary to implement this section.

[Sections 1272.065-1272.100 reserved for expansion]

SUBCHAPTER C. INFORMATION REPORTING TO DELEGATED ENTITY

Revised Law

Sec. 1272.101. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Source Law

(q) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.102. REPORTING REQUIRED. (a) The commissioner shall determine the information a health maintenance organization shall provide to a delegated entity with which the health maintenance organization has entered into a delegation agreement.

(b) The information must include:

(1) for each enrollee who is eligible or assigned to receive services from the delegated entity:

(A) the enrollee's name, birth date or social security number, age, and sex;

(B) the benefit plan and any riders to that plan that are applicable to the enrollee; and

(C) the enrollee's employer;

(2) the name and birth date or social security number of each enrollee added or terminated since the health maintenance organization last provided the information;

(3) if the health maintenance organization pays any claims on behalf of the delegated entity, a summary of the number and amount of:

(A) claims paid during the previous reporting period; and

(B) pharmacy prescriptions paid for each enrollee during the previous reporting period for which the delegated entity has taken partial risk;

(4) information that enables the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation;

(5) patient complaint data that relates to the delegated entity;

(6) detailed risk-pool data, reported quarterly and on settlement;

(7) if hospital or facility costs impact the delegated entity's costs, the percent of premium attributable to hospital or facility costs, reported quarterly; and

(8) if there are changes in hospital or facility contracts with the health maintenance organization, the projected impact of those changes on the percent of premium attributable to hospital and facility costs during the 30-day period following those changes.

(c) Notwithstanding Subsection (b)(3), a delegated entity may, on request, receive additional nonproprietary information regarding claims paid by a health maintenance organization on behalf of the entity.

(d) A health maintenance organization shall provide information required under Subsections (b)(1)-(5) in standard electronic format at least monthly unless the delegation agreement provides otherwise. (V.T.I.C. Art. 20A.18C, Secs. (b), (c).)

Source Law

(b) The commissioner shall determine the information that a health maintenance organization shall provide to each delegated entity with which the health maintenance organization has a delegation agreement. The information must include the following information, provided in standard electronic format at least monthly unless otherwise stated in the agreement:

(1) the names and dates of birth or social

security numbers of the enrollees of the health maintenance organization who are eligible or assigned to receive services from the delegated entity, including the enrollees added and terminated since the previous reporting period;

(2) the age, sex, benefit plan and any riders to that benefit plan, and employer for the enrollees of the health maintenance organization who are eligible or assigned to receive services from the delegated entity;

(3) if the health maintenance organization pays any claims for the delegated entity, a summary of the number and amount of claims paid by the health maintenance organization on behalf of the delegated entity during the previous reporting period, provided that a delegated entity is not precluded from receiving, upon request, additional nonproprietary information regarding such claims;

(4) if the health maintenance organization pays any claims for the delegated entity, a summary of the number and amount of pharmacy prescriptions paid for each enrollee for which the delegated entity has taken partial risk during the previous reporting period, provided that a delegated entity is not precluded from receiving, upon request, additional nonproprietary information regarding such claims;

(5) information that enables the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation; and

(6) patient complaint data that relates to the delegated entity.

(c) In addition to the information required by Subsection (b) of this section, a health maintenance organization shall provide to a delegated entity:

(1) detailed risk-pool data, reported quarterly and on settlement; and

(2) the percent of premium attributable to hospital or facility costs, if hospital or facility costs impact the delegated entity's costs, reported quarterly, and, if there are changes in hospital or facility contracts with the health maintenance organization, the projected impact of those changes on the percent of premium attributable to hospital and facility costs within 30 days of such changes.

Revised Law

Sec. 1272.103. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

Source Law

(r) The commissioner may adopt rules as necessary to implement this section.

[Sections 1272.104-1272.150 reserved for expansion]

SUBCHAPTER D. RESERVE REQUIREMENTS

Revised Law

Sec. 1272.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance

organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18D, Sec. (h), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(h) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.152. GENERAL RESERVE REQUIREMENTS. (a) A delegated network shall maintain reserves adequate for the liabilities and risks assumed by the network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks for which the reserves are maintained, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Except as provided by Sections 1272.153 and 1272.154, a delegated network shall maintain reserves as described by Subsection (c) only with respect to the portion of services assumed under the delegation agreement that is outside the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(c) A delegated network shall maintain financial reserves equal to the greater of:

(1) 80 percent of the amount of liabilities and risks for which reserves must be maintained under this subchapter and that have been incurred but not paid by the network; or

(2) an amount equal to two months of the premium amount assumed by the network for services with respect to which reserves must be maintained under this subchapter. (V.T.I.C. Art. 20A.18D, Secs. (a), (b), (e), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

Art. 20A.18D. (a) A delegated network shall establish and maintain reserves that are adequate for the liabilities and risks assumed by the delegated network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks reserved for, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Except as provided by Subsections (c) and

(d), the delegated network shall establish and maintain reserves as described by Subsection (e)(1) or (2) only with respect to the portion of services assumed under the delegation agreement that are not within the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(e) A delegated network shall maintain financial reserves equal to the greater of:

(1) 80 percent of the risk and liabilities that must be reserved under this section and that have been incurred but not paid by the delegated network; or

(2) two months of premium amount assumed by the delegated network for services that must be reserved under this section.

Revised Law

Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE AND HOSPITAL OR INSTITUTIONAL SERVICES. A delegated network that assumes under a delegation agreement both medical care and hospital or institutional services shall maintain reserves adequate to cover the liabilities and risks associated with medical care or hospital or institutional services, whichever category of services is allocated the largest portion of the premium by the health maintenance organization. (V.T.I.C. Art. 20A.18D, Sec. (c), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(c) If the scope of services assumed under the delegation agreement includes both medical care and hospital or institutional services, the delegated network shall establish and maintain reserves that are adequate to cover the liabilities and risks associated with medical care or with hospital or institutional services, whichever type of services has been allocated the largest portion of the premium by the health maintenance organization.

Revised Law

Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION DRUGS. A delegated network that assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, shall maintain, in addition to any other reserves required under this subchapter, reserves adequate to cover the liabilities and risks associated with the prescription drug benefits. (V.T.I.C. Art. 20A.18D, Sec. (d), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(d) If the delegated network assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, the network shall establish and maintain reserves that are adequate to cover the liabilities and risks associated with the prescription drug benefits, in addition to any other reserves required under this section.

Revised Law

Sec. 1272.155. FORM OF RESERVES. The reserves required under this subchapter must be:

(1) secured by and consist only of United States legal tender or bonds of the United States or this state;

(2) held at a financial institution in this state that is chartered by the United States or this state; and

(3) held in trust for, for the benefit of, or to provide health care services to enrollees under the delegation agreement. (V.T.I.C. Art. 20A.18D, Sec. (f), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(f) The reserves required under this section must be secured by and only consist of legal tender of the United States or bonds of the United States or this state. The reserves must be held at a financial institution in this state that is chartered by the United States or this state. The reserves must be held in trust for, for the benefit of, or to provide health care services to, enrollees of the health maintenance organization under the agreement between the health maintenance organization and the delegated network.

Revised Law

Sec. 1272.156. ESCROW ACCOUNT. (a) A delegated network required to maintain reserves under this subchapter shall establish an escrow account to pay claims and deposit the reserves into the escrow account on:

(1) notification of the network's intent to terminate or refuse to renew a contract under which the network assumed liabilities and risks from a health maintenance organization; or

(2) modification of a contract under which the network assumed liabilities and risks from a health maintenance organization if the modified contract eliminates those liabilities

and risks.

(b) The delegated network shall notify the commissioner on establishing an escrow account under this section.

(c) On the 271st day after the date the reserves are deposited into the escrow account, the delegated network is entitled to the release of funds remaining in escrow. Funds released from the escrow account shall be distributed to each individual who contributed to the reserves deposited into the account in proportion to the individual's total contribution.

(d) The commissioner shall take any action necessary to ensure the release of funds remaining in escrow after the date specified by Subsection (c). (V.T.I.C. Art. 20A.18D, Sec. (g), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

> (g)(1) A delegated network required to establish and maintain reserves under this section shall establish an escrow account for the payment of claims and deposit such reserves into the escrow account upon providing notice of its intent to terminate or non-renew a contract through which the delegated network assumed liabilities and risks from a health maintenance organization. Upon the establishment of the escrow account, the delegated network shall notify the commissioner.
>
> (2) A delegated network required to establish and maintain reserves under this section shall establish an escrow account for the payment of claims and deposit such reserves into the escrow account upon the modification of a contract through which the delegated network assumed liabilities and risks from a health maintenance organization if the modified contract eliminates the liabilities and risks previously assumed by the delegated network. Upon the establishment of the escrow account, the delegated network shall notify the commissioner.
>
> (3) Two hundred seventy days after the date the reserves are deposited into the escrow account, the delegated network shall be entitled to the release of the remaining amounts held in escrow.
>
> (4) The amounts released from the escrow account shall be distributed to those individuals who contributed to the reserves deposited into escrow in proportion to the individuals' total contribution.
>
> (5) The commissioner shall, and has the authority to, take any action necessary to ensure the release of any amounts remaining in escrow in excess of the 270-day time period in Subsection (g)(3).

Revisor's Note

Section (g)(5), V.T.I.C. Article 20A.18D, as added by Chapter 550, Acts of the 77th Legislature,

Regular Session, 2001, states that the commissioner shall, "and has the authority to," take certain actions. The revised law omits the quoted language as unnecessary because the requirement that the commissioner perform an action is sufficient to confer on the commissioner the authority to perform the action.

[Sections 1272.157-1272.200 reserved for expansion]

SUBCHAPTER E. COMPLIANCE

Revised Law

Sec. 1272.201. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Source Law

(q) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS OPERATING CONDITION. (a) If a health maintenance organization becomes aware of information that indicates a delegated entity with which the health maintenance organization has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the health maintenance organization shall in writing:

(1) notify the entity of those findings; and

(2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition.

(b) A health maintenance organization shall provide to the commissioner a copy of each notice and request submitted to a delegated entity under this section and each response or other documentation the health maintenance organization receives or

generates in response to the notice and request. (V.T.I.C. Art. 20A.18C, Sec. (d).)

Source Law

(d) A health maintenance organization that becomes aware of any information that indicates the delegated entity is not operating in accordance with its written agreement or is operating in a condition that renders the continuance of its business hazardous to the enrollees, shall:

(1) notify the delegated entity in writing of those findings;

(2) request, in writing, a written explanation, with documentation supporting the explanation, of:

(A) the delegated entity's apparent noncompliance with the written agreement; or

(B) the existence of the condition that apparently renders the continuance of the delegated entity's business hazardous to the enrollees; and

(3) provide the commissioner with copies of all notices and requests submitted to the delegated entity and the responses and other documentation the health maintenance organization generates or receives in response to the notices and requests.

Revised Law

Sec. 1272.203. RESPONSE TO NOTICE. A delegated entity shall respond in writing to a request from a health maintenance organization under Section 1272.202 not later than the 30th day after the date the entity receives the request. (V.T.I.C. Art. 20A.18C, Sec. (e).)

Source Law

(e) A delegated entity shall respond to a request from a health maintenance organization under Subsection (d) of this section in writing not later than the 30th day after the date the request is received.

Revised Law

Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE ORGANIZATION. A health maintenance organization shall cooperate with a delegated entity to correct a failure by the entity to comply with the department's regulatory requirements relating to:

(1) a function delegated to the entity by the health maintenance organization; or

(2) a matter necessary for the health maintenance organization to ensure compliance with each statutory or regulatory

requirement. (V.T.I.C. Art. 20A.18C, Sec. (f).)

Source Law

(f) The health maintenance organization shall cooperate with the delegated entity to correct any failure by the delegated entity to comply with the regulatory requirements of the department relating to any matters:

(1) delegated to the delegated entity by the health maintenance organization; or

(2) necessary for the health maintenance organization to ensure compliance with statutory or regulatory requirements.

Revised Law

Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT. (a) On receipt of a notice under Section 1272.202 or if complaints are filed with the department, the department may conduct an examination regarding:

(1) any matter contained in the notice; and

(2) any other matter relating to the financial solvency of the delegated entity or the entity's ability to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(b) Except as provided by Subsection (c), the department, on completion of an examination under this section, shall report to the delegated entity and the health maintenance organization:

(1) the results of the examination; and

(2) any action the department determines is necessary to ensure that:

(A) the health maintenance organization meets the health maintenance organization's responsibilities under this code, any other insurance laws of this state, and rules adopted by the commissioner; and

(B) the entity is able to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(c) The department may not report to the health maintenance organization information relating to fee schedules, prices, or cost of care or other information not relevant to the monitoring plan.

(V.T.I.C. Art. 20A.18C, Secs. (g), (h).)

Source Law

> (g) On receipt of a notice under Subsection (d) of this section, or if complaints are filed with the Texas Department of Insurance, the department may examine the matters contained in the notice as well as any other matter relating to the financial solvency of the delegated entity or the delegated entity's ability to meet its responsibilities in connection with any function delegated to the entity by the health maintenance organization.
>
> (h) Except as provided by this subsection, the Texas Department of Insurance, on completion of the department's examination, shall report to the delegated entity and the health maintenance organization the results of the department's examination and any action the department determines is necessary to ensure that the health maintenance organization meets its responsibilities under this Act, the Insurance Code, any other insurance laws of this state, and rules adopted by the commissioner, and that the delegated entity can meet its responsibilities in connection with any function delegated to the entity by the health maintenance organization. The department may not report to the health maintenance organization any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan.

Revised Law

Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE PLAN. The delegated entity and health maintenance organization shall respond to the department's report under Section 1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report. (V.T.I.C. Art. 20A.18C, Sec. (i).)

Source Law

> (i) The delegated entity and the health maintenance organization shall respond to the department's report and submit a corrective plan to the Texas Department of Insurance not later than the 30th day after the date of receipt of the department's report.

Revised Law

Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION. The department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relate to a function delegated by the health maintenance organization to the entity; or

(2) are necessary to ensure the health maintenance organization's compliance with each statutory or regulatory requirement. (V.T.I.C. Art. 20A.18C, Sec. (k).)

Source Law

(k) The department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relate to any matters delegated by the health maintenance organization to the delegated entity; or

(2) are necessary to ensure the health maintenance organization's compliance with statutory and regulatory requirements.

Revised Law

Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE ORDER. (a) Regardless of whether a delegated entity complies with a request for corrective action under Section 1272.207, the commissioner may order a health maintenance organization with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the health maintenance organization is complying with this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(b) Actions the commissioner may order a health maintenance organization to take under this section include:

(1) reassuming the functions delegated to the delegated entity, including claims payments for services previously provided to enrollees;

(2) temporarily or permanently ceasing assignment of new enrollees to the entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive services; or

(4) terminating the delegation agreement with the entity. (V.T.I.C. Art. 20A.18C, Sec. (l).)

Source Law

(l) Regardless of whether a delegated entity complies with a request for corrective action, the commissioner may order the health maintenance organization to take any action the commissioner determines is necessary to ensure that the health maintenance organization is in compliance with this

Act, including:

(1) reassuming the functions delegated to the delegated entity, including claims payments for services previously rendered to enrollees of the health maintenance organization;

(2) temporarily or permanently ceasing assignment of new enrollees to the delegated entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive services; or

(4) terminating the health maintenance organization's contract with the delegated entity.

Revised Law

Sec. 1272.209. PUBLIC DOCUMENTS. (a) Except as provided by Subsection (b), a report required under Section 1272.205(b) or corrective plan required under Section 1272.206 is a public document.

(b) Health care provider fee schedules, prices, costs of care, or other information that is not relevant to the monitoring plan or is confidential by law is not a public document under this section. (V.T.I.C. Art. 20A.18C, Sec. (j).)

Source Law

(j) Reports and corrective plans required under Subsection (h) or (i) of this section shall be treated as public documents, except that health care provider fee schedules, prices, costs of care, or other information not relevant to the monitoring plan and any other information that is considered confidential by law shall be considered confidential.

Revised Law

Sec. 1272.210. RECORD OF COMPLAINTS; REPORT. (a) The department shall:

(1) maintain enrollee and provider complaints in a manner that identifies complaints made about limited provider networks and delegated entities; and

(2) periodically issue a report on the complaints that includes a list of complaints organized by:

(A) category;

(B) action taken on the complaint; and

(C) entity or network name and type.

(b) The department shall make available to the public the report and information to assist the public in evaluating the information contained in the report. (V.T.I.C. Art. 20A.18C, Sec.

(m).)

Source Law

(m) The Texas Department of Insurance shall maintain enrollee and provider complaints in a manner that identifies complaints made about limited provider networks and delegated entities. The department shall periodically issue a report on the complaints received by the department that includes a list of complaints by category, by action taken on the complaint, and by entity or network name and type. The department shall make the report available to the public and shall include information to assist the public in evaluating the information contained in the report.

Revised Law

Sec. 1272.211. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

Source Law

(r) The commissioner may adopt rules as necessary to implement this section.

[Sections 1272.212-1272.250 reserved for expansion]

SUBCHAPTER F. PENALTIES

Revised Law

Sec. 1272.251. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Source Law

(q) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF THIRD-PARTY ADMINISTRATOR OR UTILIZATION REVIEW AGENT. Notwithstanding any other provision of this code or another insurance law of this state, the commissioner may suspend or revoke the license of a third-party administrator or utilization review agent that fails to comply with Subchapter B, C, or E. (V.T.I.C. Art. 20A.18C, Sec. (n).)

Source Law

(n) Notwithstanding any other provision of this Act, the Insurance Code, or any other insurance law of this state, the commissioner may suspend or revoke the license of any third party administrator or utilization review agent that fails to comply with this section.

Revised Law

Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH MAINTENANCE ORGANIZATION. The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84 on a health maintenance organization that does not provide in a timely manner information required by Subchapter C. (V.T.I.C. Art. 20A.18C, Sec. (o).)

Source Law

(o) The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84, Insurance Code, against a health maintenance organization that does not provide timely information required by Subsections (b) and (c) of this section.

Revised Law

Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED. A health maintenance organization by contract shall establish penalties for a delegated entity that does not provide in a timely manner information required under a monitoring plan established under Section 1272.053. (V.T.I.C. Art. 20A.18C, Sec. (p).)

Source Law

(p) A health maintenance organization shall by contract establish penalties for delegated entities that do not provide timely information required under a monitoring plan as required by Subsection (a)(1) of this section.

Revised Law

Sec. 1272.255. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

Source Law

(r) The commissioner may adopt rules as necessary to implement this section.

[Sections 1272.256-1272.300 reserved for expansion]

SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER NETWORK OR DELEGATED ENTITY

Revised Law

Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES. (a) A contract between a health maintenance organization and a limited provider network or delegated entity must provide that:

(1) if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity, on the request of a network physician or provider, shall:

(A) allow a referral to a non-network physician or provider; and

(B) fully reimburse the non-network physician or provider at the usual and customary rate or an agreed rate; and

(2) before the limited provider network or delegated entity may deny a referral to a non-network physician or provider, a specialist of the same or similar specialty as the type of physician or provider to whom the referral is requested must conduct a review of the request.

(b) The limited provider network or delegated entity shall allow the referral within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee who is a patient, but not later than the fifth business day after the date the network or entity receives any reasonably requested documentation.

(c) An enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or through the delegated entity.

(d) A denial of out-of-network services under this section is subject to appeal under Article 21.58A. (V.T.I.C. Art. 20A.18F.)

Source Law

Art. 20A.18F. (a) Each contract between a

health maintenance organization and a limited provider network or delegated entity must provide that if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity must, on request of a network physician or provider, allow a referral to a non-network physician or provider and shall fully reimburse the non-network provider at the usual and customary or an agreed-upon rate.

(b) The referral shall be allowed within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not later than the fifth business day after the date any reasonably requested documentation is received by the limited provider network or delegated entity.

(c) The enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or delegated entity.

(d) Each contract must also provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the limited provider network or delegated entity may deny a referral.

(e) A denial of out-of-network services under this section is subject to appeal under Article 21.58A, Insurance Code.

Revisor's Note

(1) Section (a), V.T.I.C. Article 20A.18F, states that under certain circumstances a limited provider network must allow a referral to a non-network "physician or provider" and fully reimburse the non-network "provider." It is clear from the context of Article 20A.18F that the reimbursement is to be made to the person to whom the referral is made, whether a physician or provider. The revised law is drafted accordingly.

(2) Section (b), V.T.I.C. Article 20A.18F, refers to the condition of the "patient." The revised law substitutes "enrollee who is a patient" for "patient" for accuracy and consistency of terminology throughout this section. Similar changes have been made throughout this subchapter.

Revised Law

Sec. 1272.302. CONTINUITY OF CARE. (a) In this section, "special circumstance" means a condition regarding which a treating

physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, or life-threatening illness and an enrollee who is past the 24th week of pregnancy.

(b) A contract between a health maintenance organization and a limited provider network or delegated entity must require that each contract between the network or entity and a physician or provider must:

(1) require that reasonable advance notice be given to an enrollee of an impending termination from the network or entity of a physician or provider who is currently treating the enrollee; and

(2) provide that the termination of the physician's or provider's contract, except for reason of medical competence or professional behavior, does not release the network or entity from the obligation to reimburse the physician or provider for treatment of an enrollee who has a special circumstance at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of the enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

(c) The treating physician or provider shall identify a special circumstance. That physician or provider must:

(1) request that the enrollee be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the enrollee who is a patient of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the limited provider network or delegated entity.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider

for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery.

(f) A contract between a limited provider network or delegated entity and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. (V.T.I.C. Art. 20A.18E.)

Source Law

Art. 20A.18E. (a) In this section, "special circumstance" means a condition for which the treating physician or provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the patient.

(b) Each contract between a health maintenance organization and a limited provider network or delegated entity must require that each contract between the network or entity and a physician or provider provide that:

(1) reasonable advance notice be given to an enrollee of the impending termination from the limited provider network or delegated entity of a physician or provider who is currently treating the enrollee; and

(2) the termination of the physician or provider contract, except for reason of medical competence or professional behavior, does not release the limited provider network or delegated entity from the obligation to reimburse a physician or provider who is treating an enrollee of special circumstance, such as a person who has a disability, acute condition, or life-threatening illness or is past the 24th week of pregnancy, at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of an enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

(c) A special circumstance shall be identified by the treating physician or provider, who must request that the enrollee be permitted to continue

treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still in the limited provider network or delegated entity.

(d) Contracts between a limited provider network or delegated entity and physicians or providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

(e) This section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

CHAPTER 1273. POINT-OF-SERVICE PLANS

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