

1-1 By: Oliveira, et al. (Senate Sponsor - Lucio) H.B. No. 1290  
1-2 (In the Senate - Received from the House April 22, 2009;  
1-3 May 1, 2009, read first time and referred to Committee on State  
1-4 Affairs; May 20, 2009, reported favorably, as amended, by the  
1-5 following vote: Yeas 7, Nays 1; May 20, 2009, sent to printer.)

1-6 COMMITTEE AMENDMENT NO. 1 By: Lucio

1-7 Amend H.B. No. 1290 (house engrossment) in SECTION 1 of the  
1-8 bill, by striking Section 1376.001(1)(B) (page 1, lines 45 through  
1-9 47) and substituting the following:  
1-10 (B) a health benefit plan that offered by a  
1-11 multiple employer welfare arrangement that holds a certificate of  
1-12 authority under Chapter 846;

1-13 COMMITTEE AMENDMENT NO. 2 By: Lucio

1-14 Amend H.B. No. 1290 (house engrossment) in SECTION 1 of the bill, by  
1-15 striking Sec. 1376.001 (D)(3) (page 1, lines 58 through 60).

1-16 A BILL TO BE ENTITLED  
1-17 AN ACT

1-18 relating to health benefit plan coverage for certain tests for the  
1-19 early detection of cardiovascular disease.

1-20 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:  
1-21 SECTION 1. Subtitle E, Title 8, Insurance Code, is amended  
1-22 by adding Chapter 1376 to read as follows:  
1-23 CHAPTER 1376. CERTAIN TESTS FOR EARLY DETECTION OF CARDIOVASCULAR  
1-24 DISEASE

1-25 Sec. 1376.001. APPLICABILITY OF CHAPTER. (a) This chapter  
1-26 applies only to a health benefit plan that:  
1-27 (1) provides benefits for medical or surgical expenses  
1-28 incurred as a result of a health condition, accident, or sickness,  
1-29 including:  
1-30 (A) an individual, group, blanket, or franchise  
1-31 insurance policy or insurance agreement, a group hospital service  
1-32 contract, or an individual or group evidence of coverage that is  
1-33 offered by:  
1-34 (i) an insurance company;  
1-35 (ii) a group hospital service corporation  
1-36 operating under Chapter 842;  
1-37 (iii) a fraternal benefit society operating  
1-38 under Chapter 885;  
1-39 (iv) a Lloyd's plan operating under Chapter  
1-40 941;  
1-41 (v) a stipulated premium company operating  
1-42 under Chapter 884; or  
1-43 (vi) a health maintenance organization  
1-44 operating under Chapter 843;  
1-45 (B) to the extent permitted by the Employee  
1-46 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
1-47 seq.), a health benefit plan that is offered by:  
1-48 (i) a multiple employer welfare arrangement  
1-49 as defined by Section 3 of that Act (29 U.S.C. Section 1002); or  
1-50 (ii) another analogous benefit  
1-51 arrangement;  
1-52 (C) a small employer health benefit plan written  
1-53 under Chapter 1501; or  
1-54 (D) a Medicare supplemental policy as defined by  
1-55 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);  
1-56 (2) is offered by an approved nonprofit health  
1-57 corporation operating under Chapter 844; or  
1-58 (3) provides health and accident coverage through a  
1-59 risk pool created under Chapter 172, Local Government Code,  
1-60 notwithstanding Section 172.014, Local Government Code.

(b) Notwithstanding any provision in Chapter 1601 or any other law, this chapter applies to basic coverage under Chapter 1601.

Sec. 1376.002. EXCEPTIONS. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other 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; or

(E) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy;

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

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1376.001.

Sec. 1376.003. MINIMUM COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for screening medical procedures must provide the minimum coverage required by this section to each covered individual:

(1) who is:

(A) a male older than 45 years of age and younger than 76 years of age; or

(B) a female older than 55 years of age and younger than 76 years of age; and

(2) who:

(A) is diabetic; or

(B) has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

(b) The minimum coverage required to be provided under this section is coverage of up to \$200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this section:

(1) computed tomography (CT) scanning measuring coronary artery calcification; or

(2) ultrasonography measuring carotid intima-media thickness and plaque.

SECTION 2. The change in law made by this Act applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2010, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2009.

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