By: Coleman H.B. No. 565

A BILL TO BE ENTITLED

AN ACT

relating to healthcare coverage in this state.

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

ARTICLE 1. STATE MEDICAID PROGRAM

SECTION 1.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 540 to read as follows:

SUBCHAPTER A. ACUTE CARE

Sec. 540.051. ELIGIBILITY FOR MEDICAID ACUTE CARE. (a) An individual is eligible to receive acute care benefits under the state Medicaid program if the individual:

(1) has a household income at or below 100 percent of the federal poverty level;

(2) is under 19 years of age and:

(A) is receiving Supplemental Security Income (SSI) under 42 U.S.C. Section 1381 et seq.; or

(B) is in foster care or resides in another residential care setting under the conservatorship of the Department of Family and Protective Services; or

(3) meets the eligibility requirements that were in effect on September 1, 2013.

(b) The commission shall provide acute care benefits under the state Medicaid program to each individual eligible under this section through the most cost-effective means, as determined by the commission.

(c) If an individual is not eligible for the state Medicaid program under Subsection (a), the commission shall refer the individual to the program established under Chapter 541 that helps connect eligible residents with health benefit plan coverage through private market solutions, a health benefit exchange, or any other resource the commission determines appropriate.

Sec. 540.052. MEDICAID SLIDING SCALE SUBSIDIES. (a) An individual who is eligible for the state Medicaid program under Section 540.051 may receive a Medicaid sliding scale subsidy to purchase a health benefit plan from an authorized health benefit plan issuer.

(b) A sliding scale subsidy provided to an individual under this section must:

(1) be based on:

(A) the average premium in the market; and

(B) a realistic assessment of the individual's ability to pay a portion of the premium; and

(2) include an enhancement for individuals who choose a high deductible health plan with a health savings account.

(c) The commission shall ensure that counselors are made available to individuals receiving a subsidy to advise the individuals on selecting a health benefit plan that meets the individuals' needs.

(d) An individual receiving a subsidy under this section is responsible for paying:

(1) any difference between the premium costs associated with the purchase of a health benefit plan and the amount

of the individual's subsidy under this section; and

(2) any copayments associated with the health benefit plan.

(e) If the amount of a subsidy received by an individual under this section exceeds the premium costs associated with the individual's purchase of a health benefit plan, the individual may deposit the excess amount in a health savings account that may be used only in the manner described by Section 540.054(b).

Sec. 540.053. ADDITIONAL COST-SHARING SUBSIDIES. In addition to providing a subsidy to an individual under Section 540.052, the commission shall provide additional subsidies for coinsurance payments, copayments, deductibles, and other cost-sharing requirements associated with the individual's health benefit plan. The commission shall provide the additional subsidies on a sliding scale based on income.

Sec. 540.054. DELIVERY OF SUBSIDIES; HEALTH SAVINGS ACCOUNTS. (a) The commission shall determine the most appropriate manner for delivering and administering subsidies provided under Sections 540.052 and 540.053. In determining the most appropriate manner, the commission shall consider depositing subsidy amounts for an individual in a health savings account established for that individual.

(b) A health savings account established under this section may be used only to:

(1) pay health benefit plan premiums and cost-sharing amounts; and

(2) if appropriate, purchase health care-related

goods and services.

Sec. 540.055. MEDICAID HEALTH BENEFIT PLAN ISSUERS AND MINIMUM COVERAGE. The commission shall allow any health benefit plan issuer authorized to write health benefit plans in this state to participate in the state Medicaid program. The commission in consultation with the commissioner of insurance shall establish minimum coverage requirements for a health benefit plan to be eligible for purchase under the state Medicaid program, subject to the requirements specified by this chapter.

Sec. 540.056. REINSURANCE FOR PARTICIPATING HEALTH BENEFIT PLAN ISSUERS. (a) The commission in consultation with the commissioner of insurance shall study a reinsurance program to reinsure participating health benefit plan issuers.

(b) In examining options for a reinsurance program, the commission and commissioner of insurance shall consider a plan design under which:

(1) a participating health benefit plan is not charged a premium for the reinsurance; and

(2) the health benefit plan issuer retains risk on a sliding scale.

SUBCHAPTER B. LONG-TERM SERVICES AND SUPPORTS

Sec. 540.101. PLAN TO REFORM DELIVERY OF LONG-TERM SERVICES AND SUPPORTS. The commission shall develop a comprehensive plan to reform the delivery of long-term services and supports that is designed to achieve the following objectives under the state Medicaid program or any other program created as an alternative to the state Medicaid program:

(1) encourage consumer direction;

(2) simplify and streamline the provision of services;

(3) provide flexibility to design benefits packages that meet the needs of individuals receiving long-term services and supports under the program;

(4) improve the cost-effectiveness and sustainability of the provision of long-term services and supports;

(5) reduce reliance on institutional settings; and

(6) encourage cost sharing by family members when appropriate.

ARTICLE 2. IMMEDIATE REFORM: PROGRAM TO ENSURE HEALTH BENEFIT COVERAGE FOR CERTAIN INDIVIDUALS THROUGH PRIVATE MARKETPLACE

SECTION 2.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 541 to read as follows:

CHAPTER 541. PROGRAM TO ENSURE HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN INDIVIDUALS THROUGH PRIVATE MARKET SOLUTIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 541.001. DEFINITION. In this chapter, "medical assistance program" means the program established under Chapter 32, Human Resources Code.

Sec. 541.002. CONFLICT WITH OTHER LAW. (a) Except as provided by Subsection (b), to the extent of a conflict between a provision of this chapter and:

(1) another provision of state law, the provision of this chapter controls; and

(2) a provision of federal law or any authorization described under Subchapter B, the federal law or authorization

controls.

(b) The program operated under this chapter is in addition to any medical assistance program operated under a block grant funding system under Chapter 540.

Sec. 541.003. PROGRAM FOR HEALTH BENEFIT PLAN COVERAGE THROUGH PRIVATE MARKET SOLUTIONS. Subject to the requirements of this chapter, the commission in consultation with the Texas Department of Insurance shall develop and implement a program that helps connect certain low-income residents of this state with health benefit plan coverage through private market solutions.

Sec. 541.004. NOT AN ENTITLEMENT. This chapter does not establish an entitlement to assistance in obtaining health benefit plan coverage.

Sec. 541.005. RULES. The executive commissioner shall adopt rules necessary to implement this chapter.

SUBCHAPTER B. FEDERAL AUTHORIZATION

Sec. 541.051. FEDERAL AUTHORIZATION FOR FLEXIBILITY TO ESTABLISH PROGRAM. (a) The commission in consultation with the Texas Department of Insurance shall negotiate with the United States secretary of health and human services, the federal Centers for Medicare and Medicaid Services, and other appropriate persons for purposes of seeking a waiver or other authorization necessary to obtain the flexibility to use federal matching funds to help provide, in accordance with Subchapter C, health benefit plan coverage to certain low-income individuals through private market solutions.

(b) Any agreement reached under this section must:

(1) create a program that is made cost neutral to this state by:

(A) leveraging premium tax revenues; and

(B) achieving cost savings through offsets to general revenue health care costs or the implementation of other cost savings mechanisms;

(2) create more efficient health benefit plan coverage options for eligible individuals through:

(A) program changes that may be made without the need for additional federal approval; and

(B) program changes that require additional federal approval;

(3) require the commission to achieve efficiency and reduce unnecessary utilization, including duplication, of health care services;

(4) be designed with the goals of:

(A) relieving local tax burdens;

(B) reducing general revenue reliance so as to make general revenue available for other state priorities; and

(C) minimizing the impact of any federal health care laws on Texas-based businesses; and

(5) afford this state the opportunity to develop a state-specific way with benefits that specifically meet the unique needs of this state's population.

(c) An agreement reached under this section may be:

(1) limited in duration; and

(2) contingent on continued funding by the federal

government.

SUBCHAPTER C. PROGRAM REQUIREMENTS

Sec. 541.101. ENROLLMENT ELIGIBILITY. (a) Subject to Subsection (b), an individual may be eligible to enroll in a program designed and established under this chapter if the person:

(1) is younger than 65;

(2) has a household income at or below 133 percent of the federal poverty level; and

(3) is not otherwise eligible to receive benefits under the medical assistance program, including through a program operated under Chapter 540 through a block grant funding system or a waiver, other than one granted under this chapter, to the program.

(b) The executive commissioner may amend or further define the eligibility requirements of this section if the commission determines it necessary to reach an agreement under Subchapter B.

Sec. 541.102. MINIMUM PROGRAM REQUIREMENTS. A program designed and established under this chapter must:

(1) if cost-effective for this state, provide premium assistance to purchase health benefit plan coverage in the private market, including health benefit plan coverage offered through a managed care delivery model;

(2) provide enrollees with access to health benefits, including benefits provided through a managed care delivery model, that:

(A) are tailored to the enrollees;

(B) provide levels of coverage that are customized to meet health care needs of individuals within defined

categories of the enrolled population; and

(C) emphasize personal responsibility and accountability through flexible and meaningful cost-sharing requirements and wellness initiatives, including through incentives for compliance with health, wellness, and treatment strategies and disincentives for noncompliance;

(3) include pay-for-performance initiatives for private health benefit plan issuers that participate in the program;

(4) use technology to maximize the efficiency with which the commission and any health benefit plan issuer, health care provider, or managed care organization participating in the program manages enrollee participation;

(5) allow recipients under the medical assistance program to enroll in the program to receive premium assistance as an alternative to the medical assistance program;

(6) encourage eligible individuals to enroll in other private or employer-sponsored health benefit plan coverage, if available and appropriate;

(7) encourage the utilization of health care services in the most appropriate low-cost settings; and

(8) establish health savings accounts for enrollees, as appropriate.

SECTION 2.02. The Health and Human Services Commission in consultation with the Texas Department of Insurance and the Medicaid Reform Task Force shall actively develop a proposal for the authorization from the appropriate federal entity as required

by Subchapter B, Chapter 541, Government Code, as added by this article. As soon as possible after the effective date of this Act, the Health and Human Services Commission shall request and actively pursue obtaining the authorization from the appropriate federal entity.

ARTICLE 3. FEDERAL AUTHORIZATION

SECTION 3.01. Subject to Section 2.02 of this Act, if before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

ARTICLE 4. HEALTH BENEFIT AFFORDABILITY AND ACCESSIBILITY

SECTION 4.01. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1218 to read as follows:

CHAPTER 1218. HEALTH BENEFIT AFFORDABILITY AND ACCESSIBILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1218.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

(2) a group hospital service corporation operating

under Chapter 842;

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

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

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

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

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

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

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

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code;

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code;

(13) county employee group health benefits provided under Chapter 157, Local Government Code; and

(14) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

(c) This chapter applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

Sec. 1218.002. EXCEPTIONS. (a) This chapter does not apply to:

(1) a plan that provides coverage:

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

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

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy;

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

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1218.001.

(b) This chapter does not apply to an individual health benefit plan issued on or before March 23, 2010, that has not had any significant changes since that date that reduce benefits or increase costs to the individual.

Sec. 1218.003. CONFLICT WITH OTHER LAW. If this chapter conflicts with another law relating to lifetime or annual benefit limits or the imposition of a premium, deductible, copayment, coinsurance, or other cost-sharing provision, this chapter controls.

SUBCHAPTER B. CERTAIN COST-SHARING AND COVERAGE AMOUNT LIMITS PROHIBITED

Sec. 1218.051. CERTAIN COST-SHARING PROVISIONS FOR PREVENTIVE SERVICES PROHIBITED. A health benefit plan issuer may not impose a deductible, copayment, coinsurance, or other

cost-sharing provision applicable to benefits for:

(1) a preventive item or service that has in effect a rating of "A" or "B" in the most recent recommendations of the United States Preventive Services Task Force;

(2) an immunization recommended for routine use in the most recent immunization schedules published by the United States Centers for Disease Control and Prevention of the United States Public Health Service; or

(3) preventive care and screenings supported by the most recent comprehensive guidelines adopted by the United States Health Resources and Services Administration.

Sec. 1218.052. CERTAIN ANNUAL AND LIFETIME LIMITS PROHIBITED. A health benefit plan issuer may not establish an annual or lifetime benefit amount for an enrollee in relation to essential health benefits listed in 42 U.S.C. Section 18022(b)(1), as that section existed on January 1, 2019, and other benefits identified by the United States secretary of health and human services as essential health benefits as of that date.

Sec. 1218.053. LIMITATIONS ON COST-SHARING. A health benefit plan issuer may not impose cost-sharing requirements that exceed the limits established in 42 U.S.C. Section 18022(c)(1) in relation to essential health benefits listed in 42 U.S.C. Section 18022(b)(1), as those sections existed on January 1, 2019, and other benefits identified by the United States secretary of health and human services as essential health benefits as of that date.

Sec. 1218.054. DISCRIMINATION BASED ON GENDER PROHIBITED. A health benefit plan issuer may not charge an individual a higher

premium rate based on the individual's gender.

SUBCHAPTER C. COVERAGE OF PREEXISTING CONDITIONS

Sec. 1218.101. DEFINITION. In this subchapter, "preexisting condition" means a condition present before the effective date of an individual's coverage under a health benefit plan.

Sec. 1218.102. PREEXISTING CONDITION RESTRICTIONS PROHIBITED. Notwithstanding any other law, a health benefit plan issuer may not:

(1) deny an individual's application for coverage or refuse to enroll an individual in a health benefit plan due to a preexisting condition;

(2) limit or exclude coverage under the health benefit plan for the treatment of a preexisting condition otherwise covered under the plan; or

(3) charge the individual more for coverage than the health benefit plan issuer charges an individual who does not have a preexisting condition.

SUBCHAPTER D. EXTERNAL REVIEW PROCEDURE

Sec. 1218.151. EXTERNAL REVIEW MODEL ACT RULES. (a) The department shall adopt rules as necessary to conform Texas law with the requirements of the NAIC Uniform Health Carrier External Review Model Act (April 2010).

(b) To the extent that the rules adopted under this section conflict with Chapter 843 or Title 14, the rules control.

ARTICLE 5. HEALTH BENEFIT PLAN COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

SECTION 5.01. Chapter 1355, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

Sec. 1355.251. DEFINITIONS. In this subchapter:

(1) "Financial requirement" includes a requirement relating to a deductible, copayment, coinsurance, or other out-of-pocket expense or an annual or lifetime limit.

(2) "Mental health benefit" means a benefit relating to an item or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(3) "Nonquantitative treatment limitation" includes:

(A) a medical management standard limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether a treatment is experimental or investigational;

(B) formulary design for prescription drugs;

(C) network tier design;

(D) a standard for provider participation in a network, including reimbursement rates;

(E) a method used by a health benefit plan to determine usual, customary, and reasonable charges;

(F) a step therapy protocol;

(G) an exclusion based on failure to complete a course of treatment; and

(H) a restriction based on geographic location,

facility type, provider specialty, and other criteria that limit the scope or duration of a benefit.

(4) "Substance use disorder benefit" means a benefit relating to an item or service for a substance use disorder, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(5) "Treatment limitation" includes a limit on the frequency of treatment, number of visits, days of coverage, or other similar limit on the scope or duration of treatment. The term includes a nonquantitative treatment limitation.

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

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

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

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

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

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

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

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

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

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code;

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code;

(13) county employee group health benefits provided under Chapter 157, Local Government Code; and

(14) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

(c) This subchapter applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

Sec. 1355.253. EXCEPTION. This subchapter does not apply to an individual health benefit plan issued on or before March 23, 2010, that has not had any significant changes since that date that reduce benefits or increase costs to the individual.

Sec. 1355.254. REQUIRED COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS. (a) A health benefit plan must provide benefits for mental health conditions and substance use disorders under the same terms and conditions applicable to benefits for medical or surgical expenses.

(b) Coverage under Subsection (a) may not impose treatment limitations or financial requirements on benefits for a mental health condition or substance use disorder that are generally more restrictive than treatment limitations or financial requirements imposed on coverage of benefits for medical or surgical expenses.

Sec. 1355.255. DEFINITIONS UNDER PLAN. (a) A health

benefit plan must define a condition to be a mental health condition or not a mental health condition in a manner consistent with generally recognized independent standards of medical practice.

(b) A health benefit plan must define a condition to be a substance use disorder or not a substance use disorder in a manner consistent with generally recognized independent standards of medical practice.

Sec. 1355.256. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE. This subchapter supplements Subchapters A and B of this chapter and Chapter 1368 and the department rules adopted under those statutes. It is the intent of the legislature that Subchapter A or B of this chapter or Chapter 1368 or the department rules adopted under those statutes controls in any circumstance in which that other law requires:

(1) a benefit that is not required by this subchapter; or

(2) a more extensive benefit than is required by this subchapter.

Sec. 1355.257. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

ARTICLE 6. COVERAGE OF ESSENTIAL HEALTH BENEFITS

SECTION 6.01. Subtitle E, Title 8, Insurance Code, is amended by adding Chapter 1380 to read as follows:

CHAPTER 1380. COVERAGE OF ESSENTIAL HEALTH BENEFITS

Sec. 1380.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health

condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

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

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

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

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

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

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

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

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

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code;

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code;

(13) county employee group health benefits provided under Chapter 157, Local Government Code; and

(14) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

(c) This chapter applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

Sec. 1380.002. EXCEPTION. This chapter does not apply to an individual health benefit plan issued on or before March 23, 2010, that has not had any significant changes since that date that reduce

benefits or increase costs to the individual.

Sec. 1380.003. REQUIRED COVERAGE FOR ESSENTIAL HEALTH BENEFITS. A health benefit plan must provide coverage for the essential health benefits listed in 42 U.S.C. Section 18022(b)(1), as that section existed on January 1, 2019, and other benefits identified by the United States secretary of health and human services as essential health benefits as of that date.

ARTICLE 7. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN YOUNG ADULTS

SECTION 7.01. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0054 to read as follows:

Sec. 533.0054. ELIGIBILITY AGE FOR STAR HEALTH COVERAGE. A child enrolled in the STAR Health Medicaid managed care program is eligible to receive health care services under the program until the child is 26 years of age.

SECTION 7.02. Section 846.260, Insurance Code, is amended to read as follows:

Sec. 846.260. LIMITING AGE APPLICABLE TO UNMARRIED CHILD. If children are eligible for coverage under the terms of a multiple employer welfare arrangement's plan document, any limiting age applicable to an unmarried child of an enrollee is 26 [~~25~~] years of age.

SECTION 7.03. Section 1201.053(b), Insurance Code, is amended to read as follows:

(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 26 [~~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 or dental support order, if the policy provides dental coverage, issued under Chapter 154, Family Code, or enforceable by a court in this state, and any other individual dependent on the adult.

SECTION 7.04. Section 1201.062(a), Insurance Code, is amended to read as follows:

(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 26 [~~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 or dental support, if the policy provides dental coverage, under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

SECTION 7.05. Section 1201.065(a), Insurance Code, is amended to read as follows:

(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 26 [~~25~~] years of age or older.

SECTION 7.06. Section 1251.151(a), Insurance Code, is amended to read as follows:

(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 26 [~~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.

SECTION 7.07. Section 1251.152(a), Insurance Code, is amended to read as follows:

(a) For purposes of this section, "dependent" includes:

(1) a child of an employee or member who is:

(A) unmarried; and

(B) younger than 26 [~~25~~] years of age; and

(2) a grandchild of an employee or member who is:

(A) unmarried;

(B) younger than 26 [~~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.

SECTION 7.08. Section 1271.006(a), Insurance Code, is amended to read as follows:

(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 26 [~~25~~] years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

SECTION 7.09. Section 1501.002(2), Insurance Code, is amended to read as follows:

(2) "Dependent" means:

(A) a spouse;

(B) a child younger than 26 [~~25~~] years of age, including a newborn child;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

(i) Section 1251.154; or

(ii) Section 1201.062; and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section 1503.003.

SECTION 7.10. Section 1501.609(b), Insurance Code, is amended to read as follows:

(b) Any limiting age applicable under a large employer health benefit plan to an unmarried child of an enrollee is 26 [~~25~~] years of age.

SECTION 7.11. Sections 1503.003(a) and (b), Insurance Code, are amended to read as follows:

(a) A health benefit plan may not condition coverage for a child younger than 26 [~~25~~] years of age on the child's being enrolled at an educational institution.

(b) A health benefit plan that requires as a condition of coverage for a child 26 [~~25~~] years of age or older that the child be a full-time student at an educational institution must provide the coverage:

(1) for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and

(2) continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan may terminate coverage for the child if the child does not return to full-time student status before that date.

SECTION 7.12. Section 1601.004(a), Insurance Code, is amended to read as follows:

(a) In this chapter, "dependent," with respect to an individual eligible to participate in the uniform program under

Section 1601.101 or 1601.102, means the individual's:

(1) spouse;

(2) unmarried child younger than 26 [~~25~~] years of age; and

(3) child of any age who lives with or has the child's care provided by the individual on a regular basis if the child has a mental disability or is [~~mentally retarded or~~] physically incapacitated to the extent that the child is dependent on the individual for care or support, as determined by the system.

ARTICLE 8. TRANSITION; EFFECTIVE DATE

SECTION 8.01. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2020, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 8.02. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 8.03. This Act takes effect September 1, 2019.