# CHAPTER 673

## S.B. No. 1367

An Act relating to requisite provisions for group accident, health, or accident and health policies or group hospital contracts and to continuation privileges under certain defined health insurance policies for certain dependents; amending the Insurance Code, as amended, by amending Subsection (d), Section 1 and adding Section 3B, Article 351-6; adding Subsection (i) to Chapter 214, Acts of the 64th Legislature, Regular Session, 1975, and repealing Section 3A, Article 3.51-6.

*Be it enacted by the Legislature of the State of Texas:*

**SECTION 1.** Subsection (d), Section 1, Article 3.51-6, Insurance Code, as amended, is amended to read as follows:

"(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.

*"(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 (A) provisions (v), (xi), and (xiv) 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; (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:*

*"(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;*

*"(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;*

*"(iii) a provision that the policy and any application attached shall constitute the entire contract between the parties and 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;*

*"(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;*

*"(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;*

*"(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;*

*"(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;*

*"(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.*

*"(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;*

*"(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;*

*"(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;*

*"(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;*

*"(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;*

*"(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.*

*"(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 conversion or group continuation privilege as required by this subsection. 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), (B), or (C) below. Involuntary termination for cause does not include termination for any health-related cause.*

*"(A)(i) Coverage under an individual policy or group conversion policy of accident and health insurance without evidence of insurability if written application and payment of the first premium is made within 31 days after such termination. An employee, member, or dependent shall not be entitled to have a converted policy issued if termination of the insurance under the group policy occurred because: (aa) such person failed to pay any required premium; or (bb) any discontinued group coverage was replaced by similar group coverage within 31 days.*

*"(ii) An insurer shall not be required to issue a converted policy covering any person if: (aa) such person is or could be covered by Medicare; (bb) such 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 by any other plan or program; (cc) such 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; (dd) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law; or (ee) the benefits provided under the sources herein enumerated, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner of insurance prior to their use in denying coverage. The board shall issue rules and regulations to establish minimum standards for benefits under policies issued pursuant to this subsection.*

*"(B)(i) Policies subject to Paragraph (A) above shall provide at the insurer's option in lieu of the requirements of Paragraph (A) continuation of group coverage for employees or members and their eligible dependents subject to the eligibility provisions of Paragraph (A).*

*"(ii) Continuation of group coverage need not include dental, vision care, or prescription drug benefits and must be requested in writing within 21 days following the later of: (aa) the date the group 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.*

*"(iii) In no event may the employee or member elect continuation more than 31 days after the date of such termination.*

*"(iv) An employee or member 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, but not more than the group rate for the insurance being continued under the group policy on the due date of each payment.*

*"(v) The employee's or member'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 31 days of the date coverage would otherwise terminate.*

*"(vi) Continuation may not terminate until the earliest of: (aa) six months after the date the election is made; (bb) failure to make timely payments; (cc) the date on which the group coverage terminates in its entirety; (dd) or one of the conditions specified in items (aa) through (ee) of Subparagraph (ii), Paragraph (A) above is met by the covered individual.*

*"(C) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted policy under Paragraph (A) above.*

*"The premium for the converted policy issued under Paragraph (A) of this subdivision or the group coverage under Paragraph (C) of this subdivision, should be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and the type and amount of insurance provided."*

**SECTION 2.** The amendments to Subsection (d), Section 1, Article 3.51-6, Insurance Code, as added by this Act, apply only to the health insurance policies defined in that subsection that are delivered, issued for delivery, renewed, amended, or extended on or after May 1, 1986.

**SECTION 3.** Article 3.51-6, Insurance Code, is amended by adding Section 3B to read as follows:

*"Section 3B. CONTINUATION PRIVILEGE FOR CERTAIN DEPENDENTS. (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*

*"(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.*

*"(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.*

*"(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.*

*"(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.*

*"(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.*

*"(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.*

*"(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. 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 45 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 45-day period provided the policy premiums are paid.*

*"(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.*

*"(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 establishes residence outside the state;*

*"(3) 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*

*"(4) 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.*

*"(m) Contracts executed pursuant to the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code) shall provide that:*

*"(1) Premium payments must be remitted directly to the Employees Retirement System of Texas and must be postmarked or received not later than the 10th day of the month for which the premium is due.*

*"(2) The premium for this group continuation coverage may not exceed the level established for other surviving dependents of deceased employees or retirees.*

*"(3) At the time the health insurance policy is delivered, issued for delivery, renewed, amended, or extended on or after January 1, 1986, the Employees Retirement System of Texas shall give notice of the continuation option to each commission, agency, and institution covered by the program. The commissions, agencies, and institutions shall give written notice of the continuation option to each of their employees and each dependent of those employees who are covered by the health insurance program.*

*"(4) Each member of the group shall give written notice to the employing agency within 15 days of any severance of family relationship that might activate the continuation option under Subsection (b) of this section. Upon receipt of such notice or upon the death of an employee, the employing agency shall give written notice to each affected dependent of the continuation option, which shall include a statement of the amount of the premium to be charged. Notice under this paragraph will be accompanied by any necessary enrollment forms.*

*"(5) The covered dependent must exercise this continuation option within 45 days from the severance of the family relationship or the retirement or death of the member and must provide written notification to the employing agency within 45 days. Coverage under the health insurance policy remains in effect during this 45-day period provided the policy premiums are paid.*

*"(6) 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."*

**SECTION 4.** (a) In addition to the notice required by Subsection (g), Section 3B, Article 3.51-6, Insurance Code, as added by this Act, an insurer shall give the same written notice to each member of a group and each dependent insured under a health insurance policy delivered or issued for delivery before the effective date of this Act on the first renewal of that policy on or after January 1, 1986.

(b) Section 3B, Article 3.51-6, Insurance Code, as added by this Act, applies only to the health insurance policies defined in that section that are delivered, issued for delivery, renewed, amended, or extended after January 1, 1986. Health insurance policies delivered or issued for delivery before that date are governed by the law as it existed before the adoption of this Act until those policies are renewed on or after January 1, 1986, and that law is continued in effect for that purpose.

**SECTION 5.** Article 20A.26, Insurance Code, is amended by adding a new Subsection (i) to read as follows:

*"(i) Any health maintenance organization authorized under this Act shall be subject to Article 3.51-6, Section 3B, Insurance Code."*

**SECTION 6.** Section 3A, Article 3.51-6, Insurance Code, is repealed.

**SECTION 7.** The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended, and that this Act take effect and be in force according to its terms, and it is so enacted.

Passed the Senate on May 14, 1985, by the following vote: Yeas 29, Nays 0; Senate concurred in House amendments on May 27, 1985, by a viva-voce vote; passed the House, with amendments, on May 25, 1985, by a non-record vote.

Approved: June 14, 1985
Effective: August 26, 1985