BILL ANALYSIS

C.S.H.B. 1919
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Under current law, insurance companies may not exclude coverage for medical needs resulting from a traumatic brain injury. However, families caring for someone with a traumatic brain injury are often unaware of the mandate for coverage. Additionally, many critical services are often denied despite the mandate.

H.B.1676 in the 77th Legislature (now codified as Section 1352 of the Insurance Code) required that insurance companies not exclude brain injuries from their coverage. Previously, families dealing with a traumatic brain injury to a loved one had the added burden of having to shoulder the financial cost of the injury. Since then, the Sunset Commission has released a study citing Department of Insurance (TDI) figures that show the mandate cost insurance companies a minimal amount.

Since passage in 2001 of legislation requiring coverage for traumatic brain injuries and the release of the Sunset Commission's *Study of Health Benefit Plan Coverage for Brain Injuries* in November 2006 it is clear that some areas of the existing law need improvement. C.S.H.B. 1919 makes some of those changes.

C.S.H.B. 1919 attempts to expand the mandate to post-acute care and cognitive rehabilitation for survivors of brain injuries and require notice of coverage be provided.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the Commissioner of Insurance in SECTION 2 (Section 1352.003 of the Texas Insurance Code), SECTION 3 (Section 1352.004 of the Texas Insurance Code), SECTION 4 (Section 1352.005 of the Texas Insurance Code) of this bill.

ANALYSIS

SECTION 1 of the Committee Substitute adds government health plans to the existing requirement that coverage be available on private health plans. Also, Subsection (b) and (c) are added to Section 1352.001 of the Texas Insurance Code. Subsection (b) states that this chapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code and Subsection (c) says that this chapter applies to a basic coverage plan under Chapter 1551; a basic plan under Chapter 1575; a primary care coverage plan under Chapter 1579; and basic coverage under Chapter 1601.

SECTION 2 first changes the heading of Section 1352.003 by deleting the phrase "Exclusion of Coverage Prohibited". The substitute also changes the language in a list of therapies in Section 1352.003 of the Insurance Code from “may not exclude” to “must include” coverage and changes the word "or" to "and". Also, the phrase "required for and related to treatment of an acquired brain injury" is added to Subsection (a). These changes are intended to make it clear to carriers who have not provided the coverage under the original legislation that it was and is a mandate. Specific language referencing "outpatient day treatment" is added to the existing statute as clarification of the breadth of coverage for post-acute transition services and community reintegration services that the original statute indicated but did not specify. In addition, it requires that any lifetime limitations on the number of days of post-acute care treatment be separately stated in the plan and not included in any lifetime limitation on the number of days of acute care treatment coverage. Otherwise it must include the same payment limitations, deductibles, co-payments, and coinsurance factors for coverage. Finally, SECTION 2 requires that coverage be included for "reasonable" expenses related to periodic reevaluation of care under certain circumstances; listing factors that should be considered in that determination.

In SECTION 3 the substitute further clarifies the intent of the original legislation by adding to the existing statute's requirement that the plan issuer provide adequate training for personnel responsible for pre-authorization of coverage or utilization review. The new language states that the Commissioner of the Texas Department of Insurance, in consultation with the Texas Traumatic Brain Injury Advisory Council, shall prescribe by rule the basic requirements for that training program.

SECTION 4 seeks to amend Chapter 1352 of the Texas Insurance Code by adding Sections 1352.005, 1352.006, 1352.007 and 1358.008. These Sections address the perception that many individuals with traumatic brain injuries have not been aware of the coverage that has been available to them since H.B. 1676 became law. The substitute requires those health benefit plan insurers specified in the bill to notify policyholders of the coverage specified in Chapter 1352 within 10 days after receipt of a claim that reasonably indicates a brain injury has occurred. The Commissioner, in consultation with the Texas Traumatic Brain Injury Advisory Council, shall prescribe by rule the specific contents and wording of the notice. It must include a description of the benefits; a statement pointing out the insured's right to receive benefits even if the injuries do not result in hospitalization or receipt of treatments described as acute care treatment; and a statement listing the types of treatment facilities which may provide the benefits. SECTION 4 also addresses the determination of medical necessity requiring a decision communicated by telephone within three business days after a request is made. Additionally the individual who makes the determination of medical necessity must be licensed in Texas. SECTION 4 states that a health benefit plan may not deny coverage only because treatment was provided outside of a hospital and lists those types of facilities that can provide treatment. Finally, SECTION 4 requires the Commissioner to prepare information for consumers, purchasers of health benefit plan coverage and self-insurers regarding coverages recommended for acquired brain injuries and publish it on the department's website.

SECTION 5 states that the Act applies only to health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2008, 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 6 makes the Act effective September 2007.

EFFECTIVE DATE

September 1, 2007.

COMPARISON OF ORIGINAL TO SUBSTITUTE

C.S.H.B. 1919 makes several changes to the original house bill. First, the substitute, in SECTION 2, clarifies that all listed therapies and treatments are mandated by changing each "or" to an "and". Also, the substitute amends Subsection (b) of Section 1352.003. Whereas the original house bill stated that, "A health benefit plan must include coverage for post-acute transition services, outpatient day treatment services, community reintegration services, or other analogous post-acute care treatment services necessary as a result of and related to an acquired brain injury", the substitute now states "A health benefit plan must include coverage for post-acute transition services, community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury". In Subsection (d) of Section 1352.003, the phrase "Except as provide by Subsection (c)," is added to the language found in the original house bill.

Next, C.S.H.B. 1919 amends some of the language found in Subsection (e) of Section 1352.003 in the original house bill. Whereas the original house bill stated " To ensure that appropriate post-acute care treatment is provided, a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has: (1) incurred an acquired brain injury; (2) been unresponsive to initial treatment; and (3) been institutionalized in a nursing home or other analogous care facility", the substitute now states "To ensure that appropriate post-acute care treatment is provided, a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care

of an individual covered under the plan who: (1) has incurred an acquired brain injury; (2) has been unresponsive to treatment; and (3) becomes responsive to treatment at a later date". Also, the language found in the original house bill in Subsection (f) is now found in Subsection (g) of the committee substitute. C.S.H.B. 1919 adds new language to the original house bill in Subsection (f). The exact language now found in Subsection (f) of the committee substitute was not found in the original house bill.

In SECTION 4, C.S.H.B. 1919 removes the requirement that notice is provided annually upon issuance or renewal of a policy. The substitute also changes the health plan's required response time from two days to three days. Also, Section 1352.007 which discusses treatment facilities is amended by the substitute. Whereas the original house bill stated, " Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at: (1) a hospital regulated under Chapter 241, Health and Safety Code, including an acute rehabilitation hospital; (2) an assisted living facility regulated under Chapter 247, Health and Safety Code; (3) a nursing home regulated under Chapter 242, Health and Safety Code; (4) a community home; (5) an acute or post-acute rehabilitation facility, including a residential or outpatient facility; (6) a medical office; or (7) another analogous facility at which appropriate services may be provided. (b) A health benefit plan may not deny coverage under this chapter solely because the treatment or services are provided at a facility other than a hospital" the substitute now states that, "A health benefit plan may not deny coverage under this chapter based solely on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at a facility at which appropriate services may be provided, including: (1) a hospital regulated under Chapter 241, Health and Safety Code, including an acute rehabilitation hospital; (2) an assisted living facility regulated under Chapter 247, Health and Safety Code; (3) a nursing home regulated under Chapter 242, Health and Safety Code; (4) a community home; (5) an acute or post-acute rehabilitation facility, including a residential or outpatient facility; (6) a medical office".

The language found in SECTION 5, SECTION 6 and SECTION 7 of the original house bill is not included in the substitute. Thus, SECTION 8 as found in the original house bill is moved to SECTION 5 of C.S.H.B. 1919. SECTION 9 of the original house bill is moved to SECTION 6 of the committee substitute.