BILL ANALYSIS

S.B. 568
By: Ellis
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Currently, private health insurance plans are not required to provide health insurance benefits for the diagnosis and treatment of mental disorders (with the exception of certain serious mental illnesses). When private health insurance plans do provide benefits, they are not required to provide them at a level equal to those provided for other medical and surgical care. The restrictions relating to mental health coverage in many health plans include inpatient day limits and disproportionately high deductibles and co-payments and reflect long-standing misconceptions about the efficacy and cost-effectiveness of treating mental illnesses.

State and national studies have consistently demonstrated that employers' equalization of mental health benefits results in minimal cost increases, improved employee productivity, and decreased absenteeism. Access to timely and appropriate treatment can reduce other healthcare costs as people get help for their underlying mental health conditions.

When people cannot readily access needed mental health services through their private health insurance plans, they are faced with tough decisions that may include: leaving their mental health issues untreated, resulting in loss of productive work time or potentially forcing them into crisis situations; paying out-of-pocket expenses that strain their ability to cover other family financial obligations; or seeking care through the public mental health system. In each of these cases, the lack of treatment for mental health issues can have a detrimental impact on the individual, his or her family, co-workers, and society at-large. Untreated mental health issues in children and adults have been linked with high emergency room utilization, incarceration, and increased risk for involvement in the child welfare system. The estimated economic impact of mental illness in Texas was $16 billion in 2003.

C.S.S.B. 568 seeks to address these issues by requiring group health plans to provide coverage for mental disorders to ensure that the coverage is equal to that which is provided for other medical and surgical conditions.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the Commissioner of Insurance in SECTION 2 (Section 1355.0015, Texas Insurance Code) and SECTION 7 (Section 1355.008, Texas Insurance Code) of this bill.

ANALYSIS

SECTION 1. Amends the heading to Subchapter A, Chapter 1355, Insurance Code, to read as follows:

SUBCHAPTER A. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN MENTAL DISORDERS AND SERIOUS MENTAL ILLNESSES

SECTION 2. Amends Subchapter A, Chapter 1355, Insurance Code, by amending Section 1355.001 and adding Section 1355.0015, as follows:

> Sec. 1355.001. PURPOSE. Provides that the legislature recognizes that mental illnesses are biologically based and treatable and that, with appropriate care, individuals with mental illness can live productive and successful lives. Provides that the purpose of this subchapter is to ensure that this recognition is reflected in a group health benefit plans by requiring that the benefits provided for mental disorders be equal to those provided for other medical and surgical conditions.

Sec. 1355.0015. DEFINITIONS. Defines "enrollee," "mental disorder," and "serious mental illness." "Enrollee" means an individual who is enrolled in a group health benefit plan, including a covered dependent. "Mental disorder" means a disorder defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM), fourth edition, or a subsequent edition of that manual that the commissioner by rule adopts to take the place of the fourth edition, except that the term does not include: a mental disorder classified under that manual as a "V-code" disorder; mental retardation; a learning disorder; a motor skill disorder; or a communication disorder. "Serious mental illness" means a mental disorder that is one of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM), fourth edition, or a subsequent edition of that manual that the commissioner by rule adopts to take the place of the fourth edition: bipolar disorders (hypomanic, manic, depressive, and mixed); depression in childhood and adolescence; major depressive disorders (single episode or recurrent); obsessive-compulsive disorders; paranoid and other psychotic disorders; pervasive developmental disorders; schizo-affective disorders (bipolar or depressive); and schizophrenia. "Small employer" has the meaning assigned by Section 1501.002.

SECTION 3. Amends Section 1355.002, Insurance Code, as follows:

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including: (1) a group insurance policy, group insurance agreement, group hospital service contract, or group evidence of coverage 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; or (E) a health maintenance organization operating under Chapter 843; and (2) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

SECTION 4. Subsections (a) and (b), Section 1355.003, Insurance Code, is amended to read as follows:

Sec. 1355.003 (a) This subchapter does not apply to coverage under: (1) a blanket accident and health insurance policy, as described by Chapter 1251; (2) a short-term travel policy; (3) an accident-only policy; (4) a plan that provides coverage: (A) only for benefits for a specified disease or for another limited benefit, other than a plan that provides benefits for mental health or similar services; (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) only for dental or vision care; or (F) only for indemnity for hospital confinement; (5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); (6) a workers' compensation insurance policy; (7) medical payment insurance coverage provided under an automobile insurance policy; (8) a credit insurance policy; (9) 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 group health benefit plan as described by Section 1355.002 (10) except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601; or (11) a plan offered in accordance with Section 1355.151.

(b) For the purposes of a plan described by Subsection (a)(10) "serious mental illness" has the meaning assigned by Section 1355.001.

SECTION 5. Amends Subchapter A, Chapter 1355, Insurance Code, by adding Sections 1355.0031 through 1355.0035, as follows:

Sec. 1355.0031. COVERAGE EQUITY REQUIRED. (a) Except as provided by Subsection (c), a group health benefit plan that provides coverage for any mental disorder must provide coverage for the diagnosis and medically necessary treatment of that mental

disorder under terms at least as favorable as the coverage provided under the health benefit plan for the diagnosis and treatment of medical and surgical conditions.

(b) A group health benefit plan may not establish separate cost-sharing requirements that are only applicable to coverage for mental disorders.

(c) A group health benefit plan that is a standard health benefit plan under Chapter 1507, except for a plan issued to a small employer, is required to provide coverage for a mental disorder only if the mental disorder is a serious mental illness, and only to the extent required by Sections 1355.004(b) and (c) and Sections 1507.003 and 1507.053.

Sec. 1355.0032. TREATMENT LIMITATIONS; FINANCIAL REQUIREMENTS. (a) Defines "financial requirements" and "treatment limitations."

(b) A group health benefit plan that provides coverage for the diagnosis and medically necessary treatment of mental disorders may not impose treatment limitations or financial requirements on the provision of benefits under that coverage if identical limitations or requirements are not imposed on coverage for the diagnosis and treatment of medical and surgical conditions covered by the plan.

(c) This section does not prohibit a group health benefit plan issuer from negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits that are consistent with the requirements under Subsection (b) regarding treatment limitations and financial requirements.

(d) This section does not prohibit a group health benefit plan issuer from managing the provision of benefits for treatment of mental disorders as necessary to provide services for covered benefits, including: (1) use of any utilization review, authorization, or other similar management practices; (2) application of medical necessity and appropriateness criteria applicable to behavioral health; and (3) contracting with and using a network of providers.

(e) This section does not prohibit a group health benefit plan from complying with the requirements of this subchapter in a manner that takes into consideration similar treatment settings or similar treatments.

Sec. 1355.0033. OUT-OF-NETWORK COVERAGE. (a) Provides that if a group health benefit plan offers out-of-network coverage for medical and surgical benefits under the plan, the group health benefit plan must also offer out-of-network coverage for benefits for treatment of mental disorders.

(b) If the group health benefit plan provides benefits for medical and surgical conditions and treatment of mental disorders, and provides those benefits on both an in-network and out-of-network basis under the terms of the plan, the group health benefit plan must ensure that the requirements of this subchapter are applied to both in-network and out-of-network services by comparing in-network medical and surgical benefits to in-network benefits for treatment of mental disorders and out-of-network medical and surgical benefits to out-of-network benefits for treatment of mental disorders.

(c) This section may not be construed as requiring that a group health benefit plan eliminate an out-of-network provider option from the plan under the terms of the plan.

Sec. 1355.0034. SMALL EMPLOYER PLANS. An issuer of a group health benefit plan to a small employer under Chapter 1501 must offer coverage for mental disorders that are not classified as serious mental illnesses that is equal to that provided under the plan for other medical and surgical care, but is not required to provide the coverage if the employer rejects the coverage.

Sec. 1355.0035. COST EXEMPTION. (a) If the issuer of a group health benefit plan experiences increased actual total costs of coverage, as a result of compliance with the coverage equity requirements adopted under Sections 1355.0031-1355.0034, that exceed two percent during the first year of operation of the plan, that plan is exempt in the manner prescribed by this section from application of those equity requirements for the following second plan year if the group health benefit plan issuer complies with the requirements of this section.

(b) If the issuer of a group health benefit plan experiences increased actual total costs of coverage, as a result of compliance with the coverage equity requirements adopted under Sections 1355.0031-1355.0034, that exceed one percent during a year of operation after the first plan year, that plan is exempt in the manner prescribed by this section from application of those equity requirements for the following plan year if the group health benefit plan issuer complies with the requirements of this section.

(c) A group health benefit plan issuer that seeks an exemption under Subsection (a) or (b) must apply to the department in the manner prescribed by the commissioner. A group health benefit plan issuer is only eligible to seek a cost exemption under this section after the group health benefit plan has complied with the coverage equity requirements of this subchapter for at least the first six months of the plan year in which application is made.

(d) To qualify for the cost exemption under Subsection (a) or (b), a group health benefit plan issuer must submit the application required under Subsection (c), accompanied by the written certification of a qualified actuary who is a member in good standing of the American Academy of Actuaries that the increase in costs described by Subsection (a) or (b) is solely the result of compliance with the coverage equity requirements of this subchapter.

(e) The department shall review the actuarial assessment submitted under Subsection (d). Based on the department review of the assessment, the commissioner shall inform the issuer of the group health benefit plan in writing as to whether or not the assessment satisfactorily demonstrates that the cost exemption is justified under Subsection (a) or (b). On receipt of a determination from the commissioner that the cost exemption is justified, the group health benefit plan is exempt from the coverage equity requirements of this subchapter as provided by this section.

(f) Notwithstanding Subsection (a) or (b), an employer may elect to continue to apply the coverage equity requirements adopted under this subchapter with respect to the group health benefit plan regardless of any increase in total costs.

SECTION 6. Amends Sections 1355.004, 1355.005, and 1355.007, Insurance Code, as follows:

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL ILLNESS. (a) Except as provided by Subsections (b) and (c), a group health benefit plan must provide coverage, based on medical necessity, for the diagnosis and medically necessary treatment of serious mental illness under terms at least as favorable as the coverage provided under the health benefit plan for the diagnosis and treatment of medical and surgical conditions.

(b) A group health benefit plan issuer that issues a standard health benefit plan under Chapter 1507, except for a plan issued to a small employer: (1) must provide coverage, based on medical necessity, for not less than the following treatments of serious mental illness in each calendar year: (A) 45 days of inpatient treatment; and (B) 60 visits for outpatient treatment, including group and individual outpatient treatment; (2) may not include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient

treatment covered under the plan; and (3) must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious mental illness as the plan includes for physical illness.

(c) A group health benefit plan issuer that issues a standard health benefit plan under Chapter 1507: (1) may not count an outpatient visit for medication management against the number of outpatient visits required to be covered under Subsection (b)(1)(B) and (2) must provide coverage for an outpatient visit described by Subsection (b)(1)(B) under the same terms as the coverage the issuer provides for an outpatient visit for the treatment of physical illness.

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group health benefit plan issuer may provide or offer coverage required by this subchapter through a managed care plan.

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer under Chapter 1501 must offer the coverage for serious mental illnesses described by Section 1355.004(a) to the employer but is not required to provide the coverage if the employer rejects the coverage.

SECTION 7. Amends Subchapter A, Chapter 1355, Insurance Code, by adding Section 1355.008, as follows:

Sec. 1355.008. RULES. The commissioner shall adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to administer this subchapter.

SECTION 8. The change in law made by this Act applies only to a group health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2008. A group 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 9. This Act takes effect September 1, 2007.

EFFECTIVE DATE

September 1, 2007.