BILL ANALYSIS

Senate Research Center
80R18011 PB-F

C.S.S.B. 568
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State Affairs
5/4/2007
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

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

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 2 (Section 1355.0015, Insurance Code) and SECTION 7 (Section 1355.008, Insurance Code) of this bill.

SECTION BY SECTION 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

(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." Makes nonsubstantive changes.

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

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter pertains to a multiple employer welfare arrangement holding a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements), rather than as permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.) or another analogous benefit arrangement.

SECTION 4. Amends Section 1355.003(a), Insurance Code, to includes plans providing certain forms of coverage, Medicare supplemental policies as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), workers' compensation policies, medical payment insurance coverage provided by automobile insurance policies, credit insurance policies, and long-term care insurance policies, in the list of policies and plans to which this subchapter does not apply. Removes Medicare supplement benefit plans from the list of policies and plans to which this subchapter does not apply. Makes conforming changes.

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) Provides that except as provided by Subsection (c), a 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 plan for the diagnosis and treatment of medical and surgical conditions.

(b) Prohibits a plan from establishing separate cost-sharing requirements that are only applicable to coverage for mental disorders.

(c) Provides that a plan that is a standard plan under Chapter 1507 (Consumer Choice of Benefits Plan), Insurance Code, 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 (State-Mandated Health Benefits), and 1507.0053, Insurance Code.

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

(b) Prohibits a plan that provides coverage for the diagnosis and medically necessary treatment of mental disorders from imposing 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) Provides that this section does not prohibit a 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) Provides that this section does not prohibit a plan issuer from managing the provision of benefits for treatment of mental disorders as necessary to provides cervices for covered benefits. Sets forth certain covered benefits included under this subsection.

(e) Provides that this section does not prohibit a 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 plan must also offer out-of-network coverage for benefits for treatment of mental disorders.

(b) Provides that if the 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 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) Prohibits this section from being construed as requiring that a plan eliminate an out-of-network provider option from the plan under the terms of the plan.

Sec. 1355.0034. SMALL EMPLOYER PLANS. Provides that an issuer of a plan to a small employer under Chapter 1501 (Health Insurance Portability and Availability Act), Insurance Code, 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) Provides that if the issuer of a 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 plan issuer complies with the requirements of this section.

(b) Provides that if the issuer of a 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 plan issuer complies with the requirements of this section.

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

(d) Requires a plan issuer, to qualify for the cost exemption under Subsection (a) or (b), to 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) Requires TDI to review the actuarial assessment submitted under Subsection (d). Requires the commissioner to inform the issuer of the plan in writing as to whether or not the assessment satisfactorily demonstrates that the cost exemption is justified under Subsection (a) or (b) based on TDI's review of the assessment.

Provides that on receipt of a determination from the commissioner that the cost exemption is justified, the plan is exempt from the coverage equity requirements of this subchapter as provided by this section.

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

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) Provides that except as provided by Subsections (b) and (c), a 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 plan for the diagnosis and treatment of medical and surgical conditions. Makes conforming and nonsubstantive changes.

(b) Sets forth certain coverage that a plan issuer that issues a standard plan under Chapter 1507 (Consumer Choice Benefits Plan), Insurance Code, must provide in each calendar year.

(c) Makes conforming changes.

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. Provides that a plan issuer may provide or offer coverage required by this subchapter, rather than Section 1355.004, through a managed care plan.

Sec. 1355.007. SMALL EMPLOYER COVERAGE. Provides that an issuer of a plan to a small employer under Chapter 1501 (Health Insurance Portability and Availability Act), Insurance Code must offer the coverage for serious mental illnesses described by Section 1355.004(a), rather than 1355.004, to the employer but is not required to provide coverage if the employer rejects coverage.

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

Sec. 1355.008. RULES. Requires the commissioner of insurance to adopt rules necessary to administer this subchapter.

SECTION 8. Amends Section 1355.151(b), Insurance Code, to prohibit a political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees from contracting for or providing coverage that is less extensive fore serious mental illness than the coverage required under Section 1355.004(a), rather than provided for any other physical illness.

SECTION 9. Makes application of this Act prospective to January 1, 2008.

SECTION 10. Effective date: September 1, 2007.