By: Smith of Tarrant H.B. No. 1919

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan coverage for treatment for certain brain injuries and serious mental illnesses.

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

SECTION 1. Section 1352.001, Insurance Code, is amended to read as follows:

Sec. 1352.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan, including, subject to this chapter, a small employer health benefit plan written under Chapter 1501, 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 offered by:

(1) an insurance company;

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

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

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

(5) a reciprocal exchange operating under Chapter 942;

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

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

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

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

(b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

SECTION 2. Section 1352.003, Insurance Code, is amended to read as follows:

Sec. 1352.003. REQUIRED COVERAGES--HEALTH BENEFIT PLANS OTHER THAN SMALL EMPLOYER HEALTH BENEFIT PLANS [~~EXCLUSION OF COVERAGE PROHIBITED~~]. (a) A health benefit plan must include [~~may not exclude~~] coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and [~~or~~] psychophysiological testing and [~~or~~] treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury.

(b) A health benefit plan must include coverage for [~~,~~] post-acute transition services, [~~or~~] 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.

(c) A health benefit plan may not include, in any lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan. Any limitation imposed under the plan on days of post-acute care treatment must be separately stated in the plan.

(d) Except as provided by Subsection (c), a health benefit plan must include the same payment limitations, deductibles, copayments, and coinsurance factors for coverage [~~(b) Coverage~~] required under this chapter as [~~may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum payment limits~~] applicable to other similar coverage provided under the health benefit plan.

(e) 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.

(f) A determination of whether expenses, as described by Subsection (e), are reasonable may include consideration of factors including:

(1) cost;

(2) the time that has expired since the previous

evaluation;

(3) any difference in the expertise of the physician or practitioner performing the evaluation;

(4) changes in technology; and

(5) advances in medicine.

(g) [~~(c)~~] The commissioner shall adopt rules as necessary to implement this chapter [~~section~~].

(h) This section does not apply to a small employer health benefit plan.

SECTION 3. Chapter 1352, Insurance Code, is amended by adding Section 1352.0035 to read as follows:

Sec. 1352.0035. REQUIRED COVERAGES--SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) A small employer health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this section may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum payment limits applicable to other similar coverage provided under the small employer health benefit plan.

(c) The commissioner shall adopt rules as necessary to

implement this section.

SECTION 4. Section 1352.004(b), Insurance Code, is amended to read as follows:

(b) The commissioner by rule shall require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan. The purpose of the training is to prevent denial of coverage in violation of Section 1352.003 and to avoid confusion of medical benefits with mental health benefits. The commissioner, in consultation with the Texas Traumatic Brain Injury Advisory Council, shall prescribe by rule the basic requirements for the training described by this subsection.

SECTION 5. Chapter 1352, Insurance Code, is amended by adding Sections 1352.005, 1352.006, 1352.007, and 1352.008 to read as follows:

Sec. 1352.005. NOTICE TO INSUREDS AND ENROLLEES. (a) A health benefit plan issuer subject to this chapter, other than a small employer health benefit plan issuer, must notify each insured or enrollee under the plan in writing about the coverages described by Section 1352.003.

(b) The commissioner, in consultation with the Texas Traumatic Brain Injury Advisory Council, shall prescribe by rule the specific contents and wording of the notice required under this section.

(c) The notice required under this section must include:

(1) a description of the benefits listed under Section 1352.003;

(2) a statement that the fact that an acquired brain injury does not result in hospitalization or receipt of a specific treatment or service described by Section 1352.003 for acute care treatment does not affect the right of the insured or enrollee to receive benefits described by Section 1352.003 commensurate with the condition of the insured or enrollee; and

(3) a statement of the fact that benefits described by Section 1352.003 may be provided in a facility listed in Section 1352.007.

(d) The notice described by this section must be provided not later than the 10th day after the date on which the health benefit plan issuer receives a claim for coverage for treatment that would reasonably indicate that the insured or enrollee has incurred an acquired brain injury.

Sec. 1352.006. DETERMINATION OF MEDICAL NECESSITY; EXTENSION OF COVERAGE. (a) In this section, "utilization review" has the meaning assigned by Section 4201.002.

(b) Notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under this code, a health benefit plan shall respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal. The person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document. To comply with the requirements of this

section, the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer. This subsection does not apply to a small employer health benefit plan.

(c) Notwithstanding Section 4201.152 or any other law of this state, a physician or other health care practitioner who determines the medical necessity of a health care service provided under this chapter to a resident of this state must be licensed to practice in this state.

Sec. 1352.007. TREATMENT FACILITIES. (a) 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; or

(6) a medical office.

(b) This section does not apply to a small employer health

benefit plan.

Sec. 1352.008. CONSUMER INFORMATION. The commissioner shall prepare information for use by consumers, purchasers of health benefit plan coverage, and self-insurers regarding coverages recommended for acquired brain injuries. The department shall publish information prepared under this section on the department's Internet website.

SECTION 6. Section 1355.001(1), Insurance Code, is amended to read as follows:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

(A) bipolar disorders (hypomanic, manic, depressive, and mixed);

(B) depression in childhood and adolescence;

(C) major depressive disorders (single episode or recurrent);

(D) obsessive-compulsive disorders;

(E) paranoid and other psychotic disorders;

(F) pervasive developmental disorders;

(G) schizo-affective disorders (bipolar or depressive); [~~and~~]

(H) schizophrenia; and

(I) anorexia nervosa and bulimia nervosa.

SECTION 7. Section 1355.007, Insurance Code, is amended to read as follows:

Sec. 1355.007. SMALL EMPLOYER COVERAGE. (a) An issuer of a

group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage.

(b) Regardless of whether a small employer accepts the coverage required by Subsection (a), an issuer of a group health benefit plan to a small employer must provide the coverage required by Section 1355.004 for persons under the age of 19 years for the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

(1) depression in childhood and adolescence; and

(2) anorexia nervosa and bulimia nervosa.

SECTION 8. (a) On or before September 1, 2012, the Sunset Advisory Commission shall conduct a study to determine:

(1) to what extent the health benefit plan coverage required by the change in law made by this Act to Chapter 1355, Insurance Code, is being used by enrollees in health benefit plans to which those articles apply; and

(2) the impact of the required coverage on the cost of those health benefit plans.

(b) The Sunset Advisory Commission shall report its findings under this section to the legislature on or before January 1, 2013.

(c) The Texas Department of Insurance and any other state agency shall cooperate with the Sunset Advisory Commission as necessary to implement this section.

SECTION 9. This Act applies only to a health benefit plan 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 10. This Act takes effect September 1, 2007.