SENATE AMENDMENTS

2nd Printing

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;

1 (7) a health maintenance organization operating under
2 Chapter 843;
3 (8) a multiple employer welfare arrangement that holds
4 a certificate of authority under Chapter 846; or
5 (9) an approved nonprofit health corporation that
6 holds a certificate of authority under Chapter 844.
7 (b) Notwithstanding any provision in Chapter 1551, 1575,
8 1579, or 1601 or any other law, this chapter applies to:
9 (1) a basic coverage plan under Chapter 1551;
10 (2) a basic plan under Chapter 1575;
11 (3) a primary care coverage plan under Chapter 1579;
12 and
13 (4) basic coverage under Chapter 1601.
14 SECTION 2. Section 1352.003, Insurance Code, is amended to
15 read as follows:
16 Sec. 1352.003. REQUIRED COVERAGES--HEALTH BENEFIT PLANS
17 OTHER THAN SMALL EMPLOYER HEALTH BENEFIT PLANS [~~EXCLUSION OF~~
18 ~~COVERAGE PROHIBITED~~]. (a) A health benefit plan must include [~~may~~
19 ~~not exclude~~] coverage for cognitive rehabilitation therapy,
20 cognitive communication therapy, neurocognitive therapy and
21 rehabilitation, neurobehavioral, neurophysiological,
22 neuropsychological, and [~~or~~] psychophysiological testing and [~~or~~]
23 treatment, neurofeedback therapy, and remediation required for and
24 related to treatment of an acquired brain injury.
25 (b) A health benefit plan must include coverage for [~~,~~]
26 post-acute transition services, [~~or~~] community reintegration
27 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

1 implement this section.
2 SECTION 4. Section 1352.004(b), Insurance Code, is amended
3 to read as follows:
4 (b) The commissioner by rule shall require a health benefit
5 plan issuer to provide adequate training to personnel responsible
6 for preauthorization of coverage or utilization review under the
7 plan. The purpose of the training is to prevent denial of coverage
8 in violation of Section 1352.003 and to avoid confusion of medical
9 benefits with mental health benefits. The commissioner, in
10 consultation with the Texas Traumatic Brain Injury Advisory
11 Council, shall prescribe by rule the basic requirements for the
12 training described by this subsection.
13 SECTION 5. Chapter 1352, Insurance Code, is amended by
14 adding Sections 1352.005, 1352.006, 1352.007, and 1352.008 to read
15 as follows:
16 Sec. 1352.005. NOTICE TO INSUREDS AND ENROLLEES. (a) A
17 health benefit plan issuer subject to this chapter, other than a
18 small employer health benefit plan issuer, must notify each insured
19 or enrollee under the plan in writing about the coverages described
20 by Section 1352.003.
21 (b) The commissioner, in consultation with the Texas
22 Traumatic Brain Injury Advisory Council, shall prescribe by rule
23 the specific contents and wording of the notice required under this
24 section.
25 (c) The notice required under this section must include:
26 (1) a description of the benefits listed under Section
27 1352.003;

1 (2) a statement that the fact that an acquired brain
2 injury does not result in hospitalization or receipt of a specific
3 treatment or service described by Section 1352.003 for acute care
4 treatment does not affect the right of the insured or enrollee to
5 receive benefits described by Section 1352.003 commensurate with
6 the condition of the insured or enrollee; and
7 (3) a statement of the fact that benefits described by
8 Section 1352.003 may be provided in a facility listed in Section
9 1352.007.
10 (d) The notice described by this section must be provided
11 not later than the 10th day after the date on which the health
12 benefit plan issuer receives a claim for coverage for treatment
13 that would reasonably indicate that the insured or enrollee has
14 incurred an acquired brain injury.
15 Sec. 1352.006. DETERMINATION OF MEDICAL NECESSITY;
16 EXTENSION OF COVERAGE. (a) In this section, "utilization review"
17 has the meaning assigned by Section 4201.002.
18 (b) Notwithstanding Chapter 4201 or any other law relating
19 to the determination of medical necessity under this code, a health
20 benefit plan shall respond to a person requesting utilization
21 review or appealing for an extension of coverage based on an
22 allegation of medical necessity not later than three business days
23 after the date on which the person makes the request or submits the
24 appeal. The person must make the request or submit the appeal in
25 the manner prescribed by the terms of the plan's health insurance
26 policy or agreement, contract, evidence of coverage, or similar
27 coverage document. To comply with the requirements of this

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

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

10 Sec. 1352.007. TREATMENT FACILITIES. (a) A health benefit
11 plan may not deny coverage under this chapter based solely on the
12 fact that the treatment or services are provided at a facility other
13 than a hospital. Treatment for an acquired brain injury may be
14 provided under the coverage required by this chapter, as
15 appropriate, at a facility at which appropriate services may be
16 provided, including:

17 (1) a hospital regulated under Chapter 241, Health and
18 Safety Code, including an acute rehabilitation hospital;

19 (2) an assisted living facility regulated under
20 Chapter 247, Health and Safety Code;

21 (3) a nursing home regulated under Chapter 242, Health
22 and Safety Code;

23 (4) a community home;

24 (5) an acute or post-acute rehabilitation facility,
25 including a residential or outpatient facility; or

26 (6) a medical office.

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

1 benefit plan.

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

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

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

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

15 (B) depression in childhood and adolescence;

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

18 (D) obsessive-compulsive disorders;

19 (E) paranoid and other psychotic disorders;

20 (F) pervasive developmental disorders;

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

23 (H) schizophrenia; and

24 (I) anorexia nervosa and bulimia nervosa.

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

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

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

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

12 (1) depression in childhood and adolescence; and

13 (2) anorexia nervosa and bulimia nervosa.

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

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

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

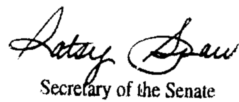
22 (b) The Sunset Advisory Commission shall report its
23 findings under this section to the legislature on or before January
24 1, 2013.

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

1 SECTION 9. This Act applies only to a health benefit plan
2 delivered, issued for delivery, or renewed on or after January 1,
3 2008. A health benefit plan delivered, issued for delivery, or
4 renewed before January 1, 2008, is governed by the law as it existed
5 immediately before the effective date of this Act, and that law is
6 continued in effect for that purpose.
7 SECTION 10. This Act takes effect September 1, 2007.

ADOPTED

FLOOR AMENDMENT NO. 1 MAY 23 2007 BY:


Secretary of the Senate

H.B. No. 1919, senate committee printing, as follows:

(1) Insert a new SECTION of the bill, appropriately numbered, to read as follows:

SECTION ___. The heading to Subchapter A, Chapter 1355, Insurance Code, is amended to read as follows:

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

(2) Insert a new SECTION of the bill, appropriately numbered, to read as follows:

SECTION ___. Section 1355.001, Insurance Code, is amended by amending Subdivision (1) and by adding Subdivisions (3) and (4) 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

(G) [~~(H)~~] schizophrenia.

(3) "Autism spectrum disorder" means a neurobiological disorder that includes autism, Asperger's

1 syndrome, or Pervasive Developmental Disorder--Not Otherwise
2 Specified.
3 (4) "Neurobiological disorder" means an illness of
4 the nervous system caused by genetic, metabolic, or other
5 biological factors.
6 (3) Insert a new SECTION of the bill, appropriately
7 numbered, to read as follows:
8 SECTION ___. Subchapter A, Chapter 1355, Insurance Code,
9 is amended by adding Section 1355.015 to read as follows:
10 Sec. 1355.015. REQUIRED COVERAGE FOR CERTAIN CHILDREN.
11 (a) At a minimum, a health benefit plan must provide coverage
12 as provided by this section to an enrollee older than two years
13 of age and younger than six years of age who is diagnosed with
14 autism spectrum disorder. If an enrollee who is being treated
15 for autism spectrum disorder becomes six years of age or older
16 and continues to need treatment, this subsection does not
17 preclude coverage of treatment and services described by
18 Subsection (b).
19 (b) The health benefit plan must provide coverage under
20 this section to the enrollee for all generally recognized
21 services prescribed in relation to autism spectrum disorder by
22 the enrollee's primary care physician in the treatment plan
23 recommended by that physician. An individual providing
24 treatment prescribed under this subsection must be a health care
25 practitioner:
26 (1) who is licensed, certified, or registered by an
27 appropriate agency of this state;
28 (2) whose professional credential is recognized and
29 accepted by an appropriate agency of the United States; or
30 (3) who is certified as a provider under the TRICARE

1 military health system.

2 (c) For purposes of Subsection (b), "generally recognized

3 services" may include services such as:

4 (1) evaluation and assessment services;

5 (2) applied behavior analysis;

6 (3) behavior training and behavior management;

7 (4) speech therapy;

8 (5) occupational therapy;

9 (6) physical therapy; or

10 (7) medications or nutritional supplements used to

11 address symptoms of autism spectrum disorder.

12 (d) Coverage under Subsection (b) may be subject to annual

13 deductibles, copayments, and coinsurance that are consistent

14 with annual deductibles, copayments, and coinsurance required

15 for other coverage under the health benefit plan.

16 (e) Notwithstanding any other law, this section does not

17 apply to a standard health benefit plan provided under Chapter

18 1507.

19 (4) Renumber the SECTIONS of the bill accordingly.

20

FLOOR AMENDMENT NO. 2 ADOPTED BY: Rodney Ellis

MAY 23 2007

Secretary of the Senate

1 Amend H.B. No. 1919 (Senate committee printing) by adding
2 the following appropriately numbered SECTIONS to the bill and
3 renumbering subsequent SECTIONS accordingly:
4 SECTION _____. The heading to Subchapter A, Chapter 1355,
5 Insurance Code, is amended to read as follows:
6 SUBCHAPTER A. [~~GROUP~~] HEALTH BENEFIT PLAN COVERAGE FOR
7 CERTAIN MENTAL DISORDERS AND SERIOUS MENTAL ILLNESSES
8 SECTION _____. Subchapter A, Chapter 1355, Insurance Code,
9 is amended by amending Section 1355.001 and by adding Section
10 1355.0015 to read as follows:
11 Sec. 1355.001. PURPOSE. The legislature recognizes that
12 mental illnesses are biologically based and treatable and that,
13 with appropriate care, individuals with mental illness can live
14 productive and successful lives. The purpose of this subchapter
15 is to ensure that this recognition is reflected in group health
16 benefit plans by requiring that the benefits provided for mental
17 disorders be equal to those provided for other medical and
18 surgical conditions.
19 Sec. 1355.0015. DEFINITIONS. In this subchapter:
20 (1) "Enrollee" means an individual who is enrolled in
21 a group health benefit plan, including a covered dependent.
22 (2) "Mental disorder" means a disorder defined by the
23 American Psychiatric Association in the Diagnostic and
24 Statistical Manual of Mental Disorders (DSM), fourth edition, or
25 a subsequent edition of that manual that the commissioner by
26 rule adopts to take the place of the fourth edition, except that
27 the term does not include:
28 (A) a mental disorder classified under that
29 manual as a "V-code" disorder;

(B) mental retardation;

(C) a learning disorder;

(D) a motor skill disorder; or

(E) a communication disorder.

(3) "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:

(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.

(4) [~~(2)~~] "Small employer" has the meaning assigned by Section 1501.002.

SECTION _____. Section 1355.002, Insurance Code, is amended to read 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

1 coverage that is offered by:
2 (A) an insurance company;
3 (B) a group hospital service corporation
4 operating under Chapter 842;
5 (C) a fraternal benefit society operating under
6 Chapter 885;
7 (D) a stipulated premium company operating under
8 Chapter 884; or
9 (E) a health maintenance organization operating
10 under Chapter 843; and
11 (2) [~~to the extent permitted by the Employee~~
12 ~~Retirement Income Security Act of 1974 (29 U.S.C. Section 1001~~
13 ~~et seq.), a plan offered under:~~
14 [~~(A)~~] a multiple employer welfare arrangement
15 that holds a certificate of authority under Chapter 846 [~~as~~
16 ~~defined by Section 3 of that Act; or~~
17 [~~(B) another analogous benefit arrangement~~].
18 SECTION _____. Subsections (a) and (b), Section 1355.003,
19 Insurance Code, is amended to read as follows:
20 (a) This subchapter does not apply to coverage under:
21 (1) a blanket accident and health insurance policy,
22 as described by Chapter 1251;
23 (2) a short-term travel policy;
24 (3) an accident-only policy;
25 (4) a plan that provides coverage:
26 (A) only for benefits for a specified disease or
27 for another limited benefit, other than a plan that provides
28 benefits for mental health or similar services;
29 (B) only for accidental death or dismemberment;
30 (C) for wages or payments in lieu of wages for a
31 period during which an employee is absent from work because of

1 sickness or injury;

2 (D) as a supplement to a liability insurance
3 policy;

4 (E) only for dental or vision care; or

5 (F) only for indemnity for hospital confinement;

6 (5) a Medicare supplemental policy as defined by
7 Section 1882(g)(1), Social Security Act (42 U.S.C. Section
8 1395ss);

9 (6) a workers' compensation insurance policy;

10 (7) medical payment insurance coverage provided under
11 an automobile insurance policy;

12 (8) a credit insurance policy;

13 (9) a long-term care insurance policy, including a
14 nursing home fixed indemnity policy, unless the commissioner
15 determines that the policy provides benefit coverage so
16 comprehensive that the policy is a group health benefit plan as
17 described by Section 1355.002 [~~limited or specified disease~~
18 ~~policy that does not provide benefits for mental health care or~~
19 ~~similar services~~];

20 (10) [~~(5)~~] except as provided by Subsection (b), a
21 plan offered under Chapter 1551 or Chapter 1601; or

22 (11) [~~(6)~~] a plan offered in accordance with Section
23 1355.151[~~; or~~

24 [~~(7) a Medicare supplement benefit plan, as defined~~
25 ~~by Section 1652.002~~].

26 (b) For the purposes of a plan described by Subsection
27 (a)(10) [~~(a)(5)~~], "serious mental illness" has the meaning
28 assigned by Section 1355.0015.

29 SECTION ____. Subchapter A, Chapter 1355, Insurance Code,
30 is amended by adding Sections 1355.0031 through 1355.0035 to
31 read as follows:

1 Sec. 1355.0031. COVERAGE EQUITY REQUIRED. (a) Except as
2 provided by Subsection (c), a group health benefit plan that
3 provides coverage for any mental disorder must provide coverage
4 for the diagnosis and medically necessary treatment of that
5 mental disorder under terms at least as favorable as the
6 coverage provided under the health benefit plan for the
7 diagnosis and treatment of medical and surgical conditions.
8 (b) A group health benefit plan may not establish separate
9 cost-sharing requirements that are only applicable to coverage
10 for mental disorders.
11 (c) A group health benefit plan that is a standard health
12 benefit plan under Chapter 1507, except for a plan issued to a
13 small employer, is required to provide coverage for a mental
14 disorder only if the mental disorder is a serious mental
15 illness, and only to the extent required by Sections 1355.004(b)
16 and (c) and Sections 1507.003 and 1507.053.
17 Sec. 1355.0032. TREATMENT LIMITATIONS; FINANCIAL
18 REQUIREMENTS. (a) For purposes of this section:
19 (1) "Financial requirements" include requirements
20 relating to deductibles, copayments, coinsurance, out-of-pocket
21 expenses, and annual and lifetime limits.
22 (2) "Treatment limitations" include limitations on
23 the frequency of treatments, number of visits, days of coverage,
24 or other similar limits on the scope and duration of coverage.
25 (b) A group health benefit plan that provides coverage for
26 the diagnosis and medically necessary treatment of mental
27 disorders may not impose treatment limitations or financial
28 requirements on the provision of benefits under that coverage if
29 identical limitations or requirements are not imposed on
30 coverage for the diagnosis and treatment of medical and surgical
31 conditions covered by the plan.

1 (c) This section does not prohibit a group health benefit
2 plan issuer from negotiating separate reimbursement or provider
3 payment rates and service delivery systems for different
4 benefits that are consistent with the requirements under
5 Subsection (b) regarding treatment limitations and financial
6 requirements.
7 (d) This section does not prohibit a group health benefit
8 plan issuer from managing the provision of benefits for
9 treatment of mental disorders as necessary to provide services
10 for covered benefits, including:
11 (1) use of any utilization review, authorization, or
12 other similar management practices;
13 (2) application of medical necessity and
14 appropriateness criteria applicable to behavioral health; and
15 (3) contracting with and using a network of
16 providers.
17 (e) This section does not prohibit a group health benefit
18 plan from complying with the requirements of this subchapter in
19 a manner that takes into consideration similar treatment
20 settings or similar treatments.
21 Sec. 1355.0033. OUT-OF-NETWORK COVERAGE. (a) If a group
22 health benefit plan offers out-of-network coverage for medical
23 and surgical benefits under the plan, the group health benefit
24 plan must also offer out-of-network coverage for benefits for
25 treatment of mental disorders.
26 (b) If the group health benefit plan provides benefits for
27 medical and surgical conditions and treatment of mental
28 disorders, and provides those benefits on both an in-network and
29 out-of-network basis under the terms of the plan, the group
30 health benefit plan must ensure that the requirements of this
31 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

1 the requirements of this section.

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

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

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

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

SECTION _____. Sections 1355.004, 1355.005, and 1355.007, Insurance Code, are amended to read as follows:

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL ILLNESS. (a) Except as provided by Subsections (b) and (c), a [~~A~~] group health benefit plan[~~:~~

[~~(1)~~] must provide coverage, based on medical necessity, for the diagnosis and medically necessary treatment [~~not less than the following treatments~~] 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) [~~(b)~~] 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) [~~(a)(1)(B)~~]; and

(2) must provide coverage for an outpatient visit described by Subsection (b)(1)(B) [~~(a)(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 [~~Section 1355.004~~] 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) [~~1355.004~~] to the employer but is not required to provide the coverage if the employer rejects the coverage.

SECTION _____. Subchapter A, Chapter 1355, Insurance Code, is amended by adding Section 1355.008 to read 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.

ADOPTED

MAY 23 2007

[signature]
Secretary of the Senate

COMMITTEE AMENDMENT NO. 1 BY: Van de Putte

1 Amend H.B. No. 1919, house engrossment, as follows:

2 (1) Strike SECTION 6 of the bill, amending Subdivision (1),
3 Section 1355.001, Insurance Code (page 8, lines 8-24).

4 (2) Strike SECTION 7 of the bill, amending Section 1355.007,
5 Insurance Code (page 8, lines 25-27, and page 9, lines 1-13).

6 (3) Strike SECTION 8 of the bill, directing the Sunset
7 Advisory Commission to conduct a study (page 9, lines 14-27).

8 (4) Renumber the SECTIONS of the bill accordingly.

COMMITTEE AMENDMENT NO. 2   BY: Van de Putte

<EOH>

1 Amend H.B. No. 1919, house engrossment printing, in SECTION
2 1 of the bill, in amended Section 1352.001, Insurance Code, by
3 striking added Subsection (b) (page 2, lines 7-13), and
4 substituting the following:
5 (b) Notwithstanding any provision in Chapter 1575, 1579,
6 or 1601 or any other law, this chapter applies to:
7 (1) a basic plan under Chapter 1575;
8 (2) a primary care coverage plan under Chapter 1579;
9 and
10 (3) basic coverage under Chapter 1601.

ADOPTED

MAY 23 2007

Secretary of the Senate

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COMMITTEE AMENDMENT NO. 3 BY: Van de Putte

1 Amend H.B. No. 1919 (House Engrossment) as follows:

2 (1) In SECTION 5 of the bill, in added Subsection (a),
3 Section 1352.005, Insurance Code, between "must" and "notify"
4 (page 5, line 18), insert "annually".

5 (2) In SECTION 5 of the bill, strike added Subsection (d),
6 Section 1352.005, Insurance Code (page 6, lines 10-14).

7 (3) In SECTION 5 of the bill, strike added Subsection (c),
8 Section 1352.006, Insurance Code (page 7, lines 5-9).

9 (4) In SECTION 5 of the bill, in added Subdivision (1),
10 Subsection (a), Section 1352.007, Insurance Code, between
11 "acute" and "rehabilitation" (page 7, line 18), insert "or post-
12 acute".

13 (5) In SECTION 5 of the bill, in added Subdivision (1),
14 Subsection (a), Section 1352.007, Insurance Code, following the
15 underlined semicolon (page 7, line 18), insert "and".

16 (6) In SECTION 5 of the bill, in added Subdivision (2),
17 Subsection (a), Section 1352.007, Insurance Code (page 7, line
18 20), strike the underlined semicolon and substitute an
19 underlined period.

20 (7) In SECTION 5 of the bill, strike added Subdivisions
21 (3)-(6), Subsection (a), Section 1352.007, Insurance Code (page
22 7, lines 21-26).

ADOPTED

MAY 23 2007

Patsy Spaw
Secretary of the Senate

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LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

May 21, 2007

TO: Honorable Robert Duncan, Chair, Senate Committee on State Affairs

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1919** by Smith, Todd (Relating to health benefit plan coverage for treatment for certain brain injuries and serious mental illnesses.), **Committee Report 2nd House, As Amended**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to require health benefit plans to provide coverage for testing, treatment, rehabilitation, and reintegration services in response to an acquired brain injury. Based on the analysis of the Teacher Retirement System, it is assumed any costs associated with the bill would be insignificant because their health benefit plans currently provide coverage in compliance with the requirements of the bill. Based on the analysis of the Employees Retirement System (ERS), it is assumed the bill would not apply to health plans administered by ERS.

Based on the analysis the Texas Department of Insurance (TDI), it is assumed that there would be a one-time revenue gain of $25,700 in the General Revenue Dedicated Account Fund 36 in fiscal year 2008 because the bill would result in 257 filings, each accompanied by a $100 filing fee. Since General Revenue Dedicated Account Fund 36 is a self-leveling account, this analysis assumes all revenue generated would go toward fund balances or the maintenance tax would be set to recover a lower level of revenue the following year. It is also assumed that any costs realized by TDI from implementing the provisions of the bill could be absorbed within existing resources.

The bill would take effect September 1, 2007, and would only apply to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008.

Local Government Impact

Montgomery County and the cities of Austin, Houston, and Sherman reported that implementing the provisions of the bill would have a significantly negative impact on their budgets. Insurance rates would have to increase to cover the potential losses for the added coverage; however, the increases would be difficult to estimate because of the lack of specialized medical information available to these local entities and the inability to predict the number of employees affected by the specified acquired brain injuries.

Dallas and Harris counties reported that the provisions of the bill would have no significant impact on their budgets.

Source Agencies: 323 Teacher Retirement System, 327 Employees Retirement System, 454 Department of Insurance

LBB Staff: JOB, KJG, JRO, MW, SK

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

May 17, 2007

TO: Honorable Robert Duncan, Chair, Senate Committee on State Affairs

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1919** by Smith, Todd (Relating to health benefit plan coverage for treatment for certain brain injuries and serious mental illnesses.), **As Engrossed**

Estimated Two-year Net Impact to General Revenue Related Funds for HB1919, As Engrossed: a negative impact of ($1,540,372) through the biennium ending August 31, 2009.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2008	$0
2009	($1,540,372)
2010	($1,718,107)
2011	($1,836,598)
2012	($1,955,088)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *GENERAL REVENUE FUND* 1	Probable (Cost) from *GR DEDICATED ACCOUNTS* 994	Probable (Cost) from *OTHER SPECIAL STATE FUNDS* 998	Probable (Cost) from *STATE HIGHWAY FUND* 6
2008	$0	$0	$0	$0
2009	($1,540,372)	($80,331)	($8,067)	($358,024)
2010	($1,718,107)	($89,600)	($8,998)	($399,335)
2011	($1,836,598)	($95,780)	($9,618)	($426,875)
2012	($1,955,088)	($101,959)	($10,239)	($454,416)

Fiscal Year	Probable (Cost) from *FEDERAL FUNDS* 555
2008	$0
2009	($340,465)
2010	($379,750)
2011	($405,939)
2012	($432,129)

Fiscal Analysis

The bill would amend the Insurance Code to require health benefit plans to provide coverage for testing, treatment, rehabilitation, and reintegration services in response to an acquired brain injury.

The bill would amend the Insurance Code to require coverage of anorexia nervosa and bulimia under certain group health benefit plans. The bill would require the Sunset Advisory Commission, with the cooperation of the Texas Department of Insurance (TDI), to conduct a study.

The bill would take effect September 1, 2007, and would require that changes made by the bill would only apply to a group health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008.

Methodology

Based on the analysis of the Employees Retirement System and Teacher Retirement System, it is assumed any costs associated with the bill's provision relating to coverage for services in response to an acquired brain injury would be insignificant because their health benefit plans currently provide coverage in compliance with the requirements of the bill.

It is assumed the bill would require health plans administered by Employees Retirement System (ERS) to include coverage for anorexia and bulimia. It is assumed ERS would incur costs for this coverage in the amounts reflected in the table above.

Based on the analysis of ERS, it is assumed the prevalence of these illnesses for females is 0.3 percent for anorexia and 1.0 percent for bulimia and the prevalence for males is 10 percent of that for females. It is assumed the treatment rate for these illnesses is 33.3 percent for anorexia and 6 percent for bulimia. It is also assumed allowable charges of $50,000 for treatment and that the amount paid for each patient would be 95 percent of allowable charges. In addition, this analysis does not include costs related to coverage for treatment facilities because the bill does not appear to address this issue.

Based on the analysis of the Sunset Advisory Commission and TDI, it is assumed duties and responsibilities associated with conducting a study regarding coverage for anorexia and bulimia under the bill could be absorbed with existing resources.

Based on the analysis the Texas Department of Insurance (TDI), it is assumed that there would be a one-time revenue gain of $31,300 in the General Revenue Dedicated Account Fund 36 in fiscal year 2008 because the bill would result in 313 filings, each accompanied by a $100 filing fee. Since General Revenue Dedicated Account Fund 36 is a self-leveling account, this analysis assumes all revenue generated would go toward fund balances or the maintenance tax would be set to recover a lower level of revenue the following year. It is also assumed that any costs realized by TDI from implementing the provisions of the bill could be absorbed within existing resources.

Local Government Impact

Counties, municipalities, and other local government entities to which the provisions of the bill requiring coverage for anorexia and bulimia would apply under the Local Government Code that either provide health insurance benefits for their employees and employees' dependents or participate in a group risk pool to provide insurance benefits could experience an increase in costs of negotiated health insurance contracts to include the additional coverage required by the bill. Whether those amounts would be absorbed by the local entity or passed on to the insured employees or in what amounts would vary depending on decisions made by local government officials and number of employees covered.

Montgomery County and the cities of Austin, Houston, and Sherman reported that implementing the provisions of the bill relating to coverage for services in response to an acquired brain injury would have a significantly negative impact on their budgets. Insurance rates would have to rise to cover the potential losses for the added coverage; however, the increases would be difficult to estimate because of the lack of specialized medical information available to these local entities and the inability to predict the number of employees affected by the specified acquired brain injuries. Dallas and Harris counties reported that provision of the bill would have no significant impact on their budgets.

Source Agencies: 323 Teacher Retirement System, 327 Employees Retirement System, 454 Department of Insurance, 116 Sunset Advisory Commission

LBB Staff: JOB, KJG, JRO, MW, SK

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

April 30, 2007

TO: Honorable John T. Smithee, Chair, House Committee on Insurance

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1919** by Smith, Todd (Relating to health benefit plan coverage for treatment for certain brain injuries.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to require health benefit plans to provide coverage for testing, treatment, rehabilitation, and reintegration services in response to an acquired brain injury.

Based on the analysis of the Employees Retirement System and Teacher Retirement System, it is assumed any costs associated with the bill would be insignificant because their health benefit plans currently provide coverage in compliance with the requirements of the bill.

Based on the analysis the Texas Department of Insurance (TDI), it is assumed that there would be a one-time revenue gain of $25,700 in the General Revenue Dedicated Account Fund 36 in fiscal year 2008 because the bill would result in 257 filings, each accompanied by a $100 filing fee. Since General Revenue Dedicated Account Fund 36 is a self-leveling account, this analysis assumes all revenue generated would go toward fund balances or the maintenance tax would be set to recover a lower level of revenue the following year. It is also assumed that any costs realized by TDI from implementing the provisions of the bill could be absorbed within existing resources.

The bill would take effect September 1, 2007, and would only apply to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008.

Local Government Impact

Montgomery county and the cities of Austin, Houston, and Sherman reported that implementing the provisions of the bill would have a significantly negative impact on their budgets. Insurance rates would have to increase to cover the potential losses for the added coverage; however, the increases would be difficult to estimate because of the lack of specialized medical information available to these local entities and the inability to predict the number of employees affected by the specified acquired brain injuries.

Dallas and Harris counties reported that the provisions of the bill would have no significant impact on their budgets.

Source Agencies: 323 Teacher Retirement System, 327 Employees Retirement System, 454 Department of Insurance

LBB Staff: JOB, JRO, MW, SK, KJG

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

March 25, 2007

TO: Honorable John T. Smithee, Chair, House Committee on Insurance

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB1919** by Smith, Todd (Relating to health benefit plan coverage for treatment for certain brain injuries.), **As Introduced**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to require health benefit plans to provide coverage for testing, treatment, rehabilitation, and reintegration services in response to an acquired brain injury.

Based on the analysis of the Employees Retirement System and Teacher Retirement System, it is assumed any costs associated with the bill would be insignificant because their health benefit plans currently provide coverage in compliance with the requirements of the bill.

Based on the analysis the Texas Department of Insurance (TDI), it is assumed that there would be a one-time revenue gain of $25,600 in the General Revenue Dedicated Account Fund 36 in fiscal year 2008 because the bill would result in 256 filings, each accompanied by a $100 filing fee. Since General Revenue Dedicated Account Fund 36 is a self-leveling account, this analysis assumes all revenue generated would go toward fund balances or the maintenance tax would be set to recover a lower level of revenue the following year. It is also assumed that any costs realized by TDI from implementing the provisions of the bill could be absorbed within existing resources.

The bill would take effect September 1, 2007, and would only apply to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008.

Local Government Impact

Montgomery County and the cities of Austin, Houston, and Sherman reported that implementing the provisions of the bill would have a significantly negative impact on their budgets. Insurance rates would have to increase to cover the potential losses for the added coverage; however, the increases would be difficult to estimate because of the lack of specialized medical information available to these local entities and the inability to predict the number of employees affected by the specified acquired brain injuries.

Dallas and Harris counties reported that the provisions of the bill would have no significant impact on their budgets.

Source Agencies: 323 Teacher Retirement System, 327 Employees Retirement System, 454 Department of Insurance

LBB Staff: JOB, JRO, MW, SK, KJG