House Bill 1919
Senate Amendments
Section-by-Section Analysis

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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	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 1575, 1579, or 1601 or any other law, this chapter applies to:	

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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.	(1) a basic plan under Chapter 1575; (2) a primary care coverage plan under Chapter 1579; and (3) 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	Same as House version.	

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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		

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(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.	Same as House version.	

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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.	Same as House version.	
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	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 annually 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	

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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.	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.	
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	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	

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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.	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:	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;	(1) a hospital regulated under Chapter 241, Health and Safety Code, including an acute or post-acute rehabilitation hospital; and	
(2) an assisted living facility regulated under Chapter 247, Health and Safety Code;	(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		

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(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.	(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.	
No equivalent provision.	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	
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);	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);	

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(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.	(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 syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified. (4) "Neurobiological disorder" means an illness of the nervous system caused by genetic, metabolic, or other biological factors.	
SECTION 7. Section 1355.007, Insurance Code, is amended to read as follows:	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 1ess than the following treatments] of serious mental illness under terms at least as favorable as the coverage	

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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)60visitsforoutpatienttreatment, 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

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	provide or offer coverage required by this subchapter [~~Section 1355.004~~] through a managed care plan.	
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.	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.	
(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.		
No equivalent provision.	SECTION __. Subchapter A, Chapter 1355, Insurance Code, is amended by adding Section 1355.015 to read as follows: Sec. 1355.015. REQUIRED COVERAGE FOR CERTAIN CHILDREN. (a) At a minimum, a health benefit plan must provide coverage as provided by this section to an enrollee older than two years of age and younger than six years of age who is diagnosed with autism spectrum disorder. If an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, this	

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	subsection does not preclude coverage of treatment and services described by Subsection (b). (b) The health benefit plan must provide coverage under this section to the enrollee for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. An individual providing treatment prescribed under this subsection must be a health care practitioner: (1) who is licensed, certified, or registered by an appropriate agency of this state; (2) whose professional credential is recognized and accepted by an appropriate agency of the United States; or (3) who is certified as a provider under the TRICARE military health system. (c) For purposes of Subsection (b), "generally recognized services" may include services such as: (1) evaluation and assessment services; (2) applied behavior analysis; (3) behavior training and behavior management; (4) speech therapy; (5) occupational therapy; (6) physical therapy; or (7) medications or nutritional supplements used to address symptoms of autism spectrum disorder. (d) Coverage under Subsection (b) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health	

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	benefit plan. (e) Notwithstanding any other law, this section does not apply to a standard health benefit plan provided under Chapter 1507.	
No equivalent provision.	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 MENTAL DISORDERS AND SERIOUS MENTAL ILLNESSES	
No equivalent provision.	SECTION __. Subchapter A, Chapter 1355, Insurance Code,is amended by amending Section 1355.001 and by adding Section 1355.0015 to read as follows: Sec. 1355.001. PURPOSE. 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. The purpose of this subchapter is to ensure that this recognition is reflected in 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. In this subchapter: (1)"Enrollee" means an individual who is enrolled in a group health benefit plan, including a covered dependent. (2)"Mental disorder" means a disorder defined by the	

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	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) a mental disorder classified under that 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.	

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No equivalent provision.	SECTION __. Section1355.002,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 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) [~~to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:~~ [~~(A)~~] a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 [~~as defined by Section 3 of that Act; or~~ [~~(B) another analogous benefit arrangement~~]	

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No equivalent provision.	SECTION __. Subsections (a) and (b), Section 1355.003, Insurance Code, is amended to read as follows: (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 [~~limited or~~	

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	~~specified disease policy that does not provide benefits for mental health care or similar services~~]; (10)[~~(5)~~] except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601; or (11)[~~(6)~~] a plan offered in accordance with Section 1355.151[~~; or~~ [~~(7)a Medicare supplement benefit plan, as defined by Section 1652.002~~]. (b) For the purposes of a plan described by Subsection (a)(10) [~~(a)(5)~~], "serious mental illness" has the meaning assigned by Section 1355.0015.	
No equivalent provision.	SECTION __. Subchapter A, Chapter 1355, Insurance Code, is amended by adding Sections 1355.0031 through 1355.0035 to read 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	

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	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) For purposes of this section: (1)"Financial requirements" include requirements relating to deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. (2)"Treatment limitations" include limitations on the frequency of treatments, number of visits, days of coverage, or other similar limits on the scope and duration of coverage. (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.	

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	(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) 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.	

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	(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	

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	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	

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	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.	
No equivalent provision.	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.	
No equivalent provision.	SECTION __. 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 8. (a) On or before September 1, 2012, the Sunset Advisory Commission shall conduct a study to determine:	No equivalent provision.	

HOUSE VERSION	SENATE VERSION	CONFERENCE
(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 9. Same as House version.	
No equivalent provision.	SECTION __. This Act takes effect September 1, 2007.	
SECTION 10. This Act takes effect September 1, 2007.	SECTION 10. Same as House version.	