BILL ANALYSIS

Senate Research Center
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H.B. 2929
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Chapter 1352 (Brain Injury), Insurance Code, extends medically necessary post-acute brain injury health care coverage to certain eligible policyholders. Most insurance carriers adhere to the intent of this statute, with one major exception. In this instance, this carrier has a huge market in this state. And its market now includes State of Texas employees and retirees.

When this carrier took over the Employees Retirement System of Texas (ERS) health care plan contract in September 2012, one Austin area provider had to request that ERS intervene on behalf of two state employees and one state retiree who were admitted at that time to its facility. The new ERS carrier had refused to take over these patients' coverage because they were receiving treatment from a provider licensed as an assisted living facility (ALF). The carrier considers such coverage custodial care, although this ALF, and several others throughout the state, are not conventional custodial care facilities. Rather, these ALFs are licensed and accredited to provide a full continuum of specialized post-acute brain injury rehabilitation.

Many or most of these specialized ALFs hold the highest level of brain injury treatment accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF).

The previous contract carrier agreed to extend its coverage to these ERS patients during the transition, allowing them to successfully complete their brain injury rehabilitation.

Long before taking over the ERS contract in 2012, this carrier repeatedly denied or limited treatment to private sector policyholders referred to these specialized ALFs. A number of consumer complaints filed by one of these providers at the Texas Department of Insurance eventually led to an enforcement case against the carrier. Rather than adhering to the law's intent, the carrier instead took advantage of a provision in the statute that allows a carrier to file a "separately stated policy" if it chooses to offer significantly reduced brain injury health care coverage benefits.

H.B. 2929 clarifies current provisions within the statute that have hindered a policyholder or enrollee from being admitted to a facility licensed by the state of Texas as ALF because a carrier deems it "custodial care"; and extends coverage to certain groups, such as ERS, that otherwise would not be covered if a policyholder or enrollee within these groups sustain a brain injury.

H.B. 2929 amends current law relating to health benefit plan coverage for brain injury.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1352.001, Insurance Code, by amending Subsection (b) and adding Subsection (c), as follows:

> (b) Provides that this chapter, notwithstanding any provision in Chapter 1551 (Texas Employees Group Benefits Act), 1575 (Texas Public School Employees Group Benefits

Program), 1579 (Texas School Employees Uniform Group Health Coverage), or 1601 (Uniform Insurance Act for Employees of the University of Texas System and the Texas A&M University System) or any other law, 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.

Makes nonsubstantive changes.

(c) Provides that this chapter applies to group health coverage made available by a school district in accordance with Section 22.004 (Group Health Benefits for School Employees), Education Code.

SECTION 2. Amends Section 1352.002, Insurance Code, as follows:

Sec. 1352.002. New heading: EXCEPTION; APPLICATION TO QUALIFIED HEALTH PLAN. (a) Creates this subsection from existing text and makes no further change.

(b) Provides that this chapter does not apply to a standard health benefit plan issued under Chapter 1507 (Consumer Choice of Benefits Plans).

(c) Provides that a qualified health plan, as defined by 45 C.F.R. Section 155.20, to the extent that a change in law made to this chapter after January 1, 2013, would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), is not required to provide a benefit under this section that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

SECTION 3. Amends Section 1352.003, Insurance Code, by amending Subsections (c) and (d) and adding Subsection (c-1), as follows:

(c) Prohibits a health benefit plan from including, in any annual or lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan. Deletes existing text requiring that any limitation imposed under the plan on days of post-acute care treatment be separately stated in the plan.

(c-1) Prohibits a health benefit plan from limiting the number of days of covered post-acute care, including any therapy or treatment or rehabilitation, testing, remediation, or other service described by Subsections (a) (relating to requiring a health benefit plan to include coverage for certain neurological and physiological resources) and (b) (relating to requiring a health benefit plan to include coverage for post-acute transition services, 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), or the number of days of covered inpatient care to the extent that the treatment or care is determined to be medically necessary as a result of and related to an acquired brain injury. Requires the insured's or enrollee's treating physician to determine whether treatment or care is medically necessary for purposes of this subsection in consultation with the treatment or care provider, the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family. Provides that the determination is subject to review under Section 1352.006 (Determination of Medical Necessity; Extension of Coverage).

(d) Requires that a health benefit plan, except as provided by Subsection (c) or (c-1), include the same amount limitations, deductibles, copayments, and coinsurance factors

for coverage required under this chapter as applicable to other medical conditions for which coverage is provided under the health benefit plan, rather than requiring that a health benefit plan, except as provided by Subsection (c), include the same payment limitations, deductibles, copayments, and coinsurance factors for coverage required under this chapter as applicable to other similar coverage provided under the health benefit plan.

SECTION 4. Amends Section 1352.0035(b), Insurance Code, as follows:

(b) Authorizes coverage required under this section to be subject to deductibles, copayments, coinsurance, or annual or maximum amount limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum amount limits applicable to other medical conditions for which coverage is provided under the small employer health benefit plan, rather than 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.

SECTION 5. Amends Section 1352.007, Insurance Code, by adding Subsections (c), (d), (e), and (f), as follows:

(c) Prohibits the issuer of a health benefit plan, including a preferred provider benefit plan or health maintenance organization plan, that contracts with or approves admission to a service provider under this chapter from, solely because a facility is licensed by this state as an assisted living facility, refusing to contract with or approve admission to that facility to provide services that are:

(1) required under this chapter;

(2) within the scope of the license of an assisted living facility; and

(3) within the scope of the services provided under a CARF-accredited rehabilitation program for brain injury or another nationally recognized accredited rehabilitation program for brain injury.

(d) Requires the issuer of a health benefit plan that requires or encourages insureds or enrollees to use health care providers designated by the plan to ensure that the services required by this chapter that are within the scope of the license of an assisted living facility and that are authorized to be provided under a program described by Subsection (c)(3) are made available and accessible to the insureds or enrollees at an adequate number of assisted living facilities.

(e) Prohibits a health benefit plan from treating care provided in accordance with this chapter as custodial care solely because it is provided by an assisted living facility if the facility holds a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury.

(f) Authorizes the commissioner of insurance, to ensure the health and safety of insureds and enrollees, to require that a licensed assisted living facility that provides covered post-acute care other than custodial care under this chapter to an insured or enrollee with acquired brain injury hold a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury.

SECTION 6. Provides that Chapter 1352, Insurance Code, as amended by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2014. Provides that a health benefit plan delivered, issued for delivery, or renewed before January 1, 2014, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 7. Effective date: September 1, 2013.