BILL ANALYSIS

C.S.H.B. 2929
By: Sheets
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties contend that, while certain Insurance Code provisions were intended to extend health care coverage for post-acute brain injury care that is medically necessary to eligible policyholders, certain insurance providers have used provisions in the statutes to deny policyholders coverage. It has been observed that many patients use licensed assisted living facilities for care, many of which are specialized facilities that hold the highest level of brain injury treatment accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF). There is concern that certain insurance providers have classified care provided by such facilities as custodial care, rather than post-acute care, which allows them to deny necessary coverage to policyholders. Interested parties further contend that some of the most affected individuals who are denied brain injury coverage are those who are enrolled in health insurance plans issued under the Employees Retirement System of Texas.

C.S.H.B. 2929 seeks to amend current law relating to health benefit plan coverage for brain injury by extending the applicability of that law to certain additional types of coverage, by prohibiting certain limitations on medically necessary care, and by setting out provisions relating to coverage for care provided by assisted living facilities.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 2929 amends the Insurance Code to expand the applicability of statutory provisions relating to certain required health benefit plan coverages for brain injury to include a basic coverage plan under the Texas Employees Group Benefits Act and group health coverage made available by a school district under statutory provisions relating to group health benefits for school employees and to exempt a standard health benefit plan issued under statutory provisions relating to consumer choice of benefits plans from those mandatory brain injury coverage provisions. The bill establishes that, to the extent a change in law made to such brain injury coverage provisions after January 1, 2013, would otherwise require the state to make a payment under federal law to or on behalf of an individual enrolled in a qualified health benefit plan, a qualified health benefit plan, as defined by federal law, is not required to provide a benefit for brain injury that exceeds the specified essential health benefits required under federal law.

C.S.H.B. 2929 prohibits a health benefit plan from including any post-acute care treatment covered under the plan in any annual limitation on the number of days of acute care treatment covered under the plan. The bill removes a provision requiring any limitation imposed under a health benefit plan on days of post-acute care treatment to be separately stated in the plan. The bill prohibits a health benefit plan from limiting the number of days of covered post-acute care 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. The bill requires

the insured's or enrollee's treating physician to determine whether treatment or care is medically necessary for such purposes in consultation with the treatment or care provider, the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family. The bill makes this determination of medical necessity subject to review under applicable statutory provisions.

C.S.H.B. 2929 clarifies that a health benefit plan is required to include the same amount limitations, deductibles, copayments, and coinsurance factors for required brain injury coverage as applicable to other medical conditions for which coverage is provided under the plan, rather than the same payment limitations, deductibles, copayments, and coinsurance factors for required brain injury coverage as applicable to other similar coverage provided under the health benefit plan. The bill makes a similar clarification to statutory provisions relating to the deductibles, copayments, coinsurance, or limits to which the coverage provided under a small employer health benefit plan may be subject.

C.S.H.B. 2929 prohibits the issuer of a health benefit plan that contracts with or approves admission to a service provider under statutory provisions relating to brain injury coverage from refusing to contract with or approve admission to an assisted living facility to provide services that are required to be covered under the plan's brain injury coverage, that are within the scope of the assisted living facility's license, and that are 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 solely because the facility is licensed as an assisted living facility. The bill 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 brain injury services for which plan coverage is required that are within the scope of an assisted living facility's license and that may be provided under an accredited rehabilitation program for brain injury are made available and accessible to the insureds or enrollees at an adequate number of assisted living facilities. The bill prohibits a health benefit plan from treating brain injury care 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.

C.S.H.B. 2929 authorizes the commissioner of insurance to require a licensed assisted living facility that provides covered post-acute care other than custodial care to an insured or enrollee with acquired brain injury to hold a CARF accreditation or other nationally recognized accreditation for a rehabilitation program for brain injury. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2014.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2929 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 1352.001, Insurance Code, is amended by amending Subsection (b) and adding Subsections (c) and (d) to read as follows: (b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any	SECTION 1. Section 1352.001, Insurance Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows: (b) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any

other law, this chapter applies to: (1) a basic coverage plan under Chapter 1551; (2) a basic plan under Chapter 1575; (3) [~~(2)~~] a primary care coverage plan under Chapter 1579; and (4) [~~(3)~~] basic coverage under Chapter 1601.	other law, this chapter applies to: (1) a basic coverage plan under Chapter 1551; (2) a basic plan under Chapter 1575; (3) [~~(2)~~] a primary care coverage plan under Chapter 1579; and (4) [~~(3)~~] basic coverage under Chapter 1601.
(c) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.	(c) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.
(d) Notwithstanding Section 172.014, Local Government Code, or any other law, this chapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.	
No equivalent provision.	SECTION 2. Section 1352.002, Insurance Code, is amended to read as follows: Sec. 1352.002. EXCEPTION; APPLICATION TO QUALIFIED HEALTH PLAN. (a) This chapter does not apply to: (1) a plan that provides coverage: (A) only for a specified disease or for another limited benefit other than an accident policy; (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) for credit insurance; (F) only for dental or vision care; (G) only for hospital expenses; or (H) only for indemnity for hospital confinement; (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended; (3) a workers' compensation insurance policy; (4) medical payment insurance coverage provided under a motor vehicle insurance policy; or (5) 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 health

benefit plan as described by Section 1352.001.

(b) This chapter does not apply to a standard health benefit plan issued under Chapter 1507.

(c) 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), a qualified health plan, as defined by 45 C.F.R. Section 155.20, 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 2. Section 1352.003, Insurance Code, is amended by amending Subsections (c) and (d) and adding Subsections (c-1) and (c-2) to read as follows:

(c) A health benefit plan may not include, 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. Any limitation imposed under the plan on days of the post-acute care treatment required by this chapter is subject to Subsections (c-1) and (c-2) and must be clearly and separately stated in the plan using language that specifically identifies each therapy or treatment or rehabilitation, testing, remediation, or other service described by Subsections (a) and (b) that is subject to the limitation. A provision that purports to limit the number of days of treatment under a health benefit plan that does not specifically identify a particular therapy or treatment or testing, remediation, or other service described by Subsection (a) or (b) is void as applied to that therapy, treatment, or service. This subsection does not authorize a limitation on the number of days of treatment that is otherwise prohibited by state or federal law.

(c-1) Notwithstanding Subsection (c), a health benefit plan may not limit 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) and (b), 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

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

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

(c-1) A health benefit plan may not limit 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) and (b), 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. The insured's or enrollee's treating

related to an acquired brain injury. The insured's or enrollee's treating physician shall 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. The determination is subject to review under Section 1352.006.

(c-2) A health benefit plan must provide coverage for custodial care for an insured or enrollee if custodial care is determined to be the appropriate level of care for the insured or enrollee as a result of and related to an acquired brain injury. Notwithstanding Subsection (c), a health benefit plan may not limit the number of days of covered custodial care under this subsection. The insured's or enrollee's treating physician shall determine whether custodial care is the appropriate level of care for purposes of this subsection in consultation with the care provider, the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family. The determination is subject to review under Section 1352.006 as if it were a determination of medical necessity.

(d) Except as provided by Subsection (c), (c-1), or (c-2), a health benefit plan must 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.

No equivalent provision.

SECTION 3. Section 1352.007, Insurance Code, is amended by adding Subsections (c), (d), (e), and (f) to read as follows:

(c) The issuer of a health benefit plan,

physician shall 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. The determination is subject to review under Section 1352.006.

(d) Except as provided by Subsection (c) or (c-1), a health benefit plan must include the same amount [~~payment~~] limitations, deductibles, copayments, and coinsurance factors for coverage required under this chapter as applicable to other medical conditions for which [~~similar~~] coverage is provided under the health benefit plan.

SECTION 4. Section 1352.0035(b), Insurance Code, is amended to read as follows:

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

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

(c) The issuer of a health benefit plan,

including a preferred provider benefit plan or health maintenance organization plan, that contracts with a hospital to provide services under this chapter to insureds and enrollees may not, solely because a facility is an assisted living facility, refuse to contract with that facility to provide services that are:

(1) required under this chapter; and

(2) within the scope of the license of the assisted living facility.

including a preferred provider benefit plan or health maintenance organization plan, that contracts with or approves admission to a service provider under this chapter may not, solely because a facility is licensed by this state as an assisted living facility, refuse 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) The issuer of a health benefit plan that requires or encourages insureds or enrollees to use health care providers designated by the plan shall ensure that the services required by this chapter that are within the scope of the license of an assisted living facility are made available and accessible to the insureds or enrollees at an adequate number of assisted living facilities.

(d) The issuer of a health benefit plan that requires or encourages insureds or enrollees to use health care providers designated by the plan shall ensure that the services required by this chapter that are within the scope of the license of an assisted living facility and that may 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) A health benefit plan may not treat care provided in accordance with this subchapter as custodial care solely because it is provided by an assisted living facility.

(e) A health benefit plan may not treat 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) To ensure the health and safety of insureds and enrollees, the commissioner by rule may require that an 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 meet specific criteria in addition to licensure or obtain a nationally recognized accreditation specified by the commissioner.

(f) To ensure the health and safety of insureds and enrollees, the commissioner may 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 4. 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. 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 6. Same as introduced version.

SECTION 5. This Act takes effect September 1, 2013.	SECTION 7. Same as introduced version.