BILL ANALYSIS

Senate Research Center
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H.B. 3276
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State Affairs
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Current law requires insurers to cover expenses for enrollees diagnosed with autism spectrum disorder from the date of diagnosis until the enrollee completes nine years of age. However, interested parties assert that a critical oversight exists with respect to insurers' coverage of screening for autism spectrum disorder, even though coverage of treatment begins on the date a child is diagnosed. H.B. 3276 seeks to address this oversight by requiring a health benefit plan to, at a minimum, provide coverage for screening for autism spectrum disorder at 18 and 24 months.

H.B. 3276 amends current law relating to the coverage by certain health benefit plans for the screening and treatment of autism spectrum disorder.

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 1355.015, Insurance Code, by amending Subsections (a) and (b) and adding Subsections (a-1) and (f), as follows:

(a) Requires that a health benefit plan, at a minimum, provide coverage for screening a child for autism spectrum disorder at the ages of 18 and 24 months.

(a-1) Redesignates existing Subsection (a) as Subsection (a-1). Requires that a health benefit plan, at a minimum, provide coverage for treatment of autism spectrum disorder as provided by this section to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis until the enrollee completes nine years of age.

(b) Requires an individual providing treatment prescribed under this subsection to be:

(1) a health care practitioner:

(A) who is licensed, certified, or registered by an appropriate agency of this state;

(B) whose professional credential is recognized and accepted by an appropriate agency of the United States; or

(C) who is certified as a provider under the TRICARE military health system; or

(2) an individual acting under the supervision of a health care practitioner described by Subdivision (1).

(f) Provides that Subsection (a) does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter (Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses and Other Disorders) requires the qualified health plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state is required to make payments to defray the cost of the additional benefits mandated by this subchapter.

SECTION 2. Provides that Section 1355.015, 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 3. Effective date: September 1, 2013.