

By: Muñoz, Jr.

H.B. No. 2605

A BILL TO BE ENTITLED

AN ACT

relating to benefits for mental health conditions and substance use disorders.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1355, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

Sec. 1355.251. DEFINITIONS. In this subchapter:

(1) "Financial requirement" includes a requirement relating to a deductible, copayment, coinsurance, or other out-of-pocket expense or an annual or lifetime limit.

(2) "Mental health benefit" means a benefit relating to an item or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(3) "Nonquantitative treatment limitation" includes:

(A) a medical management standard limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether a treatment is experimental or investigational;

(B) formulary design for prescription drugs;

(C) network tier design;

(D) a standard for provider participation in a

1 network, including reimbursement rates;

2 (E) a method used by a health benefit plan to
3 determine usual, customary, and reasonable charges;

4 (F) a step therapy protocol;

5 (G) an exclusion based on failure to complete a
6 course of treatment; and

7 (H) a restriction based on geographic location,
8 facility type, provider specialty, and other criteria that limit
9 the scope or duration of a benefit.

10 (4) "Substance use disorder benefit" means a benefit
11 relating to an item or service for a substance use disorder, as
12 defined under the terms of a health benefit plan and in accordance
13 with applicable federal and state law.

14 (5) "Treatment limitation" includes a limit on the
15 frequency of treatment, number of visits, days of coverage, or
16 other similar limit on the scope or duration of treatment. The term
17 includes a nonquantitative treatment limitation.

18 Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This
19 subchapter applies only to a health benefit plan that provides
20 benefits for medical or surgical expenses incurred as a result of a
21 health condition, accident, or sickness, including an individual,
22 group, blanket, or franchise insurance policy or insurance
23 agreement, a group hospital service contract, an individual or
24 group evidence of coverage, or a similar coverage document, that is
25 offered by:

26 (1) an insurance company;

27 (2) a group hospital service corporation operating

1 under Chapter 842;

2 (3) a fraternal benefit society operating under
3 Chapter 885;

4 (4) a stipulated premium company operating under
5 Chapter 884;

6 (5) a health maintenance organization operating under
7 Chapter 843;

8 (6) a reciprocal exchange operating under Chapter 942;

9 (7) a Lloyd's plan operating under Chapter 941;

10 (8) an approved nonprofit health corporation that
11 holds a certificate of authority under Chapter 844; or

12 (9) a multiple employer welfare arrangement that holds
13 a certificate of authority under Chapter 846.

14 (b) Notwithstanding Section 1501.251 or any other law, this
15 subchapter applies to coverage under a small employer health
16 benefit plan subject to Chapter 1501.

17 (c) This subchapter applies to a standard health benefit
18 plan issued under Chapter 1507.

19 Sec. 1355.253. EXCEPTIONS. (a) This subchapter does not
20 apply to:

21 (1) a plan that provides coverage:

22 (A) for wages or payments in lieu of wages for a
23 period during which an employee is absent from work because of
24 sickness or injury;

25 (B) as a supplement to a liability insurance
26 policy;

27 (C) for credit insurance;

1 (D) only for dental or vision care;

2 (E) only for hospital expenses; or

3 (F) only for indemnity for hospital confinement;

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

7 (3) a workers' compensation insurance policy;

8 (4) medical payment insurance coverage provided under
9 a motor vehicle insurance policy; or

10 (5) a long-term care policy, including a nursing home
11 fixed indemnity policy, unless the commissioner determines that the
12 policy provides benefit coverage so comprehensive that the policy
13 is a health benefit plan as described by Section 1355.252.

14 (b) To the extent that this section would otherwise require
15 this state to make a payment under 42 U.S.C. Section
16 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45
17 C.F.R. Section 155.20, is not required to provide a benefit under
18 this subchapter that exceeds the specified essential health
19 benefits required under 42 U.S.C. Section 18022(b).

20 Sec. 1355.254. REQUIRED COVERAGE FOR MENTAL HEALTH
21 CONDITIONS AND SUBSTANCE USE DISORDERS. (a) A health benefit plan
22 must provide benefits for mental health conditions and substance
23 use disorders under the same terms and conditions applicable to
24 benefits for medical or surgical expenses.

25 (b) Coverage under Subsection (a) may not impose treatment
26 limitations or financial requirements on benefits for a mental
27 health condition or substance use disorder that are generally more

1 restrictive than treatment limitations or financial requirements
2 imposed on coverage of benefits for medical or surgical expenses.

3 Sec. 1355.255. DEFINITIONS UNDER PLAN. (a) A health
4 benefit plan must define a condition to be a mental health condition
5 or not a mental health condition in a manner consistent with
6 generally recognized independent standards of medical practice.

7 (b) A health benefit plan must define a condition to be a
8 substance use disorder or not a substance use disorder in a manner
9 consistent with generally recognized independent standards of
10 medical practice.

11 Sec. 1355.256. COORDINATION WITH OTHER LAW; INTENT OF
12 LEGISLATURE. This subchapter supplements Subchapters A and B of
13 this chapter and Chapter 1368 and the department rules adopted
14 under those statutes. It is the intent of the legislature that
15 Subchapter A or B of this chapter or Chapter 1368 or the department
16 rules adopted under those statutes controls in any circumstance in
17 which that other law requires:

18 (1) a benefit that is not required by this subchapter;
19 or
20 (2) a more extensive benefit than is required by this
21 subchapter.

22 Sec. 1355.257. RULES. The commissioner shall adopt rules
23 necessary to implement this subchapter.

24 SECTION 2. (a) The Texas Department of Insurance shall
25 conduct a study and prepare a report on benefits for medical or
26 surgical expenses and for mental health conditions and substance
27 use disorders.

1 (b) In conducting the study, the department must collect and
2 compare data from health benefit plan issuers subject to Subchapter
3 F, Chapter 1355, Insurance Code, as added by this Act, on medical or
4 surgical benefits and mental health condition or substance use
5 disorder benefits that are:

6 (1) subject to prior authorization or utilization
7 review;

8 (2) denied as not medically necessary or experimental
9 or investigational;

10 (3) internally appealed, including data that
11 indicates whether the appeal was denied; or

12 (4) subject to an independent external review,
13 including data that indicates whether the denial was upheld.

14 (c) Not later than September 1, 2018, the department shall
15 report the results of the study and the department's findings.

16 SECTION 3. (a) The Health and Human Services Commission
17 shall conduct a study and prepare a report on benefits for medical
18 or surgical expenses and for mental health conditions and substance
19 use disorders provided by Medicaid managed care organizations.

20 (b) In conducting the study, the commission must collect and
21 compare data from Medicaid managed care organizations on medical or
22 surgical benefits and mental health condition or substance use
23 disorder benefits that are:

24 (1) subject to prior authorization or utilization
25 review;

26 (2) denied as not medically necessary or experimental
27 or investigational;

1 (3) internally appealed, including data that
2 indicates whether the appeal was denied; or

3 (4) subject to an independent external review,
4 including data that indicates whether the denial was upheld.

5 (c) Not later than September 1, 2018, the commission shall
6 report the results of the study and the commission's findings.

7 SECTION 4. Subchapter F, Chapter 1355, Insurance Code, as
8 added by this Act, applies only to a health benefit plan delivered,
9 issued for delivery, or renewed on or after January 1, 2018. A
10 health benefit plan delivered, issued for delivery, or renewed
11 before January 1, 2018, is governed by the law as it existed
12 immediately before the effective date of this Act, and that law is
13 continued in effect for that purpose.

14 SECTION 5. This Act takes effect September 1, 2017.