By: Zaffirini S.B. No. 860

A BILL TO BE ENTITLED

AN ACT

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

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02251 and 531.02252 to read as follows:

Sec. 531.02251. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE. (a) In this section, "ombudsman" means the individual designated as the ombudsman for behavioral health access to care.

(b) The executive commissioner shall designate an ombudsman for behavioral health access to care.

(c) The ombudsman is administratively attached to the office of the ombudsman for the commission.

(d) The ombudsman serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

(e) The ombudsman shall:

(1) interact with consumers and behavioral health care providers with concerns or complaints to help the consumers and providers resolve behavioral health care access issues;

(2) identify, track, and help report potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to nonquantitative treatment limitations;

(3) report concerns, complaints, and potential violations described by Subdivision (2) to the appropriate regulatory or oversight agency;

(3) provide appropriate referrals to help consumers obtain behavioral health care;

(4) develop appropriate points of contact for referrals to other state and federal agencies; and

(5) provide appropriate referrals and information to help consumers or providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies.

(f) The ombudsman shall participate on the mental health condition and substance use disorder parity work group established under Section 531.02252, and provide summary reports of concerns, complaints, and potential violations described by Subsection (e)(2) to the work group. This subsection expires September 1, 2021.

(g) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations described by Subsection (e)(2) from the ombudsman, consumers, or behavioral health care

providers.

Sec. 531.02252. MENTAL HEALTH CONDITION AND SUBSTANCE USE DISORDER PARITY WORK GROUP. (a) The commission shall establish and facilitate a mental health condition and substance use disorder parity work group at the office of mental health coordination to increase understanding of and compliance with state and federal rules, regulations, and statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions and substance use disorders.

(b) The work group may be a part of or a subcommittee of the behavioral health advisory committee.

(c) The work group is composed of:

(1) a representative of:

(A) Medicaid and the child health plan program;

(B) the office of mental health coordination;

(C) the Texas Department of Insurance;

(D) Medicaid managed care organizations;

(E) commercial health benefit plans;

(F) mental health provider organizations;

(G) substance use disorder providers;

(H) mental health consumer advocates;

(I) substance use disorder treatment consumers;

(J) family members of mental health or substance use disorder treatment consumers;

(K) physicians;

(L) hospitals;

(M) children's mental health providers;

(N) utilization review agents; and

(O) independent review organizations; and

(2) the ombudsman for behavioral health access to care.

(d) The work group shall meet at least quarterly.

(e) The work group shall study and make recommendations on:

(1) increasing compliance with the rules, regulations, and statutes described by Subsection (a);

(2) strengthening enforcement and oversight of these laws at state and federal agencies;

(3) improving the complaint processes relating to potential violations of these laws for consumers and providers;

(4) ensuring the commission and the Texas Department of Insurance can accept information concerns relating to these laws and investigate potential violations based on de-identified information and data submitted to providers in addition to individual complaints; and

(5) increasing public and provider education on these laws.

(f) The work group shall develop a strategic plan with metrics to serve as a roadmap to increase compliance with the rules, regulations, and statutes described by Subsection (a) in this state and to increase education and outreach relating to these laws.

(g) Not later than September 1 of each even-numbered year, the work group shall submit a report to the appropriate committees of the legislature and the appropriate state agencies on the findings, recommendations, and strategic plan required by

Subsections (e) and (f).

(h) The work group is abolished and this section expires September 1, 2021.

SECTION 2. 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 network, including reimbursement rates;

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

(F) a step therapy protocol;

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

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

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

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

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan 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, an individual or group evidence of coverage, or a 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 health maintenance organization operating under Chapter 843;

(6) a reciprocal exchange operating under Chapter 942;

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

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

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

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

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

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

(1) a plan that provides coverage:

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

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

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) 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(g)(1));

(3) a workers' compensation insurance policy;

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

(5) a long-term care 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 1355.252.

(b) To the extent that this section 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 subchapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

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

(b) Coverage under Subsection (a) may not impose treatment limitations or financial requirements on benefits for a mental health condition or substance use disorder that are generally more restrictive than treatment limitations or financial requirements imposed on coverage of benefits for medical or surgical expenses.

Sec. 1355.255. DEFINITIONS UNDER PLAN. (a) A health benefit plan must define a condition to be a mental health condition

or not a mental health condition in a manner consistent with generally recognized independent standards of medical practice.

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

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

(1) a benefit that is not required by this subchapter; or

(2) a more extensive benefit than is required by this subchapter.

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

SECTION 3. (a) The Texas Department of Insurance shall conduct a study and prepare a report on benefits for medical or surgical expenses and for mental health conditions and substance use disorders.

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

disorder benefits that are:

(1) subject to prior authorization or utilization review;

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

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

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

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

SECTION 4. (a) The Health and Human Services Commission shall conduct a study and prepare a report on benefits for medical or surgical expenses and for mental health conditions and substance use disorders provided by Medicaid managed care organizations.

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

(1) subject to prior authorization or utilization review;

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

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

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

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

SECTION 5. Subchapter F, Chapter 1355, Insurance Code, as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2018. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2018, 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 6. This Act takes effect September 1, 2017.