

By: Zaffirini

S.B. No. 1141

A BILL TO BE ENTITLED

AN ACT

relating to group health benefit plan coverage for early treatment of first episode psychosis.

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

SECTION 1. Section 1355.001, Insurance Code, is amended by adding Subdivision (5) to read as follows:

(5) "First episode psychosis" means the initial onset of psychosis or symptoms associated with psychosis, caused by:

(A) medical or neurological conditions;

(B) serious mental illness; or

(C) substance use.

SECTION 2. Subchapter A, Chapter 1355, Insurance Code, is amended by adding Section 1355.016 to read as follows:

Sec. 1355.016. REQUIRED COVERAGE FOR EARLY TREATMENT OF FIRST EPISODE PSYCHOSIS. (a) A group health benefit plan must provide coverage, based on medical necessity, as provided by this section to an individual who is younger than 26 years of age and who is diagnosed with first episode psychosis.

(b) The group health benefit plan must provide coverage under this section to the enrollee for all generally recognized services prescribed in relation to first episode psychosis.

(c) For purposes of Subsection (b), "generally recognized services" include:

(1) coordinated specialty care for first episode

1 psychosis treatment, covering each element of the treatment model  
2 included in the Recovery After an Initial Schizophrenia Episode  
3 (RAISE) early treatment program study conducted by the National  
4 Institute of Mental Health regarding treatment for psychosis, as  
5 completed July 2017, including:

6 (A) psychotherapy;

7 (B) medication management;

8 (C) case management;

9 (D) family education and support; and

10 (E) education and employment support;

11 (2) assertive community treatment as described by the  
12 Texas Health and Human Services Commission's Texas Resilience and  
13 Recovery Utilization Management Guidelines: Adult Mental Health  
14 Services, as updated in April 2017, or a more recently updated  
15 version adopted by the commissioner; and

16 (3) peer support services, including:

17 (A) recovery and wellness support;

18 (B) mentoring; and

19 (C) advocacy.

20 (d) Only coordinated specialty care or assertive community  
21 treatment provided by a provider that adheres to the fidelity of the  
22 applicable treatment model and that has contracted with the Health  
23 and Human Services Commission to provide coordinated specialty care  
24 or assertive community treatment for first episode psychosis is  
25 required to be covered under this section.

26 (e) If a group health benefit plan issuer credentials a  
27 psychiatrist or licensed clinical leader of a treatment team to

1 provide generally recognized services for the treatment of first  
2 episode psychosis, all members of the treatment team serving under  
3 the credentialed psychiatrist or licensed clinical leader are  
4 considered to be credentialed by the health benefit plan issuer.

5 (f) A group health benefit plan issuer shall reimburse a  
6 provider of coordinated specialty care or assertive community  
7 treatment for first episode psychosis based on a bundled payment  
8 model instead of providing reimbursement for each service provided  
9 to the enrollee by the member of a treatment team.

10 (g) If requested by a group health benefit plan issuer on or  
11 after March 1, 2027, the department shall contract with an  
12 independent third party with expertise in analyzing health benefit  
13 plan premiums and costs to perform an independent analysis of the  
14 impact of requiring coverage of the team-based treatment models  
15 described by Subsection (c) on health benefit plan premiums.  
16 Notwithstanding Subsection (c), if the analysis finds that premiums  
17 increased annually by more than one percent solely due to requiring  
18 coverage of a specific treatment model, a group health benefit plan  
19 is not required to provide coverage under this section for that  
20 treatment model.

21 SECTION 3. (a) As soon as practicable after the effective  
22 date of this Act, the Texas Department of Insurance shall convene  
23 and lead a work group that includes the Health and Human Services  
24 Commission, providers of generally recognized services described  
25 by Section 1355.016(c), Insurance Code, as added by this Act, and  
26 group health benefit plan issuers. The work group shall:

27 (1) develop the criteria to be used to determine

1 medical necessity for purposes of coverage under Section 1355.016,  
2 Insurance Code, as added by this Act; and

3 (2) determine a coding solution that allows for  
4 coordinated specialty care and assertive community treatment to be  
5 coded and reimbursed as a bundle of services as required under  
6 Section 1355.016(f), Insurance Code, as added by this Act.

7 (b) Not later than January 1, 2022, the work group shall  
8 make recommendations to the department based on its findings.

9 (c) Not later than March 30, 2022, the department shall  
10 adopt rules:

11 (1) establishing the criteria to be used to determine  
12 medical necessity under Section 1355.016(a), Insurance Code, as  
13 added by this Act;

14 (2) creating a coding solution that allows for  
15 reimbursement based on a bundled payment model for coordinated  
16 specialty care and assertive community treatment as required by  
17 Section 1355.016(f), Insurance Code, as added by this Act; and

18 (3) otherwise necessary to implement Section  
19 1355.016, Insurance Code, as added by this Act.

20 SECTION 4. Section 1355.016, Insurance Code, as added by  
21 this Act, applies only to a health benefit plan that is delivered,  
22 issued for delivery, or renewed on or after March 30, 2022. A  
23 health benefit plan delivered, issued for delivery, or renewed  
24 before March 30, 2022, is governed by the law as it existed  
25 immediately before that date, and that law is continued in effect  
26 for that purpose.

27 SECTION 5. This Act takes effect September 1, 2021.