By: Menéndez S.B. No. 336

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan coverage of treatments for pediatric neuroinflammatory disorder.

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

SECTION 1. Chapter 1367, Insurance Code, is amended by adding Subchapter H to read as follows:

SUBCHAPTER H. PEDIATRIC NEUROINFLAMMATORY DISORDERS

Sec. 1367.351. DEFINITIONS. In this subchapter:

(1) "Off-label use" means the use of a prescription drug or therapy approved for use by the United States Food and Drug Administration in a manner other than the approved use.

(2) "Pediatric neuroinflammatory disorder" means an immune-mediated inflammatory condition affecting the central nervous system in an individual younger than 18 years of age, including but not limited to autoimmune encephalitis, post-infectious encephalitis, acute disseminated encephalomyelitis (ADEM), optic neuritis, transverse myelitis, neuromyelitis optica spectrum disorder (NMOSD), pediatric acute-onset neuropsychiatric syndrome (PANS), pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), and other clinically recognized neuroimmune or neuroinflammatory disorders diagnosed by a physician using accepted clinical criteria, diagnostic testing, and clinical judgment.

Sec. 1367.352. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical, surgical, or prescription drug 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, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843;

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

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(6) a stipulated premium company operating under Chapter 884;

(7) a fraternal benefit society operating under Chapter 885;

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this subchapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575; and

(3) a primary care coverage plan under Chapter 1579.

Sec. 1367.353. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage for the treatment of pediatric neuroinflammatory disorder if:

(1) that condition was diagnosed by a physician with appropriate specialty training, including neurology, pediatric neurology, pediatric immunology, pediatric rheumatology, and an equivalent specialty, based on accepted clinical criteria, diagnostic testing, and the physician's clinical judgment;

(2) the treatment is prescribed by the enrollee's treating physician as medically necessary for an individual diagnosed with that condition; and

(3) the enrollee's treating physician documents, in the enrollee's medical record, the clinical rationale for the treatment and the basis for the diagnosis of that condition.

(b) The coverage required by this section must include coverage of:

(1) the following treatments:

(A) immunomodulating therapies, including:

(i) intravenous immunoglobulin therapy;

(ii) rituximab;

(iii) therapeutic plasma exchange;

(iv) cyclophosphamide;

(v) mycophenolate mofetil;

(vi) azathioprine; and

(vii) other disease-modifying therapies used to treat pediatric neuroinflammatory disorder under accepted

clinical practices;

(B) antibiotics; and

(C) behavioral therapy;

(2) costs related to inpatient or outpatient administration of a treatment described by Subdivision (1), including infusion services; and

(3) any other costs associated with administering a treatment described by Subdivision (1), including clinical monitoring, laboratory testing, imaging, and other ancillary services.

(c) In determining whether a treatment is medically necessary under this section, a health benefit plan issuer shall give substantial deference to the clinical judgment of the enrollee's treating physician who has appropriate experience in diagnosing or treating pediatric neuroimmune or neuroinflammatory disorders, taking into consideration the enrollee's clinical presentation, diagnostic findings, treatment history, and response to previous treatment.

Sec. 1367.354. APPROVAL OF TREATMENT. A health benefit plan issuer may not deny or delay approval of a treatment for which coverage is required under Section 1367.353 on the sole basis that:

(1) the treatment is prescribed for an off-label use or is classified by the health benefit plan issuer as experimental or investigational, if the treatment is medically necessary and supported by peer-reviewed medical literature, recognized clinical practice guidelines, or other generally accepted medical evidence applicable to the enrollee's condition;

(2) the enrollee has previously received the same treatment for pediatric neuroinflammatory disorder or another diagnosis; or

(3) the enrollee's diagnosis is listed under a diagnostic code or label other than pediatric neuroinflammatory disorder.

Sec. 1367.355. LIMIT ON COST-SHARING REQUIREMENT. A health benefit plan issuer may not impose a cost-sharing requirement, including a copayment, coinsurance cost, or deductible for a treatment required to be covered under Section 1367.353 that is greater than the cost-sharing requirement applied to other covered health care services within the same benefit tier under the enrollee's health benefit plan.

Sec. 1367.356. PROHIBITION ON MULTIPLE PREAUTHORIZATIONS. For purposes of this section, a subsequent prescription, treatment order, infusion, or administration of the same treatment during the applicable 12-month period does not constitute a new treatment requiring additional preauthorization solely because the treatment is prescribed or administered in separate doses or courses, provided the treatment remains medically necessary for the covered condition under Section 1367.353.

Sec. 1367.357. REPORTING. (a) The department shall:

(1) collect data on any denial or appeal of a denial of a treatment required to be covered under Section 1367.353; and

(2) annually submit to the legislature a written report summarizing the data collected under Subdivision (1).

(b) The department may require a health benefit plan issuer

to submit data to the department in the form and manner prescribed by the commissioner for purposes of complying with this subchapter.

SECTION 2. The changes in law made by this Act apply only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2028.

SECTION 3. This Act takes effect September 1, 2027.