BILL ANALYSIS

C.S.H.B. 3194
By: Bernal
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

While a mammogram serves as an effective early detection method for breast cancer, interested parties note that an individual with dense breast tissue may require a supplemental screening to detect if a tumor is present. Currently, a notice is sent to such a patient on completion of a mammogram regarding the condition and the potential necessity of supplemental screening. The interested parties consider insurance coverage essential in these cases because those who cannot afford the additional testing may lose treatment advantages available to an individual whose breast cancer is detected in its early stages. The parties assert that the use of additional screenings in determining whether tumors are present is a simple preventive measure that could save lives. C.S.H.B. 3194 seeks to provide coverage for diagnostic mammography under certain health benefit plans.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3194 amends the Insurance Code to require an issuer of a health benefit plan that provides coverage for a screening mammogram to provide coverage for a diagnostic mammogram that is no less favorable than coverage for a screening mammogram. The bill requires the coverage for a diagnostic mammogram to be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for a screening mammogram. The bill applies to certain health benefit plans and coverages offered by certain insurers, employers, programs, and organizations as specified by the bill, with certain other specified health benefit plans, policies, and coverages specifically exempted. The bill applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2016.

EFFECTIVE DATE

September 1, 2015.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 3194 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. The heading to Chapter 1356, Insurance Code, is amended.	SECTION 1. Same as introduced version.
SECTION 2. Sections 1356.001 through 1356.005, Insurance Code, are designated as Subchapter A, Chapter 1356, Insurance Code, and a heading is added.	SECTION 2. Same as introduced version.
SECTION 3. Section 1356.001, Insurance Code, is amended.	SECTION 3. Same as introduced version.
SECTION 4. Section 1356.002, Insurance Code, is amended.	SECTION 4. Same as introduced version.
SECTION 5. Section 1356.003, Insurance Code, is amended.	SECTION 5. Same as introduced version.
SECTION 6. Section 1356.004, Insurance Code, is amended.	SECTION 6. Same as introduced version.
SECTION 7. Chapter 1356, Insurance Code, is amended by adding Subchapter B to read as follows: SUBCHAPTER B. DIAGNOSTIC MAMMOGRAPHY Sec. 1356.051. DEFINITIONS. In this subchapter: (1) "Diagnostic mammography" means a method of screening, including x-ray and ultrasound imaging, that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast. (2) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or created under Section 1311(b), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031). (3) "Qualified health plan" has the meaning assigned by Section 1301(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18021).	SECTION 7. Chapter 1356, Insurance Code, is amended by adding Subchapter B to read as follows: SUBCHAPTER B. DIAGNOSTIC MAMMOGRAPHY Sec. 1356.051. DEFINITION. In this subchapter, "diagnostic mammography" means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.
Sec. 1356.052. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies	Sec. 1356.052. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies

only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and 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 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 Lloyd's plan operating under Chapter 941;

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

(6) a reciprocal exchange operating under Chapter 942;

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

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

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

(b) This subchapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(d) This subchapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(e) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this subchapter applies to a church benefits board established under Chapter 22, Business Organizations Code.

(f) Notwithstanding Section 157.008, Local Government Code, or any other law, this subchapter applies to a county employee

only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and 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 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 Lloyd's plan operating under Chapter 941;

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

(6) a reciprocal exchange operating under Chapter 942;

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

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

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

(b) This subchapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(d) This subchapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(e) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this subchapter applies to a church benefits board established under Chapter 22, Business Organizations Code.

(f) Notwithstanding Section 157.008, Local Government Code, or any other law, this subchapter applies to a county employee

health benefit plan established under Chapter 157, Local Government Code.	health benefit plan established under Chapter 157, Local Government Code.
(g) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this subchapter applies to a regional or local health care program established under Chapter 75, Health and Safety Code.	(g) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this subchapter applies to a regional or local health care program established under Chapter 75, Health and Safety Code.
(h) Notwithstanding Section 172.014, Local Government Code, or any other law, this subchapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.	
(i) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:	(h) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:
(1) a basic coverage plan under Chapter 1551;	(1) a basic coverage plan under Chapter 1551;
(2) a basic plan under Chapter 1575;	(2) a basic plan under Chapter 1575;
(3) a primary care coverage plan under Chapter 1579; and	(3) a primary care coverage plan under Chapter 1579; and
(4) basic coverage under Chapter 1601.	(4) basic coverage under Chapter 1601.
(j) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this subchapter.	(i) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this subchapter.
(k) To the extent allowed by federal law, this subchapter applies to:	(j) To the extent allowed by federal law, this subchapter applies to:
(1) the child health plan program operated under Chapter 62, Health and Safety Code;	(1) the child health plan program operated under Chapter 62, Health and Safety Code;
(2) the health benefits plan for children operated under Chapter 63, Health and Safety Code;	(2) the health benefits plan for children operated under Chapter 63, Health and Safety Code;
(3) a state Medicaid program operated under Chapter 32, Human Resources Code; and	(3) a state Medicaid program operated under Chapter 32, Human Resources Code; and
(4) a Medicaid managed care program operated under Chapter 533, Government Code.	(4) a Medicaid managed care program operated under Chapter 533, Government Code.
Sec. 1356.053. EXCEPTIONS. (a) This subchapter does not apply to:	Sec. 1356.053. EXCEPTIONS. This subchapter does not apply to:
(1) a plan that provides coverage:	(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;	(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;	(B) as a supplement to a liability insurance policy;
(C) for credit insurance;	(C) for credit insurance;
(D) only for dental or vision care;	(D) only for dental or vision care;
(E) only for hospital expenses; or	(E) only for hospital expenses;
(F) only for indemnity for hospital confinement;	(F) only for indemnity for hospital confinement; or
	(G) only for a specified disease or for another limited benefit;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); (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 1356.052. (b) This subchapter does not apply to a qualified health plan if a determination is made under 45 C.F.R. Section 155.170 that: (1) this subchapter requires the 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 defray the cost of the benefits mandated under this subchapter.	(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); (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 1356.052.
Sec. 1356.054. COVERAGE REQUIRED. An issuer of a health benefit plan must provide coverage for a diagnostic mammogram as part of an annual well-woman examination covered under the plan if ordered by a licensed health care professional treating the enrollee.	Sec. 1356.054. COVERAGE FOR DIAGNOSTIC MAMMOGRAM. (a) An issuer of a health benefit plan that provides coverage for a screening mammogram must provide coverage for a diagnostic mammogram that is no less favorable than coverage for a screening mammogram. (b) The coverage for a diagnostic mammogram described by Subsection (a) must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for a screening mammogram.
SECTION 8. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.	SECTION 8. Same as introduced version.
SECTION 9. This Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2016. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2016, is governed by the	SECTION 9. Same as introduced version.

law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	
SECTION 10. This Act takes effect September 1, 2015.	SECTION 10. Same as introduced version.