BILL ANALYSIS

Senate Research Center | C.S.S.B. 585
By: Nelson
Economic Development
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Committee Report (Substituted)

DIGEST

Currently, in order for state regulation of health benefit plans not to be preempted by federal law, necessary changes are needed to enact federal health reforms. In 1996, the 104th Congress enacted the Health Insurance Portability and Accountability Act to provide portability and greater availability and accessibility to health insurance in the group and individual markets. This bill provides for modifications of the Texas Health Maintenance Organization Act and certain articles of the Insurance Code to comply with these federal health reforms. Additionally, this bill modifies certain health insurance benefits relating to parity of mental health benefits, maternity care, and access to obstetric and gynecological care.

PURPOSE

As proposed, C.S.S.B. 585 modifies certain health insurance benefits relating to adopted children, parity between certain mental health benefits and medical and surgical benefits, the Texas Health Maintenance Organization Act, newborn children, obstetric or gynecological care, and maternity care.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the commissioner of insurance under SECTION 3 (Article 3.51-15(6), Insurance Code), SECTION 5 (Articles 20A.09(k)(2) and (l)(5) & (10), Insurance Code), and SECTION 7 (Articles 21.53D(6) and 21.53E(3), Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 3D(b), Article 3.51-6, Insurance Code, to require the insurer to provide full coverage under the policy to the child of an insured without limiting coverage of a preexisting condition if an application for coverage for the child is made not later than the 31st day after the date on which the adoption is final or, for the period during which the adoption is not final, not later than the 31st day after the date on which the insured becomes a party in a suit in which adoption of the child by the insured is sought.

SECTION 2. Amends Article 3.51-14, Insurance Code, by adding Section 4, as follows:

> Sec. 4. COMPLIANCE REQUIRED. Requires any coverage provided under this article to an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)) to comply with Article 3.51-15 of this code.

SECTION 3. Amends Chapter 3E, Insurance Code, by adding Article 3.51-15, as follows:

ARTICLE 3.15-15. CERTAIN INSURERS MUST MEET REQUIREMENTS FOR PARITY

> Sec. 1. PURPOSE. Provides that the purpose of this article is to coordinate the requirements of Texas law with federal law relating to a requirement of a parity between certain mental health benefits and medical and surgical benefits.
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> Sec. 2. DEFINITIONS. Defines "aggregate lifetime limit," "annual limit," "insurer," "medical or surgical benefits," and "mental health benefits."

Sec. 3. PARITY REQUIREMENTS. (a)-(c) Sets forth the specific requirements that any coverage for services and benefits for the condition of mental illness or serious mental illness provided by an insurer to an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)) must meet in regard to parity in annual and lifetime aggregate dollar limits between medical and surgical benefits and mental illness benefits, unless exempted under Section 4 of this article.

(d) Sets forth the specific provisions in the case of coverage that provides both medical and surgical benefits and mental health benefits in regard to parity in annual and lifetime aggregate dollar limits between medical and surgical benefits and mental illness benefits.

(e) Requires an insurer to follow the rules promulgated by the U.S. Secretary of Treasury under the Mental Health Parity Act of 1996 (Title VII, Pub. L. No. 104-204) in the case of coverage that is not described in Subsection (d) and includes no or different annual limits on different categories of medical and surgical benefits.

(f) Provides that nothing in this section shall be construed as requiring an insurer to provide or offer any mental health benefits, except as otherwise specified in this code; or in the case of coverage that provides mental health benefits, as affecting the terms and conditions relating to the benefits under the coverage, except as specifically provided in this article in regard to parity in the imposition of aggregate lifetime and annual limits for mental health benefits.

Sec. 4. EXEMPTIONS. Sets forth certain insurance coverages offered to an employee welfare benefit plan to which this section does not apply.

Sec. 5. SEPARATE APPLICATION TO EACH OPTION OFFERED. Requires this article to be applied separately to each coverage package offered by an insurer or provider with respect to each option if the employee welfare benefit plan offers a participant or beneficiary two or more benefit package options.

Sec. 6. RULEMAKING AUTHORITY. Authorizes the commissioner of insurance (commissioner) to promulgate reasonable rules to implement this article and to coordinate or comply with minimum requirements of federal law and regulations relating to parity of mental health benefits with any other health or accident benefits.

SECTION 4. Amends Articles 3.70-2(E), (F), (I), and (K), Insurance Code, to prohibit an individual policy or group policy of accident and sickness insurance, including policies delivered or issued for delivery to any person in this state which provides for accident and sickness coverage of immediate family or children of an enrollee, which permits the enrollment of any enrollee's immediate family or children for such coverage, or which provides maternity benefits, from being issued if it contains any provisions excluding or limiting certain coverage relating to newborns. Redefines "emergency care" to mean health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize certain medical conditions of a recent onset and severity. Makes conforming and nonsubstantive changes.

SECTION 5. Amends Article 20A.09, Insurance Code (Texas Health Maintenance Organization Act), by adding Subsections (k), (l), and (m), as follows:

(k) Requires a health maintenance organization (HMO) to provide a group continuation privilege. Provides that any enrollee whose coverage under the group contract has been terminated for any reason except involuntary termination for cause and who has been continuously covered under the group contract and under any group contract providing similar services and benefits which it replaces for at least three consecutive months immediately prior to termination is entitled to the group continuation privilege. Provides that involuntary termination for cause does not include termination for any health-related cause. Requires HMO contracts subject to this section to provide continuation of group coverage for enrollees subject to certain eligibility provisions. Authorizes a health maintenance organization to offer each enrollee a conversion contract. Sets forth the guidelines and

conditions of such a conversion contract. Requires the commissioner to issue rules and regulations to establish standards for services and benefits. Sets forth the required guidelines for the premium of a conversion contract.

(l) Requires an individual health care plan provided by an HMO to meet the requirements of this subsection. Defines "individual health care plan." Authorizes an HMO to limit its enrollees to those who live, reside, or work within the service area for an individual health care plan. Requires an individual health care plan or a conversion contract providing health care services to be renewable with respect to an enrollee at the option of the enrollee and may be nonrenewable under certain conditions. Authorizes the commissioner to adopt rules necessary to implement this section and to meet the minimum requirements of federal law and regulations. Requires an HMO to impose an affiliation period as an alternative to a preexisting condition limitation. Defines "affiliation period" as a period not to exceed 60 days, or 90 days in the case of late enrollee, during which no premiums shall be collected and coverage issued will not become effective. Prohibits an HMO from modifying or excluding an individual health care plan with respect to an enrollee or dependent of certain conditions otherwise covered by the health benefit plan. Sets forth the required conditions for a denial by an HMO. Sets forth the characteristics and formulas for an HMO in establishing rates. Requires the commissioner to issue rules and regulations to establish minimum standards for benefits and determine the percentage increase in the premium rates charged.

(m) Provides that Articles 3.51-14, 3.51-15, and 3.70-2(F) & (L), Insurance Code, apply to HMOs.

SECTION 6. Amends Article 20A, Insurance Code, by adding Section 9A, as follows:

Sec. 9A. REQUIRED COVERAGE FOR NEWBORNS; ADOPTED CHILDREN. (a) Prohibits each HMO that provides coverage for health care services for the spouse and dependant children of an enrollee or permits the enrollment of any enrollee's immediate family or children under a health benefit plan from excluding or limiting certain coverage for a newborn if the child is enrolled in the health care plan not later than the 31st day after the date of the child's birth. Provides that a child is considered to be the child of an enrollee if the enrollee is a party in a suit in which the adoption of the child by the enrollee is sought.

(b) Prohibits an HMO that provides coverage for the immediate family or children of an enrollee or permits the enrollment of any enrollee's immediate family or children under a health benefit plan from excluding coverage from a child of an enrollee or limiting coverage under the plan to a child of an enrollee solely because the child is adopted. Sets forth the conditions upon which the HMO is required to provide full coverage to the adopted child. Provides that a child is considered to be the child of an enrollee if the enrollee is a party in a suit in which the adoption of the child by the enrollee is sought.

SECTION 7. Amends Chapter 21E, Insurance Code, by adding Articles 21.53D-E, as follows:

ARTICLE 21.53D. ACCESS TO CERTAIN OBSTETRIC OR GYNECOLOGICAL CARE

Sec. 1. DEFINITIONS. Defines "enrollee," "health benefit plan," and "physician."

Sec. 2. SCOPE OF ARTICLE. (a) Provides that this article applies to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness; a plan that is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, V.T.C.S.), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code; or a plan that is offered by any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis. Sets forth the plans that this article does not pertain to in regard to access to certain obstetrical or gynecological care. Provides that this article applies to each health benefit plan that requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper.

Sec. 3. ACCESS OF FEMALE ENROLLEE TO HEALTH CARE. Requires each health benefit plan subject to this article to permit a woman who is entitled to coverage under the plan to select an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist. Requires the plan to include in the classification of persons authorized to provide medical services under the plan a number of properly credentialed obstetricians and gynecologists sufficient to ensure access to the services that fall within the scope of that credential. Provides that this section does not affect the authority of a health benefit plan to establish selection criteria regarding other physicians who provide services through the plan.

Sec. 4. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR GYNECOLOGIST. Requires each health benefit plan to permit a woman who designates an obstetrician or gynecologist as provided under Section 3 direct access to the health care services of the designated obstetrician or gynecologist without a referral by the woman's primary care physician or prior authorization or precertification from a health benefit plan. Sets forth a non-exclusive list of health care services required under this article. Prohibits a health benefit plan from imposing a copayment or deductible for direct access to the health care services of an obstetrician or gynecologist under this section unless such an additional cost is imposed for access to other health care services. Provides that this section does not affect the authority of a health benefit plan to require the designated obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician; however, failure to provide such information shall not result in any penalty being imposed upon the obstetrician or gynecologist or the patient by the health benefit plan. Authorizes a health benefit plan to limit a woman enrolled in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. Provides that this section does not affect the right of the woman to select the physician who provides that care. Prohibits a health benefit plan from sanctioning or terminating primary care physicians as a result of female enrollees' access to participating obstetricians and gynecologists under this section.

Sec. 5. NOTICE. Requires each health benefit plan to provide to persons covered by the plan a timely written notice in clear and accurate language of the direct access to health care services required by this article.

Sec. 6. RULES. Requires the commissioner to adopt rules as necessary to implement this article.

Sec. 7. ADMINISTRATIVE PENALTY. Provides that an insurance company, HMO, or other entity that operates a health benefit plan in violation of this article is subject to an administrative penalty as provided by Article 1.10E, Insurance Code.

ARTICLE 21.53E. COVERAGE FOR MINIMUM INPATIENT STAY IN HEALTH CARE FACILITY

Sec. 1. DEFINITIONS. Defines "health benefit plan" and "provider."

Sec. 2. REQUIRED COVERAGE FOR MINIMUM INPATIENT STAY FOLLOWING BIRTH; EXCEPTION. Sets forth the required provisions for a health benefit plan that provides maternity benefits, including benefits for childbirth. Requires, notwithstanding the required provisions of this section, the hospital length of stay to be left to the decision of the provider in consultation with the mother.

Sec. 3. RULES. Requires the commissioner to adopt rules as necessary to administer this article.

SECTION 8. Effective date: July 1, 1997.
Makes application of this Act prospective.

SECTION 9. Makes application of Article 3.51-15, Insurance Code, as added by this Act, prospective to January 1, 1998.

SECTION 10. Makes application of Articles 21.53D-E, Insurance Code, as added by this Act, prospective to January 1, 1998.

SECTION 11. Emergency clause.

SUMMARY OF COMMITTEE CHANGES

Amends SECTION 3, Section 3(b)(2)(A), Article 3.51-15, Insurance Code, to make a nonsubstantive change.

Amends SECTION 4, Subsection (I), Article 3.70-2, Insurance Code, to revise the proposed changes to the redefining of "emergency care."

Amends SECTION 5, Subsection (l), Article 20A.09, Insurance Code (Texas Health Maintenance Organization Act), to revise the amount of time within an "affiliation period" for a late enrollee.

Amends SECTION 6, Section 9A(b), Article 20A, Insurance Code, to revise extended coverage provided by an HMO that provides coverage for the immediate family or children of an enrollee.

Amends SECTION 7, Article 21.53D, Insurance Code, to revise the proposed guidelines for access to certain obstetrical or gynecological care in regard to "definitions," "scope of the article," "access of female enrollee to health care," and "direct access to services of obstetrician or gynecologist." Makes conforming changes to such guidelines in regard to "notice," "rulemaking authority," and "administrative penalty" by redesignating those sections as Sections 5-7.

Amends SECTION 8-10, to make conforming and nonsubstantive changes to the session law.