

BILL ANALYSIS

Senate Research Center
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H.B. 10
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Despite existing federal mental health parity laws, many consumers encounter barriers due to lack of clear regulatory and enforcement guidelines. Currently, the Texas Department of Insurance (TDI) regulates some forms of parity for fully insured plans sold to large employers, but not for similar plans sold to small employers. What's more, TDI can enforce quantitative treatment limitations but has no ability to enforce parity for non-quantitative treatment limitations. Because TDI does not have clear authority to enforce many parity complaints, enforcement falls to federal counterparts.

S.B. 860 expands TDI's regulatory authority to include parity protections for all fully insured plans, including both quantitative treatment limitations and non-quantitative treatment limitations. The bill also designates a person within the Health and Human Services Commission (HHSC) to be an ombudsman for behavioral health access to care to address complaints regarding mental health parity; creates a mental health and substance use disorder stakeholder work group to develop a framework to implement and enforce mental health parity in Texas; and requires TDI and HHSC to gather data regarding the denial rate of mental health and substance use disorder services compared to denials of medical and surgical services to better understand parity issues currently experienced by consumers.

H.B. 10 amends current law relating to access to and benefits for mental health conditions and substance use disorders.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 2 (Section 1355.258, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02251 and 531.02252, as follows:

Sec. 531.02251. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE.

(a) Defines "ombudsman."

(b) Requires the executive commissioner of the Health and Human Services Commission (executive commissioner; HHSC) to designate an ombudsman for behavioral health access to care.

(c) Provides that the ombudsman is administratively attached to the office of the ombudsman for HHSC.

(d) Authorizes HHSC to use an alternate title for the ombudsman in consumer-facing materials if HHSC determines that an alternate title would be beneficial to consumer understanding or access.

(e) Provides that 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.

(f) Requires the ombudsman to perform certain duties.

(g) Requires the ombudsman to participate in the mental health condition and substance use disorder parity work group (work group) established under Section 531.02252 and provide summary reports to the work group of certain concerns, complaints, and potential violations. Provides that this subsection expires September 1, 2021.

(h) Requires the Texas Department of Insurance (TDI) to appoint a liaison to the ombudsman to receive reports of certain concerns, complaints, and potential violations from the ombudsman, consumers, or behavioral health care providers.

Sec. 531.02252. MENTAL HEALTH CONDITION AND SUBSTANCE USE DISORDER PARITY WORK GROUP. (a) Requires HHSC to establish and facilitate a 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) Authorizes the work group to be a part of or a subcommittee of the behavioral health advisory committee.

(c) Provides that the work group is composed of certain persons.

(d) Requires the work group to meet at least quarterly.

(e) Requires the work group to 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 HHSC and TDI can accept information on 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) Requires the work group to develop a strategic plan with metrics to serve as a roadmap to increase compliance with the described rules, regulations, and statutes in this state and to increase education and outreach relating to these laws.

(g) Requires the work group, not later than September 1 of each even-numbered year, to 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) Provides that the work group is abolished and this section expires September 1, 2021.

SECTION 2. Amends Chapter 1355, Insurance Code, by adding Subchapter F, as follows:

SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

Sec. 1355.251. DEFINITIONS. Defines “mental health benefit,” “nonquantitative treatment limitation,” “quantitative treatment limitation,” and “substance use disorder benefit.”

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter applies only to a health benefit plan (plan) that provides benefits or coverage for medical or surgical expenses incurred as a result of a health condition, accident, or sickness and for treatment expenses incurred as a result of a mental health condition or substance use disorder, including certain insurance policies or agreements, a group hospital service contract, an individual or group evidence of coverage, or a similar coverage document, that is offered by certain providers.

(b) Provides that, notwithstanding Section 1501.251 (Exception From Certain Mandated Benefit Requirements) or any other law, this subchapter applies to coverage under a small employer plan subject to Chapter 1501 (Health Insurance Portability and Availability Act).

(c) Provides that this subchapter applies to a standard plan issued under Chapter 1507 (Consumer Choice of Benefits Plans).

Sec. 1355.253. EXCEPTIONS. (a) Provides that this subchapter does not apply to:

- (1) a plan that provides certain coverage;
- (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 of insurance (commissioner) determines that the policy provides benefit coverage so comprehensive that the policy is a plan as described by Section 1355.252.

(b) Provides that, 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. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS. (a) Requires a plan to provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan’s medical and surgical benefits and coverage.

(b) Prohibits coverage under Subsection (a) from imposing quantitative or nonquantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Sec. 1355.255. COMPLIANCE. Requires the commissioner to enforce compliance with Section 1355.254 by evaluating the benefits and coverage offered by a plan for quantitative and nonquantitative treatment limitations in certain categories.

Sec. 1355.256. DEFINITIONS UNDER PLAN. (a) Requires that a plan 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) Requires that a plan 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. 1355.257. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE. Provides that this subchapter supplements Subchapters A (Group Health Benefit Plan Coverage) and B (Alternative Mental Health Treatment Benefits) of this chapter (Benefits for Certain Mental Disorders) and Chapter 1368 (Availability of Chemical Dependency Coverage) and TDI rules adopted under those statutes. Provides that it is the intent of the legislature that Subchapter A or B of this chapter or Chapter 1368 or a TDI rule adopted under those statutes controls in any circumstance in which that other law requires a benefit that is not required by this subchapter or a more extensive benefit than is required by this subchapter.

Sec. 1355.258. RULES. Requires the commissioner to adopt rules necessary to implement this subchapter.

SECTION 3. (a) Requires TDI to conduct a study and prepare a report on benefits for medical or surgical expenses and for mental health conditions and substance abuse disorders.

(b) Requires TDI, in conducting the study, to 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) Requires TDI to, not later than September 1, 2018, report the results of the study and TDI's findings.

SECTION 4. (a) Requires HHSC to 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 (MCOs).

(b) Requires HHSC, in conducting the study, to collect and compare data from Medicaid MCOs 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) Requires HHSC to, not later than September 1, 2018, report the results of the study and HHSC's findings.

SECTION 5. Makes application of Subchapter F, Chapter 1355, Insurance Code, as added by this Act, prospective to January 1, 2018.

SECTION 6. Effective date: September 1, 2017.