By: Price, Bonnen of Galveston, Rose, Muñoz, Jr., Coleman, et al. H.B. No. 10

A BILL TO BE ENTITLED

AN ACT

relating to access to and benefits for mental health conditions and substance use disorders.

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02251 and 531.02252 to read as follows:

Sec. 531.02251. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE. (a) In this section, "ombudsman" means the individual designated as the ombudsman for behavioral health access to care.

(b) The executive commissioner shall designate an ombudsman for behavioral health access to care.

(c) The ombudsman is administratively attached to the office of the ombudsman for the commission.

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

(e) 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) The ombudsman shall:

(1) interact with consumers and behavioral health care providers with concerns or complaints to help the consumers and providers resolve behavioral health care access issues;

(2) identify, track, and help report potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to quantitative and nonquantitative treatment limitations;

(3) report concerns, complaints, and potential violations described by Subdivision (2) to the appropriate regulatory or oversight agency;

(4) receive and report concerns and complaints relating to inappropriate care or mental health commitment;

(5) provide appropriate information to help consumers obtain behavioral health care;

(6) develop appropriate points of contact for referrals to other state and federal agencies; and

(7) provide appropriate information to help consumers or providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies.

(g) The ombudsman shall participate in the mental health condition and substance use disorder parity work group established under Section 531.02252 and provide summary reports of concerns, complaints, and potential violations described by Subsection (f)(2) to the work group. This subsection expires September 1,

2021.

(h) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations described by Subsection (f)(2) from the ombudsman, consumers, or behavioral health care providers.

Sec. 531.02252. MENTAL HEALTH CONDITION AND SUBSTANCE USE DISORDER PARITY WORK GROUP. (a) The commission shall establish and facilitate a mental health condition and substance use disorder parity 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) The work group may be a part of or a subcommittee of the behavioral health advisory committee.

(c) The work group is composed of:

(1) a representative of:

(A) Medicaid and the child health plan program;

(B) the office of mental health coordination;

(C) the Texas Department of Insurance;

(D) a Medicaid managed care organization;

(E) a commercial health benefit plan;

(F) a mental health provider organization;

(G) physicians;

(H) hospitals;

(I) children's mental health providers;

(J) utilization review agents; and

(K) independent review organizations;

(2) a substance use disorder provider or a professional with co-occurring mental health and substance use disorder expertise;

(3) a mental health consumer;

(4) a mental health consumer advocate;

(5) a substance use disorder treatment consumer;

(6) a substance use disorder treatment consumer advocate;

(7) a family member of a mental health or substance use disorder treatment consumer; and

(8) the ombudsman for behavioral health access to care.

(d) The work group shall meet at least quarterly.

(e) The work group shall 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 the commission and the Texas Department of Insurance 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) The work group shall develop a strategic plan with metrics to serve as a roadmap to increase compliance with the rules, regulations, and statutes described by Subsection (a) in this state and to increase education and outreach relating to these laws.

(g) Not later than September 1 of each even-numbered year, the work group shall 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) The work group is abolished and this section expires September 1, 2021.

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

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

Sec. 1355.251. DEFINITIONS. In this subchapter:

(1) "Mental health benefit" means a benefit relating to an item or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(2) "Nonquantitative treatment limitation" means a limit on the scope or duration of treatment that is not expressed numerically. The term includes:

(A) a medical management standard limiting or excluding benefits based on medical necessity or medical

appropriateness or based on whether a treatment is experimental or investigational;

(B) formulary design for prescription drugs;

(C) network tier design;

(D) a standard for provider participation in a network, including reimbursement rates;

(E) a method used by a health benefit plan to determine usual, customary, and reasonable charges;

(F) a step therapy protocol;

(G) an exclusion based on failure to complete a course of treatment; and

(H) a restriction based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of a benefit.

(3) "Quantitative treatment limitation" means a treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount such as an annual or lifetime limit on days of coverage or number of visits. The term includes a deductible, a copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

(4) "Substance use disorder benefit" means a benefit relating to an item or service for a substance use disorder, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit 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 an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an individual or group evidence of coverage, or a 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 stipulated premium company operating under Chapter 884;

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

(6) a reciprocal exchange operating under Chapter 942;

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

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

(9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(b) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(c) This subchapter applies to a standard health benefit

plan issued under Chapter 1507.

Sec. 1355.253. EXCEPTIONS. (a) This subchapter does not apply to:

(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;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses;

(F) only for indemnity for hospital confinement; or

(G) only for accidents;

(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 determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1355.252.

(b) 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) A health benefit plan must 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) Coverage under Subsection (a) may not impose 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. The commissioner shall enforce compliance with Section 1355.254 by evaluating the benefits and coverage offered by a health benefit plan for quantitative and nonquantitative treatment limitations in the following categories:

(1) in-network and out-of-network inpatient care;

(2) in-network and out-of-network outpatient care;

(3) emergency care; and

(4) prescription drugs.

Sec. 1355.256. DEFINITIONS UNDER PLAN. (a) A health benefit plan must 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) A health benefit plan must 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. This subchapter supplements Subchapters A and B of this chapter and Chapter 1368 and the department rules adopted under those statutes. It is the intent of the legislature that Subchapter A or B of this chapter or Chapter 1368 or a department rule adopted under those statutes controls in any circumstance in which that other law requires:

(1) a benefit that is not required by this subchapter; or

(2) a more extensive benefit than is required by this subchapter.

Sec. 1355.258. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

SECTION 3. (a) The Texas Department of Insurance shall conduct a study and prepare a report on benefits for medical or surgical expenses and for mental health conditions and substance use disorders.

(b) In conducting the study, the department must 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) Not later than September 1, 2018, the department shall report the results of the study and the department's findings.

SECTION 4. (a) The Health and Human Services Commission shall 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.

(b) In conducting the study, the commission must collect and compare data from Medicaid managed care organizations 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) Not later than September 1, 2018, the commission shall report the results of the study and the commission's findings.

SECTION 5. Subchapter F, Chapter 1355, Insurance Code, as added by this Act, applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2018. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2018, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 6. This Act takes effect September 1, 2017.