

BILL ANALYSIS

C.S.H.B. 10
By: Price
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties contend that regulatory inconsistencies exist between federal and state law regarding behavioral health parity. Concerns have also been raised regarding public access to certain behavioral health services and supports. C.S.H.B. 10 seeks to address these issues by reconciling those differences between state and federal law, providing for the designation of an ombudsman for behavioral health access to care, establishing a work group to provide recommendations on the implementation of behavioral health parity, and providing for studies regarding behavioral health parity.

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 rulemaking authority is expressly granted to the commissioner of insurance in SECTION 2 of this bill.

ANALYSIS

C.S.H.B. 10 amends the Insurance Code to require a health benefit 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. The bill prohibits such coverage 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. The bill requires the commissioner of insurance to enforce compliance with those bill provisions by evaluating the benefits and coverage offered by a health benefit plan for quantitative and nonquantitative treatment limitations in in-network and out-of-network inpatient and outpatient care, emergency care, and prescription drugs. The bill requires a health benefit plan to define a condition to be a mental health condition or not a mental health condition and 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. These bill provisions expressly supplement statutory provisions relating to group health benefit plan coverage for certain serious mental illnesses and other disorders, alternative mental health treatment benefits, availability of chemical dependency coverage, and Texas Department of Insurance (TDI) rules adopted under those statutory provisions. The bill establishes that those statutory provisions and rules control in any circumstance in which that other law requires a benefit that is not required by the bill or a more extensive benefit than is required by the bill. The bill requires the commissioner of insurance to adopt rules necessary to implement these bill provisions. The bill establishes, and provides certain exceptions to, the applicability of these provisions. These provisions apply only to a health benefit plan delivered, issued for delivery, or renewed on or

after January 1, 2018.

C.S.H.B. 10 amends the Government Code to require the executive commissioner of the Health and Human Services Commission (HHSC) to designate an ombudsman for behavioral health access to care who is administratively attached to the office of the ombudsman for HHSC. The bill 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. The bill establishes that the ombudsman serves as a neutral party to help consumers and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care. The bill requires the ombudsman to interact with consumers and behavioral health care providers with concerns or complaints to help the consumers and providers resolve behavioral health care access issues; 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; report certain concerns, complaints, and potential violations to the appropriate regulatory or oversight agency; receive and report concerns and complaints relating to inappropriate care or mental health commitment; provide appropriate information to help consumers obtain behavioral health care; develop appropriate points of contact for referrals to other state and federal agencies; and provide appropriate information to help consumers or providers file appeals or complaints with the appropriate entities. The bill requires TDI to appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations from the ombudsman, consumers, or behavioral health care providers. The bill requires the ombudsman, in a temporary provision set to expire September 1, 2021, to participate in the mental health condition and substance use disorder parity work group established by the bill and to provide summary reports of certain concerns, complaints, and potential violations to the work group.

C.S.H.B. 10 requires HHSC to 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. The bill authorizes the work group to be a part of or a subcommittee of the behavioral health advisory committee and provides for the composition and meeting requirements of the work group. The bill requires the work group to study and make recommendations on increasing compliance with those rules, regulations, and statutes; strengthening enforcement and oversight of those laws at state and federal agencies; improving the complaint processes relating to potential violations of those laws for consumers and providers; ensuring HHSC and TDI can accept information on concerns relating to those laws and investigate potential violations based on de-identified information and data submitted to providers in addition to individual complaints; and increasing public and provider education on those laws. The bill requires the work group to develop a strategic plan with metrics to serve as a roadmap to increase compliance in Texas with those rules, regulations, and statutes and to increase education and outreach relating to those laws. The bill 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 the bill. The work group is abolished and these provisions expire September 1, 2021.

C.S.H.B. 10 requires TDI to conduct a study and prepare a report on benefits for medical or surgical expenses and for mental health conditions and substance use disorders. The bill 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. The bill requires TDI and HHSC, in conducting the agency's respective study, to collect and compare data from health benefit plan issuers subject to the bill's provisions and from Medicaid managed care organizations, respectively, on medical or surgical benefits and mental health condition or substance use disorder benefits that are subject to prior authorization or utilization review, denied as not medically necessary or experimental or investigational,

internally appealed, or subject to an independent external review. The bill requires TDI and HHSC, not later than September 1, 2018, to report the results of the respective agency's study and findings.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 10 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

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 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.

(e) 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

HOUSE COMMITTEE SUBSTITUTE

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 nonquantitative treatment limitations;

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

(3) provide appropriate referrals to help consumers obtain behavioral health care;

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

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

(f) The ombudsman shall participate on 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 (e)(2) to the work group. This subsection expires September 1, 2021.

(g) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations described by Subsection (e)(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

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) Medicaid managed care organizations;
(E) commercial health benefit plans;
(F) mental health provider organizations;
(G) substance use disorder providers;
(H) mental health consumer advocates;
(I) substance use disorder treatment consumers;
(J) family members of mental health or substance use disorder treatment consumers;
(K) physicians;
(L) hospitals;
(M) children's mental health providers;
(N) utilization review agents; and
(O) independent review organizations; and

(2) 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 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

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) "Financial requirement" includes a requirement relating to a deductible, copayment, coinsurance, or other out-of-pocket expense or an annual or lifetime limit.

(2) "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.

(3) "Nonquantitative treatment limitation"

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,

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.

(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.

(5) "Treatment limitation" includes a limit on the frequency of treatment, number of visits, days of coverage, or other similar limit on the scope or duration of treatment. The term includes a nonquantitative treatment limitation.

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical 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, 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

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; or

(F) only for indemnity for hospital confinement;

(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. REQUIRED COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS.

(a) A health benefit plan must provide benefits for mental health conditions and substance use disorders under the same terms and conditions applicable to benefits

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

for medical or surgical expenses.

(b) Coverage under Subsection (a) may not impose treatment limitations or financial requirements on benefits for a mental health condition or substance use disorder that are generally more restrictive than treatment limitations or financial requirements imposed on coverage of benefits for medical or surgical expenses.

Sec. 1355.255. DEFINITIONS UNDER PLAN.

Sec. 1355.256. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE.

Sec. 1355.257. RULES.

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

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.

Sec. 1355.257. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE.

Sec. 1355.258. RULES.

SECTION 3. Same as introduced version.

SECTION 4. Same as introduced version.

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.

SECTION 5. Same as introduced version.

SECTION 6. Same as introduced version.