SUBJECT: Requiring health plans to treat mental health and physical benefits equally

COMMITTEE: Public Health — committee substitute recommended

VOTE: 11 ayes — Price, Sheffield, Arévalo, Burkett, Coleman, Collier, Cortez, Guerra, Klick, Oliverson, Zedler

0 nays

WITNESSES: For — Sherri Layton, Association of Substance Abuse Programs; Monica Villarreal, Center for Public Policy Priorities; Christine Bryan, Clarity Child Guidance Center; Lauren Kreeger, League of Women Voters of Texas; Deborah Rosales-Elkins, NAMI Texas; Nakia Winfield, NASW-Texas Chapter; Jamie Dudensing, Texas Association of Health Plans; Jacob Cuellar, Texas Hospital Association; (*Registered, but did not testify*: Amanda Fredriksen, AARP; Jennifer Henager, Central Texas Regional Advisory Council; Linda Townsend, CHRISTUS Health; Kathryn Lewis, Disability Rights Texas; Eric Woomer, Federation of Texas Psychiatry; Christine Reeves, Heart of Texas Regional Advisory Council; Gyl Switzer, Mental Health America of Texas; Greg Hansch, NAMI Texas; Michelle Hansford, One Voice Texas; Anthoney Farmer-Guerra, Spread Hope Like Fire; Mark Mendez, Tarrant County; Danielle Roberts, Tarrant County College Nursing (NSA); Josette Saxton, Texans Care for Children; Dan Hinkle, Texas Academy of Family Physicians; Cassandra Hulsey, Texas Association of School Psychologists; Lee Johnson, Texas Council of Community Centers; Carl Dunn, American College of Obstetricians and Gynecologists-Texas District; Joel Ballew, Texas Health Resources; Thomas Kim, Texas Medical Association, Texas Pediatric Society, FTP, Texas Society of Clinical Oncology; Karen Jeffries, Chrystal Brown, Cathryn El Burley, Connie Castleberry, Naomi Clifton-Hernandez, Gabrielle Frey, Kimberley Grant, Janice Miller, Dorothy Sanders-Thompson, Jill Steinbach, and Eugenia "Jeanie" Zelanko, Texas Nurses Association; Kathy Hutto, Texas Occupational Therapy Association; Kaitlyn Clifton, Texas Pediatric Society; Emily Alexanderson and Melinda Hester, Texas State University School of Nursing; Nancy Walker, University Health System/Bexar County; and

eight individuals)

Against — Lee Spiller, Citizens Commission on Human Rights; (*Registered, but did not testify*: Monica Ayres; Stephanie Croman; Zoe Croman; Jon Ellzey; Jeff Fischer; Jean LeFebvre; Norman Moore; John Schoenfield; Pam Spiller; Savita Wadhwani; Eric Whittier; George Weir; and Anja Wulf)

On — Russell Smith, Austin Child Guidance Center; Alison Boleware, Hogg Foundation for Mental Health; (*Registered, but did not testify*: Trina Ita, Lauren Lacefield Lewis, and Alejandrina "Sherry" Valdez, Health and Human Services Commission; Rachel Bowden, Texas Department of Insurance)

BACKGROUND: The Mental Health Parity and Addiction Equity Act was signed into federal law in 2008 and amended in 2010 by the Affordable Care Act. The law, with a few exceptions, prevents group health plans and individual health insurance plans that provide mental health or substance use disorder benefits from setting benefit limitations on behavioral health benefits that are more restrictive than medical or surgical benefits.

28 TAC, part. 1, ch. 21, subch. P, sec. 21.2402(16) defines treatment limitations as limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Sec. 21.2402(5) defines a financial requirement as one that includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit.

Subch. P, secs. 21.2403 and 21.2404 require the Texas Department of Insurance to regulate mental health parity for large employer group health plans, but do not require it to regulate mental health parity for individual health plans or small employer group health plans.

DIGEST: CSHB 10 would require a health benefit plan that provides benefits for mental health conditions and substance use disorders to provide those benefits under the same terms and conditions as the plan's medical and

surgical benefits. The bill also would establish a behavioral health ombudsman, create a mental health parity work group, and require state agencies and other stakeholders to submit reports on behavioral health care access issues.

Mental health parity requirements. The bill would prohibit a health benefit plan from setting quantitative or nonquantitative treatment limitations on behavioral health conditions that are more restrictive than the plan's treatment limitations for medical or surgical expenses.

The bill would define a quantitative treatment limitation as a limit 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 would include a deductible, a copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

The bill would define a nonquantitative treatment limitation as a limit on the scope or duration of treatment that is not expressed numerically, including standards for determining medical necessity or appropriateness, restrictions based on geographic location, facility type, or provider specialty, and other criteria.

The Texas Department of Insurance (TDI) commissioner would enforce the mental health parity requirements by evaluating the benefits and coverage offered by a health benefit plan for quantitative and nonquantitative treatment limitations for in-network and out-of-network inpatient and outpatient care, emergency care, and prescription drugs.

A health benefit plan would have to define a mental health condition and a substance use disorder in a manner consistent with generally recognized independent standards of practice.

The TDI commissioner would adopt rules to administer the bill's behavioral health parity provisions.

Affected health benefit plans. CSHB 10 would apply 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 that is offered by: an insurance company; a group hospital service corporation; a fraternal benefit society; a stipulated premium company; a health maintenance organization; a reciprocal exchange; a Lloyd's plan; a nonprofit health corporation that holds a certificate of authority; or an Employee Retirement Income Security Act (ERISA) group health plan that holds a certificate of authority.

The bill also would apply to a small employer health benefit plan subject to the Health Insurance Portability and Availability Act in Insurance Code, ch. 1501 and to a consumer choice of benefits plan issued under Insurance Code, ch. 1507.

Qualified health plans under the Affordable Care Act. CSHB 10 would not require a qualified health plan, as defined by the federal Affordable Care Act (ACA), to provide a benefit for mental health conditions and substance use disorders that exceeds the ACA-specified essential health benefits and if the state would have to make a payment as required by the ACA.

Exceptions. CSHB 10 would not apply to a health benefit plan that provided coverage:

- only for wages or payments in lieu of wages for a period during which an employee was absent from work because of a sickness or injury;
- as a supplement to a liability insurance policy;
- for credit insurance;
- only for dental or vision care;
- only for hospital expenses;
- only for indemnity for hospital confinement or;
- only for accidents.

CSHB 10 also would not apply to a Medicare supplemental policy, a workers' compensation insurance policy, or medical payment insurance coverage provided under a motor vehicle insurance policy. It also would not apply to a long-term insurance policy, including a nursing home fixed indemnity policy, unless the TDI commissioner determined that the policy provided benefit coverage so comprehensive that the policy was a health benefit plan affected by the bill.

Ombudsman duties. CSHB 10 would require the Health and Human Services Commission (HHSC) executive commissioner to designate an ombudsman for behavioral health access to care. The ombudsman would help insured and uninsured consumers and behavioral health care providers navigate and resolve issues regarding consumer access to behavioral health care, including for mental health conditions and substance use disorders. The ombudsman also would be required to monitor and report potential parity violations of state or federal regulations and to receive and report concerns and complaints related to inappropriate care or mental health commitment, among other duties listed in the bill.

TDI would be required to appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential parity violations from the ombudsman, consumers, or behavioral health care providers.

Mental health parity work group. CSHB 10 would require HHSC to create and facilitate a mental health condition and substance use disorder parity work group to increase understanding of and compliance with state and federal rules on the availability and terms of behavioral health care benefits. The work group would include the ombudsman; various mental health and substance use disorder consumers, advocates, providers, and professionals; and representatives from health benefit plans and state agencies.

The work group would hold quarterly meetings and study and make recommendations on federal and state regulations of behavioral health care benefits. A report on the work group's findings would be due to the

applicable House and Senate committees and state agencies by September 1 every even-numbered year. The workgroup would be abolished on September 1, 2021.

Reports. The bill would require TDI and HHSC to conduct separate studies and submit reports comparing medical or surgical benefits and behavioral health benefits provided by health benefit plan issuers and Medicaid managed care organizations (MCOs), respectively. They would have to collect and report data on benefits that are subject to prior authorization or utilization review; denied as not medically necessary or experimental or investigational; internally appealed, including whether the appeal was denied; or subject to an independent external review, including data that indicates whether the denial was upheld. TDI and HHSC would have to submit their findings by September 1, 2018.

Effective date. CSHB 10 would take effect September 1, 2017, and would apply to a health benefit plan issued on or after January 1, 2018.

SUPPORTERS SAY:

CSHB 10 would strengthen enforcement of mental health parity at the state level by enacting recommendations from the House Select Committee on Mental Health. Federal law since 2008 has required that health care plans that provide both mental and physical health benefits treat those benefits equally. The bill would address consumer and industry concerns that in some circumstances health insurance plans in Texas may violate the federal parity law by denying patients mental health benefits because the requested treatment requires prior authorization or the treatment falls outside the scope of what the insurance plan deems medically necessary.

Patients who experience difficulties receiving mental health treatment are especially at risk for being readmitted for the same condition, and high readmission rates increase the cost of health care. By creating guidelines for state enforcement of existing federal mental health parity law, the bill would reduce the long-term costs of health care by helping to ensure timely and appropriate treatment for patients with mental health issues.

Consumers often do not know how to navigate a complex system of health

care plans and providers. CSHB 10 would simplify the complaint process for consumers and providers by establishing a behavioral health ombudsman at the Health and Human Services Commission (HHSC) and a liaison to the ombudsman at the Texas Department of Insurance (TDI). The ombudsman would protect consumers further by collecting and reporting complaints about inappropriate care or mental health commitment. The partnership between HHSC and TDI would ensure consumers and providers received appropriate information and assistance for resolving claim denials and behavioral health access issues.

The bill would create a process for better communication among TDI, HHSC, health plans, providers, and consumers about parity enforcement. The work group's recommendations would help entities address barriers hindering consumer access to behavioral health care.

CSHB 10 also would create clear definitions for quantitative and nonquantitative treatment limitations. Enforcing parity for a quantitative treatment limitation means, for example, that the co-pay amount for a cardiologist appointment would equal the co-pay amount for a psychiatrist appointment. Enforcing parity for a nonquantitative treatment limitation would mean a patient admitted to the hospital for a broken leg would also have to be admitted to the hospital for a severe acute or chronic episode of bipolar disorder, schizophrenia, paranoia, or post-traumatic stress disorder. Including these definitions in statute would create clarity for consumers, insurance regulators, and the industry, and would eliminate differences in how treatment for physical and mental health conditions is reimbursed and administered.

CSHB 10 would not mandate new mental health coverage but rather would enforce federal legislation enacted in 2008 by the Bush administration. The bill would not change existing regulations of health insurance plans nor the type of plan a consumer could purchase. It also would not increase the cost of health insurance plans because parity already is calculated in benefit premiums.

OPPONENTS SAY:

CSHB 10 would decrease consumers' flexibility in choosing a health insurance plan with benefits that best fit their needs. Some consumers do

not want a plan to have the same benefits for mental health as for physical health.

Any expansion of mental health coverage could creative incentives that could lead to increased involuntary confinements for patients in psychiatric hospitals.

NOTES:

A companion bill, SB 860 by Zaffirini, was scheduled for a public hearing today in the Senate Committee on Business and Commerce.

CSHB 10 differs from the bill as filed by:

- defining quantitative treatment limitation and expanding on the definition of nonquantitative treatment limitation;
- exempting insurance plans that provide coverage only for accidents;
- specifying that the TDI commissioner would enforce compliance of the mental health parity requirements by evaluating a health benefit plan's quantitative and nonquantitative treatment limitations;
- increasing representation in the work group of mental health and substance use disorder stakeholders; and
- requiring the ombudsman to receive and report concerns and complaints about inappropriate care or mental health commitment.