Subchapter AA. Consumer Choice Health Benefit Plans

Division 1. General Provisions.
28 TAC §21.3502

Division 2. State-Mandated Health Benefits
28 TAC §§21.3510 - 21.3513 and §§21.3515 - 21.3518

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28 TAC §21.3540 and §21.3543

Subchapter JJ. Autism Spectrum Disorder Coverage
28 TAC §§21.4401 - 21.4404

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §§21.3502, 21.3510 - 21.3513, 21.3515 - 21.3518, 21.3540, and 21.3543, concerning exclusion of certain state-mandated health benefits in consumer choice health benefit plans, and new §§21.4401 - 21.4404, concerning mandated health benefit plan coverage for autism spectrum disorder coverage. Section 21.4402 and §21.4403 are adopted with changes to the proposed text published in the April 3, 2009 issue of the *Texas Register* (34 TexReg 2217). Sections 21.3502, 21.3510 - 21.3513, 21.3515 - 21.3518, 21.3540, 21.3543, 21.4401, and 21.4404 are adopted without changes.

2. REASONED JUSTIFICATION. The adopted amendments and new sections implement (i) House Bill (HB) 1919, 80th Legislature, Regular Session, effective January 1, 2008, relating to required autism spectrum disorder coverage for certain children; (ii) HB 1485, 79th Legislature, Regular Session, effective September 1, 2005, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans; and (iii) HB 1030, 79th

Legislature, Regular Session, effective September 1, 2005, relating to an insured's coinsurance amount applicable to payment to a non-preferred provider. The adopted amendments are necessary to: (i) update existing rules relating to the exclusion of certain state-mandated health benefits in consumer choice health benefit plans; (ii) update obsolete statutory citations to the Insurance Code as a result of the enactment of the non-substantive revision of the Insurance Code; and (iii) correct citation style errors. New Subchapter JJ, consisting of §§21.4401 - 21.4404, is necessary to implement §1355.015 of the Insurance Code, which requires that health benefit plans provide autism spectrum disorder coverage for certain children.

A public hearing on the rule proposal was held on June 17, 2009. No public comments were received at the hearing. In response to written comments on the published proposal, the Department has changed some of the proposed language in the text of the rule as adopted. None of the changes made to the proposed text materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

The following changes are made to the proposed text as a result of comments.

The Department has revised the definition of "primary care physician" in §21.4402(7) as adopted to provide that if an enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a primary care physician is "a physician selected or otherwise designated by the enrollee or the enrollee's parent or guardian to develop a treatment plan for the purpose of treating autism spectrum disorder." The Department has added the words "by the

enrollee or the enrollee's parent or guardian" in response to comments requesting that the rules ensure that health benefit plans cannot select or designate an enrollee's primary care physician. The purpose of this change is to ensure that the adopted rules do not inadvertently give a health benefit plan the ability to designate an enrollee's primary care physician in instances where selection or designation of the enrollee's primary care physician is not addressed within the health benefit plan policy or evidence of coverage.

The Department has revised §21.4403(a)(1) as adopted to provide that "[a]t a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by Insurance Code §1355.015(a). The Department has also revised §21.4403(a)(2) as adopted to provide that "[p]ursuant to the Insurance Code §1355.015(a), the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a)." These changes are made in response to a comment requesting that the Department withdraw the rule as a result of the enactment of HB 451, passed by the 81st Legislature, Regular Session, effective September 1, 2009. The Department does not agree that it is necessary to withdraw the rule proposal because of the enactment of HB 451. Existing §1355.015(a) provides that at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee older than two years of age and younger than six years of age who is diagnosed with autism spectrum disorder, and that if an enrollee who is being

treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Existing §1355.015(a) is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2008. HB 451 amends §1355.015(a) to provide that, at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee who is diagnosed with autism spectrum disorder *from the date of diagnosis until the enrollee completes nine years of age.* HB 451 also amends §1355.015(a) to provide that if an enrollee who is being treated for autism spectrum disorder becomes *10* years of age or older and continues to need treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Section 1355.015(a) as amended by HB 451 is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010. These changes in §1355.015(a) by HB 451 to raise the age requirements for children eligible for coverage for autism spectrum disorder treatment under §1355.015 are the only changes enacted by HB 451 that impact the rules as proposed. The revision of §21.4403(a)(1) and (2) as adopted to reference the applicable statutory provision is consistent both with existing §1355.015(a) and §1355.015(a) as amended by HB 451.

HB 1919, relating to required autism spectrum disorder coverage for certain children. HB 1919 amends Insurance Code Chapter 1355, which regulates benefits for certain mental disorders. HB 1919 enacts §1355.015 to include, as a state-mandated benefit, coverage for certain children for all generally recognized services

prescribed in relation to autism spectrum disorder by an insured's primary care physician in the treatment plan recommended by that physician. As a result of the enactment of HB 1919, the Department adopts new Subchapter JJ, consisting of §§21.4401 - 21.4404, to implement the Insurance Code §1355.015. The new adopted sections do not impose any new or additional requirements to those in the statute. Pursuant to §1355.015(e), Chapter 1507 consumer choice health benefit plans are not required to provide the state-mandated coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. It is, therefore, necessary to amend existing rules regulating consumer choice health benefit plans to provide that the state-mandated coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A, is not required to be offered or provided by these consumer choice health benefit plans.

The following paragraphs provide a brief summary as well as an analysis of the reasons for the adopted amendments and new sections necessitated by the enactment of HB 1919.

New Subchapter JJ consisting of §§21.4401 - 21.4404 is necessary to implement §1355.015 of the Insurance Code. Section 1355.015 requires that health benefit plans provide autism spectrum disorder coverage for certain children. The new sections simply set forth statutory provisions and provide necessary interpretations of those provisions. The new sections do not impose any new or additional requirements to those in the statute. New §21.4401 addresses the purpose and applicability of Subchapter JJ. New §21.4401(a) states that the subchapter implements those

provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of the new subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services for certain child enrollees diagnosed with autism spectrum disorder in accordance with the Insurance Code Chapter 1355, Subchapter A. New §21.4401(b)(1) and (2) is necessary to address the applicability of the subchapter, specifying the types of health benefit plans to which Subchapter JJ does and does not apply.

New §21.4402 provides definitions of terms used in Subchapter JJ. The terms defined in the section include: "applied behavior analysis," "autism spectrum disorder," "enrollee," "generally recognized services," "health care practitioner," "neurobiological disorder," and "primary care physician."

New §21.4403 addresses required coverage for autism spectrum disorder in accordance with the Insurance Code §1355.015. New §21.4403(a)(1) is necessary to specify that, at a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by Insurance Code §1355.015(a). New §21.4403(a)(2) is necessary to provide that a health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a).

In accordance with the Insurance Code §1355.015, new §21.4403(b) is necessary to clarify that a health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for

enrollees of other ages. New §21.4403(c) specifies that in accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. New §21.4403(d) specifies that pursuant to the Insurance Code §1355.015(d), coverage under the section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

New §21.4404 addresses health care practitioners. Pursuant to the Insurance Code §1355.015(b), new §21.4404(a) specifies that, a health care practitioner providing treatment for autism spectrum disorder under Chapter 1355, Subchapter A, of the Insurance Code and proposed new Subchapter JJ must meet one of the following requirements: (i) be licensed, certified, or registered by an appropriate agency of this state; (ii) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or (iii) be certified as a provider under the TRICARE military health system. In accordance with the Insurance Code §1355.015(b), new §21.4404(b) specifies that a health benefit plan issuer may not deny coverage for services for autism spectrum disorder on the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by an agency of this state, as long the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).

Existing §§21.3510 - 21.3513 and §§21.3515 - 21.3518 specify state-mandated health benefits that are not required to be included in specific types of consumer choice benefit plans that may be provided under Insurance Code Chapter 1507. The amendments to these sections are necessary to update existing rules relating to the exclusion of certain state-mandated health benefits in consumer choice health benefit plans. The amendments simply reflect statutory provisions and do not impose any new or additional requirements to those in the statute. The Insurance Code in Chapter 1507, which regulates consumer choice health benefit plans, specifies those health benefit plans that are not required to offer or provide state-mandated health benefits, including individual indemnity policies, group association indemnity policies, small employer indemnity policies, large employer indemnity policies, individual HMO plans, group HMO plans, small employer HMO plans, and large employer HMO plans. Pursuant to §1507.001 and §1507.051, Chapter 1507 was enacted in recognition of the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans and health maintenance organization plans that are more affordable and flexible than policies offering accident and sickness insurance coverage and health care plans offered by health maintenance organizations available in the existing market. The purpose of Chapter 1507, therefore, is to increase the availability of health insurance coverage by allowing authorized insurers and health maintenance organizations to issue health plans that, in whole or in part, do not offer or provide state-mandated health benefits. Because of the §1355.015(e) provision that the statutorily mandated coverage of autism spectrum disorder does not apply to a standard

health benefit plan provided under Chapter 1507, it is necessary to amend certain existing rules for consistency with §1355.015(e). The Insurance Code Chapter 1355, Subchapter A, applies to group health benefit plans. There are six types of consumer choice group health benefit plans. However, pursuant to §1355.015(e), no consumer choice health benefit plans are required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. As a result, the following amendments are adopted to reflect this statutory exemption: (i) §21.3511(23) reflects the exemption for group association indemnity consumer choice health benefit plans; (ii) §21.3512(16) reflects the exemption for small employer group indemnity consumer choice health benefit plans; (iii) §21.3513(23) reflects the exemption for large employer group indemnity consumer choice health benefit plans; (iv) §21.3516(27) reflects the exemption for non-employer group HMO consumer choice health benefit plans; (v) §21.3517(20) reflects the exemption for small employer group HMO consumer choice health benefit plans; and (vi) §21.3518(27) reflects the exemption for large employer group HMO consumer choice health benefit plans.

HB 1485, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans. It is also necessary to adopt amendments to existing rules to implement HB 1485, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans. Enacted by the 79th Legislature, HB 1485 amended former Insurance Code Articles 3.80 §3 and 20A.09N(d), now §1507.003 and §1507.053, respectively. The 79th Legislature also enacted HB 2018 which, as part of

the non-substantive revision of the Insurance Code, adopted without substantive change both Article 3.80 §3 as the Insurance Code §1507.003 and Article 20A.09N(d) as the Insurance Code §1507.053, effective September 1, 2005. The HB 1485 amendment to Article 3.80 §3 (now §1507.003) revised the definition of "state mandated benefits," to not include "coverage for serious mental illness under Subchapter A, Chapter 1355." Prior to the amendment, the term did not include coverage for serious mental illness "under Article 3.51-14, Insurance Code, if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The amendment updated the statutory reference and deleted the qualifying phrase "if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The result of this amendment is: (i) a small employer group indemnity consumer choice health benefit plan is required to include the offer of serious mental illness under Subchapter A, Chapter 1355; and (ii) a standard health benefit plan issued as part of a group association indemnity policy is required to include serious mental illness under Subchapter A, Chapter 1355. The HB 1485 amendment to Article 20A.09N(d) (now §1507.053) revised the definition of "state mandated benefits," to not include coverage for "serious mental illness under Subchapter A, Chapter 1355 of the Insurance Code." Prior to the amendment, the term did not include coverage for serious mental illness "under Article 3.51-14, Insurance Code, if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The amendment deleted the qualifying phrase "if the standard health benefit plan is issued to a large employer as defined in Article 26.02, Insurance Code." The result of this

amendment is: (i) a small employer group Health Maintenance Organization (HMO) consumer choice health benefit plan is required to include the offer of serious mental illness under Subchapter A, Chapter 1355; and (ii) a non-employer group HMO consumer choice health benefit plan is required include serious mental illness under Subchapter A, Chapter 1355.

Prior to the HB 1485 amendments to Articles 3.80 §3 and 20A.09N(d), four types of consumer choice health benefit plans were not required to include either the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness as required by the Insurance Code Article 3.51-14 (now Chapter 1355, Subchapter A, of the Insurance Code). As a result, the exemptions were reflected in §§21.3511(9), 21.3512(9), 21.3516(13), and 21.3517(13). Section 21.3511(9) provided that the state-mandated health coverage for serious mental illness was not required to be included in a group association indemnity consumer choice health benefit plan. Section 21.3512(9) provided that the state-mandated offer of health coverage for serious mental illness was not required to be included in a small employer group indemnity consumer choice health benefit plan. Therefore, when these state-mandated exemptions in §21.3511(9) and §21.3512(9) were originally adopted in 2004, the exclusions were consistent with the Insurance Code Article 3.80 §3 (now §1507.003 of the Insurance Code). Section 21.3516(13) provided that the state-mandated health coverage of serious mental illness was not required to be included in a non-employer group HMO consumer choice health benefit plan. Section 21.3517(13) provided that the state-mandated offer of health coverage for serious mental illness was not required to be included in a small employer

group HMO consumer choice health benefit plan. Therefore, when these state-mandated exemptions in §21.3516(13) and §21.3517(13) were originally adopted in 2004, the exclusions were consistent with the Insurance Code Article 20A.09N(d) (now §1507.053 of the Insurance Code). All four of these exemptions are deleted in this adoption because the exemptions are no longer statutorily authorized pursuant to the Insurance Code §§1507.003 and 1507.053. The adopted deletions are necessary for consistency with statutory provisions revised by the enactment of HB 1485.

HB 1030, relating to an insured's coinsurance amount applicable to payment to a non-preferred provider. Deletion of some existing rules is necessary to implement HB 1030, enacted by the 79th Legislature, which added §1301.0046 to the Insurance Code. Section 1301.0046 provides that an insured's coinsurance amount applicable to payment to a non-preferred provider may not exceed 50 percent of the total covered amount applicable to the medical or health care services. The §1301.0046 coinsurance limitation supersedes the Department's rule in §3.3704(a)(6), relating to Freedom of Choice, Availability of Preferred Providers.

Prior to the enactment of HB 1030, the Insurance Code did not specify a specific percentage limit by which an insured's coinsurance amount applicable to payment to a non-preferred provider could exceed the total covered amount applicable to the medical or health care services. Therefore, pursuant to the Insurance Code Article 3.42(i)(2) (now §1701.055(a)(2)), the Department adopted a limit by rule in §3.3704(a)(6).

Section 3.3704(a)(6) specifies the basic level of coverage required for a preferred provider benefit plan to not be considered unjust or unfair discrimination under the

Insurance Code. Section 3.3704(a)(6) provides that: "A preferred provider benefit plan shall not be considered unjust under the Insurance Code Article 3.42, or unfair discrimination under the Insurance Code Articles 21.21-6 or 21.21-8, or to violate Articles 3.70-2(B) or 21.52 of the Insurance Code provided that . . . (6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 30% less than the higher level of coverage. A reasonable difference in deductibles shall be determined considering the benefits of each individual policy; . . . ." However, prior to this adoption, §§21.3510 - 21.3513 specified exemptions for certain consumer choice health benefit plan to the limitations or restrictions on coinsurance imposed by §3.3704(a)(6) based on Chapter 1507 of the Insurance Code. As previously noted, Chapter 1507 of the Insurance Code regulates consumer choice health benefit plans. Section 1507.001 states the purpose of the chapter: "The legislature recognizes the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. The legislature, therefore, seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in this state to issue accident and sickness policies that, in whole or in part, do not offer or provide state-mandated health benefits." To meet the stated purpose of Chapter 1507 to provide for more affordable and flexible health insurance plans, the Department adopted the exemptions to §3.3704(a)(6) in §§21.3510 - 21.3513. These exemptions, which are deleted in this adoption, were specified in the following consumer choice health benefit

plan rules: (i) §21.3510(5), individual indemnity consumer choice health benefit plans; (ii) §21.3511(5), group association indemnity consumer choice health benefit plans; (iii) §21.3512(5), small employer group indemnity consumer choice health benefit plans; and (iv) §21.3513(5), large employer group indemnity consumer choice health benefit plans. However, as a result of the enactment of HB 1030, it is no longer necessary to include exemptions to §3.3704(a)(6) in §§21.3510(5), 21.3511(5), 21.3512(5), and 21.3513(5). With the enactment of HB 1030, an insured's coinsurance amount applicable to payment to a non-preferred provider may not exceed 50 percent of the total covered amount applicable to the medical or health care services. As previously noted, the §1301.0046 coinsurance limitation is applicable to all health benefit plans, including consumer choice health benefit plans. Also, as previously noted, the §1301.0046 coinsurance limitation supersedes the §3.3704(a)(6) requirement. According to the Senate Research Center bill analysis for HB 1030, the purpose of the legislation is to provide more options for employers and individuals looking for affordable health insurance. (SENATE RESEARCH CENTER, BILL ANALYSIS (ENGROSSED), HB 1030, 79TH Legislature, Regular Session effective September 1, 2005.) This purpose is consistent with the purpose of the Insurance Code Chapter 1507 as stated in §1507.001. Therefore, because the exemptions are no longer statutorily authorized and because HB 1030 addresses the purpose for adopting them, it is necessary to delete the exemptions in §§21.3510(5), 21.3511(5), 21.3512(5), and 21.3513(5) from the §3.3704(a)(6) requirement.

Update of obsolete statutory citations and conformation with current Department citation style. Amendments are also necessary to update obsolete statutory citations to the Insurance Code as a result of the enactment of the non-substantive revision of the Insurance Code. This will result in easier use and readability of the rules. Additionally, amendments are necessary throughout the amended sections to change references to "Insurance Code" to "the Insurance Code" to conform to current Department citation style. Amendments are adopted in the following sections to update statutory citations to conform with the non-substantive revised Insurance Code: §21.3502(3), (7), (10)(A)(ii) and (B); §21.3510(1) – (4); renumbered §21.3510(5) – (8), (11), and (13); §21.3511(1) – (4); renumbered §21.3511(5) – (7), (8) – (20), and (22); §21.3512(1) – (4); renumbered §21.3512(5) – (7), (8) – (13), and (15); §21.3513(1) – (4); renumbered §21.3513(5) – (20) and (22); §21.3515(1) – (7), (10) – (14), and (16); §21.3516(1) – (7) and (10) – (12); renumbered §21.3516(13) – (24) and (26); §21.3517(1) – (7) and (10) – (12); renumbered §21.3517(13) – (17) and (19); §21.3518(1) – (7), (10) – (24), and (26); §21.3540; and §21.3543(1)(A) and (B).

3. HOW THE SECTIONS WILL FUNCTION. Adopted §21.3511(23) provides that a group association indemnity consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. Under adopted §21.3512(16), a small employer group indemnity consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter

A. Adopted §21.3513(23) provides that a large employer group indemnity consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. A non-employer group HMO consumer choice health benefit plan is not required under adopted §21.3516(27) to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. Under adopted §21.3517(20), a small employer group HMO consumer choice health benefit plan is not required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. A large employer group HMO consumer choice health benefit plan is not required under adopted §21.3518(27) to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

Adopted new Subchapter JJ implements the coverage for autism spectrum disorder mandated by HB 1919, 80th Legislature, Regular Session, effective January 1, 2008. Adopted new §21.4401 addresses the purpose and applicability of Subchapter JJ. Adopted §21.4401(a) states that the subchapter implements those provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of the proposed new subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services for certain child enrollees diagnosed with autism spectrum disorder in accordance with the Insurance Code Chapter 1355, Subchapter A. Adopted §21.4401(b)(1) and (2) addresses the applicability of the subchapter, specifying the types of health benefit plans to which Subchapter JJ does and does not apply.

New §21.4402 defines terms used in Subchapter JJ. The terms defined in the section include: "applied behavior analysis," "autism spectrum disorder," "enrollee," "generally recognized services," "health care practitioner," "neurobiological disorder," and "primary care physician."

New §21.4403 addresses required coverage for autism spectrum disorder. New §21.4403(a)(1) specifies that, at a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by Insurance Code §1355.015(a). New §21.4403(a)(2) provides that a health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a).

New §21.4403(b) clarifies that a health benefit plan is not precluded from providing coverage of treatment and services described by the Insurance Code §1355.015(b) for enrollees of other ages. New §21.4403(c) specifies that in accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. New §21.4403(d) specifies that pursuant to the Insurance Code §1355.015(d), coverage under the section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

New §21.4404 addresses health care practitioners. New §21.4404(a) specifies that, pursuant to the Insurance Code §1355.015(b), a health care practitioner providing treatment for autism spectrum disorder under Chapter 1355, Subchapter A, of the Insurance Code and proposed new Subchapter JJ must meet one of the following requirements: (i) be licensed, certified, or registered by an appropriate agency of this state; (ii) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or (iii) be certified as a provider under the TRICARE military health system. New §21.4404(b) specifies that a health benefit plan issuer may not deny coverage for services for autism spectrum disorder on the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by an agency of this state, as long the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).

Several provisions are adopted with updated statutory citations to conform to the non-substantive revised Insurance Code. These provisions include: §21.3502(3), (7), (10)(A)(ii) and (B); §21.3510(1) – (8), (11), and (13); §21.3511(1) – (20) and (22); §21.3512(1) – (13) and (15); §21.3513(1) – (20) and (22); §21.3515(1) – (7), (10) – (14), and (16); §21.3516(1) – (7) and (10) – (24) and (26); §21.3517(1) – (7) and (10) – (17) and (19); §21.3518(1) – (7), (10) – (24), and (26); §21.3540; and §21.3543(1)(A) and (B).

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comments

Withdrawal of the rule proposal

Comment: A commenter requests that the rule proposal be withdrawn because HB 451 was filed in the 2009 Texas Legislature, and the bill amends the existing law created by HB 1919 in order to change the age range of coverage for children with autism spectrum disorder. The commenter says that this change makes the proposed rule's interpretation of the covered ages null and void.

Agency Response: The Department disagrees with the commenter's suggestion to withdraw the rule proposal and declines to take this action. HB 451 was passed by the Texas Legislature and amends the existing law enacted by HB 1919 to change the age of coverage for children with autism spectrum disorder. As a result, the Department has modified the text of §21.4403(a)(1) as adopted to provide: "At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by the Insurance Code §1355.015(a). Additionally, the Department has modified the text of §21.4403(a)(2) as adopted to provide: "Pursuant to the Insurance Code §1355.015(a), the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a)." Existing §1355.015(a) provides that at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee older than two years of age and younger than six years of age who is diagnosed with autism spectrum disorder, and that if an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need

treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Existing §1355.015(a) is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2008. HB 451 amends §1355.015(a) to provide that, at a minimum, a health benefit plan must provide coverage as provided by §1355.015 to an enrollee who is diagnosed with autism spectrum disorder *from the date of diagnosis until the enrollee completes nine years of age*. HB 451 also amends §1355.015(a) to provide that if an enrollee who is being treated for autism spectrum disorder becomes *10* years of age or older and continues to need treatment, §1355.015(a) does not preclude coverage of treatment and services described by subsection (b) of §1355.015. Section 1355.015(a) as amended by HB 451 is applicable to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010. The revision of §21.4403(a)(1) and (2) as adopted is consistent with the Insurance Code §1355.015(a) as enacted by HB 1919 and by HB 451.

Creation of a Resource Guide

Comment: Two hundred and two commenters ask that the Department work with stakeholders to create a Frequently Asked Questions list regarding autism coverage in Texas. Another commenter requests that the Department work in cooperation with health benefit plans, providers, and consumers to create and post a web-based resource guide or list of Frequently Asked Questions to provide specific guidance on implementation of HB 1919.

Agency Response: While the Department already has a web-based resource page addressing coverage for autism spectrum disorder, it does not currently contain a list of Frequently Asked Questions (FAQs). This is because the Department has not yet received enough inquiries regarding coverage for autism spectrum disorder with which to compile such a list. In accordance with the Department's current procedure, when enough such questions are received, a list of FAQs will be compiled and posted on the Department's web-based resource page addressing coverage for autism spectrum disorder.

§21.4401. Purpose and applicability

Comment: A commenter suggests striking the following statement from proposed §21.4401: "The general purpose of this subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services of certain children enrollees diagnosed with autism spectrum disorder, as provided in the Insurance Code Chapter 1355, Subchapter A." According to the commenter, the purpose of HB 1919 is determined by the language of the bill, and absent any legislative finding or direction, the rule should reflect the language of the statute.

Agency Response: The Department disagrees with the commenter and declines to make a change. Section 21.4401 does not state the purpose of HB 1919; it states the purpose of the Department's rules.

Comment: Two hundred and three commenters request that the adopted rule clarify that the Texas Health Risk Pool is required to provide autism coverage under HB 1919.

Agency Response: The Department cannot make the requested change because it would exceed the Department's rulemaking authority. Neither the Insurance Code Chapter 1506 (relating to the Texas Health Risk Pool) nor the Insurance Code Chapter 1355, Subchapter A, (relating to Group Benefit Health Plan Coverage for Certain Serious Mental Illnesses and Other Disorders) provide that the Texas Health Risk Pool is to provide coverage for autism spectrum disorder. Neither Chapter 1506 nor Chapter 1355 authorizes the Department to require coverage that is not authorized by statute. Rather, the Insurance Code §1506.151(a) provides that the Texas Health Risk Pool is required to offer "coverage consistent with major medical expense coverage to each eligible individual." Section 1506.151(b) provides that the specific coverages to be provided by the Texas Health Risk Pool are to be established by the Board of Directors of the Texas Health Risk Pool with the approval of the Commissioner. Therefore, in order for the Texas Health Risk Pool to be required to provide coverage for autism spectrum disorder, the Board of Directors of the Risk Pool would have to authorize such coverage, and such coverage would have to be approved by the Commissioner.

§21.4402(1). Definition of "applied behavior analysis"

Comment: One commenter objects to the definition of "applied behavior analysis" in proposed §21.4402(1) because, while it is an improvement over earlier drafts, it is still "vague to the point of providing no direction." A second commenter suggests revising the definition to include reference to empirical validation by adding the following: ". .

.meaningful degree. This would include the collection and analysis of individual data collected on treatment progress."

Agency Response: The Department disagrees with the commenters and declines to make any change. The proposed definition for "applied behavior analysis," which is adopted without change, is based on the definition developed and used by TRICARE. Because TRICARE certified providers are expressly permitted to provide ASD services and treatment under the Insurance Code §1355.015, the Department believes that it is appropriate that this definition apply for all other statutorily recognized providers of ASD treatment as required under §1355.015 of the Insurance Code. Therefore, the Department does not agree that the definition is "vague to the point of providing no direction" or that the requested change to the proposed definition is necessary or appropriate.

Comment: A commenter suggests referencing "board certified" behavior analysis in proposed §21.4402(1), so that individuals with some other credential that would meet the state requirement but who do not have training in applied behavior analysis cannot practice or bill for it.

Agency Response: The Department disagrees with the comment and declines to make a change. The Department does not have the authority to regulate the practice of medicine. Additionally, the Insurance Code §1355.015(b) specifies the types of health care practitioners who meet the statutory requirements to provide ASD treatment under §1355.015 of the Insurance Code. The Department does not have the authority to prevent a health care practitioner who meets those qualifications from billing for the

treatment the health care practitioner provides as long as the treatment is in accordance with §1355.015 and these rules.

§21.4402(4). Definition of "generally recognized services"

Comment: One commenter requests that the definition of "generally recognized services" in proposed §21.4402(4) be revised to track the statutory language in §1355.015(c) of the Insurance Code. The statutory language provides that "generally recognized services" "may include services such as. . ." and then specifies those services listed in §21.4402(4). Section 1355.015(c), however, does not include the language in §21.4402(4) "The term includes, but is not limited. . . ." The commenter also observes that the proposed definition of "generally recognized services" does not include a requirement that services prescribed be "medically necessary." The commenter asserts that with the exception of preventive care services, the commenter is not aware of any precedent that provides for coverage of medical care that does not have to meet a standard of medical necessity. According to the commenter, removing the ability of an insurer to establish that proposed care is appropriate removes any restriction on the reasonableness of care and can result in increased expenses. Additionally, it can also result in danger to consumers, as review of proposed care by a third party protects the consumer by comparing the proposed care to well established standards of care.

Agency Response: The Department disagrees with the commenter and declines to make a change. Pursuant to the Government Code §311.005(13), the term "includes"

when used in a statute is a term of enlargement, not limitation, and use of the term does not create a presumption that components not expressed are excluded. Therefore, the provision in proposed §21.4402(4), stating that the term "generally recognized service. . . includes, but is not limited to, the following services. . . ." is consistent with the Government Code §311.005(13) rule of construction and is adopted without change. It is the Department's position that this statement is a necessary and accurate clarification of §1355.015(c) of the Insurance Code. With regard to the comment concerning the addition of an express requirement that generally recognized services must be "medically necessary," the Department disagrees that such a requirement should be included. The inclusion of such a requirement is not consistent with the Insurance Code §1355.015, which does not address medical necessity. The Insurance Code §1355.015 neither mandates that utilization review be conducted nor restricts a health benefit plan's ability to conduct utilization review. These rules are consistent with §1355.015.

§21.4402(5). Definition of "health care practitioner"

§21.4404(b). Coverage for applied behavior analysis

Comment: A commenter objects to the definition for "health care practitioner" in proposed §21.4402(5) because it appears to allow for any type of provider, qualified or not, to deliver services. The commenter points out that the Insurance Code already contains a definition of "health care practitioner" in §1451.001 of the Insurance Code. The commenter also objects to proposed §21.4404(b), which provides that a health plan may not deny coverage on the basis that a health care practitioner does not hold a

license issued by an agency of this state because the Insurance Code contains a definition of health care practitioner in the Insurance Code §1451.001. The commenter again points out that §1451.001 provides a list of practitioners, and the commenter states that all of the listed practitioners are required to be licensed by a state board or agency.

Agency Response: The Department disagrees with the commenter and declines to make a change. The definition in the Insurance Code §1451.001 is applicable to the Insurance Code Chapter 1451, which regulates access to certain practitioners and facilities. These rules implement the Insurance Code Chapter §1355.015, which regulates autism spectrum disorder coverage for certain children. The definition in proposed §21.4402(5) and the provision proposed in §21.4404(b), which are adopted without change, are based on provisions in the Insurance Code §1355.015(b) that specify the qualifications of a health care practitioner whose autism spectrum disorder treatment is covered under §1355.015.

§22.4402(7). Definition of "primary care physician"

Comment: One commenter references the words "develop a treatment plan for the purpose of treating autism spectrum disorder" in proposed §21.4402(7) and states that clarification is needed regarding what is to be involved in such a treatment plan. The commenter asserts that the final rule should indicate that any treatment plan developed by a primary care physician should be a very general treatment plan. According to the commenter, the final rule should not leave open the possibility of a physician dictating to

other specially and appropriately trained professionals details of what to do and how to do it. Otherwise, the rule could result in physicians recommending or prescribing inappropriate interventions or inappropriately sequenced interventions as well as inappropriate therapeutic methods or time and resource wasting delays in development of appropriate treatment plans.

Agency Response: The Department disagrees with the commenter and declines to make a change. The treatment plan is part of the medical care provided by a doctor, and the Department does not have the authority to regulate or direct the care that a doctor provides. In regard to the commenter's concern that a physician might recommend or prescribe inappropriate care that results in a waste of time or resources, neither the Insurance Code §1355.015 nor these adopted rules prevent a health benefit plan from conducting utilization review. Through use of a utilization review program, health benefit plans can prevent the use of inappropriate or wasteful treatments.

Comment: A commenter requests that proposed §22.4402(7) be revised to read: " A physician selected or otherwise designated *by the enrollee* as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated *by the enrollee* to develop a treatment plan for the purpose of treating autism spectrum disorder." The commenter notes that the proposed definition for "primary care physician" includes the words "selected or designated." According to the commenter, insurance companies, historically, have used "designated" primary care physicians

combined with financial disincentive plans to ensure extremely low uptake of particular services which might otherwise be covered. The commenter also asserts that many primary care physicians have no more than a cursory knowledge of autism and that these physicians would prefer the enrollee switch to a primary care physician who has extensive experience with autism and autism treatment programs. The commenter states that if autism treatment program quality is to be kept high the person prescribing and managing it should be knowledgeable about the intricacies of quality treatment. According to the commenter, the proposed definition for "primary care physician" potentially allows health benefit plans the ability to select or designate an enrollee's primary care physician, even without specific plan authorization to do so.

Agency Response: The Department agrees in part with the commenter and has revised §22.4402(7) as adopted similarly to the change requested. The first instance in which the phrase "A physician selected or otherwise designated as the enrollee's primary care physician. . . ." is used references health benefit plans that contain provisions specifying how a primary care physician is to be selected or designated. Such health benefit plans might have instances in which the health benefit plan issuer is permitted to designate a primary care physician. It is not appropriate for the rule to exclude or negate such permitted instances. The second instance in which the phrase "a physician selected or otherwise designated as the enrollee's primary care physician. . . ." is used references health benefit plans that do not contain provisions specifying how a primary care physician is to be selected or designated. It is necessary to stipulate what a "primary care physician" is in regard to such health benefit plans; otherwise there

would be no "primary care physician" to prescribe treatment. It is not the intent of these rules to authorize health benefit plans to designate an enrollee's primary care physician in the absence of a contract provision that gives the plan that authority. Therefore, it is appropriate and necessary to clarify that in those instances in which a health benefit plan does not contain provisions specifying how a primary care physician is to be selected or designated, it is the enrollee that has the ability to choose a primary care physician. However, because the enrollees subject to the Insurance Code §1355.015 are young children suffering from a condition that often limits one's ability to communicate, it is not feasible to make the change exactly as requested by the commenter. Therefore, the Department has revised the definition of "primary care physician" in §22.4402(7) as adopted to read: "A physician selected or otherwise designated as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated *by the enrollee or the enrollee's parent or guardian* to develop a treatment plan for the purpose of treating autism spectrum disorder."

§21.4403(a)(1). Age range of covered enrollees

Comment: A commenter suggests that the lower limit of the age range for covered children in proposed §21.4403(a)(1) be set at two rather than three. The commenter offers the following reasons for the suggestion: (i) this would be in line with the legislative intent of HB 1919; (ii) such a provision would also facilitate very early

intervention for children with ASD, which is important because scientific research has shown that intensive intervention for children two years of age results in a need for less intensive and expensive services in the future; and (iii) ensuring availability of another year of services for children between their second and third birthdays would be beneficial and consistent with best practice in the field of autism intervention.

Agency Response: The change requested by the commenter is unnecessary as a result of the revision made to adopted §21.4403(a)(1) in response to another comment. Section 21.4403(a)(1) as adopted reads: "At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by the Insurance Code §1355.015(a)."

§21.4403(c). ASD coverage as a medical and surgical benefit

Comment: One commenter questions the authority of the Department to include in the rules proposed §21.4403(c), which provides that services provided for autism spectrum disorder must be provided under the medical and surgical provisions of the benefit plan as a medical and surgical benefit. The commenter points out that HB 1919 amended Chapter 1355 of the Insurance Code which is entitled "Benefits For Certain Mental Disorders." According to the commenter, because coverage for mental disorders often have different terms of coverage than medical and surgical benefits, the proposed language appears to impose a higher standard than authorized by HB 1919.

Agency Response: The Department disagrees with the commenter and declines to make a change. The Department's reasons are the following. First, pursuant to

Government Code §311.024, "The heading of a title, subtitle, chapter, subchapter, or section does not limit or expand the meaning of a statute." Therefore, the fact that the heading of the Insurance Code Chapter 1355 is "Benefits For Certain Mental Disorders" does not limit or prevent implementation of the autism spectrum disorder coverage mandate in a way that reflects the legislative intent of HB 1919. Second, documents in the legislative history of HB 1919, along with a reading of the changes made to the Insurance Code by HB 1919, indicates legislative intent to apply the autism spectrum disorder coverage mandate as a medical benefit. For example, SB 419, 80th Legislature, Regular Session, was a predecessor bill to HB 1919, and the author of SB 419 was also the author of the amendment that added the autism spectrum disorder coverage mandate to HB 1919. The bill analysis for the Introduced version of SB 419 states that "Insurers deny treatment coverage for children with ASD by classifying ASD as a mental illness, although autism is recognized as a neurobiological disorder in the [DSM-IV] of the American Psychiatric Association." This statement indicates intent by the author of SB 419 for autism spectrum disorder to be classified as something other than a mental illness. Third, the author's intent is also reflected in the changes made by HB 1919 to the Insurance Code. For example, the heading for the Insurance Code Chapter 1355, Subchapter A was changed from "Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses" to "Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses **and Other Disorders**." (Emphasis added.) While the addition of the reference to "Other Disorders" in the Subchapter A heading cannot be argued to expand the meaning of the statute pursuant to the Government §311.024, it

arguably provides insight into the author's intent in amending the subchapter. Fourth, a definition for "autism spectrum disorder" was added to the Insurance Code §1355.001 that defines the condition as a "neurobiological disorder." Also, a definition for "neurobiological disorder" was added to the Insurance Code §1355.001 which provides that a neurobiological disorder is an illness of the nervous system, and the term "pervasive developmental disorder," which is a form of autism spectrum disorder, was removed from the definition of "serious mental illness" and incorporated into the definition of "autism spectrum disorder."

§21.4402(5). Definition of "health care practitioner"

§21.4404(a). Requirements for health care practitioner who provides treatment

§21.4404(b). Coverage for applied behavior analysis

Comment: Numerous commenters suggest that the proposed rules directly recognize and address practitioners that have credentials issued by the Behavior Analyst Certification Board.

Two hundred and two commenters request that the definition of "health care practitioner" in §21.4402(5) ensure that health benefit plans clearly understand that Board Certified Behavior Analysts are covered health care practitioners. Fourteen other commenters suggest explicitly listing Board Certified Behavior Analysts as a type of health care practitioner in proposed §21.4402(5). According to the commenters, Board Certified Behavior Analysts are eligible practitioners by virtue of the fact that they are eligible to provide these services under TRICARE, which makes them eligible as health

care practitioners as provided by §21.4404(a)(3). Another commenter requests that the following sentence be added to proposed §21.4402(5): "Board Certified Behavior Analysts (BCBAs) are health care practitioners as it relates to §1355.015(b), and as such, treatment programs supervised by BCBA certified individuals will be covered when prescribed in accordance with 1355.015(b)." According to the commenter, this is needed to send a clear message to insurance companies that Board Certified Behavior Analysts are covered practitioners. The commenter asserts that the legislative intent of HB 1919 is to enable children with ASD to access high quality intensive intervention and that programs supervised by Board Certified Behavior Analysts are clearly part of that intent. According to the commenter, the Board Certified Behavior Analysts certifications are consistent with the associated requirements for becoming a provider under §1355.015(b) of the Insurance Code. The commenter asserts additional reasons for the requested language: (i) the Board Certified Behavior Analyst credential is certified through the national Behavior Analyst Certification Board and is recognized by the National Council for Certifying Agencies; (ii) the following professional organizations endorse the credential: the Association of Professional Behavior Analysts, the Association for Behavior Analysis International, and Division 25 (Behavior Analysis) of the American Psychological Association; (iii) the Defense Department has recognized the credential under its TRICARE health plan; (iv) the U.S. Centers for Disease Control refers patients to the Association for Behavior Analysis International; and (v) at the state level, the Texas Home Living Medicaid Waiver and the Home and Community

Services Waiver have certified Board Certified Behavior Analysts as approved service providers for applied behavior analysis.

One commenter suggests that proposed §21.4404(a)(3) be revised to clearly spell out that Board Certified Behavior Analysts are eligible practitioners under the rule, rather than just providing that a practitioner certified as a provider under TRICARE is an eligible practitioner. The commenter asserts the following reasons for the suggested revision: (i) the third option in the Insurance Code §1355.015(b), requiring that a provider providing treatment under the Insurance Code §1355.015, be certified as a provider under TRICARE military health system was inserted in HB 1919 to enable reimbursement for Board Certified Behavior Analysts, who are certified by the Board Certified Behavior Analysts; (ii) Board Certified Behavior Analysts do not meet the second or third qualification in §1355.015(b) because there is not a state or federal licensure or certification, but the Board Certified Behavior Analyst credential is recognized under TRICARE, and thus the Board Certified Behavior Analyst credential must be recognized in this rule and its implementation; and (iii) Board Certified Behavior Analysts do not have to be individually credentialed by TRICARE, but are certified as eligible merely by their inclusion on the certificate registry maintained by the Behavior Analyst Certification Board.

One commenter requests that the rule be more direct in stating that §21.4404(b) applies to Board Certified Behavior Analysts. The commenter objects to proposed §21.4404(b), which relates to coverage for applied behavior analysis, because it raises concerns that anyone can provide services under the rule. According to the

commenter, these fears will be allayed if §21.4404(b) is more direct in stating that the rule applies to Board Certified Behavior Analysts. Another commenter opines that proposed §21.4404(b) regarding which health care practitioners are included in coverage for applied behavior analysis is circuitous, and that the clear intent of the statute is that insurance cover applied behavior analysis services provided by any person who is a Board Certified Behavior Analyst. Fourteen commenters assert that proposed §21.4404(b) should explicitly state that an insurer "shall provide coverage for services for autism spectrum disorder by a practitioner with the Board Certified Behavior Analyst credential issued by the Behavior Analyst Certification Board."

Agency Response: The Department disagrees with the commenters and declines to make the requested changes because the requested changes are not in compliance with the Insurance Code §1355.015(b). Therefore, §21.4402(5) and §21.4404(a) and (b) are adopted without changes to the proposed text. For the following reasons, the Department does not have the authority under the Insurance Code Chapter 1355 to explicitly list Board Certified Behaviors Analysts as a type of health care practitioner in the definitions section of the rules or to require that treatment provided by individuals certified by the Behavior Analyst Certification Board is to automatically be covered as a benefit under the ASD coverage mandate in the Insurance Code Chapter 1355, Subchapter A.

First, the Behavior Analyst Certification Board is a non-governmental professional association, and the Department is not authorized under the Insurance Code Chapter 1355 to recognize or specify that providers certified by non-governmental

professional associations are qualified to provide treatment under the Insurance Code §1355.015.

Second, the Insurance Code §1355.015(b)(1) - (3) specifies that a health care practitioner must be "licensed, certified, or registered by an appropriate agency of this state," must have a professional credential "recognized and accepted by an appropriate agency of the United States," or must be "certified as a provider under the TRICARE military health system" to provide services under §1355.015(b), and the paragraphs in proposed §21.4404(a) simply reiterate §1355.015(b)(1) – (3), and proposed §21.4404(b) clearly references the health care practitioner requirements in the Insurance Code §1355.015(b) (1) – (3). The authority of a person holding a certification issued by the Behavior Analyst Certification Board to provide services under the Insurance Code §1355.015(b)(2) hinges on recognition and acceptance of the professional credential issued by the Behavior Analyst Certification Board by an appropriate agency of the United States. Currently TRICARE, a healthcare delivery system that is a part of the Department of Defense, does recognize and accept the certifications issued by the Behavior Analyst Certification Board. Therefore, practitioners holding certifications issued by the Behavior Analyst Certification Board are qualified to provide services under the Insurance Code §1355.015 pursuant to the Insurance Code §1355.015(b)(2). However, the fact that TRICARE currently recognizes and accepts the certifications issued by the Behavior Analyst Certification Board does not mean that TRICARE will accept such certifications in the future. According to Chapter 11, Section 3.2 of the TRICARE Policy Manual 6010.54-M, August 1, 2002,

certified membership in a national or professional association that sets standards for the profession is accepted in place of state licensure or certification in instances when the state where a provider practices does not offer licensure or certification. Chapter 11, Section 3.2 of the TRICARE Policy Manual also provides that when a new state law is enacted that requires or provides for licensing or certification of a provider, authorized providers must obtain the license as soon as the state begins issuance. This means that if Texas begins to license or certify applied behavior analysis providers, TRICARE will no longer recognize and accept the certifications issued by the Behavior Analyst Certification Board within this state. While other federal agencies may also recognize and accept the certifications issued by the Behavior Analyst Certification Board, the Department is not aware of any such federal agencies. One commenter references recognition by the "National Council for Certifying Agencies." There does not appear to be such an agency. A "National Commission for Certifying Agencies" exists, but it is not a federal agency. The commenter also states that the U.S. Centers for Disease Control refers patients to the Association for Behavior Analysis International. However, "referral" does not correlate to "recognition and acceptance." Additionally, the Association for Behavior Analysis International does not issue certifications on behalf of the Behavior Analyst Certification Board. Finally, the same commenter lists various professional organizations and state agencies that it asserts recognizes and accepts the Board Certified Behavior Analyst credential. Recognition and acceptance by a professional organization or a state agency, however, is not sufficient for compliance with the Insurance Code §1355.015(b)(2). The authority of a person holding a

certification issued by the Behavior Analyst Certification Board to provide covered services under the Insurance Code §1355.015(b)(3) hinges on certification by TRICARE. While one of the requirements for certification as an applied behavior analysis provider under the TRICARE military health system is that the provider be certified by the Behavior Analyst Certification Board, the TRICARE military health system also requires that an applied behavior analysis provider meet "all best standards of the medical community" and be "verified as having met those standards by one of the TRICARE regional contractors."

During this rulemaking process, numerous stakeholders have asserted that TRICARE does not require certification of applied behavior analysis providers, and have expressed confusion over the reference to TRICARE certification in the statute and the rule drafts. Therefore, the following summarizes the TRICARE certification process that is currently required for a practitioner to be authorized to provide applied behavior analysis treatment services pursuant to the Insurance Code §1355.015(b)(3). Chapter 20, Section 10 of the TRICARE Operations Manual, 6010.51-M, August 1, 2002, identifies three types of applied behavior analysis providers that can become certified: Autism Demonstration Corporate Services Providers (ACSPs), EIA Supervisors, and EIA Tutors (EIA is an acronym for "Educational Interventions for Autism spectrum disorder"). Pursuant to the TRICARE Operations Manual, ACSPs must meet the following requirements: (i) submit evidence of professional liability insurance; (ii) submit all documentation necessary to support an application for designation as a TRICARE ACSP; (iii) enter into a TRICARE participation agreement; (iv) employee

directly or contract with EIA Supervisors and EIA Tutors; (v) certify that all EIA Supervisors and EIA Tutors employed by or contracted with the ACSP meet the education, training, experience, competency, supervision, and demonstration requirements specified by the TRICARE Operations Manual; (vi) comply with all applicable organizational and individual licensing or certification requirements in the state, county, municipality, or other political subdivision in which services are provided; and (vii) comply with all other requirements applicable to TRICARE-authorized providers. Additionally, an ACSP who is an individual must undergo a criminal history review by the TRICARE regional contractor. Pursuant to the TRICARE Operations Manual, an EIA Supervisor must have: (i) a current, unrestricted state-issued license to provide applied behavior analysis services; (ii) a current, unrestricted state-issued certificate as a provider of applied behavior analysis services; or (iii) be certified by the Behavior Analyst Certification Board as either a Board Certified Behavior Analyst or a Board Certified Assistant Behavior Analyst where state issued licenses or certificates are not available. Additionally, an EIA Supervisor must meet the following requirements: (i) enter into a TRICARE participation agreement; (ii) employee directly or contract with EIA Tutors; (iii) report sanctions by the Behavior Analyst Certification Board or loss of Behavior Analyst Certification Board certification to TRICARE's regional contractor within 30 days; (iv) ensure that the quality of services provided by EIA Tutors meets the current Behavior Analyst Certification Board evidence-based standards; (v) maintain all applicable business licenses and employment or contractual documentation in accordance with federal, state, and local requirements; (vi) meet all applicable

requirements of the state in which services are provided; (vii) cooperate fully with TRICARE's designated utilization and clinical quality management organization; and (viii) comply with all other requirements applicable to TRICARE-authorized providers. Pursuant to the TRICARE Operations Manual, an EIA Tutor must have completed 40 hours of classroom training in applied behavior analysis techniques in accordance with BACB guidelines prior to providing services. Additionally, an EIA Tutor must have: (i) completed a minimum of 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development, or related fields and be currently enrolled in a course of study leading to an associate's or bachelor's degree by an accredited college or university; (ii) completed a minimum of 48 semester hours of college courses in an accredited college or university; or (iii) have a High School diploma or GED equivalent and have completed 500 hours of employment providing ABA services as verified by the ACSP. Finally, an EIA Tutor must receive no less than two hours supervision per month from the EIA Supervisor, in accordance with BACB guidelines.

§21.4404(a). Requirements for health care practitioner who provides treatment

Comment: One commenter questions whether the term "appropriate" in proposed §21.4404(a)(1) and (2) means that there is some type of standard a provider must meet in order to provide services. Proposed §21.4404(a)(1) and (2) read: "a health care practitioner. . . must. . . be licensed, certified, or registered by an *appropriate* agency of this state. . . [or] have professional credentials that are recognized by and accepted by

an *appropriate* agency of the United States." According to the commenter, inclusion of the term "appropriate" in both of these paragraphs suggests that some level of expertise should be required under each paragraph. As an example, the commenter asserts that there are no inappropriate agencies of the United States.

Agency Response: The standards a health care practitioner must meet under the Insurance Code §1355.015 and §21.4404(a)(1) - (3) are those standards (i) that are required to become licensed, certified or registered by an appropriate agency of this state; (ii) that are necessary to obtain professional credentials that are recognized and accepted by an appropriate agency of the United States; or (iii) that are required to become certified as a provider under the TRICARE military health system. The specific standards a health care practitioner must meet depend on the services that the health care practitioner provides. For example, in order for an individual to be qualified to provide speech therapy services pursuant to §21.4404(a)(1), the individual must be licensed as a speech-language pathologist by the Texas State Board of Examiners for Speech-Language Pathology and Audiology, the appropriate state agency to license a provider of speech therapy services. If the individual providing the speech therapy services only has a license for accounting issued by the Texas State Board of Public Accountancy, the provider of the speech therapy services would be licensed by an inappropriate state agency and would not be qualified to provide speech therapy services pursuant to §21.4404(a).

Comment: A commenter suggests that §21.4404(a)(1) and (2) be revised to provide that only those with a minimum of a Master level license in the Human Developmental

Field (Social Worker, Marriage and Family Therapists, Licensed Professional Counselors, Psychologists) be permitted to treat autism. The commenter expresses concern that under proposed §21.4404(a)(1) and (2) "just about anyone with minimum education and credentials approved by an appropriate agency" may treat a disorder as complex as autism. The commenter asserts that there is no reference to type of education, such as GED or credentials that could be obtained through a weekend workshop, and asks which agencies are appropriate and who determines them. The commenter expresses concern that this is a way for insurance companies to cut costs, and enrollees will suffer inadequate care from lack of knowledge of the behavioral health care provider.

Agency Response: The Department disagrees with the commenter and declines to make a change. The Insurance Code §1355.015(d) specifies the requirements for a health care practitioner who may provide covered treatment under §1355.015. There is no statutory requirement for any of the minimum Master degree levels requested by the commenter. Additionally, the minimum Master degree levels cited by the commenter would not necessarily ensure appropriate providers to deliver all of the treatments authorized in the Insurance Code §1355.015(c). For example, such licensed providers could not necessarily provide generally recognized services such as speech therapy or medications or nutritional supplements.

Comment: A commenter objects to proposed §21.4404(a) because it permits unlicensed providers to provide care for autism. According to the commenter, only licensed mental health providers should treat autistic individuals. The commenter

asserts the following reasons: (i) licensure exists to protect the public, and qualifications for licensure ensure that one has met stringent requirements for training at accredited universities and provides the public with the assurance that the state of Texas is vetting all providers of mental health services; (ii) children are an especially vulnerable population and children with autism even more so as many are not capable of communicating with parents or care givers should any abuse occur; and (iii) there is particular concern about pedophiles having access to children suffering from autism; and while licensure does not provide a 100 percent guarantee of protection, individuals convicted of a felony cannot hold a license to practice.

Agency Response: The Department disagrees with the commenter and declines to make a change because required licensure for all health care practitioners providing treatment under the Insurance Code §§1355.015 would not be in compliance with the statute. Under proposed §21.4404(a), which is derived directly from the Insurance Code §1355.015(b), practitioners do not have to be licensed to provide treatment for autism spectrum disorder under the Insurance Code Chapter 1355, Subchapter A, if the practitioner either has a "professional credential [that] is recognized and accepted by an appropriate agency of the United States" or is "certified as a provider under the TRICARE military health system."

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: None.

For, with changes: Texana, Texas Association of Health Plans, Shorkey Center, Behavioral Innovations, Families for Effective Autism Treatment, Texas Autism Advocacy, and 218 individuals.

Against: One individual.

6. STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1355.015, 1507.009, 1507.059, and 36.001. Section 1355.015 establishes the requirement that health benefit plans provide autism spectrum disorder coverage for certain children. Section 1507.009 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter A, related to Consumer Choice of Benefits Health Insurance Plans. Section 1507.059 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter B, related to Consumer Choice of Benefits Health Maintenance Organization Plans. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

Subchapter AA. Consumer Choice Health Benefit Plans
Division 1. General Provisions.

§21.3502. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Basic health care services--Health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.

(2) Commissioner--The commissioner of insurance.

(3) Consumer choice health benefit plan--A group or individual accident or sickness insurance policy, or evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits, but that provides creditable coverage as defined by the Insurance Code §1205.004(a) or §1501.102(a).

(4) Consumer choice of benefits health insurance plan--A consumer choice health benefit plan.

(5) Department--The Texas Department of Insurance.

(6) HMO--a person defined in Insurance Code §843.002(14)

(7) Health carrier--Any entity authorized under the Insurance Code or another insurance law of this state that provides health benefits in this state, including an insurance company, a group hospital service corporation under the Insurance Code Chapter 842, a health maintenance organization under the Insurance Code Chapter 843, and a stipulated premium company under the Insurance Code Chapter 884.

(8) Health insurer--Any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 842 of the Insurance Code, and a stipulated premium company under Chapter 884 of the Insurance Code.

(9) Standard health benefit plan--A consumer choice health benefit plan.

(10) State-mandated health benefits--

(A) Coverage required under the Insurance Code, this code, or other law of this state to be provided in an individual, blanket, or group policy for accident and health insurance, a contract for coverage of a health-related condition, or an evidence of coverage that:

(i) includes coverage for specific health care services or benefits;

(ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts, including limitations provided in the Insurance Code §1271.151; or

(iii) includes a specific category of licensed health care practitioner from whom an insured or enrollee is entitled to receive care.

(B) Do not include benefits or coverage mandated by federal law, or standard provisions or rights required under the Insurance Code, this code, or other law of this state, to be provided in an individual, blanket, or group policy for accident and health insurance, a contract for coverage of a health-related condition, or an evidence of coverage unrelated to specific health illnesses, injuries, or conditions of an insured or enrollee, including those benefits or coverages enumerated in the Insurance Code §1507.003(b) and §1507.053(b).

Division 2. State-Mandated Health Benefits

§21.3510. State-mandated Health Benefits in Individual Indemnity Policies. The following enumerated items are state-mandated health benefits a health insurer does not have to include in an individual indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(5) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B;

(6) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A;

(7) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455;

(8) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A;

(9) coverage of mental/nervous disorders with demonstrable organic disease as required by §3.3057(d) of this title (relating to Standards for Exceptions, Exclusions, and Reductions Provision);

(10) coverage of transplant donor coverage as required by §3.3040(h) of this title (relating to Prohibited Policy Provisions);

(11) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E;

(12) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services; and

(13) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451.

§21.3511. State-mandated Health Benefits in Group Association Indemnity Policies. The following enumerated items are state-mandated health benefits that a health insurer does not have to include in a group association indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(5) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A;

(6) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364;

(7) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368;

(8) the offer of mental or emotional illness coverage as required by the Insurance Code Chapter 1355, Subchapter C;

(9) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code Chapter 1355, Subchapter C;

(10) the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365;

(11) the offer of home health care coverage as required by the Insurance Code Chapter 1351;

(12) coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code Chapter 1355, Subchapter B;

(13) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B;

(14) continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B;

(15) coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360;

(16) coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361;

(17) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A;

(18) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455;

(19) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A;

(20) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E;

(21) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;

(22) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that

exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and

(23) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3512. State-mandated Health Benefits in Small Employer Indemnity Policies. The following enumerated items are state-mandated health benefits that a health insurer does not have to include in a small employer group indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(5) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A;

(6) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364;

(7) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368;

(8) the offer of mental or emotional illness coverage as required by the Insurance Code Chapter 1355, Subchapter C;

(9) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code Chapter 1355, Subchapter C;

(10) the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365;

(11) the offer of home health care coverage as required by the Insurance Code Chapter 1351;

(12) coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B;

(13) coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361;

(14) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;

(15) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and

(16) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3513. State-mandated Health Benefits in Large Employer Indemnity Policies. The following enumerated items are state-mandated health benefits that a health insurer does not have to include in a large employer group indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(5) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A;

(6) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364;

(7) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368;

(8) the offer of mental or emotional illness coverage as required by the Insurance Code Chapter 1355, Subchapter C;

(9) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code Chapter 1355, Subchapter C;

(10) the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365;

(11) the offer of home health care coverage as required by the Insurance Code Chapter 1351;

(12) coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code Chapter 1355, Subchapter B;

(13) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B;

(14) continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B;

(15) coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360;

(16) coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361;

(17) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A;

(18) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455;

(19) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A;

(20) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E;

(21) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;

(22) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and

(23) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3515. State-mandated Health Benefits in Individual HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in an individual HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053;

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201;

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156;

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B;

(11) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A;

(12) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455;

(13) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A;

(14) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E;

(15) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services; and

(16) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451.

§21.3516. State-mandated Health Benefits in Group HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in a non-employer group HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053;

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201;

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156;

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A;

(11) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364;

(12) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368;

(13) the offer of mental or emotional illness coverage as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C;

(14) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C;

(15) the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365;

(16) coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B ;

(17) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B ;

(18) continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B ;

(19) coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360;

(20) coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361;

(21) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A;

(22) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455;

(23) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A;

(24) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E;

(25) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;

(26) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and

(27) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3517. State-mandated Health Benefits in Small Employer HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in a small employer group HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053;

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201;

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156;

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A;

(11) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364;

(12) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368;

(13) the offer of mental or emotional illness coverage as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C;

(14) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C;

(15) the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365;

(16) coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B;

(17) coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361;

(18) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;

(19) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and

(20) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3518. State-mandated Health Benefits in Large Employer HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in a large employer group HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053;

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B;

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A;

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352;

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201;

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156;

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A;

(11) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364;

(12) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368;

(13) the offer of mental or emotional illness coverage as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C;

(14) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C;

(15) the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365;

(16) coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B;

(17) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B;

(18) continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B;

(19) coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360;

(20) coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361;

(21) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A;

(22) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455;

(23) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A;

(24) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E;

(25) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;

(26) the requirements of the Insurance Code Chapter 1451, Subchapter D regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and

(27) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

Division 4. Additional Requirements.

§21.3540. Direct Access to Services. Any consumer choice health benefit plan must include coverage for direct access to the health care services of an obstetrical or gynecological care provider as required by the Insurance Code Chapter 1451, Subchapter F.

§21.3543. Required Plan Filings. A health carrier shall:

(1) file the consumer choice health benefit plan with the Filings and Operations Division in accordance with:

(A) the Insurance Code Chapter 1271 and Chapter 11 of this title (relating to Health Maintenance Organizations) including the filing fee requirements; and

(B) the Insurance Code Chapter 1701 and Chapter 3, Subchapter A of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, Endorsements for Life, Accident, and Health Insurance and Annuities) including the filing fee requirements.

(2) include with the filing of a consumer choice health benefit plan:

(A) the disclosures required by §21.3530 of this subchapter (relating to Health Carrier Disclosure);

(B) a statement of the reduction in premium resulting from the differences in coverage and design between the consumer choice health benefit plan and an identical plan providing all state-mandated health benefits;

(C) certification of compliance with §21.3542 of this subchapter (relating to Offer of State-Mandated Plan); and

(D) for informational purposes, the rates to be used with a consumer choice health benefit plan.

Subchapter JJ. Autism Spectrum Disorder Coverage

§21.4401. Purpose and Applicability.

(a) General Purpose. This subchapter implements those provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of this subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services of certain child enrollees diagnosed with autism spectrum disorder, as provided in the Insurance Code Chapter 1355, Subchapter A.

(b) Applicability.

(1) This subchapter applies to:

(A) the health benefit plans specified in the Insurance Code §1355.002; and

(B) small employer health benefit plans offered pursuant to the Insurance Code §1501.252(c).

(2) This subchapter does not apply to:

(A) a standard health benefit plan provided under the Insurance Code Chapter 1507, pursuant to the Insurance Code §1355.015(e);

(B) a health benefit plan issued by a health carrier through a health group cooperative under the Insurance Code §1501.058, pursuant to the Insurance Code §1501.0581(i); or

(C) a health benefit plan specified in the Insurance Code §1355.003(a)(1) – (7).

§21.4402. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) Applied behavior analysis--The design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. Applied behavior analysis includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

(2) Autism spectrum disorder--As defined in the Insurance Code §1355.001(3).

(3) Enrollee--A person covered by a health benefit plan described by the Insurance Code §1355.002.

(4) Generally recognized services--The term includes, but is not limited to, the following services, when such services are prescribed in accordance with the

Insurance Code §1355.015(b) and §21.4403(b) of this subchapter (relating to Required Coverage):

(A) evaluation and assessment services;

(B) applied behavior analysis;

(C) behavior training and behavior management;

(D) speech therapy;

(E) occupational therapy;

(F) physical therapy; or

(G) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

(5) Health care practitioner--A physician, advance practice nurse, physician assistant, or other individual appropriately licensed, registered, or certified, or whose professional credential is recognized and accepted as described by the Insurance Code §1355.015(b).

(6) Neurobiological disorder--As defined in the Insurance Code §1355.001(4).

(7) Primary care physician--A physician selected or otherwise designated as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated by the enrollee or the enrollee's parent or guardian to develop a treatment plan for the purpose of treating autism spectrum disorder.

§21.4403. Required Coverage.

(a) Certain Children Enrollees.

(1) At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee described by the Insurance Code §1355.015(a).

(2) Pursuant to the Insurance Code §1355.015(a), the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code because an enrollee who is being treated for autism spectrum disorder becomes older than the age range specified by §1355.015(a).

(b) Enrollees of Other Ages. A health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for enrollees of other ages.

(c) Medical and Surgical Benefit. In accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.

(d) Deductibles, Copayments, and Coinsurance. Pursuant to the Insurance Code §1355.015(d), coverage under this section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

§21.4404. Health Care Practitioners.

(a) Health Care Practitioner Who Provides Treatment. Pursuant to the Insurance Code §1355.015(b), a health care practitioner providing treatment for autism spectrum disorder under the Insurance Code Chapter 1355, Subchapter A, and this subchapter must:

(1) be licensed, certified, or registered by an appropriate agency of this state;

(2) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or

(3) be certified as a provider under the TRICARE military health system.

(b) Coverage for Applied Behavior Analysis. A health benefit plan issuer may not deny coverage for services for autism spectrum disorder on the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by an agency of this state, as long the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).

CERTIFICATION. This agency hereby certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2009.

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§21.3502, 21.3510 - 21.3513, 21.3515 - 21.3518, 21.3540, and 21.3543, and new §§21.4401 - 21.4404 specified herein, concerning exclusion of certain state-mandated health benefits in consumer choice health benefit plans, and mandated health benefit plan coverage for autism spectrum disorder coverage, are adopted.

AND IT IS SO ORDERED.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO. 09-0761

SEP 11 2009