SUBCHAPTER P. MENTAL HEALTH PARITY
28 TAC §§21.2401 – 21.2407

1. INTRODUCTION. The Commissioner of Insurance (Commissioner) adopts amendments to Subchapter P, §§21.2401 - 21.2407, concerning requirements for parity between mental health or substance use disorder benefits and medical/surgical benefits. Section 21.2401 is adopted with changes to the proposed text published in the December 3, 2010 issue of the *Texas Register* (35 TexReg 10588). Sections 21.2402 – 21.2407 are adopted without changes.

2. REASONED JUSTIFICATION. The amendments are necessary to implement the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which was enacted October 3, 2008, as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Publ. L. 110-343, Division C) (122 Stat. 3881). The MHPAEA amends the Employee Retirement Income Security Act of 1974 (ERISA), at 29 USCA §1185a; the Public Health Service Act (PHS Act), at 42 USCA §300gg-26; and the Internal Revenue Code of 1986 (Code), at 26 USCA §9812.

The amendments also are necessary to allow the Department to maintain state regulatory authority over health plan issuers that issue coverage to group health plans in Texas, as required by §1501.010 of the Insurance Code.

The MHPAEA became effective in terms of application to group health plans for plan years beginning after October 3, 2009. The Act preempts state law regarding mental health and substance use disorder coverage to the extent that such state law prevents the application of a requirement of the MHPAEA. Moreover, the Act requires full parity if coverage is included in a health benefit plan. The Act does not, however, require that such coverage be included in a health benefit plan.

For plans that offer mental health or substance use disorder benefits, MHPAEA requires group health plans and group health plan issuers to ensure that financial requirements such as copayments or deductibles and treatment limitations such as visit limits applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits. The term *predominant* is defined as the most common or frequent of such type of limitation or requirement.

On April 15, 2010, the Department posted on its website, for informal comment, the draft rule text and cost note estimates. On April 29, 2010, the Department held a public meeting to receive oral informal comments on the draft rule text and the note of estimated costs.

The statement of estimated costs was considered further as a result of comments received during the informal posting. As indicated in the Public Benefit/Cost Note portion of the published proposal, however, the Department did not receive information adding to or conflicting with its cost estimates.

The proposed amendments were formally published in the December 3, 2010 issue of the *Texas Register* (35 TexReg 10588). The Department received comments

on the proposed amendments. No request for public hearing on the published proposal was received.

The following changes are made to the proposed text.

Section 21.2401(1) is changed in response to a request to clarify the date of application of the amendments. The change provides that the subchapter applies to health plan issuers providing coverage to group health plans for both medical/surgical benefits and mental health or substance use disorder benefits which are delivered, issued for delivery, or renewed on or after March 1, 2011.

Section 21.2401(2) is changed in connection with the request to clarify the date of application of the amendments. The change provides that coverage to group health plans delivered, issued for delivery, or renewed prior to March 1, 2011 is subject to the provisions of the subchapter in effect at the time such plans were delivered, issued for delivery, or renewed.

Section 21.2401(3) is removed in connection with a request to modify the text to clarify the application date of provisions with which it is associated. The changes to paragraphs (1) and (2) in response to and connection with comment and request for clarification of application date of the amended sections makes it unnecessary to retain paragraph (3) as a further amendment to the section.

3. HOW THE SECTIONS WILL FUNCTION. The amendments to the subchapter set forth rules for health plan issuers that provide coverage to group health plans affected by the MHPAEA, to assure that the coverage offered by those group health plans will be in compliance with the federal statute.

Section 21.2401 states the purpose and scope of the subchapter. Amendments identify, with reference to issuance or renewal of the health plan issuers' coverage, the date on and after which the sections apply.

Section 21.2402 defines the terms used in the subchapter. Definitions of the terms *aggregate lifetime limit, annual limit, base period, coverage, group health plan,* and *mental health benefits* include conforming amendments. The definitions of *incurred expenditures* and *medical/surgical benefits* are amended to include reference to substance use disorder benefits. The term *mental health benefits* contains conforming amendments and further is amended to remove exclusion of benefits for treatment of substance abuse or chemical dependency. New definitions for the terms *financial requirement, health plan issuer, large employer, predominant, small employer, substance use disorder benefits,* and *treatment limitation* are included in the amendments to the section. The term *health plan issuer* is defined to include all providers of group health insurance coverage, group health care coverage or group health benefit coverage that are regulated under the Insurance Code.

Amendments to §21.2403 change the section heading to indicate that it addresses large employer health plan parity requirements. Amendments to §21.2403 provide a working, applicational definition of the term "substantially all" in relation to the medical benefits covered by a group health plan, or within a classification of benefits in a group health plan, as applicable.

For purposes of the section, "substantially all" means at least two-thirds of all medical benefits covered by the group health plan, or within such classification of benefits, as applicable.

Amendments to the section make conforming references to *health plan issuer* to describe an entity issuing a group health plan, as well as conforming additional references to substance use disorder benefits at each reference location of the term *mental health benefits*. Amendments to §21.2403(a) add a new paragraph (5) to provide that financial requirements must be no more restrictive for mental health or substance use disorder benefits than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the group health plan. The amendments to the subsection add a new paragraph (6) to provide that treatment limitations must be no more restrictive for mental health or substance use disorder benefits than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the group health plan.

Amendments to §21.2403(a) add a new paragraph (7) to prohibit separate cost-sharing requirements or separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. The amendments to the subsection add a new paragraph (8) to provide that for purposes of the section, whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The amendments set forth the classifications to be utilized in applying the provisions of this subsection.

Amendments to §21.2403 add a new subsection (c) to provide that if a large employer group health plan provides both medical and surgical benefits and mental health or substance use disorder benefits, utilization review for mental health or

substance use disorder benefits shall be conducted in accordance with provisions of the Insurance Code Chapter 4201.

The amendments to the section also add a new subsection (d) to provide that if a large employer group health plan provides both medical and surgical benefits and mental health or substance use disorder benefits and the plan provides coverage for medical and surgical benefits provided by out-of-network providers, the plan also must provide coverage for mental health or substance use disorder benefits provided by and services performed by out-of-network providers.

Amendments to §21.2403 add a new subsection (e) to require that regardless of whether a large employer group health plan provides both medical and surgical benefits and mental health or substance use disorder benefits, it must nonetheless provide coverage for treatment of serious mental illness, based on medical necessity, for no fewer than 45 days of inpatient treatment and no fewer than 60 visits for outpatient treatment in accordance with the Insurance Code Chapter 1355 and subsection (b)(1) of the amended section.

The amendments to the section also add a new subsection (f) to require that pursuant to the Insurance Code Chapter 1368 and in accordance with subsection (b)(1) of the section, a large employer group health plan must provide coverage for the necessary care and treatment of chemical dependency in accordance with minimum standard requirements set forth in §§1368.004 - 1368.006(a) and §1368.007, and Chapter 3, Subchapter HH of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

Amendments to §21.2404 change the section heading to indicate that it addresses small employer health plan parity requirements. Amendments to the section also make conforming references to *health plan issuer* to describe an entity issuing a group health plan.

Amendments to §21.2404(b) replace existing text with new text to require that, notwithstanding provisions in subsection (a) stating that the subchapter does not apply to a health plan issuer with respect to a plan year of a small employer, a health plan issuer must offer coverage for serious mental illness as described in the Insurance Code §1355.004, and that if the employer accepts the coverage, such coverage must meet the requirements of §1355.004.

The amendments to the section also add a new subsection (c) to require that, notwithstanding provisions in subsection (a) stating that the subchapter does not apply to a health plan issuer with respect to a plan year of a small employer, a health plan issuer must nonetheless provide coverage for substance use disorder that meets the minimum coverage requirements of the Insurance Code Chapter 1368.

Amendments to §21.2405 add a new subsection (a) to provide that a health plan issuer's coverage is not subject to the large-employer parity requirements described in §21.2403 if such issuer demonstrates an increase in the cost for such coverage in accordance with the section. The amendments to the section redesignate existing subsection (a) as subsections (b) and (c).

The amendments add new paragraphs (1) and (2) to subsection (b) as redesignated to provide that the issuer must demonstrate with actual data that application of the subchapter results in an increased cost of coverage of at least two

percent in the first plan year in which it was applied and at least one percent in subsequent years.

The amendments add new paragraphs (1) and (2) to subsection (c) as redesignated to provide that the base period for increased cost measure is six months, within which period the coverage must comply with the provisions of the subchapter. The amendments redesignate existing subsection (b) as subsection (d) and add text to that subsection as redesignated to provide that the determination of increases to actual costs must be made and certified by a qualified, licensed actuary who is a member in good standing of the American Academy of Actuaries. The amendments delete Figure 28 TAC §21.2405(b) from existing subsection (b). The amendments delete text to existing subsection (c).

In addition, the amendments to §21.2405 add a new subsection (e) to require that a health plan issuer that qualifies for and elects to implement the exemption must promptly notify the Department, as well as the federal Secretary of Health and Human Services, and the beneficiaries in the plan of such election. The amendments to the section redesignate existing subsection (d) as subsection (f), redesignate existing subsection (e) as subsection (g) and delete text to existing subsection (f).

Finally, the amendments to the section add a new subsection (h) to provide that an employer may elect to continue to apply mental health and substance use disorder parity with respect to the health plan for which the determination is made regardless of any increase in total costs.

The amendment to §21.2406 conforms the reference to a health plan issuer.

Amendments to §21.2407 provide that a health plan issuer may not sell coverage that does not meet the large-employer parity requirements described in §21.2403 unless such coverage meets the small employer parity requirements addressed in §21.2404, or the criteria relating to the cost-of-coverage exemption set forth in §21.2405.

The amendments apply to health plan issuers providing coverage to group health plans for both medical/surgical benefits and mental health or substance use disorder benefits which are delivered, issued for delivery, or renewed on or after March 1, 2011, the effective date of the amendments as adopted.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Comment: One commenter requested that clarifying language be added to §21.2401(1) to assure that provisions in the subchapter as amended which directly correspond to federal regulatory provisions relating to mental health or substance use disorder benefits are effective and applicable on or after July 1, 2010, the applicability date of the federal regulation to health plan issuers of such coverage benefits.

Agency Response: The Department agrees that clarification to §21.2401(1) regarding applicability of the subchapter to coverage for benefits to which the subchapter applies is helpful. It makes a clarifying change to §21.2401(1) and (2) to provide for a March 1, 2011 application date for the amendments, so that provisions of the amended subchapter apply to health plan issuers providing coverage to group health plans for both medical/surgical benefits and mental health or substance use disorder benefits which is delivered, issued for delivery, or renewed on or after March 1,

2011, the effective date of the amendments. The clarifying change in paragraph (2) provides that coverage to group health plans delivered, issued for delivery, or renewed prior to March 1, 2011 is subject to the provisions of the subchapter in effect at the time such plans were delivered, issued for delivery, or renewed.

Comment: One commenter requested that §21.2401(3) be revised to more clearly indicate effectiveness and applicability dates of any provisions of Public Law 111-148, the Patient Protection and Affordable Care Act of 2010 applicable to coverage for mental health and substance use disorder benefits, as well as any such federal regulations promulgated pursuant to the provisions of the Act, by stating that such provisions are applicable to and effective for coverage to group health plans delivered, issued for delivery, or renewed for a plan year beginning on or after the effective date provided in the Act or in such federal regulations.

Agency Response: The Department agrees that clarification of the applicability date of the amended sections to coverage issued or renewed on or after such date is helpful. Because the Department has changed paragraphs (1) and (2) to indicate a date certain for applicability of the amended sections in response to and connection with other comments on §21.2401 relating to clear statement of applicability date, paragraph (3) has been removed.

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

For: None.

Against: None.

Neither for nor against, with changes: Texas Association of Health Plans.

6. STATUTORY AUTHORITY. The amendments are adopted under the Insurance Code Chapters 843, 846, 1251 and 1501, and §36.001. Chapter 843 addresses health maintenance organizations. Section 843.151 provides that the Commissioner may adopt reasonable rules as necessary and proper to meet the requirements of federal law and regulations. Chapter 846 relates to certain multiple employer welfare arrangements. Section 846.005 requires the Commissioner to adopt rules necessary to meet the minimum requirements of federal law and regulations. Chapter 1251 addresses group and blanket health insurance. Section 1251.008 provides that the Commissioner may adopt rules necessary to administer the chapter. Chapter 1501 implements provisions regarding small and large employers which were necessary to comply with the federal requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Section 1501.010 requires the Commissioner to adopt rules necessary to implement Chapter 1501, and to meet the minimum requirements of federal law, including regulations, which for small and large employer health plan issuers are contained in HIPAA and in regulations adopted by federal agencies to implement HIPAA. 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.

§21.2401. Purpose and Scope. The purpose of this subchapter is to coordinate the requirements of Texas law with federal law requiring parity between certain mental health or substance use disorder benefits and medical/surgical benefits.

(1) This subchapter applies to health plan issuers providing, as allowed by law, coverage to group health plans for both medical/surgical benefits and mental health or substance use disorder benefits, which is delivered, issued for delivery, or renewed on or after March 1, 2011.

(2) Coverage to group health plans delivered, issued for delivery, or renewed prior to March 1, 2011 is subject to the provisions of this subchapter in effect at the time such plans were delivered, issued for delivery, or renewed.

§21.2402. Definitions. The following words and terms, when used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) Aggregate lifetime limit--A dollar limitation on the total amount of specified benefits that may be paid under a health plan issuer's coverage for an individual (or for a group of individuals considered a single coverage unit in applying this dollar limitation, such as a family or an employee plus spouse).

(2) Annual limit--A dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health plan issuer's coverage for an individual (or for a group of individuals considered a single coverage unit in applying this dollar limitation, such as a family or an employee plus spouse).

(3) Base period--The period used to calculate whether a group health plan may claim, with respect to its coverage, the increased cost exemption provided for

in §21.2405 of this subchapter (relating to Cost of Coverage Exemption). The base period must begin on the first day in the group health plan's plan year that the health plan issuer's coverage complies with this subchapter, and must extend for a period of at least six consecutive calendar months.

(4) Coverage--Group health insurance coverage, group health care coverage or group health benefit coverage issued by a health plan issuer to a group health plan.

(5) Financial requirement--A requirement that includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit in accordance with the definitions and applications of those limits in this subchapter.

(6) Group health plan--An employee welfare benefit plan, as defined in 29 U.S.C. 1002(1), that provides medical care to participants or their dependents through the purchase of coverage from a health plan issuer.

(7) Health plan issuer--Any entity authorized under the Insurance 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 operating under the Insurance Code Chapter 842, a fraternal benefit society operating under the Insurance Code Chapter 885, a stipulated premium insurance company operating under the Insurance Code Chapter 884, a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 843), an approved nonprofit health corporation that is certified under the Occupations Code Chapter 151 (Medical Practice Act) and that holds a certificate of authority under the

Insurance Code Chapter 844, or a multiple employer welfare arrangement that holds a certificate of authority under the Insurance Code Chapter 846.

(8) Incurred expenditures--Actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health or substance use disorder benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(9) Large Employer--For purposes of this subchapter, an employer that, in connection with a group health plan with respect to a calendar year and a plan year, meets the definition of a large employer as defined in the Insurance Code §1501.002(8), except that the reference to "eligible employee" for purposes of this subchapter is a reference to "employee."

(10) Medical care--Amounts paid for:

(A) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) transportation primarily for and essential to medical care described in subparagraph (A) of this paragraph, and

(C) coverage for medical care described in subparagraphs (A) and (B) of this paragraph.

(11) Medical/surgical benefits--Benefits for medical or surgical services, as defined under the terms of the coverage, but does not include mental health or substance use disorder benefits.

(12) Mental health benefits--Benefits with respect to services for mental health conditions, as defined under the terms of the coverage and in accordance with applicable federal and state law.

(13) Predominant--A financial requirement or treatment limitation as defined in this section is considered to be predominant if it is the most common or frequent of such type of limitation or requirement.

(14) Small Employer--For purposes of this subchapter, an employer that, in connection with a group health plan with respect to a calendar year and a plan year, meets the definition of a small employer as defined in the Insurance Code §1501.002(14), except that the reference to "eligible employee" for purposes of this subchapter is a reference to "employee."

(15) Substance use disorder benefits--Benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law. The term includes coverage for chemical dependency as set out in the Insurance Code Chapter 1368.

(16) Treatment limitation--A limitation that includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

§21.2403. Large Employer Health Plan Parity Requirements.

(a) Coverage that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraphs (1) - (8) of this subsection. For purposes of this section, a treatment limitation or financial requirement

is considered to apply to substantially all medical/surgical benefits covered by the group health plan, or within a classification of benefits as addressed in paragraph (8) of this subsection, if it applies to at least two-thirds of all medical benefits covered by the group health plan, or within such classification of benefits.

(1) If a health plan issuer's coverage does not include an aggregate lifetime limit or an annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, the health plan issuer may not impose any aggregate lifetime or annual limit, respectively, on mental health or substance use disorder benefits.

(2) If a health plan issuer's coverage includes an aggregate lifetime limit or an annual limit on substantially all medical/surgical benefits, the health plan issuer must either:

(A) apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health and substance use disorder benefits in a manner that does not distinguish between the medical/surgical and mental health and substance use disorder benefits; or

(B) not include an aggregate lifetime limit or an annual limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(3) For purposes of this section, the determination of whether the portion of medical/surgical benefits subject to a limit represents at least one-third of or substantially all medical/surgical benefits is based on the dollar amount of all payments by the health plan issuer for medical/surgical benefits expected to be paid under a given

group health plan for the plan year (or for the portion of the plan year after a change in coverage that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the coverage will constitute at least one-third of or substantially all of the dollar amount of all payments for medical/surgical benefits.

(4) Coverage that is not described in paragraphs (1) or (2) of this subsection must either impose:

(A) no aggregate lifetime or annual limit, as appropriate, on mental health or substance use disorder benefits; or

(B) an aggregate lifetime limit or an annual limit on mental health or substance use disorder benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner:

(i) The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits.

(ii) Limits based on delivery systems, such as inpatient/outpatient treatment, or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of clause (i) of this subparagraph.

(iii) For purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the coverage are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a health plan issuer may

reasonably be expected to incur with respect to such benefits for a given group health plan, taking into account any other applicable restrictions under the coverage.

(C) For purposes of this paragraph, the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (3) of this subsection for determining substantially all medical/surgical benefits.

(5) Financial requirements as defined in this subchapter must be no more restrictive for mental health or substance use disorder benefits than the predominant financial requirements as defined in this subchapter applied to substantially all medical and surgical benefits covered by the group health plan.

(6) Treatment limitations as defined in this subchapter must be no more restrictive for mental health or substance use disorder benefits than the predominant treatment limitations as defined in this subchapter applied to substantially all medical and surgical benefits covered by the group health plan.

(7) Separate cost-sharing requirements or separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits are prohibited.

(8) For purposes of this subsection, whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The classifications set forth in subparagraphs (A) – (F) of this paragraph are the classifications to be utilized in applying the provisions of this subsection. The classifications are as follows:

(A) benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage;

(B) benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage, including inpatient benefits under a plan or health insurance coverage that has no network of providers;

(C) benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage;

(D) benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage, including outpatient benefits under a plan or health insurance coverage that has no network of providers;

(E) benefits for emergency care; and

(F) benefits for prescription drugs.

(b) This subchapter does not:

(1) require a health plan issuer to provide any mental health or substance use disorder benefits, except as otherwise specified in the Insurance Code; or

(2) affect the terms and conditions (including, as allowed by law, cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health or substance use disorder benefits under the health plan issuer's coverage, except as specifically provided in this section.

(c) If a large employer group health plan provides both medical and surgical benefits and mental health or substance use disorder benefits, utilization review for mental health or substance use disorder benefits shall be conducted in accordance with provisions of the Insurance Code Chapter 4201.

(d) If a large employer group health plan provides both medical and surgical benefits and mental health or substance use disorder benefits and the plan provides coverage for medical and surgical benefits provided by out-of-network providers, the plan also shall provide coverage for mental health or substance use disorder benefits provided by and services performed by out-of-network providers.

(e) Notwithstanding subsection (a) of this section, pursuant to the Insurance Code Chapter 1355 and in accordance with subsection (b)(1) of this section, a large employer group health plan must provide coverage for treatment of serious mental illness, based on medical necessity, for no fewer than 45 days of inpatient treatment and no fewer than 60 visits for outpatient treatment.

(1) Pursuant to the Insurance Code §1355.004(a)(2), a large employer group health plan may not include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment for serious mental illness covered under the plan.

(2) Pursuant to the Insurance Code §1355.004(b)(1), a large employer group health plan may not count an outpatient serious mental illness visit for medication management against the number of outpatient visits required to be covered.

(f) Pursuant to the Insurance Code Chapter 1368 and in accordance with subsection (b)(1) of this section, a large employer group health plan must provide

coverage for the necessary care and treatment of chemical dependency in accordance with minimum standard requirements set forth in §§1368.004 - 1368.006(a) and §1368.007, and Chapter 3, Subchapter HH of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

§21.2404. Small Employer Health Plan Parity Requirements.

(a) This subchapter does not apply to a health plan issuer offering coverage in connection with a group health plan for a plan year of a small employer as defined in this subchapter.

(1) In determining employer size, all persons treated as a single employer under subsections (b), (c), (m), and (o) of §414 of the federal Internal Revenue Code are treated as one employer.

(2) For an employer who was not in existence throughout the preceding calendar year, the determination as to whether the employer is a small employer is based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year.

(3) A reference to an employer for purposes of the exemption set forth in this subsection includes a reference to the predecessor of the employer.

(b) Notwithstanding subsection (a) of this section, pursuant to the Insurance Code §1355.007, an issuer of a group health plan to a small employer must offer coverage for serious mental illness as described in §1355.004. The employer may

reject the coverage, but if the employer accepts the coverage, such coverage must meet the requirements of §1355.004.

(c) Notwithstanding subsection (a) of this section, pursuant to the Insurance Code Chapter 1368, an issuer of a group health plan to a small employer must provide coverage for substance use disorder that meets the minimum coverage requirements of Chapter 1368 and Chapter 3, Subchapter HH of this title (Relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

§21.2405. Cost of Coverage Exemption.

(a) Coverage is not subject to the requirements of this subchapter if the application of §21.2403 of this subchapter (relating to Large Employer Parity Requirements) to such coverage results in an increase in the cost for such coverage as determined by and in accordance with the provisions of this section.

(b) To qualify for an exemption from this subchapter on the basis that the application of this subchapter increases the cost of coverage by a qualifying amount, at the request of a group health plan, a health plan issuer must demonstrate with actual data that the application of this subchapter resulted in an increase of cost of the health plan issuer's coverage in connection with that group health plan of at least:

(1) two percent in the first plan year in which it is applied; and

(2) one percent in subsequent plan years.

(c) The determination and data relied upon by a health plan issuer demonstrating such an increase must be:

(1) based upon a base period of no fewer than six months; and

(2) determined only after such coverage has complied with the provisions of this subchapter for the first six months of the plan year for which the determination is made.

(d) The calculation of the cost of coverage and determination of increases to actual costs under a plan for which exemption is sought shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the health plan issuer for a period of six years following the notification made under subsection (e) of this section.

(e) A health plan issuer offering coverage in connection with a group health plan that, based on certification under subsection (d) of this section, qualifies for an exemption and elects to implement the exemption, shall promptly notify the department, the Secretary of Health and Human Services, and the beneficiaries in the plan of such election. Notification to the Secretary must comply with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.

(f) A health plan issuer may contract with a group health plan to provide to the plan's participants and beneficiaries, and to applicable federal agencies, any notice of exemption required by applicable federal regulations.

(g) A health plan issuer may contract with a group health plan to provide to the plan's participants and beneficiaries (or their representatives), on request and at no

charge to the recipient, a summary of the information on which the exemption was based. If a health plan issuer so contracts with a group health plan:

(1) An individual who is not a participant or beneficiary and who presents the health plan issuer a notice described in subsection (e) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under subsection (e) of this section with any individually identifiable information redacted.

(2) The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with subsection (a) of §21.2403 of this subchapter (relating to Large Employer Parity Requirements), the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements for the exemption. In no event should the summary of information include any individually identifiable information.

(h) An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this subchapter with respect to the health plan for which the determination is made regardless of any increase in total costs.

§21.2406. Separate Application to Each Benefit Package Offered. If a health plan issuer provides coverage to a group health plan that offers two or more coverages to participants or their dependents, the requirements of this subchapter, including the exemptions, shall be applied separately to each coverage. An example of a group

health plan that provides two or more coverages is a group health plan that offers both indemnity coverage and HMO coverage.

§21.2407. Sale of Nonparity Policies or Coverage. A health plan issuer may not sell coverage without parity, as described in §21.2403 of this subchapter (relating to Large Employer Parity Requirements) to a group health plan unless:

(1) the coverage meets the requirements of §21.2404 of this subchapter (relating to Small Employer Parity Requirements); or

(2) the group health plan meets the criteria set out in §21.2405 of this subchapter (relating to Cost of Coverage Exemption).

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

Issued at Austin, Texas, on February 9th, 2010.

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 §§21.2401 - 21.2407 specified herein, concerning requirements for parity between mental health or substance use disorder benefits and medical/surgical benefits, 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. 11-0129

FEB 09 2011