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

1. INTRODUCTION. The Texas Department of Insurance proposes amendments to Subchapter P, §§21.2401 - 21.2407, concerning requirements for parity between mental health or substance use disorder benefits and medical/surgical benefits. 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-5; and the Internal Revenue Code of 1986 (Code), at 26 USCA §9812. Enactment of Public Law 111-148, the Patient Protection and Affordable Care Act of 2010 (PPACA) results in reclassifying 42 USCA §300gg-5 to 42 USCA §300gg-26.

The proposed 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. None of the comments directed to the rule text posted for informal comment resulted in change to that text.

The proposed 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, and proposed amendments identify by date of issuance or renewal of the health plan issuers' coverage to which the sections apply. The proposed amendments to the section also state that the Patient Protection and Affordable Care Act of 2010 (PPACA), Public Law 111-148, and any federal regulations promulgated pursuant to its provisions apply to

group health plan coverage delivered, issued or renewed for a plan year beginning on or after the date of PPACA enactment.

Section 21.2402 defines the terms used in the subchapter. Conforming amendments to the definitions of the terms *aggregate lifetime limit, annual limit, base period, coverage, group health plan,* and *mental health benefits* are proposed. 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.

Proposed amendments to §21.2403 change the section heading to indicate that it addresses large employer health plan parity requirements. Proposed 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. Proposed 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*. Proposed 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 proposed 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. Proposed 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 proposed 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 proposed amendments then set forth the classifications to be utilized in applying the provisions of this subsection. Proposed 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 proposed 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. Proposed 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 proposed amended section. The proposed 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).

Proposed amendments to §21.2404 change the section heading to indicate that it addresses small employer health plan parity requirements. Proposed amendments to the section also make conforming references to *health plan issuer* to describe an entity issuing a group health plan. Proposed amendments to §21.2404(b) replace existing text with proposed 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 proposed 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.

Proposed 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 proposed amendments to the section redesignate existing subsection (a) as subsections (b) and (c). The proposed 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 proposed 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 proposed 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 proposed amendments delete Figure 28 TAC §21.2405(b) from existing subsection (b). The proposed amendments delete text to existing subsection (c).

In addition, the proposed 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 proposed 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 proposed 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.

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

Proposed 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.

2. FISCAL NOTE. Katrina Daniel, Senior Associate Commissioner of Life, Health, and Licensing, has determined that for each year of the first five years the proposed amended sections will be in effect there will be no fiscal impact to state or local governments as a result of the enforcement or administration of the rule amendments. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Daniel also has determined that for each year of the first five years the amended sections are in effect, the public benefit anticipated as a result of the proposed amended sections will be that persons receiving mental health or substance use disorder benefits through a health plan issuer providing coverage to a group health plan will receive, with respect to those mental health or substance use disorder benefits, parity with medical/surgical benefits in annual dollar and aggregate lifetime benefit limits. Moreover, the Department will retain its authority to regulate health plan issuers providing coverage to group health plans in Texas, which authority would be preempted by federal regulation under HIPAA if these sections are not amended.

Further, Ms. Daniel estimates that the costs to comply with this subchapter if the proposed amendments are adopted will result from the federal legislative enactment of the MHPEA, rather than from adoption of the proposed amended rules, as the Act requires group health plans and group health plan issuers to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits offered under a group health plan are no more restrictive than the

predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits. However, the Act also contains provisions that clearly indicate that the Act itself does not require a group health plan or group health plan issuer to provide any mental health or substance disorder benefits.

The Department estimates that the potential costs of compliance with the rule will involve the removal of current mental health and substance use disorder language from policy documents, the addition of new language in policy documents, and the prospective potential increases in administration costs associated with the removal of the language.

Anticipated Cost Components and Costs. The Department anticipates that most health plan issuers have already chosen to file one or more endorsements with the Department to be attached to their policy forms to override the mental health and substance use disorder language in the forms. Some health plan issuers might not have filed such endorsements and will need to do so after the proposed amendments are adopted.

1. Filing fees. The filing fees are $100 for forms subject to review and $50 for forms exempt from review, such as health policies. It is anticipated that if a health plan issuer does not file a single endorsement for use with all policies, the number of re-filings per health plan issuer will depend on the size of the health plan issuer. A large health plan issuer may have dozens of forms impacted, whereas a smaller health plan issuer may have very few forms. Therefore, it is anticipated that large health plan issuers could incur the highest costs as a result of the proposed amendments.

2. Administrative costs. Additionally, health plan issuers will incur

administrative costs through the use of staff time in preparing and sending the filings to the Department. The Department anticipates that various types of employees may be involved in the process of revising forms or drafting endorsements and filing them with the Department. In total, the Department estimates that on average two to 10 total employee hours will be necessary to prepare each filing with the Department. The Department anticipates that the types of employees that may be involved include operations managers, supervisors, and office clerks. According to wage data obtained from the Texas Workforce Commission website, the average salary of an operations manager working at an insurance carrier in Texas is $56.50 per hour, the average salary of a supervisor is $25.53 per hour, and the average salary of an office clerk is $12.21. Accordingly, the Department estimates the administrative cost of filing at between $24.42 and $565 per form.

The Department is unaware of any other costs that health plan issuers would incur as a result of the changed requirements related to mental health and substance use disorder benefits.

In its April 15, 2010 posting, the Department estimated the cost of the proposed amendments, consistent with the costs described in this Public Benefit/Cost Note, and sought additional information on its cost estimates and components. 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 Department has not received any information adding to or conflicting with its cost estimates either from issuers or from association representatives of such issuers.

The Department has determined that any effect of the amendments to these sections on small businesses subject to the federal law and this subchapter results from the federal legislative enactment of the MHPAEA and the statutory requirement in §1501.010 of the Insurance Code to adopt such federal requirements by rule. In addition, total cost to a health plan issuer is not dependent upon the size of the issuer, but rather is dependent upon that issuer's number of enrollees under the affected health benefit plans and the number of employers seeking exemptions.

Both small and micro businesses as well as the largest businesses affected by the proposed amendments will incur the same cost per unit. The cost per hour of labor should not vary between the smallest and largest businesses, based on the types of forms or systems that will require either modification or creation, and the nature of technical requirements associated with creating or updating such forms or systems. Total costs for both a small business and the largest business will depend on the percentage of applicants or insured groups for which such issuers will have to create or modify forms or systems.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small or micro businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines "small

business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.001(1) does not specify a maximum level of gross receipts for a "micro business." The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

In accordance with the Government Code §2006.002(c), the Department has determined that the proposed amended sections if adopted might have an adverse economic effect on 10 - 40 health plan issuers that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that would be required to comply with the proposed amended sections if they offered plans that provide mental health or substance use disorder benefits.

The estimated number of small and micro businesses is based on an analysis of the financial data collected by the Department, such as the annual gross premiums of large and small employer health benefit plan issuers and on self-reporting by preferred provider benefit plan issuers regarding whether they qualify as small businesses. The potential adverse economic impact will result from the necessary costs incurred to comply with this proposal that are discussed in the Public Benefit/Cost Note part of this proposal for health plan issuers.

Section 2006.002(c)(2) requires a state agency, before adopting a rule that may

have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule.

Section 2006.002(c-1) requires that the regulatory analysis "consider, if consistent with the health, safety, and environmental welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses."

As described and indicated in the Public Benefit/Cost Note portion of this proposal, the costs incurred by health plan issuers to comply with the proposed amendments with respect to a plan providing coverage for mental health or substance use disorder benefits are the direct result of federal legislative enactment of the MHPAEA. The Act creates the requirement that group health plans and group health plan issuers ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits offered under a group health plan are no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits. Conversely, and also as noted in the Public Benefit/Cost Note portion of this proposal, the Act also contains provisions that clearly indicate that the Act itself does not require a group health plan or group health plan issuer to provide any mental health or substance disorder benefits.

The Department considered regulatory alternatives for achieving the purpose of the MHPAEA and the proposed rule amendments to minimize any adverse impact on the estimated 10 - 40 large or small employer health benefit plan issuers that qualify as small or micro businesses under the Government Code §2006.001(1) and (2).

The fundamental purpose of the MHPAEA is to achieve substantial parity between medical/surgical benefits and mental health/substance use disorder benefits for group health plans with more than 50 employees.

Alternative methods considered by the Department were whether to fully or partially exempt small or micro business health plan issuers from the requirements of the proposed amendments. The Department rejected both alternatives because either of them would frustrate the fundamental purpose of the MHPAEA, and in so doing would create a regulatory standard clearly inconsistent with the requirements of the federal law. One result of implementing either alternative would have been the activation of federal preemption provisions of the MHPAEA, which apply to a state law to the extent that such state law prevents the application of a requirement of the MHPAEA.

For reasons set out in this part, the Department has determined, in accordance with the Government Code §2006.002, that regardless of the economic effect, it is neither legal nor feasible to waive or modify the requirements of the proposed rule amendments for small or micro businesses because the proposed amendments are required by federal statute. State waiver or partial waiver of such requirements would result in improper differentiation of coverage for benefits between individuals covered under plans which provide mental or substance use disorder benefits issued by small and micro issuers, compared to the same or similar plans issued by large issuers. The referenced differentiation would activate federal preemption to the extent that such a regulatory alternative would prevent application of a requirement of the MHPAEA.

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on January 3, 2011, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be submitted simultaneously to Doug Danzeiser, Deputy Commissioner for Regulatory Matters, Life, Health, & Licensing Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing should be submitted separately to the Office of the Chief Clerk before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The amendments are proposed 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.

8. CROSS REFERENCE TO STATUTE. The following chapters are affected by this proposal:

Rule	Statute
§§21.2401 - 21.2407	Insurance Code Chapters 843, 846, 1251, and 1501

9. 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 [~~carriers~~] 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 October 3, 2009 [~~January 1, 1998~~].

(2) Coverage to group health plans delivered, issued for delivery, or renewed prior to October 3, 2009 is subject to the provisions of this subchapter in effect at the time such plans were delivered, issued for delivery, or renewed.

(3) Notwithstanding the provisions of this subchapter, coverage to group health plans delivered, issued for delivery, or renewed for a plan year beginning on or after the date of enactment of Public Law 111-148, the Patient Protection and Affordable Care Act of 2010, is subject to the provisions of the Act and any federal regulations promulgated pursuant to the provisions of the Act applicable to coverage for mental health and substance use disorder benefits.

§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 [~~carrier'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 [~~carrier'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 [~~one percent~~] 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 [~~carrier's~~] coverage complies with this subchapter [~~or September 26, 1996, the date of the enactment of the federal Mental Health Parity Act, Part 7 of Subtitle B of Title I of ERISA, 29 U.S.C. §1001, et seq.~~], and must extend for a period of at least six consecutive calendar months.

[~~(4) Carrier - An insurance company, a group hospital service corporation operating under Chapter 20 of the Texas Insurance Code, a fraternal benefit society operating under Chapter 10 of the Code, a stipulated premium insurance company operating under Chapter 22 of the Code, a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Texas Insurance Code), an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Texas Civil Statutes) and that holds a certificate of authority under Texas Insurance Code Article 21.52F, or a multiple employer welfare arrangement that holds a certificate of authority under Texas Insurance Code Article 3.95-2.~~]

(4) [~~(5)~~] Coverage--Group health insurance coverage, group health care coverage or group health benefit coverage issued by a health plan issuer [~~carrier~~] 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 [~~carrier~~].

(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) [~~(7)~~] 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) [~~(8)~~] 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) [~~(9)~~] 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) [~~(10)~~] Mental health benefits--Benefits with respect to services for mental health conditions [~~services~~], as defined under the terms of the coverage and in accordance with applicable federal and state law[~~, but does not include benefits for treatment of substance abuse or chemical dependency~~].

(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)[~~, (2), or (5)~~] 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 [~~carrier'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 [~~carrier~~] 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 [~~carrier's~~] coverage includes an aggregate lifetime limit or an annual limit on substantially [~~at least two-thirds of~~] all medical/surgical benefits, the health plan issuer [~~carrier~~] 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) The provisions of paragraphs (1) and (2) are illustrated in the following examples:~~]

[~~(A) Prior to January 1, 1998, a carrier issuing coverage had no annual limit on medical/surgical benefits and a $10,000 annual limit on mental health benefits. To comply with the parity requirements of this subsection (a), a carrier is considering each of the following options. In this example, each of the three options being considered would comply with the requirements of this subsection because each option offers parity in the dollar limits placed on medical/surgical and mental health benefits:~~]

[~~(i) eliminating the annual limit on mental health benefits;~~]

[~~(ii) replacing the annual limit on mental health benefits with a $500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and~~]

[~~(iii) replacing the previous annual limit on mental health benefits with a $250,000 annual limit on medical/surgical benefits and a $250,000 annual limit on mental health benefits.~~]

[~~(B) Prior to January 1, 1998, a carrier issued coverage with a $100,000 annual limit on medical/surgical inpatient benefits, a $50,000 annual limit on medical/surgical outpatient benefits, and a $100,000 annual limit on all mental health benefits. To comply with the parity requirements of this subsection (a), the carrier is considering each of the following options. In this example, both options under consideration would comply with the requirements of this section because each offers parity in the dollar limits placed on medical/surgical and mental health benefits:~~]

[~~(i) replacing the previous annual limit on mental health benefits with a $150,000 annual limit on mental health benefits; and~~]

[~~(ii) replacing the previous annual limit on mental health benefits with a $100,000 annual limit on mental health in-patient benefits and a $50,000 annual limit on mental health outpatient benefits.~~]

[~~(C) A carrier has issued coverage that is subject to the requirements of this section which has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the coverage provides medical/surgical benefits with respect to both network and out-of-network providers it~~

~~does not provide mental health benefits with respect to out-of-network providers. In this example, the coverage complies with the requirements of this subsection because it offers parity in the dollar limit placed on medical/surgical and mental health benefits.~~]

[~~(D) Notwithstanding Insurance Code Article 3.51-9 the following example is provided for illustration only and does not relieve a carrier from compliance with that article. Prior to January 1, 1998, a carrier issued coverage with an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The coverage included benefits for treatment of chemical dependency and substance abuse in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this subsection (a), the carrier is considering each of the following options. In this example, the option in clause (i) would not comply with the requirements of this section because the definition of mental health benefits excludes benefits for treatment of substance abuse and chemical dependency. However, options set forth in clauses (ii) (iii) and (iv) would comply with the requirements of subsection (a) because they offer parity in the dollar limits placed on medical/surgical and mental health benefits:~~]

[~~(i) making no change in the coverage so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;~~]

[~~(ii) amending the coverage to count claims paid for the treatment of substance abuse and chemical dependency in applying the annual limit on~~

~~medical/surgical benefits as opposed to counting those claims in applying the annual limit on mental health benefits;~~]

[~~(iii) amending the coverage to provide a new category of benefits for treatment of substance abuse and chemical dependency that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and~~]

[~~(iv) amending the coverage to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on coverage offered under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.~~]

(3) [~~(4)~~] 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 [~~two-thirds of~~] substantially all medical/surgical benefits is based on the dollar amount of all payments by the health plan issuer [~~carrier~~] 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 [~~two-thirds~~] substantially all of the dollar amount of all payments for medical/surgical benefits.

(4) [~~(5)~~] Coverage that is not described in paragraphs (1) or (2) of this subsection [~~(a) of this section~~] 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 [~~(B) of paragraph (5) of this section~~].

(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 [~~carrier~~] 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 [~~(5)~~], 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 [~~one-third or two-thirds of~~] all medical/surgical benefits.

[~~(D) The provisions of paragraph (5) are illustrated by the following example:~~]

[~~(i) A carrier issued coverage that is subject to the requirements of this section which includes a $100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The coverage does not include an annual limit on any other category or medical/surgical benefits. It is determined that 40% of the dollar amount of coverage for medical/surgical benefits is related to cardio-pulmonary diseases. It is also determined that $1,000,000 is a reasonable estimate of the upper limit on the dollar amount that may be incurred with respect to the other 60% of payments for medical/surgical benefits.~~]

[~~(ii) In this example, the coverage issued is not described in subsection (a)(2) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the coverage is not described in subsection (a)(1) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this subsection (a)(5) the carrier may choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is $640,000 (40% x $100,000 + 60% x $1,000,000 = $640,000).~~]

(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 [~~carrier~~] to provide any mental health or substance use disorder benefits, except as otherwise specified in the [~~Texas~~] 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 [~~carrier'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 [~~Exemptions~~].

(a) This subchapter does not apply to a health plan issuer [~~carrier~~] offering coverage in connection with a group health plan for a plan year of a small employer as defined in this subchapter. [~~For purposes of this subchapter, a small employer in connection with a group health plan with respect to a calendar year and a plan year, is an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.~~]

(1) In determining employer size, all persons treated as a single employer under subsections (b), (c), (m), and (o) of §414 of the federal [~~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. [~~Coverage is not subject to the requirements of this subchapter if the application of §21.2403 of this title (relating to Parity Requirements) to such coverage results in an increase in the cost for such coverage of at least one percent, as determined by §21.2405 of this title (relating to Cost of Coverage Exemption).~~]

(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) [~~(a)~~] 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 least one percent~~], at the request of a group health plan, a health plan issuer [~~carrier~~] must demonstrate with actual data that the application of this subchapter resulted in an

increase of cost of the health plan issuer's [~~carrier'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 [~~or more~~].

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

(1) based upon a base period of no fewer [~~shorter~~] 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) [~~(b)~~] 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. [~~by the following formula:~~]

[~~FIGURE: 28 TAC §21.2405(b)~~]

[~~(1) IE - the incurred expenditures during the base period.~~]

[~~(2) CE - the claims incurred during the base period that would have been denied under the terms of the carrier's coverage absent amendments to coverage required to comply with this subchapter or the federal Mental Health Parity Act.~~]

[~~(3) AE - administrative costs related to claims in CE and other administrative costs attributable to complying with the requirements of this subchapter or the federal Mental Health Parity Act.~~]

[~~(c) The provisions of these subsections (a) and (b) are illustrated by the following example: A carrier issued coverage to a group health plan has a plan year that is the calendar year. The coverage issued satisfies the requirements of §21.2403 of this title (relating to Parity Requirements) as of January 1, 1998. On September 15, 1998, it is determined that $1,000,000 in administrative costs have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. It is also determined that $100,000 in administrative costs have been incurred for all benefits under the coverage issued to the group health plan, including mental health benefits. Thus, it is determined that the incurred expenditures for the base period are $1,100,000. It is also determined that the claims incurred during the base period that would have been denied under the terms of the plan absent any amendments required to comply with these subsections are $40,000 and that administrative expenses attributable to complying with the requirements of this subsection (b) are $10,000. Thus, the total amount of expenditures for the base period had the coverage not been amended to comply with the requirements of §21.2403 of this title (relating to Parity Requirements) are $1,050,000 ($1,100,000—($40,000 + $10,000) = $1,050,000). In this example, the coverage issued to the group health plan satisfies the requirements of subsection (a) of this section because the application of this section results in an increased cost of at least one percent under the terms of the coverage ($1,100,000/$1,050,000 = 1.04762).~~]

(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) [~~(d)~~] A health plan issuer [~~carrier~~] 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) [~~(e)~~] A health plan issuer [~~carrier~~] 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 [~~carrier~~] so contracts with a group health plan:

(1) An individual who is not a participant or beneficiary and who presents the health plan issuer [~~carrier~~] a notice described in subsection (e) [~~(c)~~] 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) [~~(c)~~] 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 [~~title~~] (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.

[~~(f) The provisions of these subsections (d) and (e) are illustrated by the following example:~~]

[~~(1) A carrier issued a group health plan that has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. It is determined on September 15 that the coverage satisfies the requirements of subsection (a) of this section. The group health plan enters into a contract with a carrier which provides that as part of the plan's open enrollment materials and pursuant to the notice requirement of any federal notice requirements, the carrier mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of all federal notice requirements as set forth in subsection (c) of the section.~~]

[~~(2) In this example, the notice requirements have been met as required by subsections (d) and (e) of this section.~~]

(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 [~~carrier~~] 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 [~~carrier~~] may not sell coverage without parity, as described in §21.2403 of this subchapter [~~title~~] (relating to Large Employer Parity Requirements) to a group health plan unless [~~only if~~]:

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

(2) the group health plan meets the criteria set out in §21.2405 [~~has already met the requirements of §21.2404~~] of this subchapter [~~title~~] (relating to Cost of Coverage Exemption).