

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN COVERAGE

FOR CERTAIN SERIOUS MENTAL ILLNESSES AND OTHER DISORDERS

Sec. 1355.001. DEFINITIONS. In this subchapter:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- (A) bipolar disorders (hypomanic, manic, depressive, and mixed);
- (B) depression in childhood and adolescence;
- (C) major depressive disorders (single episode or recurrent);
- (D) obsessive-compulsive disorders;
- (E) paranoid and other psychotic disorders;
- (F) schizo-affective disorders (bipolar or depressive); and
- (G) schizophrenia.

(2) "Small employer" has the meaning assigned by Section [1501.002](#).

(3) "Autism spectrum disorder" means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified.

(4) "Neurobiological disorder" means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. [1919](#)), Sec. 7, eff. September 1, 2007.

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. (a) This

subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) a group insurance policy, group insurance agreement, group hospital service contract, or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843; and

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement.

(b) Notwithstanding any provision in Chapter 1575 or 1579 or any other law, Section 1355.015 applies to:

(1) a basic plan under Chapter 1575; and

(2) a primary care coverage plan under Chapter 1579.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1107 (H.B. 451), Sec. 1, eff. September 1, 2009.

Sec. 1355.003. EXCEPTION. (a) This subchapter does not apply to coverage under:

(1) a blanket accident and health insurance policy, as described by Chapter 1251;

(2) a short-term travel policy;

(3) an accident-only policy;

(4) a limited or specified-disease policy that does

not provide benefits for mental health care or similar services;

(5) except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601;

(6) a plan offered in accordance with Section 1355.151; or

(7) a Medicare supplement benefit plan, as defined by Section 1652.002.

(b) For the purposes of a plan described by Subsection (a)(5), "serious mental illness" has the meaning assigned by Section 1355.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL ILLNESS. (a) A group health benefit plan:

(1) must provide coverage, based on medical necessity, for not less than the following treatments of serious mental illness in each calendar year:

(A) 45 days of inpatient treatment; and

(B) 60 visits for outpatient treatment, including group and individual outpatient treatment;

(2) may not include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment covered under the plan; and

(3) must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious mental illness as the plan includes for physical illness.

(b) A group health benefit plan issuer:

(1) may not count an outpatient visit for medication management against the number of outpatient visits required to be covered under Subsection (a)(1)(B); and

(2) must provide coverage for an outpatient visit described by Subsection (a)(1)(B) under the same terms as the coverage the issuer provides for an outpatient visit for the treatment of physical illness.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group

health benefit plan issuer may provide or offer coverage required by Section 1355.004 through a managed care plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO CONTROLLED SUBSTANCE OR MARIHUANA NOT REQUIRED. (a) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

(b) This subchapter does not require a group health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.015. REQUIRED COVERAGE FOR CERTAIN ENROLLEES. (a) At a minimum, a health benefit plan must provide coverage for screening a child for autism spectrum disorder at the ages of 18 and 24 months.

(a-1) At a minimum, a health benefit plan must provide coverage for treatment of autism spectrum disorder as provided by this section to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis, only if the diagnosis was in place prior to the child's 10th birthday.

(b) The health benefit plan must provide coverage under this section to the enrollee for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. An individual providing treatment prescribed

under this subsection must be:

(1) a health care practitioner:

(A) who is licensed, certified, or registered by an appropriate agency of this state;

(B) whose professional credential is recognized and accepted by an appropriate agency of the United States; or

(C) who is certified as a provider under the TRICARE military health system; or

(2) an individual acting under the supervision of a health care practitioner described by Subdivision (1).

(c) For purposes of Subsection (b), "generally recognized services" may include services such as:

(1) evaluation and assessment services;

(2) applied behavior analysis;

(3) behavior training and behavior management;

(4) speech therapy;

(5) occupational therapy;

(6) physical therapy; or

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

(c-1) The health benefit plan is not required to provide coverage under Subsection (b) for benefits for an enrollee 10 years of age or older for applied behavior analysis in an amount that exceeds \$36,000 per year.

(d) Coverage under Subsection (b) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

(e) Notwithstanding any other law, this section does not apply to a standard health benefit plan provided under Chapter [1507](#).

(f) Subsection (a) does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter requires the qualified health plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by this subchapter.

(g) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this section that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2007, 80th Leg., R.S., Ch. 877 (H.B. 1919), Sec. 8, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1107 (H.B. 451), Sec. 2, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 1070 (H.B. 3276), Sec. 1, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1359 (S.B. 1484), Sec. 1, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1359 (S.B. 1484), Sec. 2, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 11.003(a), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 11.003(b), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 21.001(37), eff. September 1, 2015.

## SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

Sec. 1355.051. DEFINITIONS. In this subchapter:

(1) "Crisis stabilization unit" means a 24-hour residential program that provides, usually for a short term, intensive supervision and highly structured activities to individuals who demonstrate a moderate to severe acute psychiatric crisis.

(2) "Individual treatment plan" means a treatment plan with specific attainable goals and objectives that are appropriate to:

(A) the patient; and

(B) the program's treatment modality.

(3) "Residential treatment center for children and adolescents" means a child-care institution that:

(A) is accredited as a residential treatment center by:

(i) the Council on Accreditation;

(ii) the Joint Commission on Accreditation of Healthcare Organizations; or

(iii) the American Association of Psychiatric Services for Children; and

(B) provides residential care and treatment for emotionally disturbed children and adolescents.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group health benefit plan that is delivered or issued for delivery in this state and that is:

(1) an accident and health insurance group policy;

(2) a group policy issued by a group hospital service corporation operating under Chapter 842; or

(3) a group health care plan provided by a health maintenance organization operating under Chapter 843.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND DISORDERS. A group health benefit plan that provides coverage for treatment of mental or emotional illness or disorder for a covered individual when the individual is confined in a hospital must also provide coverage for treatment in a residential treatment center for children and adolescents or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of mental or emotional illness or disorder in a hospital.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of coverage provided under this subchapter may be used only in a

situation in which:

(1) the covered individual has a serious mental illness that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and

(2) the covered individual's mental illness:

(A) substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or

(B) as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.

(b) The service for which benefits are to be paid from coverage provided under this subchapter must be:

(1) based on an individual treatment plan for the covered individual; and

(2) provided by a service provider licensed or operated by the appropriate state agency to provide those services.

(c) Benefits under coverage provided under this subchapter are subject to the same benefit maximums, durational limitations, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment under the coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS. (a) Treatment in a residential treatment center for children and adolescents must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining policy benefits and benefit maximums, each two days of treatment in a residential treatment center for children and adolescents is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit



must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining plan benefits and benefit maximums, each two days of treatment in a crisis stabilization unit is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.

(c) Treatment provided to an individual by a crisis stabilization unit licensed or certified by the Texas Department of Mental Health and Mental Retardation shall be reimbursed.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM RATIOS OF REIMBURSEMENT. (a) The commissioner shall monitor and review the minimum ratios of reimbursement for alternative treatments required by Sections [1355.055](#) and [1355.056](#).

(b) If the commissioner finds that the limits provided by this subchapter are creating an artificial increase in the costs of services, the commissioner by rule may adjust the ratios to the extent necessary to prevent the artificial increase.

(c) Before the commissioner adjusts a ratio under Subsection (b), the commissioner must give notice and hold a hearing to:

- (1) consider information related to the adjustment;
- and
- (2) determine whether the information justifies the adjustment.

(d) The department shall review the reimbursement ratios at least every two years.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. (a) The Texas Department of Mental Health and Mental Retardation shall assist the department in carrying out the department's responsibilities under this subchapter.

(b) The department and the Texas Department of Mental Health

and Mental Retardation by rule may adopt a memorandum of understanding to carry out this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

#### SUBCHAPTER C. PSYCHIATRIC DAY TREATMENT FACILITIES

Sec. 1355.101. DEFINITION. In this subchapter, "psychiatric day treatment facility" means a mental health facility that:

(1) provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program using individualized treatment plans with specific attainable goals and objectives that are appropriate to the patient and the program's treatment modality; and

(2) is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group policy of accident and health insurance delivered or issued for delivery in this state, including a group policy issued by a group hospital service corporation operating under Chapter [842](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter [1201](#), including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy that provides coverage for treatment of mental or emotional illness

or disorder when an individual is confined in a hospital must also provide coverage for treatment obtained under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an inpatient program.

(b) The psychiatric day treatment facility coverage required by this section may not be less favorable than the hospital coverage and must be subject to the same durational limits, deductibles, and coinsurance factors.

(c) A group insurance policy subject to this section may require that:

(1) the treatment obtained in a psychiatric day treatment facility be provided by a facility that treats a patient for not more than 8 hours in any 24-hour period;

(2) the attending physician certify that the treatment is in lieu of hospitalization; and

(3) the psychiatric day treatment facility be accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Healthcare Organizations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) Benefits provided under this subchapter shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital.

(b) For the purpose of determining policy benefits and benefit maximums, each full day of treatment in a psychiatric day treatment facility is the equivalent of one-half of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE BENEFITS. (a) An insurer shall offer, and a policyholder is

entitled to reject, coverage under a group insurance policy for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility.

(b) A policyholder may select an alternative level of benefits under the group insurance policy if the alternative level is offered by or negotiated with the insurer.

(c) The alternative level of benefits must provide policy benefits and benefit maximums for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in a hospital, except that benefits for treatment in a psychiatric day treatment facility may not exceed the usual and customary charges of the facility.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

#### SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF CERTAIN COVERAGES. (a) In this section, "serious mental illness" has the meaning assigned by Section [1355.001](#).

(b) A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that is less extensive for serious mental illness than the coverage provided for any other physical illness.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

#### SUBCHAPTER E. BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION

Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter [1201](#), including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR MENTAL RETARDATION BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION. (a) An individual or group accident and health insurance policy delivered or issued for delivery to a person in this state that provides coverage for mental illness or mental retardation may not exclude benefits under that coverage for support, maintenance, and treatment provided by a tax-supported institution of this state, or by a community center for mental health or mental retardation services, that regularly and customarily charges patients who are not indigent for those services.

(b) In determining whether a patient is not indigent, as provided by Subchapter B, Chapter 552, Health and Safety Code, a tax-supported institution of this state or a community center for mental health or mental retardation services shall consider any insurance policy or policies that provide coverage to the patient for mental illness or mental retardation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

#### SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

Sec. 1355.251. DEFINITIONS. In this subchapter:

(1) "Mental health benefit" means a benefit relating to an item or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(2) "Nonquantitative treatment limitation" means a limit on the scope or duration of treatment that is not expressed numerically. The term includes:

(A) a medical management standard limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether a treatment is experimental or investigational;

(B) formulary design for prescription drugs;

(C) network tier design;

(D) a standard for provider participation in a

network, including reimbursement rates;

(E) a method used by a health benefit plan to determine usual, customary, and reasonable charges;

(F) a step therapy protocol;

(G) an exclusion based on failure to complete a course of treatment; and

(H) a restriction based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of a benefit.

(3) "Quantitative treatment limitation" means a treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount such as an annual or lifetime limit on days of coverage or number of visits. The term includes a deductible, a copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

(4) "Substance use disorder benefit" means a benefit relating to an item or service for a substance use disorder, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits or coverage for medical or surgical expenses incurred as a result of a health condition, accident, or sickness and for treatment expenses incurred as a result of a mental health condition or substance use disorder, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an individual or group evidence of coverage, or a similar coverage document, that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under

Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a health maintenance organization operating under Chapter 843;

(6) a reciprocal exchange operating under Chapter 942;

(7) a Lloyd's plan operating under Chapter 941;

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(b) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(c) This subchapter applies to a standard health benefit plan issued under Chapter 1507.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.253. EXCEPTIONS. (a) This subchapter does not apply to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses;

(F) only for indemnity for hospital confinement;

or

(G) only for accidents;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss(g)(1));

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section [1355.252](#).

(b) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this subchapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. [10](#)), Sec. 2, eff. September 1, 2017.

Sec. 1355.254. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS. (a) A health benefit plan must provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage.

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

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. [10](#)), Sec. 2, eff. September 1, 2017.

Sec. 1355.255. COMPLIANCE. The commissioner shall enforce compliance with Section [1355.254](#) by evaluating the benefits and coverage offered by a health benefit plan for quantitative and nonquantitative treatment limitations in the following categories:

- (1) in-network and out-of-network inpatient care;
- (2) in-network and out-of-network outpatient care;
- (3) emergency care; and
- (4) prescription drugs.



Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.256. DEFINITIONS UNDER PLAN. (a) A health benefit plan must define a condition to be a mental health condition or not a mental health condition in a manner consistent with generally recognized independent standards of medical practice.

(b) A health benefit plan must define a condition to be a substance use disorder or not a substance use disorder in a manner consistent with generally recognized independent standards of medical practice.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.257. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE. This subchapter supplements Subchapters A and B of this chapter and Chapter 1368 and the department rules adopted under those statutes. It is the intent of the legislature that Subchapter A or B of this chapter or Chapter 1368 or a department rule adopted under those statutes controls in any circumstance in which that other law requires:

(1) a benefit that is not required by this subchapter;  
or

(2) a more extensive benefit than is required by this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.2571. PARITY COMPLAINT PORTAL. (a) The commissioner shall develop and maintain a parity complaint portal that is an integrated system that allows for the enrollee of a health benefit plan to submit complaints of suspected violations of the provisions of this subchapter. The parity complaint portal must:

(1) allow for an enrollee to submit a complaint through multiple ways;

(2) provide updates on the status of an enrollee's

complaint;

(3) ensure timely, effective, and equitable resolution for submitted complaints;

(4) include educational materials regarding:

(A) benefits for mental health conditions and substance use disorders required under this subchapter;

(B) an enrollee's rights and responsibilities under a health benefit plan concerning coverage under this subchapter;

(C) circumstances under which a claim may be denied; and

(D) the processes for reviewing a complaint submitted through the portal;

(5) adhere to national best practices as determined by the commissioner; and

(6) include the findings of the report required by Section [1355.2572\(b\)](#).

(b) In developing the parity complaint portal under Subsection (a), the commissioner:

(1) shall conduct an assessment of complaint portals and similar systems used by other relevant public or private entities;

(2) shall develop best practice standards for complaint submissions and tracking consistent with the findings of the assessment conducted under Subdivision (1); and

(3) may develop a new complaint portal or modify an existing complaint portal.

(c) The Health and Human Services Commission shall appoint a liaison to the department to receive reports of concerns, complaints, and potential violations submitted through the parity complaint portal established under Subsection (a).

Added by Acts 2021, 87th Leg., R.S., Ch. 703 (H.B. [2595](#)), Sec. 2, eff. September 1, 2021.

Sec. 1355.2572. EDUCATIONAL MATERIALS AND PARITY LAW TRAINING; REPORT. (a) The commissioner, in collaboration with the Health and Human Services Commission's ombudsman for behavioral

health, shall develop educational materials and parity law training sessions regarding the coverage for mental health conditions and substance use disorders required under this subchapter. The commissioner shall ensure that the materials and training sessions:

(1) are available to health benefit plan issuers and enrollees;

(2) include online, print, and in-person formats;

(3) are made available through the parity complaint portal established under Section [1355.2571](#) and at relevant locations and settings, including:

(A) any relevant agency offices;

(B) health benefit plan provider service locations; and

(C) relevant professional conferences and trade association meetings; and

(4) include a list of relevant third-party organization educational and parity law awareness materials that provide additional information regarding mental health conditions and substance use disorder parity and, if provided in an online format, provide the links needed to access those materials online.

(b) Not later than September 1 of each year, the commissioner, in collaboration with the Health and Human Services Commission's ombudsman for behavioral health, shall:

(1) prepare and submit a report to the appropriate committees of the legislature and the appropriate state agencies on the status of:

(A) rights and responsibilities for mental health condition and substance use disorder benefits; and

(B) resolved and unresolved complaints submitted through the parity complaint portal established under Section [1355.2571](#)(a); and

(2) publish the findings of the report under Subdivision (1) to the parity complaint portal established under Section [1355.2571](#)(a).

Added by Acts 2021, 87th Leg., R.S., Ch. 703 (H.B. [2595](#)), Sec. 2, eff. September 1, 2021.

Sec. 1355.258. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.