INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM COVERAGE REQUIRED

Sec. 1358.001. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan.

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

Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual 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;

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

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

(B) another analogous benefit arrangement; and

(3) health and accident coverage provided by a risk

pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

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

Sec. 1358.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

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

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

(E) only for dental or vision care; or

(F) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) a long-term care insurance 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 1358.002.

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

Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS. The commissioner, in consultation with the Texas Diabetes Council, by rule shall adopt minimum standards for coverage provided to an enrollee with diabetes.

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

Sec. 1358.005. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage in accordance with the standards adopted under Section 1358.004.

(b) Coverage required under this section may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the deductible, coinsurance, or copayment requirement applicable to other similar coverage provided under the health benefit plan.

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

SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES TREATMENT

Sec. 1358.051. DEFINITIONS. In this subchapter:

(1) "Diabetes equipment" means:

(A) blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;

(B) insulin pumps and associated appurtenances;

(C) insulin infusion devices; and

(D) podiatric appliances for the prevention of complications associated with diabetes.

(2) "Diabetes supplies" means:

(A) test strips for blood glucose monitors;

(B) visual reading and urine test strips;

(C) lancets and lancet devices;

(D) insulin and insulin analogs;

(E) injection aids;

(F) syringes;

(G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and

(H) glucagon emergency kits.

(3) "Nutrition counseling" has the meaning assigned by Section 701.002, Occupations Code.

(4) "Qualified enrollee" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:

(A) insulin dependent or noninsulin dependent

diabetes;

(B) elevated blood glucose levels induced by pregnancy; or

(C) another medical condition associated with elevated blood glucose levels.

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

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.038(a), eff. September 1, 2005.

Sec. 1358.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

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

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

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

(v) a reciprocal exchange operating under Chapter 942; or

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

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

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

Sec. 1358.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for accidental death or dismemberment;

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

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

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

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

(4) a workers' compensation insurance policy;

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

(6) a long-term care insurance 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 1358.052.

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

Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for:

(1) diabetes equipment;

(2) diabetes supplies; and

(3) diabetes self-management training in accordance

with the requirements of Section 1358.055.

(a-1) A health benefit plan described by Subsection (a) must provide to each qualified enrollee coverage for emergency refills of diabetes equipment or diabetes supplies dispensed to the enrollee in accordance with Section 562.0541, Occupations Code, in the same manner as for a nonemergency refill of diabetes equipment or diabetes supplies.

(b) A health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under this section. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

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

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 679 (H.B. 1935), Sec. 2, eff. September 1, 2021.

Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a) Diabetes self-management training must be provided by a health care practitioner or provider who is:

(1) licensed, registered, or certified in this state to provide appropriate health care services; and

(2) acting within the scope of practice authorized by the license, registration, or certification.

(b) For purposes of this subchapter, "self-management training" includes:

(1) training provided to a qualified enrollee, after the initial diagnosis of diabetes, in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;

(2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified enrollee's symptoms or condition that requires changes in the qualified enrollee's self-management regime; and

(3) periodic or episodic continuing education

training prescribed by an appropriate health care practitioner as warranted by the development of new techniques or treatments for diabetes.

(c) If the diabetes self-management training is provided on the written order of a physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a physician, the training must also include:

(1) a diabetes self-management training program recognized by the American Diabetes Association;

(2) diabetes self-management training provided by a multidisciplinary team:

(A) the nonphysician members of which are coordinated by:

(i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or

(ii) an individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

(B) that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and

(C) each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

(3) diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or

(4) diabetes self-management training that provides one or more of the following components:

(A) a nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

(B) a pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

(C) a component provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

(D) a component provided by a physician.

(d) An individual may not provide a component of diabetes self-management training under Subsection (c)(4) unless:

(1) the subject matter of the component is within the scope of the individual's practice; and

(2) the individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health.

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

Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND SUPPLIES. A health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

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

Sec. 1358.057. RULES. (a) The commissioner shall adopt rules necessary to implement this subchapter.

(b) In adopting rules under this section, the commissioner may consult with the commissioner of public health and other appropriate entities.

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

Sec. 1358.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or 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 reciprocal exchange operating under Chapter 942;

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

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

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

(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(d) Notwithstanding any other law, this subchapter applies to coverage under:

(1) the child health plan program under Chapter 62,

Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; and

(2) the medical assistance program under Chapter 32, Human Resources Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. 827), Sec. 1, eff. September 1, 2021.

Sec. 1358.102. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

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

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

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

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

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

(4) a long-term care insurance 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 1358.101;

(5) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code; or

(6) a workers' compensation insurance policy.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. 827), Sec. 1, eff. September 1, 2021.

Sec. 1358.103. LIMIT ON COST-SHARING REQUIREMENT. (a) In this section, "insulin" means a prescription drug that contains insulin and is used to treat diabetes. The term does not include an insulin drug that is administered to a patient intravenously.

(b) A health benefit plan may not impose a cost-sharing provision for insulin that is included in the health benefit plan's formulary if the total amount the enrollee is required to pay exceeds $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the enrollee's prescription.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. 827), Sec. 1, eff. September 1, 2021.

Sec. 1358.104. FORMULARY REQUIREMENT. A health benefit plan must include at least one insulin from each therapeutic class in the plan's formulary.

Added by Acts 2021, 87th Leg., R.S., Ch. 589 (S.B. 827), Sec. 1, eff. September 1, 2021.