From: Victoria Ibric [mailto:dribric@sbcglobal.net]
Sent: Saturday, May 23, 2009 3:51 PM
To: EBSA, E-OHPSCA - EBSA
Subject: Parity Regulations

AN ACT

relating to health benefit plan coverage for certain benefits related to brain injury.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.53Q to read as follows:

Art. 21.53Q. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN BENEFITS RELATED TO BRAIN INJURY

Sec. 1. APPLICABILITY OF ARTICLE. (a) This article 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 an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a Lloyd's plan operating under Chapter 18 of this code;

(7) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(8) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) This article applies to a small employer health benefit plan written under Chapter 26 of this code.

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for benefits for a specified disease or for another limited benefit other than an accident policy;

(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), as amended;

(3) a workers' compensation insurance policy;

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

(5) 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 Subsection (a) of this section.

Sec. 2. EXCLUSION OF COVERAGE PROHIBITED. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this article may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with deductibles, copayments, cosinsurance, and annual or maximum payment limits applicable to other similar coverage under the plan.

(c) The commissioner shall adopt rules as necessary to implement this section.

Sec. 3. TRAINING FOR CERTAIN PERSONNEL REQUIRED. (a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether the issuer of a health benefit plan will pay the physician or provider for proposed medical or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer of a health benefit plan to a physician or health care provider.

(b) The commissioner by rule shall require the issuer of a health benefit plan to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan to prevent wrongful denial of coverage required under this article and to avoid confusion of medical benefits with mental health benefits.

SECTION 2. (a) On or before September 1, 2006, the Sunset Advisory Commission shall conduct a study to determine:

(1) to what extent the health benefit plan coverage required by Article 21.53Q, Insurance Code, as added by this Act, is being used by enrollees in health benefit plans to which that article applies; and

(2) the impact of the required coverage on the cost of those health benefit plans.

(b) The Sunset Advisory Commission shall report its findings under this section to the legislature on or before January 1, 2007.

(c) The Texas Department of Insurance and any other state agency shall cooperate with the Sunset Advisory Commission as necessary to implement this section.

(d) This section expires September 1, 2007.

SECTION 3. This Act takes effect September 1, 2001, and applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2002. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2002, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

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President of the Senate Speaker of the House

I certify that H.B. No. 1676 was passed by the House on April 30, 2001, by a non-record vote.

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Chief Clerk of the House

I certify that H.B. No. 1676 was passed by the Senate on May 22, 2001, by a viva-voce vote.

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Secretary of the Senate

APPROVED: _____

Comments Regarding Regulatory Guidance USCG-2007-27022
page 19157, II B specific areas 1 and 4

I am a <*input your profession*> who provides neurofeedback treatment to individuals with Attention Deficit Hyperactivity Disorder and Mood Disorders. Neurofeedback is an empirically validated and widely recognized effective non-medication treatment for ADHD, as well as other conditions. There are over 50 studies evaluating the effectiveness of neurofeedback in the treatment of ADHD, substance use disorders and Autism. A recent review of this literature concluded "Neurofeedback meets the American Academy of Child and Adolescent Psychiatry criteria for Clinical Guidelines for treatment of ADHD." This means that neurofeedback meets the same criteria as medication for treating ADHD, of which 60% of prescriptions are in fact prescribed "off label," and that neurofeedback "should always be considered as an intervention for this disorder by the clinician."

This service has been denied by Georgia Medicaid, Aetna, United Behavioral Health, Blue Cross, Cigna, and Amerigroup.

This is limitation of an effective and validated treatment for a mental health problem. The reasons given by the insurance companies for this denial fell into two categories: 1) our company does not cover biofeedback for mental health problems or 2) there is not yet sufficient evidence for the efficacy of neurofeedback. As such, they are using evidence-based criteria that are far more restrictive for mental health services than the criteria which are used for medical/surgical services. There are many routine medical and surgical procedures which have far fewer controlled studies about their efficacy than does neurofeedback. These medical and surgical procedures are generally not limited because of concerns about how many controlled studies have been performed about them.

We believe that the parity regulations, based on legal reviews of the parity statute should require that employers and plans pay for the same range and scope of services for behavioral treatments as they do for medical surgical benefits and that a plan cannot be more restrictive in their managed care criteria and reviews for mental health and substance abuse disorders when compared to medical surgery. Today plans are being more restrictive in how they review evidenced-based mental health and Substance Abuse Treatments when compared to medical

surgical treatments. This violates both the intent and letter of the parity statute and we hope that the regulations will clarify that this can't continue.

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*"The mark of a moderate man is freedom from his own ideas. Tolerant like the sky, all-pervading like sunlight, firm like a mountain, supple like a tree in the wind..."*Tao Te Ching