SUBCHAPTER P. MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY

DIVISION 1. GENERAL PROVISIONS AND PARITY REQUIREMENTS
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DIVISION 4. AUTISM SPECTRUM DISORDER
28 TAC §21.2451 and §21.2452

INTRODUCTION. The Commissioner of Insurance adopts the repeal of 28 TAC Chapter 21, Subchapter P, §§21.2401 - 21.2407, relating to Mental Health Parity, and 28 TAC Chapter 21, Subchapter JJ, §§21.4401 - 21.4404, relating to Autism Spectrum Disorder Coverage. The Commissioner also adopts new 28 TAC Chapter 21, Subchapter P, relating to Mental Health and Substance Use Disorder Parity, §§21.2401 - 21.2409, 21.2411, 21.2413, 21.2414, 21.2421 - 21.2427, 21.2431 - 21.2441, 21.2451, and 21.2452, concerning parity between medical/surgical benefits and mental health and substance use disorder (MH/SUD) benefits. The repeals and adoption implement House Bill 10, 85th Legislature, 2017. The repeals are adopted without changes to the proposal published in the February 19, 2021, issue of the *Texas Register* (46 TexReg 1191).

The Commissioner of Insurance adopts §§21.2403, 21.2405, 21.2408, 21.2409, 21.2411, 21.2414, 21.2432, 21.2434, 21.2436 - 21.2440, 21.2451, and 21.2452 without changes to the proposed text published in the February 19, 2021, issue of the *Texas Register*. The Commissioner adopts §§21.2401, 21.2402, 21.2404, 21.2406, 21.2407,

21.2413, 21.2421 - 21.2427, 21.2431, 21.2433, 21.2435, and 21.2441 with changes to the proposed text.

The Commissioner withdraws the proposal of new §§21.2410, 21.2412, and 21.2453.

REASONED JUSTIFICATION. This rule is required to implement the legislature's directives in HB 10 to health benefit plan issuers (issuers) and the Commissioner. Issuers are to provide benefits and coverage for MH/SUD under the same terms and conditions applicable to the plan's medical/surgical benefits and coverage. An issuer 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 the limitations imposed on coverage of benefits for medical or surgical expenses. The Commissioner is required to enforce compliance with the legislature's directive to issuers by evaluating the benefits and coverage offered by an issuer's health benefit plan for quantitative and nonquantitative treatment limitations in several 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.

This rule is designed to provide issuers guidance on compliance with the legislature's directive and to collect information and require issuer analyses of data that will allow the Commissioner to enforce compliance.

Subchapter Name Change. With the adoption of new Subchapter P, the Texas Department of Insurance (TDI) changes the previous name "Mental Health Parity" to

"Mental Health and Substance Use Disorder Parity" to reflect that new Subchapter P applies to parity for both mental health and substance use disorders.

Summary of New Subchapter. Insurance Code §1355.255, concerning Compliance, requires the Commissioner to enforce compliance with Insurance Code §1355.254, concerning Coverage for Mental Health Conditions and Substance Use Disorders, by evaluating the benefits and coverage offered by a health benefit plan (plan) for quantitative treatment limitations (QTLs) and nonquantitative treatment limitations (NQTLs). New §§21.2401 - 21.2452 implement Insurance Code Chapter 1355.

Sections 21.2401 - 21.2406 of Division 1 contain general provisions that apply to the entire subchapter. The remaining sections of Division 1, §§21.2407 - 21.2409, 21.2411, 21.2413, and 21.2414, restate (with a few noted exceptions) the federal medical/surgical and MH/SUD parity requirements established in 45 CFR §146.136(b) - (h) (concerning Parity in Mental Health and Substance Use Disorder Benefits) (federal parity rule).

Division 2, consisting of §§21.2421 - 21.2427, addresses requirements for issuers to provide data on plans' claims, utilization reviews, and reimbursement rates.

Division 3, consisting of §§21.2431 - 21.2441, contains requirements for issuers to analyze parity compliance and maintain documentation of their analyses of plans' QTLs and NQTLs. The requirements to perform and document comparative analyses of the design and application of NQTLs are consistent with 42 USC §300gg-26(a)(8) (concerning Parity in Mental Health and Substance Use Disorder Benefits), as added by the Consolidated Appropriations Act, 2021.

Division 4, consisting of §21.2451 and §21.2452, adopts and updates autism spectrum disorder (ASD) rules based on those from repealed Subchapter JJ. Differences

between the repealed and new sections reflect that this coverage is subject to Insurance Code Chapter 1355, Subchapter F, concerning Coverage for Mental Health Conditions and Substance Use Disorders.

TDI received written and oral comments on the rule proposal. TDI considered those comments when drafting this adoption.

DIVISION 1. GENERAL PROVISIONS AND PARITY REQUIREMENTS

28 TAC §21.2401 -21.2409, 21.2411, 21.2413, and 21.2414

Section 21.2401. Section 21.2401 states the purpose and scope of Subchapter P. It explains that the rules are intended to be consistent with Insurance Code provisions on coverage for MH/SUD and with the federal rules implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), found at 45 CFR §146.136 and 45 CFR §146.121. TDI will consider federal guidance and interpretive materials, including bulletins and FAQs on the federal rules, in interpreting and applying this rule. A change to the proposed text is made to clarify a citation to a federal rule.

Section 21.2402. Section 21.2402 states that Subchapter P applies to all plans subject to Insurance Code Chapter 1355, Subchapter F. This includes any plan that provides coverage for treatment expenses incurred as a result of mental health or substance use disorders unless a specific exception applies. TDI makes a change to the citation under subsection (b)(2) as proposed.

Section 21.2403. Section 21.2403 restricts an issuer's limitations on coverage to those limitations that do not violate the parity requirements in Insurance Code Chapter 1355, Subchapter F and 28 TAC Chapter 21, Subchapter P. For example:

(1) Insurance Code §1355.006(b)(2) allows a plan to exclude coverage of a serious mental illness if it results from the illegal use of certain substances. A plan could theoretically exclude all benefits for both medical/surgical and MH/SUD treatments that result from the illegal use of certain substances (if the plan were not otherwise required to cover substance use disorder). But if the plan excludes only benefits for mental illness, the plan would violate parity requirements.

(2) Insurance Code §1355.015(a-1) allows a plan to exclude ASD coverage for people diagnosed at age 10 or older, and §1355.015(c-1) allows a dollar limit for applied behavioral analysis treatment. These limits are unlikely to apply to medical/surgical benefits. A plan may need to remove these limits to comply with parity.

(3) Insurance Code §1355.054 and §§1355.104 - 1355.106 may allow a plan to restrict coverage for mental health treatment in certain types of facilities in a way that it would not restrict comparable coverage for medical/surgical care. If the plan imposes limits for facility treatment for MH/SUD that are more restrictive than those for medical/surgical, it would violate parity requirements.

(4) Insurance Code §1368.005(b) allows a plan to apply less favorable dollar and durational limits if they are "sufficient." Insurance Code §1368.006(b) allows a plan to impose a three-series lifetime limit on treatment for chemical dependency. Less favorable financial requirements and QTLs violate parity if they fail the "substantially all" and "predominant" tests used to assess parity.

(5) Insurance Code §1355.004(a)(3) and Insurance Code §1368.005(a)(2) require that a plan's QTLs be "the same" as for physical illness. But providing an equivalent benefit may violate parity if the financial requirement or limit applied is more restrictive than the "substantially all" and "predominant" tests.

Section 21.2404. Section 21.2404 lists differences between terms used and provisions in Subchapter P and the federal rules. TDI makes changes to the proposed text of this section to conform to the withdrawal of §21.2410 and §21.2412, which provided for an increased cost exemption. TDI also changes the proposed text by updating references to the federal provisions that are not duplicated in this division because there is no analogous Texas law. TDI does not adopt subsection (d) because it referenced the definition of "base period" under §21.2406, which was not adopted, and §21.2412, which is withdrawn in response to comment. Finally, TDI makes two changes to the proposed text to correct punctuation in subsection (a).

Section 21.2405. Section 21.2405 notifies issuers that should there be deficiencies in an issuer's submissions, TDI may require submission of a corrective action plan, and TDI may also require notice to enrollees. The section also provides that a court's invalidation of a provision or application of Subchapter P does not affect or invalidate other provisions or applications of the subchapter.

Section 21.2406. Section 21.2406 defines terms used in Subchapter P and restates the meanings listed in the federal rule. Defined terms not used in Division 1 are meant to help issuers identify the information and data they are required to report in the spreadsheets described in Divisions 2 and 3. In response to comment, TDI makes a change to the proposed definition of "applied behavior analysis." The adopted definition of "applied behavior analysis" is consistent with the practice of applied behavior analysis in Occupations Code §506.003. In response to comment, TDI makes a change to the proposed definition of "reported claims." The change clarifies that reported claims are to be characterized by the date they are received by the issuer. In response to comment, TDI makes changes to the proposed definition of "peer-to-peer review or physician-to-

physician review," to indicate that it "may" occur (instead of "must"), and to replace a description of the review requirements with a reference to the statute. Clarifying changes are also made to the proposed definitions of "administrative denial" and "reasonable method." TDI does not adopt the definition of "base period" because, in response to comment, TDI has withdrawn §21.2410 and §21.2412, making the definition no longer necessary; subsequent definitions are renumbered.

Section 21.2407. Section 21.2407 requires parity in aggregate lifetime and annual dollar limits. A plan's aggregate lifetime or annual dollar limits on MH/SUD benefits is limited in proportion to the plan's aggregate limits on medical/surgical limits. The section explains how to determine the applicable proportionality of benefits. In response to comment, TDI makes conforming changes to this section as proposed to reflect the withdrawal of proposed §21.2410 and §21.2412.

Section 21.2408. Section 21.2408 restates, without any changes that affect its meaning, the federal rule titled "Parity Requirements with Respect to Financial Requirements and Treatment Limitations," located at 45 CFR §146.136(c)(1) - (3). Section 21.2408 provides generally that a plan that provides both medical/surgical and MH/SUD benefits may not apply any financial requirement or treatment limitation to MH/SUD benefits that is more restrictive than the comparable limitation applied to substantially all comparable medical/surgical benefits. The rule also includes instructions explaining how to apply the rule and examples of plan terms that do and do not comply with the rule.

Section 21.2409. Section 21.2409 restates, without any changes that affect its meaning, the federal rule titled "Nonquantitative Treatment Limitations," at 45 CFR §146.136(c)(4). The rule provides generally that a plan may only impose an NQTL on an MH/SUD benefit, either by the plan's terms or in its operation, if the NQTL is comparable

to and applied no more stringently than the same limitation on comparable medical/surgical benefits. The rule includes instructions that explain how to apply the rule and examples of plan terms that do and do not comply with the rule.

Section 21.2410. TDI withdraws this section in response to a comment that noted that the statute does not support the cost exemption in §21.2412.

Section 21.2411. Section 21.2411 requires that, when asked, an issuer must give an enrollee or contracted provider the plan's criteria for a medical necessity determination for an MH/SUD benefit. It also requires that, when asked, an issuer must give an enrollee the reason for a denial of benefits, consistent with Insurance Code §4201.303, concerning Adverse Determination: Contents of Notice. An issuer that complies with the rule may still need to give an enrollee more information under other federal or state laws.

Section 21.2412. TDI withdraws this section in response to a comment that noted that the statute does not support the cost exemption addressed in the proposed section.

Section 21.2413. Section 21.2413 prohibits an issuer from contracting to provide a plan that does not comply with the parity requirements in §§21.2407 - 21.2409. TDI makes changes to §21.2413 as proposed to remove a reference to an exemption, to conform the section with the withdrawal of proposed §21.2410.

Section 21.2414. Section 21.2414 prohibits a plan from denying benefits it would otherwise provide for treatment of a type of injury, if the injury was the result of domestic violence or a medical condition, including both physical and mental health conditions. This rule applies even if the medical condition was not diagnosed before the injury.

DIVISION 2. PLAN INFORMATION AND DATA COLLECTION

28 TAC §21.2421 - §21.2427

Section 21.2421. Section 21.2421 lists defined terms for Division 2. TDI makes changes to the section as proposed to provide additional clarity on the cited rules for "in-network." TDI also revises the proposed text to include additional examples of place of service codes for "inpatient" and "outpatient." TDI also capitalizes the reference to Division 2.

Section 21.2422. Section 21.2422 sets out the deadline for an issuer to report the data required by Division 2. The section provides that the required information and data are due annually, based on a calendar-year reporting period. In response to comment, TDI makes changes to these deadlines as proposed. Future annual reporting will be made on July 1. This puts the reporting on a slightly offset reporting schedule as compared with other reports due June 1. For 2020 reporting, TDI sets the deadline as December 1, 2021. TDI also makes a change to capitalize the reference to Division 2.

Section 21.2423. Section 21.2423 explains to issuers that they must provide, in a specified template worksheet, information to TDI for each data collection template the issuer provides to TDI. The data to be reported in separate templates is based on the type of plan and the market in which it is offered. The section includes an example (§21.2423(c)) to illustrate the requirements of the rule. TDI changes the name of the data collection template as proposed to be "MH/SUD Parity Rule Division 2 Data Collection Reporting Form."

Section 21.2424. Section 21.2424 requires an issuer to provide issuer information and information on market type, plan type, number of policies for which data is reported, number of covered lives, and premium volume. It also requires issuers providing health plans that are grandfathered under federal rules to report certain data to TDI. TDI changes the name of the data collection template as proposed to conform to the change made in

§21.2423. TDI also changes the proposed text to clarify that the plan information should be reported with respect to the policies or contracts for which data is reported. TDI also makes changes in the worksheet titled "Issuer and Plan Information" to conform to the changes in the rule text.

Section 21.2425. Section 21.2425 requires an issuer to report claims for medical/surgical and MH/SUD benefits on a worksheet titled "Claims and Utilization Review." The rule requires the claims to be separately reported for mental health and substance use disorders. Section 21.2425 sets forth the types of conditions, based on International Classification of Diseases (ICD) diagnosis codes that must be included in the worksheet, and the classifications for the claims to be reported. Section 21.2425 specifies that the classifications are based on inpatient/outpatient status, network status, emergency status, and prescription drug status. In response to comment on other sections, TDI renames the section as proposed to be "Claims and Utilization Review: Reporting Classifications," and renames the worksheet as proposed to be "Claims and Utilization Review." TDI also makes changes to the proposed text to clarify that the requirements apply to both reported claims and requests for utilization review. TDI changes the name of the data collection template to conform to the change made in §21.2423.

Section 21.2426. Section 21.2426 requires an issuer to report its plans' aggregate claims data on a worksheet titled "Claims and Utilization Review" for each of the reporting categories listed in §21.2425. Section 21.2426 provides that the aggregate claims data must be reported for the reporting year. The spreadsheet requires a detailed breakout of all reported claims. In response to comment, TDI makes changes to the rule text as proposed to clarify that the data collection requires both claims and utilization review

data. In addition, the rule section as adopted is renamed to be "Claims and Utilization Review: Aggregate Data Fields." Conforming changes are also made to the proposed text of the section to reflect the changes made to the names of the template and the worksheet in §21.2423 and §21.2425. TDI adds the word "and" to §21.2426(2)(L)(iii). TDI also makes changes in the "Claims and Utilization Review" worksheet to conform to the text of the section, including deleting some references to "N/A" in the data columns relating to emergency care. While preauthorization data is not applicable to emergency care, such care may be subject to concurrent or retrospective reviews and appeals of adverse determinations resulting from such reviews.

Section 21.2427. Section 21.2427 requires an issuer to report plans' average reimbursement rate data separately for in-network and out-of-network providers, within the "MH/SUD Parity Rule Division 2 Data Collection Reporting Form" template in a worksheet titled "Reimbursement Rates." TDI makes a conforming change to the proposed text of §21.2427 to reflect the change to the name of the template made in §21.2423. Data is collected for specific types of physicians and mental health and substance use disorder providers. In the worksheet, TDI specifies billing codes and comparative Medicare reimbursement rate data. The spreadsheet includes a column that calculates the percentage of the Medicare reimbursement rate that a plan's reimbursement rate represents. Insurance Code §1355.255 directs the Commissioner to enforce compliance with §1355.254 by evaluating the benefits and coverage offered by a plan for quantitative and nonquantitative treatment limitations. The Commissioner collects reimbursement rate data as part of this enforcement effort. TDI also has authority to collect issuers' reimbursement rates under Insurance Code Chapter 38, Subchapter H. That subchapter also authorizes TDI to publish aggregated data.

DIVISION 3. COMPLIANCE ANALYSES FOR MH/SUD PARITY

28 TAC §§21.2431 - 21.2441

Section 21.2431. Section 21.2431 states the division's overall requirement that issuers perform quantitative and nonquantitative parity analyses for each of their plan designs. Section 21.2431 also advises issuers that they may use an alternative tool to perform their quantitative parity analysis, rather than the template provided on TDI's website, if the issuer demonstrates to TDI's satisfaction that it is using a methodology for the "predominant" and "substantially all" tests that is consistent with §21.2408 and provides the same level of specificity as the QTL template. TDI will assess whether the alternative compliance tool satisfies the requirements of this section at the time TDI requests that the issuer submit its compliance analysis. Section 21.2431 also advises issuers that they may use an alternative tool to perform their nonquantitative parity analysis, rather than the template provided on TDI's website, if TDI is satisfied that it collects the information required to perform each of the four steps stated in §21.2441, and if the issuer can produce documentation that provides the same level of specificity as the NQTL template. TDI anticipates requesting this documentation during market conduct exams. TDI makes a change to the text of this section as proposed by adding a comma between the section headings listed in subsection (b)(1).

Section 21.2432. Section 21.2432 provides deadlines, including phased-in deadlines for nonquantitative parity analyses. Issuers are notified of the requirements they must meet when marketing new plans or materially modifying existing plans.

Section 21.2433. Section 21.2433 informs issuers about the QTL template and instructions on TDI's website that they may use to provide the issuer and plan information

required by §§21.2434 - 21.2436. The section also provides instructions on how to perform the compliance analysis for quantitative parity required by §21.2437.

Issuers are advised that they may complete a single analysis for multiple plans with the same plan design, including plans in different markets. Issuers are also informed that they must retain their completed quantitative parity analyses so that those analyses are available to TDI upon request for any plan or plan design that is available for purchase, and for at least five years after coverage terminates for the last enrollee covered. TDI makes a change to the text of this section as proposed to conform to the title of §21.2435.

Section 21.2434. Section 21.2434 requires issuers to provide identifying information for each plan design, the plan's quantitative parity analysis, and market type and plan type. TDI makes changes in the QTL template to conform to the text of the rule.

Section 21.2435. Section 21.2435 requires issuers to explain in detail their quantitative parity analysis methodology and the data sources used in performing their quantitative analyses. If an issuer does not have enough plan-level data to perform the analysis, the issuer must provide an actuarial certification explaining why the substitute data set used for the analysis is reasonable and actuarially appropriate. TDI changes "dataset" to "data set" for consistency within the rule.

Section 21.2436. Section 21.2436 requires issuers to perform quantitative parity analyses for all covered benefits under the plan documents as detailed in the QTL template's covered benefits worksheet.

Section 21.2437. Section 21.2437 requires that issuers, using the worksheets named for each classification and subclassification, perform the quantitative parity "substantially all" and "predominant" tests. TDI makes a change to the QTL template to

provide an explanatory note in the classification worksheets regarding the use of per member per month data.

Section 21.2438. Section 21.2438 provides issuers general instructions to use in performing the nonquantitative parity analyses. Issuers are instructed to use the NQTL template to perform the plan identification and nonquantitative parity compliance analyses required by §21.2440 and §21.2441. Issuers may complete a single analysis for multiple plans that contain an identical set of NQTLs.

Section 21.2439. Section 21.2439 explains generally what NQTLs are and provides a non-exhaustive list of examples.

Section 21.2440. Section 21.2440 requires issuers to provide identifying information for each plan or plan design for their nonquantitative parity analyses.

Section 21.2441. Section 21.2441 requires issuers to identify each NQTL in a plan's documents, and to complete the four-step analysis detailed in the section for each NQTL contained in the plan documents for each plan. The four-step analysis is intended to replicate the Department of Labor's (DOL's) four-step NQTL parity analysis set out in the DOL's 2020 Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA), found at www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf. In response to comment, TDI makes a clarification to the proposed rule text by replacing the words "the factors" with "each factor."

As adopted, §21.2441(c) states, "Step 2. Within the NQTL Template, in each classification or subclassification worksheet, an issuer must identify each factor considered in the design and application of the NQTL. Illustrative examples of factors are provided in the NQTL template." To be consistent with the "design and application" language in

subsection (c), TDI adds "and apply" to the text of subsection (d) as proposed. This change also ensures the rule is consistent with 42 USC §300gg-26(a)(8)(A)(iii), as added by the Consolidated Appropriations Act, 2021. TDI makes clarifying grammatical changes to "Step 1" and "NQTL template" to be consistent with other parts of the rule. TDI makes a change to subsection (d)(5)(B) to move the semicolon outside of the quotation marks. TDI also makes changes in the NQTL template to conform to the text of the rule.

DIVISION 4. AUTISM SPECTRUM DISORDER

28 TAC §§21.2451 - 21.2453

Section 21.2451. Section 21.2451 states that Division 4 applies only to plans that provide coverage for autism spectrum disorder as required by Insurance Code Chapter 1355.

Section 21.2452. Section 21.2452 provides that the section applies only if a plan is subject to both Subchapters A and F of Insurance Code Chapter 1355. This is because the government plans created in Insurance Code Chapters 1575 and 1579, which are subject to Subchapter A, are not subject to Subchapter F. The section then requires that if an issuer's plan includes a treatment limitation that is permissible under Subchapter A but does not satisfy Subchapter F's parity requirement in §1355.254, the issuer must modify its plan to ensure compliance with Subchapter F.

Section 21.2453. TDI withdraws the proposal of §21.2453. The proposed rule revision was intended to clarify that an applied behavior analyst could provide services, but this was superseded by Occupations Code Chapter 506 (Behavior Analysts), enacted in 2017. Elimination of this provision clarifies that the adopted rule does not depart from statute.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: Commenters in support of the proposal were Autism Society of Texas, Every Texan, La Hacienda Treatment Center, NAMI Texas, and The Kennedy Forum. Commenters in support of the proposal with changes were Texas Medical Association, Texas Hospital Association, and Meadows Mental Health Policy Institute. Commenters against the proposal were two individuals, America's Health Insurance Plans, and Texas Association of Health Plans.

Comments on proposed rules generally

Comment. Several commenters expressed support for the proposed rules.

Agency Response. TDI thanks the commenters for the support of the proposed rules.

Comment. A commenter with a dispute before TDI's Division of Workers' Compensation relating to the compensability of an injury expressed dissatisfaction over the handling of their matter.

Agency Response. TDI declines to make a change in response to this comment and notes that the commenter's concerns are outside the scope of the rule.

Comment. Two commenters request that TDI pause rulemaking and evaluate the federal MHPAEA law and new provisions passed in December 2021 as part of the Consolidated Appropriations Act of 2021. They state that the new provisions may affect NQTLs and QTLs, and that studying these changes will provide opportunities for efficient and uniform regulatory oversight.

Another commenter states that the suggestion that TDI should wait for forthcoming guidance before requiring insurers to submit parity compliance analyses is a "red herring." The commenter notes that the DOL's requirements are directly aligned with TDI's proposed rule. A commenter notes that insurers have had nearly seven years to comply with the final MHPAEA rule issued in November 2013, and federal statute now requires plans to have a completed parity compliance analysis for each NQTL.

The commenter opposes delaying the adoption of rules. The commenter notes that Congress recently reinforced the stepwise approach in the Consolidated Appropriations Act of 2021. The commenter states that claims by insurers that these requirements are too burdensome or that plans should have more time to comply should be dismissed, particularly in light of the new unambiguous federal requirements and the significant harm to patients when they experience illegal discrimination in mental health and addiction coverage. Federal statute now requires plans to have a completed parity compliance analysis for each NQTL. The commenter states that if submitting these analyses to TDI now is burdensome, it raises significant questions about whether plans are currently complying with existing federal statutory and regulatory requirements.

Agency Response. TDI does not agree that it is necessary to pause or withdraw the rulemaking. Plans can comply with federal MHPAEA law and guidance while responding to the rule's required NQTL and QTL analyses. TDI sees no need to further delay implementation of HB 10. TDI has considered the most recent federal statute and guidance and has determined that the proposed rules are consistent with those requirements and will not result in duplicative efforts. TDI will closely monitor federal implementation and be ready to provide additional guidance or rulemaking as needed.

Comment. A commenter expresses concern with various theoretical possible coverages or benefits that a plan could exclude or restrict based on statutes that precede HB 10. The commenter refers specifically to the potential to exclude or restrict (1) benefits for both medical/surgical and MH/SUD treatments that result from the illegal use of a controlled substance (Insurance Code §1355.006), (2) autism coverage for people diagnosed at age 10 or older (§1355.015(a-1), (3) coverage for mental health treatment in certain types of facilities (§1355.106), and (4) changes to the plan benefit intended to avoid the intent of HB 10.

Agency Response. TDI declines to make changes to the proposed rule in response to the comment. Insurance Code Chapter 1355, Subchapter F, supersedes provisions in other parts of the Insurance Code to the extent that those other provisions authorize a limitation that violates parity requirements, including Insurance Code §§ 1355.006, 1355.015(a-1), and 1355.106 as previously referenced by a commenter. This coordination is addressed in §21.2403.

Comment on rule proposal cost note

Comment. A commenter states that its member stakeholders think that TDI's estimates of programmer and programming supervisor costs are very low.

Agency Response. TDI declines to republish the rule proposal and modify the cost note. The salary data used by TDI in its rule proposal came from the DOL's Occupational Employment and Wage Statistics webpage. However, TDI acknowledges that regulated industry and affected stakeholders may have more applicable cost information. TDI sought general stakeholder involvement and specific cost note input prior to proposal, when the initial rule draft was posted on TDI's website for stakeholder review and

comment, and all information that TDI received was considered in drafting this rulemaking, including the cost note.

Comments on Division 1

Comments on §21.2406

Comment. A commenter states concerns related to the definition of "applied behavior analysis" in §21.2406. The commenter states that the definition is inaccurate.

Agency Response. TDI agrees to make a change. The definition as proposed mirrored the definition of "applied behavior analysis" in 28 TAC §21.4402, in the rules for autism spectrum disorder coverage. This definition was based on Tricare's usage. Subsequent to that rule adoption, Senate Bill 589, 85th Legislature, 2017, added a provision for the practice of applied behavior analysis in Occupations Code §506.003. TDI changes the definition as proposed to refer to this meaning.

Comment. A commenter states concerns related to the definition of "denial" in §21.2406. The commenter states that this definition combines claim denials and utilization review denials, which are not the same and should not be combined for reporting purposes. The commenter also requests that the rule clarify that administrative denials apply to claims only and not utilization review processes.

Agency Response. TDI declines to make a change to the definition of "denial." The data collection specifically separates data collected about adverse determinations and administrative denials. There is no field that calls for combining those numbers. The definition is instead relevant for other parts of the rule that speak broadly about both

types of denials. TDI agrees that an administrative denial applies only to claims, and it has modified the definition of "administrative denial" as proposed to make this clarification.

Comment. A commenter states concerns related to the definition of "peer-to-peer review or physician-to-physician review" in §21.2406. The commenter requests that the definition be clarified to acknowledge that a peer-to-peer conversation is not required. The commenter notes that statute requires that the health plan must provide a reasonable opportunity for such a discussion but has no control over whether the requesting provider avails itself of the opportunity.

Agency Response. TDI agrees that statute and rules do not require a peer-to-peer review or physician-to-physician review to have occurred, and it has modified the definition as proposed to change "must" to "may." Consistent with 28 TAC §19.1711, relating to written procedures for appeal of adverse determination, the utilization review must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with the physician, and TDI assumes that the opportunity is provided in each case. The intention of the rule is to collect data on how frequently the peer-to-peer review actually occurs.

Comment. A commenter objects to the definition of "plan documents" in §21.2406. The commenter contends that including provider contracts and manuals within this definition is incorrect. The commenter states that those documents are not plan documents that affect the benefits provided to enrollees.

Agency Response. TDI disagrees and declines to make a change. Provider contracts and manuals reflect what providers must do to provide covered services. These documents

may include NQTLs and affect the quality and scope of networks, and therefore are relevant to assessing parity. The DOL's MHPAEA Self-Compliance Tool specifically states, "NOTE: NQTLs may also be included in other documents, such as internal guidelines or provider contracts."

TDI understands that plans may have confidentiality and market competition concerns, and TDI notes that information held by TDI is subject to the statutory confidentiality protections afforded by Government Code Chapter 552, including §552.110, concerning Confidentiality of Trade Secrets and Certain Commercial or Financial Information.

Comment. A commenter recommends a change to the definition of "reported claims" in §21.2406. The commenter asks that claims be reported based on claim processing date. The commenter represents that until a claim has been processed, health plan systems do not include the data needed for reporting.

Agency Response. The purpose of the data collection is to receive data for a consistent reporting period using a consistent methodology. Using the claim processing date rather than the claim reported date could skew the data because of different issuers' claim payment practices. Texas requires prompt payment of claims, and issuers report prompt pay data based on the date that claims are received.

However, TDI has revised the definition as proposed to clarify that reported claims are those received by the issuer in a year, and to allow issuers to omit data for any claim that is still pending at the time data is submitted. TDI understands concerns regarding sufficient time for claims processing and has adjusted the data collection due date to July 1 for claims received by December 31 of the previous calendar year.

Comments on §21.2412

Comment. A commenter asks for confirmation that the proposed rule does not apply to Medicaid plans.

Agency Response. TDI affirms that the proposed rule does not apply to Medicaid plans.

Comment. A commenter questions whether §21.2412 should be adopted as proposed. The commenter states that Insurance Code Chapter 1355 does not have an increased cost exemption, and that proposed §21.2412 is not grounded in statute and is contrary to the public policy in HB 10. The commenter states that there is concern about unforeseen consequences of the provision. The commenter recommends rule adoption without the exemption, and to allow insurers to provide information to TDI on any cost increase that the commenter believes may justify future legislative consideration of an exemption.

Agency Response. TDI agrees and withdraws §21.2410 and §21.2412.

Comments on Division 2

Comment on §21.2421

Comment. A commenter states concerns related to the definition of "emergency care" in §21.2421. The commenter objects to including services provided in an ambulance in the definition. The commenter notes that most plans subject to the proposed rules are likely HMOs regulated by Insurance Code Chapter 843, or PPOs regulated by Chapter 1301. Because ambulance services are not included in the meaning of "emergency care" under

Chapters 843 and 1301, TDI would be exceeding its statutory authority in applying the proposed definition to those plans.

Agency Response. TDI declines to make changes to the proposed rule in response to the comment. TDI agrees that ambulance transportation and services are generally excluded from the definitions of emergency care in Insurance Code Chapters 843 and 1301. However, not all plans subject to the rule are governed under Insurance Code Chapters 843 or 1301. Inclusion of ambulance services within the definition is for data collection purposes. The intent of the inclusion of emergency ambulance services is to identify whether disparities exist that would demonstrate a lack of parity. A more in-depth parity analysis may be warranted, for example, if a health plan denies claims or utilization requests for emergency care more frequently for mental health emergencies as compared with medical emergencies.

Comment on §21.2422

Comment. A commenter objects to having to report on June 1, 2021. The commenter states that health plans will need more time for necessary computer programming and related tasks in order to prepare these reports for submission to TDI. The commenter requests that TDI delay the due date for this report for 2021 and suggests that health plans be given six months from the effective date of the rule.

Agency Response. TDI agrees and has made changes to the proposed text. Data for calendar year 2020 will be due December 1, 2021. In future years, data for the previous calendar year will be due July 1.

Comment on §21.2425

Comment. A commenter requests that plans be allowed to report the total number of office visits and all other subclassifications together. The commenter states that it is administratively challenging to separate out these subclassifications for MH/SUD services.

Agency Response. TDI declines to make changes to the proposed rule in response to the comment. Billing codes (such as Current Procedural Terminology codes) will allow issuers to distinguish between office visits and other types of outpatient services. Collecting data separately for office visits and all other outpatient services is necessary to ensure consistent data and accommodate issuers' ability to choose to subclassify under §21.2408(c)(3)(C) for the purposes of parity compliance.

Comments on §21.2426

Comment. A commenter states that the proposed section's title is confusing because it refers only to "utilization review," while requiring the reporting of aggregate claim and utilization review data. The commenter requests clarification on whether the intent is to capture claims data for services provided or for prior authorization requests and outcomes only.

Agency Response. TDI agrees and makes changes to the rule text as proposed to clarify that the data collection requires both claims and utilization review data. In addition, the rule section heading as adopted is renamed to be "Claims and Utilization Review: Aggregate Data Fields." TDI also makes conforming changes to the name of the worksheet and the title for §21.2425, "Claims and Utilization Review: Reporting Classifications." These changes more accurately reflect the scope of the data; the first five rows of the worksheet under §21.2426(1) require claims data, while the subsequent rows under §21.2426(2) - (4) require utilization review data.

Comment. A commenter asserts that the rule requires reporting of "administrative UR denials," while TDI has made clear that such denials are not permitted. The commenter states that if a utilization review request was insufficient, then an adverse determination has occurred, triggering appeal requirements. The commenter notes that plans do not track administrative denials of a utilization review separately from adverse determinations because they are not treated differently.

Agency Response. TDI agrees that an administrative denial is not permitted for a utilization review request and believes the commenter misunderstood the data being requested on administrative denials. Under §21.2426(1)(D), issuers must report "the number of reported claims for services or benefits that have been provided . . . that were administratively denied." TDI has modified the section headings as proposed to clarify that claims data, in addition to utilization review data, is being requested.

Comment. A commenter objects to being required to categorize emergency care into either medical/surgical or MH/SUD categories. The commenter represents that the emergency category should be combined for medical/surgical and MH/SUD claims, since it is difficult to determine whether emergency care was for medical or behavioral conditions. The commenter suggests either deletion of this category or that TDI provide additional guidance on this required categorization.

Agency Response. TDI declines to make changes to the proposed rules in response to the comment. In accordance with §21.2425, plans will use ICD diagnosis codes to distinguish between medical/surgical and MH/SUD categories. Since standardized claim

forms include a field for ICD diagnosis codes to be identified, this information should be readily available in issuers' claim data.

Comment. A commenter objects to the requirement to segregate data by age bands. The commenter states that this requirement is not authorized by the MHPAEA or state law and creates an additional and unnecessary administrative burden for health plans.

Agency Response. TDI declines to make changes to the proposed rule in response to the comment. TDI collected this information in the previous data collection for HB 10, and health plans were able to provide the requisite breakdowns. Previous analyses have demonstrated that this information can highlight significant disparities and aid in parity compliance and enforcement. TDI disagrees that state law does not authorize this requirement. Age band inclusion will help TDI pinpoint specific areas where disparities exist and more efficiently direct resources for parity investigations. It has already proven to be useful to TDI in evaluating plan compliance with the MH/SUD coverage requirements in Insurance Code Chapter 1355, as required by §1355.255.

Comment. A commenter objects to the collection of data on the number of adverse determinations that were internally appealed that "then received a peer-to-peer or physician-to-physician review." The commenter notes that an appeal does not require an opportunity for a peer-to-peer discussion; rather, an opportunity must be provided prior to adverse determination. The commenter also requests additional guidance to clarify the meaning of a peer-to-peer review.

Agency Response. TDI declines to make changes to the proposed data collection in response to the comment, but has modified the proposed definition of "peer-to-peer

review or physician-to-physician review" to clarify the meaning. TDI disagrees that an opportunity for a peer-to-peer review is not required in the context of an internal appeal. In the example of a prior authorization, an opportunity for a peer-to-peer review must be provided before the plan may issue an adverse determination denying the prior authorization. If that initial adverse determination is appealed, the plan can either reverse the initial determination and approve the care or uphold the original decision and issue an adverse determination. Before issuing an adverse determination, the plan must again provide an opportunity for a peer-to-peer review, consistent with Insurance Code §4201.456 and 28 TAC §19.1710. The data requested is for the number of peer-to-peer reviews that actually occur, recognizing that issuers are required to offer them in every case before issuing an adverse determination.

Comment. A commenter objects to reporting of administrative claim denials as part of the data reporting. The commenter states that an administrative claim denial has nothing to do with prior authorization, utilization review, or medical necessity in general. The commenter strongly recommends that the rule not include this reporting category.

Agency Response. TDI declines to make changes to the proposed rules in response to this comment. TDI agrees that an administrative denial is not relevant or permitted in the context of a request for utilization review. Rather, this data is requested only in the context of claims. The data collected on administrative claim denials is relevant for understanding potential parity issues.

Comment on §21.2427

Comment. A commenter requests that TDI pre-populate the reporting forms with the appropriate Medicare reimbursement rate. The commenter states this would save administrative resources and expenses for health plans.

Agency Response. In response to comment, TDI has pre-populated the reporting forms with the appropriate Medicare reimbursement rate for calendar year 2020. Issuers are not responsible under §21.2427 for reporting the appropriate Medicare reimbursement rate. The percentages of Medicare are calculated by the form.

Comments on Division 3

Comment. Two commenters suggest that TDI use the existing NAIC Market Conduct Annual Statement compliance tool. A commenter states that since this tool has already been thoroughly vetted and operationalized, it should be used in lieu of the proposed compliance analysis. The commenter believes this would serve as an effective vehicle for data collection and both commenters state the NAIC tool allows for a more useful baseline of standardized data elements for TDI.

Agency Response. TDI declines to make changes to the proposed rules in response to the comment. TDI has considered the NAIC Market Regulation Handbook, but the tools adopted in Division 3 are more thorough and will better ensure compliance with parity requirements.

Comment. One commenter strongly supports the required NQTL compliance analyses and highlights the importance of determining compliance prospectively. The commenter

also requests that TDI better ensure transparency by requiring compliance analyses to be submitted to TDI and made available to the public.

Agency Response. TDI declines to make a change to the proposed rule. Under §21.2431, issuers must provide their compliance analyses upon request. Information held by TDI will be managed consistent with existing statutes, including Government Code Chapter 552.

Comment on §21.2431

Comment. A commenter is concerned that issuers' use of alternative tools for quantitative and nonquantitative analyses will result in the receipt of inconsistent, incomplete, and potentially nonresponsive information. The administrative burden for TDI will also be greatly increased by having to examine analyses, provided through alternative tools, to determine whether those analyses yield information that is specific enough and consistent with the templates, and potentially requiring issuers to resubmit such analyses according to the templates provided. The commenter recommends that issuers be required to use the templates and associated technical instructions published on TDI's website for all quantitative and nonquantitative analyses, as is required for data collection and reporting, and that the option to use alternative tools be removed.

Agency Response. TDI declines to make a change to the proposed rule. When TDI requests an issuer's compliance analyses, staff will evaluate the issuer's tool and confirm that it uses the correct methodology, provides the same level of specificity, and includes all required information, consistent with TDI's QTL and NQTL templates.

Comment on §21.2434

Comment. A commenter objects to having to report separately by market and plan type and strongly recommends that the rules require reporting by legal entity. The commenter represents that this level of collection is prevalent in other states. The commenter states that the level of detailed reporting is overly granular, causing plans with low membership to yield statistically insignificant data.

Agency Response. TDI declines to make changes to the proposed rule in response to comment. However, TDI agrees that it is more efficient for an issuer to combine reporting where applicable information is the same. Under §21.2433(c), issuers may combine the QTL analysis for any plans that have the same plan design and identify the applicable plans consistent with §21.2434(c). Under §21.2438, issuers may complete a single analysis for multiple plans that contain an identical set of NQTLs and identify the applicable plans consistent with §21.2440(c).

Comment on §21.2435

Comment. A commenter requests clarification on whether there is a required review period for claims or other past data under Division 3. If a particular review period is required, the commenter recommends that it be the prior calendar year.

Agency Response. TDI declines to make changes to the proposed rule in response to comment. TDI notes that the proposed definition of "reasonable method" under §21.2406 provides guidance relevant for determining expected payments, and §21.2435(b)(2) allows for flexibility in reporting by the issuer. TDI agrees that the previous calendar year is appropriate if there is sufficient data at the time the issuer is completing the analysis.

Comment on §21.2436

Comment. A commenter recommends that the rule allow health plans to create their own covered benefits list, rather than being held to the specific proposed list.

Agency Response. TDI agrees with the comment but does not make a change to the proposed text or worksheet. The template for covered benefits is blank. Consistent with §21.2436(b), issuers are able to create their own list.

Comment on §21.2439

Comment. A commenter requests clarification that the list of illustrative examples of NQTLs does not require reporting for each of the examples listed.

Agency Response. TDI declines to make changes to the proposed rule in response to comment. The illustrative examples are a non-exhaustive list of NQTLs that are commonly applied. Section 21.2441 makes clear that plans are required to provide the analysis for each NQTL contained in the plan documents.

Comment on §21.2441

Comment. A commenter recommends that the proposed rules be amended to require issuers to identify "all" factors considered or "each" factor considered in the design of the NQTL. The commenter states that issuers often only identify a single factor or example of factors considered.

Agency Response. TDI agrees and has made a change to the proposed text of §21.2441 in response to comment. As adopted, §21.2441(c) states, "Step 2. Within the NQTL Template, in each classification or subclassification worksheet, an issuer must identify each factor considered in the design and application of the NQTL. Illustrative examples of

factors are provided in the NQTL template." This change will provide additional clarification.

Comments on Division 4

Comment. An individual expresses concern that including autism spectrum disorder regulations in a rule that also addresses substance use disorder may give the impression that ASD is an acquired condition.

Agency Response. HB 10 requires issuers to 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. The protections apply to all types of mental health conditions, including ASD. TDI agrees that ASD is not an acquired condition, and that insurance coverage is important for helping people with ASD receive the services they need to achieve their full potential.

Comment on §21.2453

Comment. A commenter objects to the proposed text of §21.2453 to the extent that it does not fully capture existing law in Insurance Code §1355.015(b). The commenter states that the proposed language in §21.2453 appears to address only the requirements of §1355.015(b)(1) and (2), and that this could unintentionally be interpreted to remove the important role of the primary care physician. The commenter provides alternate language for TDI to consider.

Agency Response. TDI declines to adopt the specific language suggested. However, TDI has withdrawn proposed §21.2453. The proposed rule revision was intended to clarify that

an applied behavior analyst could provide services, but this was superseded by Occupations Code Chapter 506, concerning Behavior Analysts, which was enacted in 2017. Not adopting the proposed amendments to this section ensures that the rule does not depart from statute.

SUBCHAPTER P. MENTAL HEALTH PARITY
REPEAL OF 28 TAC §§21.2401 - 21.2407

STATUTORY AUTHORITY. The Commissioner adopts the repeal of 28 TAC Subchapter P, §§21.2401 - 21.2407, under Insurance Code §§1355.257, 1355.258, and 36.001.

Insurance Code §1355.257 provides that Chapter 1355, Subchapter F, supplements Subchapters A and B of that chapter, and Chapter 1368, and the rules adopted under those statutes. Insurance Code §1355.257 also provides that the legislature intends that Subchapter A or B of Insurance Code Chapter 1355, Chapter 1368, or a department rule adopted under those statutes, controls over Subchapter F in any circumstance in which those statutes or rules require a benefit that is not required by Subchapter F, or require a more extensive benefit than is required by Subchapter F.

Insurance Code §1355.258 states that the Commissioner is to adopt rules necessary to implement Chapter 1355, Subchapter F.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

SUBCHAPTER P. MENTAL HEALTH PARITY

SUBCHAPTER JJ. AUTISM SPECTRUM DISORDER COVERAGE
REPEAL OF DIVISION 1. GENERAL PROVISIONS
28 TAC §§21.4401 - 21.4404

STATUTORY AUTHORITY. The Commissioner adopts the repeal of 28 TAC Subchapter JJ, §§21.4401 - 21.4404, under Insurance Code §§1355.257, 1355.258, and 36.001.

Insurance Code §1355.257 provides that Chapter 1355, Subchapter F, supplements Subchapters A and B of that chapter, and Chapter 1368, and the rules adopted under those statutes. Insurance Code §1355.257 also provides that the legislature intends that Insurance Code Chapter 1355's Subchapter A or B, Chapter 1368, or a department rule adopted under those statutes, control over Subchapter F in any circumstance in which those statutes or rules require a benefit that is not required by Subchapter F, or require a more extensive benefit than is required by Subchapter F.

Insurance Code §1355.258 states that the Commissioner may adopt rules necessary to implement Chapter 1355, Subchapter F.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

SUBCHAPTER JJ. AUTISM SPECTRUM DISORDER COVERAGE

DIVISION 1. GENERAL PROVISIONS

§21.4401. Purpose and Applicability.

§21.4402. Definitions.

§21.4403. Required Coverage.

§21.4404. Health Care Practitioners.

SUBCHAPTER P. MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY
DIVISION 1. GENERAL PROVISIONS AND PARITY REQUIREMENTS
28 TAC §§21.2401 – 21.2409, 21.2411, 21.2413, and 21.2414

STATUTORY AUTHORITY. The Commissioner adopts §§21.2401 - 21.2414 under Insurance Code §§1355.255, 1355.257, 1355.258, and 36.001.

Insurance Code §1355.255 directs the Commissioner to enforce compliance with §1355.254 by evaluating the benefits and coverage offered by a plan for quantitative and nonquantitative treatment limitations.

Insurance Code §1355.257 provides that Chapter 1355, Subchapter F, supplements Subchapters A and B of that chapter, and Chapter 1368, and the rules adopted under those statutes. Insurance Code §1355.257 also provides that the legislature intends that Insurance Code Chapter 1355's Subchapter A or B, Chapter 1368, or a department rule

adopted under those statutes, control over Subchapter F in any circumstance in which those statutes or rules require a benefit that is not required by Subchapter F, or require a more extensive benefit than is required by Subchapter F.

Insurance Code §1355.258, addressing coverage for mental health conditions and substance use disorders, states that the Commissioner shall adopt rules necessary to implement Chapter 1355, Subchapter F.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§21.2401. Purpose and Scope.

This subchapter provides rules to interpret, implement, and enforce Insurance Code Chapter 1355, Subchapter F, concerning Coverage for Mental Health Conditions and Substance Use Disorders. Except as identified in §21.2404 of this title (relating to Differences from Federal Rules), these rules are intended to be consistent with the Insurance Code and to closely track the federal rules found at 45 CFR §146.136 (concerning Parity in Mental Health and Substance Use Disorder Benefits), 45 CFR §146.121(b)(2)(iii) (concerning Prohibiting Discrimination Against Participants and Beneficiaries Based on a Health Factor), and 45 CFR §147.160 (concerning Parity in Mental Health and Substance Use Disorder Benefits) as published in the *Federal Register*, Vol. 78, No. 219 on November 13, 2013.

§21.2402. Applicability.

(a) Plans subject to this subchapter. This subchapter applies to all health benefit plans subject to Insurance Code Chapter 1355, Subchapter F, concerning Coverage for Mental Health Conditions and Substance Use Disorders. Health benefit plans subject to Insurance Code Chapter 1355, Subchapter F, are plans that provide benefits or coverage for treatment expenses incurred as a result of a mental health condition or offer mental health or substance use disorder benefits, whether as mandatory coverage under Insurance Code Chapter 1355, concerning Benefits for Certain Mental Disorders, or under another Insurance Code chapter, or as optional coverage (for instance, in an individual short-term limited duration plan).

(b) Excepted plans. This subchapter does not apply to a plan that is excepted from:

(1) Insurance Code Chapter 1355, Subchapter F, as identified in Insurance Code §1355.253, concerning Exceptions; or

(2) Insurance Code Chapter 1425, concerning Application of Subtitle to Certain Coverage, as identified in Insurance Code §1425.001, concerning Exemption from Application of Subtitle.

§21.2403. Coordination of Statutory Language.

Restrictions on coverage limitations. If a provision of the Insurance Code or Texas Department of Insurance regulations allows a health benefit plan issuer to place quantitative or nonquantitative treatment limitations on coverage for mental health and substance use disorder conditions, an issuer may apply the limitation only to the extent that the limitation does not violate the parity requirements of Insurance Code Chapter 1355, Subchapter F, concerning Coverage for Mental Health Conditions and Substance Use Disorders, and this subchapter.

§21.2404. Differences from Federal Rules.

(a) Global substitution of terms. This subchapter substitutes the following terms for terms used in 45 CFR §146.136 (concerning Parity in Mental Health and Substance Use Disorder Benefits) with no change in meaning:

(1) the term "enrollees" is substituted for the term "participants and beneficiaries";

(2) the term "health benefit plan" is substituted for the terms "group health plan" (or health insurance coverage offered in connection with such plans) and "plan or coverage"; and

(3) the terms "requirement" or "requirements" are substituted for the terms "rule" or "rules."

(b) Omission of federal provisions. The following federal provisions are not duplicated in this division either because they were superseded by a later federal rule or there is no analogous Texas law, or because they are otherwise captured in this subchapter:

(1) 45 CFR §146.136(b)(1)(ii), which addresses exemptions;

(2) 45 CFR §146.136(c)(5), which addresses exemptions;

(3) 45 CFR §146.136(f), which addresses small employer exemption; and

(4) 45 CFR §146.136(g), which addresses increased cost exemption.

(c) Substitutions for federal provisions. Where a state requirement exists, a corresponding but incongruent federal provision has been omitted. Specifically, §21.2411 of this title (relating to Availability of Plan Information) replaces the federal provision at

45 CFR §146.136(d)(2), which addresses reason for any denial. In addition, a portion of 45 CFR §146.136(d)(3), which addresses provisions of other law, has been omitted.

§21.2405. Corrective Action; Severability.

(a) The department may require the issuer to:

(1) submit a corrective action plan to correct deficiencies in the issuer's submissions and analyses under Divisions 2 and 3 of this subchapter. The corrective action plan will specify the actions the issuer will take to comply with this subchapter; or

(2) notify all individuals enrolled in the applicable plan or plans that such coverage does not comply with this subchapter; or

(3) a combination of the actions described in paragraphs (1) and (2) of this subsection.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

§21.2406. Definitions.

Definitions. For purposes of this subchapter, the following terms have the meanings indicated, except where the context clearly indicates otherwise:

(1) Administrative denial--A denial of a claim that is not an adverse determination, including, but not limited to, denials of claims for noncovered benefits, duplicate claims, incorrect billing, and because an individual is not an enrollee.

(2) Adverse determination--A determination by a health benefit plan or utilization review agent that health care services or benefits provided or proposed to be provided to an enrollee are not medically necessary, appropriate, or are experimental or investigational. Consistent with Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, the following are adverse determinations:

(A) a denial of a fail-first (or step therapy) protocol exception request; and

(B) an issuer's refusal to treat the drug as a covered benefit, if an enrollee's physician has determined that a drug is medically necessary and the drug is not included in the enrollee's plan formulary.

(3) Aggregate lifetime dollar limit--A dollar limitation on the total amount of specified benefits that may be paid under a health benefit plan for any coverage unit.

(4) Allowed amount--The dollar amount covered under the plan for a particular service or benefit, including the amount of cost sharing owed by the enrollee and the amount to be paid by the plan. This term refers both to the contracted amount for in-network services or benefits and the amount designated by the plan for out-of-network services or benefits.

(5) Annual dollar limit--A dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health benefit plan for any coverage unit.

(6) Applied behavior analysis--the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant

improvements in human behavior that is consistent with the practice of applied behavior analysis as addressed in Occupations Code §506.003.

(7) Approved claim--A claim for a service or benefit that is determined, at initial review or upon receipt of additional information, to be covered and payable at the plan's allowed amount.

(8) Concurrent review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(9) Coverage unit--Coverage unit as described in §21.2408(a)(4) of this title (relating to Parity Requirements with Respect to Financial Requirements and Treatment Limitations).

(10) Cumulative financial requirements--Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. Cumulative financial requirements do not include aggregate lifetime or annual dollar limits.

(11) Cumulative quantitative treatment limitations--Treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. The term includes a deductible, a copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

(12) Denial--An administrative denial or an adverse determination.

(13) Fail-first or step therapy--A treatment protocol that requires an enrollee to use a prescription drug or sequence of prescription drugs other than the drug that the enrollee's physician recommends for the enrollee's treatment before the health benefit plan provides coverage for the recommended drug.

(14) Financial requirements--Plan deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

(15) Health benefit plan or plan--A plan that is subject to Insurance Code Chapter 1355, Subchapter F, concerning Coverage for Mental Health Conditions and Substance Use Disorders.

(16) Independent review--A system for final administrative review by an independent review organization (IRO) of an adverse determination regarding the medical necessity, the appropriateness, or the experimental or investigational nature of health care services or benefits.

(17) Individual market--Health benefit plans subject to Insurance Code Chapter 1355, Subchapter F, that are bought on an individual or family basis in which the contract holder is also personally enrolled under the plan, other than in connection with a group health plan.

(18) Internal appeal--A formal process by which an enrollee, an individual acting on behalf of an enrollee, or an enrollee's provider of record may request reconsideration of an adverse determination.

(19) Large group market--Health benefit plans subject to Insurance Code Chapter 1355, Subchapter F, that are sold to groups that have 51 or more members, whether through an employer or through an association.

(20) Market type--Individual, small group, or large group market.

(21) Medical or surgical (medical/surgical) benefit--A benefit with respect to an item or service for medical conditions or surgical procedures, as defined under the terms of the health benefit plan and in accordance with applicable federal and state law,

but does not include mental health or substance use disorder benefits. Any condition defined by a plan as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most recent edition of the ICD or state guidelines).

(22) Mental health benefit--A benefit with respect 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. Any condition defined by a health benefit plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the most recent edition of the ICD, or state guidelines).

(23) NQTL--Nonquantitative treatment limitation.

(24) Peer-to-peer review or physician-to-physician review--A utilization review process that may occur before an adverse determination is issued by a utilization review agent, consistent with Insurance Code §4201.206, concerning Opportunity to Discuss Treatment Before Adverse Determination.

(25) Plan design--A plan's discrete package of benefits, cost-sharing structure, provider network, plan type, quantitative treatment limitations, and nonquantitative treatment limitations.

(26) Plan documents--All instruments under which a plan is established or operated, including, but not limited to, policies, certificates of coverage, contracts of insurance, evidences of coverage, provider contracts, provider manuals, internal guidelines and procedures, medical guidelines, and other documents used in making claims determinations and conducting utilization reviews. Instruments under which the

plan is established or operated includes the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation (NQTL) with respect to medical/surgical benefits and mental health/substance use disorder (MH/SUD) benefits under the plan.

(27) Plan type--A preferred provider organization (PPO) plan, exclusive provider organization (EPO) plan, health maintenance organization (HMO) plan, health maintenance organization-point of service (HMO-POS) plan, and indemnity policy.

(28) Preauthorization or prior authorization--A utilization review process in which an issuer conditions coverage of a health care service, benefit, or prescription drug on the issuer's approval of the provider's request to provide an enrollee the service, benefit, or drug. For purposes of this rule:

(A) preauthorization includes reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed;

(B) preauthorization does not include utilization review needed to reauthorize ongoing services or benefits (concurrent review); and

(C) a request for preauthorization is one received during the reporting period, regardless of the date the claim is incurred.

(29) Prescription drugs--Drugs covered under a plan's prescription drug benefit.

(30) QTL--Quantitative treatment limitation.

(31) Reasonable method--To determine the dollar amount or the per member per month amount of plan payments for the substantially all or predominant analyses required by §21.2408 of this title, reasonable methods are:

(A) a projection based on claims data for the plan or the plan design, if there is sufficient claims data for a reasonable projection of future claims costs; or

(B) a projection based on appropriate and sufficient data (such as data from other similarly structured plans with similar demographics) to perform the analysis in compliance with applicable Actuarial Standards of Practice set by the Actuarial Standards Board if:

(i) there is not enough claims data;

(ii) the plan significantly changed its benefit package;

(iii) the plan experienced a significant workforce change that would impact claims costs; or

(iv) the group health plan (or the plan design) is new.

(32) Reported claims--Claims that are received by an issuer in a year, regardless of the incurred date, the final decision date, or a claim's pending status. For example, claims reported in 2020 could include claims incurred in 2019, claims with final decisions made in the first few months of 2020, or claims awaiting a determination.

(33) Retrospective review--The process of reviewing the medical necessity and reasonableness of health care that has been provided to an enrollee.

(34) Small group market--Health benefit plans subject to Insurance Code Chapter 1355, Subchapter F, that are sold to groups that have at least two but no more than 50 members.

(35) Substance use disorder benefit--A benefit with respect to an item, treatment, 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. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be

consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most recent edition of the ICD, or state guidelines).

(36) Treatment limitations--This term includes limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan. (An illustrative list of NQTLs is provided in §21.2409(b) of this title (relating to Nonquantitative Treatment Limitations).) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

(37) Utilization review--A system for prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care services or benefits and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services or benefits. The term does not include a review in response to an elective request for clarification of coverage.

§21.2407. Parity Requirements with Respect to Aggregate Lifetime and Annual Dollar Limits.

This section details application of the parity requirements under this subchapter with respect to aggregate lifetime and annual dollar limits that may be permitted by state or federal law.

(1) General parity requirement. A health benefit plan that provides both medical/surgical benefits and MH/SUD benefits must comply with paragraph (2), (3), or (5) of this section, as applicable.

(2) Plan with no limit or limits on less than one-third of all medical/surgical benefits. If a health benefit plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) Plan with a limit on at least two-thirds of all medical/surgical benefits. If a health benefit plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either:

(A) apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to MH/SUD benefits in a manner that does not distinguish between the medical/surgical benefits and MH/SUD benefits; or

(B) not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (Some cumulative financial requirements and cumulative quantitative treatment limitations other than aggregate lifetime or annual dollar limits are prohibited in §21.2408 of this title (relating to Parity Requirements with Respect to Financial Requirements and Treatment Limitations).)

(4) Determining one-third and two-thirds of all medical/surgical benefits. For purposes of this section, the determination of whether the portion of medical/surgical

benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(5) Plan not described in paragraph (2) or (3) of this section.

(A) In general. A health benefit plan that is not described in paragraph (2) or (3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either:

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

(ii) impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. 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 this clause. In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately designated dollar limit under the plan are taken into account

as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(B) Weighting. For purposes of this paragraph, the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (4) of this section for determining one-third or two-thirds of all medical/surgical benefits.

§21.2408. Parity Requirements with Respect to Financial Requirements and Treatment Limitations.

(a) Clarification of terms.

(1) Classification of benefits. When reference is made in this subchapter to a classification of benefits, the term "classification" means a classification as described in subsection (b)(2) of this section.

(2) Type of financial requirement or treatment limitation. When reference is made in this subchapter to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. An illustrative list of nonquantitative treatment limitations is provided in §21.2409(b) of this title (relating to Nonquantitative Treatment Limitations).

(3) Level of a type of financial requirement or treatment limitation. When reference is made in this subchapter to a level of a type of financial requirement or treatment limitation, "level" refers to the magnitude of the type of financial requirement

or treatment limitation. For example, different levels of coinsurance include 20% and 30%, different levels of a copayment include $15 and $20, different levels of a deductible include $250 and $500, and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(4) Coverage unit. When reference is made in this subchapter to a coverage unit, "coverage unit" refers to the way in which a health benefit plan groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

(b) General parity requirement.

(1) General requirement. A health benefit plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. 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 application of the requirements of this subsection to financial requirements and quantitative treatment limitations is addressed in subsection (c) of this section; the application of the requirements of this subsection to nonquantitative treatment limitations is addressed in §21.2409 of this title.

(2) Classifications of benefits used for applying requirements.

(A) In general. If a health benefit plan provides mental health or substance use disorder benefits in any classification of benefits described in this subparagraph, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a health benefit plan must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a health benefit plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the requirements of this subsection apply separately with respect to that classification for all financial requirements or treatment limitations (illustrated in examples in paragraph (2)(C) of this subsection). The following classifications of benefits are the only classifications used in applying the requirements of this subsection:

(i) An "inpatient, in-network" classification is for benefits furnished on an inpatient basis and within a network of providers established or recognized under a health benefit plan. Special requirements for plans with multiple network tiers are addressed in subsection (c)(3) of this section.

(ii) An "inpatient, out-of-network" classification is for benefits furnished on an inpatient basis and outside any network of providers established or recognized under a health benefit plan. This classification includes inpatient benefits under a health benefit plan that has no network of providers.

(iii) An "outpatient, in-network" classification is for benefits furnished on an outpatient basis and within a network of providers established or

recognized under a health benefit plan. Special requirements for office visits and plans with multiple network tiers are addressed in subsection (c)(3) of this section.

(iv) An "outpatient, out-of-network" classification is for benefits furnished on an outpatient basis and outside any network of providers established or recognized under a health benefit plan. This classification includes outpatient benefits under a health benefit plan that has no network of providers. Special requirements for office visits are addressed in subsection (c)(3) of this section.

(v) An "emergency care" classification is for benefits for emergency care.

(vi) A "prescription drug" classification is for benefits for prescription drugs. See special requirements for multi-tiered prescription drug benefits in paragraph (c)(3) of this section.

(B) Application to out-of-network providers. Application to out-of-network providers is addressed in subparagraph (A) of this paragraph, under which a health benefit plan that provides mental health or substance use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided, including out-of-network classifications.

(C) Examples. The requirements of this paragraph are illustrated by examples provided in the figure §21.2408(b)(2)(C). In each example, the health benefit plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Figure: 28 TAC §21.2408(b)(2)(C)

Example 1

Facts. A health benefit plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a $500 deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

Conclusion. In this example, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the requirements of this section apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

Example 2

Facts. A plan imposes a $500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20% coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency care, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

Conclusion. In this example, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the requirements of this section apply with respect to the deductible and the coinsurance across all benefits.

Example 3

Facts. Same facts as Example 2, except the plan exempts emergency care benefits from the 20% coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

Conclusion. In this example, because the plan imposes separate financial requirements based on classifications, the requirements of this section apply with respect to the deductible and the coinsurance separately for:

(I) benefits in the emergency care classification, and

(II) all other benefits.

Example 4

Facts. Same facts as Example 2, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

Conclusion. In this example, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the requirements of this section apply with respect to the deductible and coinsurance separately for:

(I) inpatient, out-of-network benefits; and

(II) all other benefits.

(c) Financial requirements and quantitative treatment limitations.

(1) Determining "substantially all" and "predominant."

(A) Substantially all. For purposes of this section, a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of

all medical/surgical benefits in that classification. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) Predominant.

(i) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under subparagraph (A) of this paragraph, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

(ii) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the

classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) Portion based on plan payments. For purposes of this section, the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

(D) Clarifications for certain threshold requirements. For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account toward the out-of-pocket maximum, as well as all plan payments associated with out-of-pocket payments that would have been made toward the out-of-pocket maximum if it had not been satisfied.

(E) Determining the dollar amount of plan payments. Subject to subparagraph (D) of this paragraph, any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(2) Application to different coverage units. If a health benefit plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

(3) Special requirements.

(A) Multi-tiered prescription drug benefits. If a health benefit plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the requirements in §21.2409(a) of this title and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the health benefit plan satisfies the parity requirements of this section with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(B) Multiple network tiers. If a health benefit plan provides benefits through multiple tiers of in-network providers (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers), the plan may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the requirements in §21.2409(a) of this title (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the subclassifications are established, the issuer may not impose any financial requirement or treatment limitation on mental health or substance

use disorder benefits in any subclassification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the subclassification using the methodology in subsection (c)(1) of this section.

(C) Subclassifications permitted for office visits, separate from other outpatient services. For purposes of applying the financial requirement and treatment limitation requirements of this section, a plan may divide its benefits furnished on an outpatient basis into the two subclassifications described in this subparagraph. After the subclassifications are established, the plan may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any subclassification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the subclassification using the methodology in paragraph (1) of this subsection. Subclassifications other than these special requirements, such as separate subclassifications for generalists and specialists, are not permitted. The two subclassifications permitted under this subparagraph are:

(i) office visits (such as physician visits), and

(ii) all other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

(4) Examples. The requirements of paragraph (3)(A) - (C) of this subsection are illustrated by examples provided in figure 28 TAC §21.2408(c)(4). In each example, the health benefit plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Figure: 28 TAC §21.2408(c)(4)

Example 1

Facts. For inpatient, out-of-network medical/surgical benefits, a health benefit plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

Coinsurance rate	0%	10%	15%	20%	30%	Total
Projected payments	$200x	$100x	$450x	$100x	$150x	$1,000x
Percent of total plan costs	20%	10%	45%	10%	15%	
Percent subject to coinsurance level	N/A	12.5% (100x/800x)	56.25% (450x/800x)	12.5% (100x/800x)	18.75% (150x/800x)	

The plan projects plan costs of $800x to be subject to coinsurance ($100x + $450x + $100x + $150x = $800x). Thus, 80% ($800x/$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25% of the benefits subject to coinsurance are projected to be subject to the 15% coinsurance level.

Conclusion. In this example, the two-thirds threshold of the substantially all standard is met for coinsurance because 80% of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15% coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15% level of coinsurance.

Example 2

Facts. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount	$0	$10	$15	$20	$50	Total
Projected payments	$200x	$200x	$200x	$300x	$100x	$1,000x
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25% (200x/800x)	25% (200x/800x)	37.5% (300x/800x)	12.5% (100x/800x)	

The plan projects plan costs of $800x to be subject to copayments ($200x + $200x + $300x + $100x = $800x). Thus, 80% ($800x/$1,000x) of the benefits are projected to be subject to a copayment.

Conclusion. In this example, the two-thirds threshold of the substantially all standard is met for copayments because 80% of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the $10 copayment, 25%; for the $15 copayment, 25%; for the $20 copayment, 37.5%; and for the $50 copayment, 12.5%). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the $50 copayment and the $20 copayment, are not more than one-

half of the outpatient, in-network medical/surgical benefits subject to a copayment because they are exactly one-half ($300x + $100x = $400x; $400x/$800x = 50%). The combined projected payments for the three highest copayment levels--the $50 copayment, the $20 copayment, and the $15 copayment--are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments ($100x + $300x + $200x = $600x; $600x/$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the $15 copayment.

Example 3

Facts. A plan imposes a $250 deductible on all medical/surgical benefits for self-only coverage and a $500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

Conclusion. In this example, because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4

Facts. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as "generic," "preferred brand name," "non-preferred brand name," or "specialty" complies with the requirements of §21.2409(a) of this title (relating to Requirements for Nonquantitative Treatment Limitations).

Tier level	Tier 1	Tier 2	Tier 3	Tier 4
Tier description	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

Conclusion. In this example, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with §21.2409(a) of this title; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this subsection.

Example 5

Facts. A plan has two tiers of network of providers: A preferred provider tier and a participating provider tier. Providers are placed in either the preferred tier or participating tier based on reasonable factors determined in accordance with the requirements in

§21.2409(a) of this title, such as accreditation, quality and performance measures (including customer feedback), and relative reimbursement rates. Furthermore, provider tier placement is determined without regard to whether a provider specializes in the treatment of mental health conditions or substance use disorders, or medical/surgical conditions. The plan divides the in-network classifications into two subclassifications (in-network/preferred and in-network/participating). The plan does not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in either of these subclassifications that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in each subclassification.

Conclusion. In this example, the division of in-network benefits into subclassifications that reflect the preferred and participating provider tiers does not violate the parity requirements of this subsection.

Example 6

Facts. With respect to outpatient, in-network benefits, a plan imposes a $25 copayment for office visits and a 20% coinsurance requirement for outpatient surgery. The plan divides the outpatient, in-network classification into two subclassifications (in-network office visits and all other outpatient, in-network items and services). The plan does not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in either of these subclassifications that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in each subclassification.

Conclusion. In this example, the division of outpatient, in-network benefits into subclassifications for office visits and all other outpatient, in-network items and services does not violate the parity requirements of this subsection.

Example 7

Facts. Same facts as Example 6, but for purposes of determining parity, the plan divides the outpatient, in-network classification into outpatient, in-network generalists and outpatient, in-network specialists.

Conclusion. In this example, the division of outpatient, in-network benefits into any subclassifications other than office visits and all other outpatient items and services violates the requirements of paragraph (3)(C) of this subsection.

(5) No separate cumulative financial requirements or cumulative quantitative treatment limitations.

(A) A health benefit plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

(B) The requirements of this paragraph are illustrated by examples provided in figure 28 TAC §21.2408(c)(5)(B).

Figure: 28 TAC §21.2408(c)(5)(B)

Example 1

Facts. A group health plan imposes a combined annual $500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

Conclusion. In this example, the combined annual deductible complies with the requirements of this paragraph.

Example 2

Facts. A plan imposes an annual $250 deductible on all medical/surgical benefits and a separate annual $250 deductible on all mental health and substance use disorder benefits.

Conclusion. In this example, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph.

Example 3

Facts. A plan imposes an annual $300 deductible on all medical/surgical benefits and a separate annual $100 deductible on all mental health or substance use disorder benefits.

Conclusion. In this example, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph.

Example 4

Facts. A plan generally imposes a combined annual $500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits subject to deductible	Total benefits	Percent subject to deductible
Inpatient, in-network	$1,800x	$2,000x	90%
Inpatient, out-of-network	$1,000x	$1,000x	100%
Outpatient, in-network	$1,400x	$2,000x	70%
Outpatient, out-of-network	$1,880x	$2,000x	94%
Emergency care	$300x	$500x	60%

Conclusion. In this example, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because, in each of those other classifications, at least two-thirds of medical/surgical benefits are subject to the $500 deductible. Moreover, the $500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the $500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.

§21.2409. Nonquantitative Treatment Limitations.

(a) General requirement. A health benefit plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the

processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

(b) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include:

(1) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) for plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(4) standards for provider admission to participate in a network, including reimbursement rates;

(5) plan methods for determining usual, customary, and reasonable charges;

(6) refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(7) exclusions based on failure to complete a course of treatment; and

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits provided under the plan or coverage.

(c) Examples. The requirements of this section are illustrated by examples provided in figure 28 TAC §21.2409(c). In each example, the health benefit plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Figure: 28 TAC §21.2409(c)(1)

Example 1

Facts. A plan requires preauthorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan.

Conclusion. In this example, the plan violates the requirements of this section because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits.

Example 2

Facts. A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60% of mental health conditions and substance use disorders, but only 30% of medical/surgical conditions.

Conclusion. In this example, the plan complies with the requirements of this section because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Example 3

Facts. A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits and uses comparable criteria in determining whether a course of treatment is medically necessary. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25% reduction in the benefits the plan would otherwise pay.

Conclusion. In this example, the plan violates the requirements of this section. Although the same nonquantitative treatment limitation--medical necessity--is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, it is not applied in a comparable way. The penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 4

Facts. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.

Conclusion. In this example, the plan complies with the requirements of this section because the processes for developing the evidentiary standards used to determine

medical appropriateness and the application of these standards to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

Example 5

Facts. A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

Conclusion. In this example, the plan violates the requirements of this section. Although the standard for applying a nonquantitative treatment limitation is the same for both mental health and substance use disorder benefits and medical/surgical benefits--whether a drug has a black box warning--it is not applied in a comparable manner. The plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 6

Facts. An employer maintains both a major medical plan and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical plan only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical plan.

Conclusion. In this example, limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this section. Because no comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

Example 7

Facts. Training and state licensing requirements often vary among types of providers. A plan applies a general standard that any provider must meet the highest licensing requirement related to supervised clinical experience under applicable state law in order to participate in the plan's provider network. Therefore, the plan requires master's-level mental health therapists to have post-degree, supervised clinical experience but does not impose this requirement on master's-level general medical providers because the scope of their licensure under applicable state law does require clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD-level psychologists since their licensing already requires supervised training.

Conclusion. In this example, the plan complies with the requirements of this section. The requirement that master's-level mental health therapists must have supervised clinical experience to join the network is permissible, as long as the plan consistently applies the same standard to all providers, even though it may have a disparate impact on certain mental health providers.

Example 8

Facts. A plan considers a wide array of factors in designing medical management techniques for both mental health and substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, preauthorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, the plan requires preauthorization for outpatient surgery; speech, occupational, physical, cognitive, and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and

clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented by the plan.

Conclusion. In this example, the plan complies with the requirements of this section. Under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits.

Example 9

Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual based on clinically appropriate standards of care.

Conclusion. In this example, the plan violates the requirements of this section. Although the same nonquantitative treatment limitation--medical appropriateness--is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Example 10

Facts. A plan generally provides coverage for medically appropriate medical/surgical benefits as well as mental health and substance use disorder benefits. The plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the state where the policy is written. There is no similar exclusion for medical/surgical benefits within the same classification.

Conclusion. In this example, the plan violates the requirements of this section. The plan is imposing a nonquantitative treatment limitation that restricts benefits based on geographic location. Because there is no comparable exclusion that applies to medical/surgical benefits, this exclusion may not be applied to mental health or substance use disorder benefits.

Example 11

Facts. A plan requires preauthorization for all outpatient mental health and substance use disorder services after the ninth visit and will only approve up to five additional visits per authorization. With respect to outpatient medical/surgical benefits, the plan allows an initial visit without preauthorization. After the initial visit, the plan preapproves benefits based on the individual treatment plan recommended by the attending provider based on that individual's specific medical condition. There is no explicit, predetermined cap on the amount of additional visits approved per authorization.

Conclusion. In this example, the plan violates the requirements of this section. Although the same nonquantitative treatment limitation--preauthorization to determine medical appropriateness--is applied to both mental health and substance use disorder benefits and medical/surgical benefits for outpatient services, it is not applied in a comparable way. While the plan is more generous with respect to the number of visits initially provided without preauthorization for mental health benefits, treating all mental

health conditions and substance use disorders in the same manner, while providing for individualized treatment of medical conditions, is not a comparable application of this nonquantitative treatment limitation.

§21.2411. Availability of Plan Information.

(a) Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a health benefit plan with respect to mental health or substance use disorder benefits must be made available by the issuer to any enrollee or contracting provider upon request, consistent with Insurance Code Chapters 843 and 1301.

(b) Reason for denial. The reason for any denial under a health benefit plan with respect to mental health or substance use disorder benefits in the case of any enrollee must be made available by the issuer in a form and manner consistent with Insurance Code §4201.303, concerning Adverse Determination: Contents of Notice.

(c) Provisions of other law. Compliance with the disclosure requirements in subsections (a) and (b) of this section is not determinative of compliance with any other provision of applicable federal or state law.

§21.2413. Sale of Nonparity Health Benefit Plans.

An issuer may not sell a health benefit plan, policy, certificate, or contract of insurance that fails to comply with §21.2407 of this title (relating to Parity Requirements with Respect to Aggregate Lifetime and Annual Dollar Limits), §21.2408 of this title (relating to Parity Requirements with Respect to Financial Requirements and Treatment Limitations), and §21.2409 of this title (relating to Nonquantitative Treatment Limitations).

§21.2414. Source-of-Injury Exclusions.

(a) No denial of benefits. If a health benefit plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

(b) Example. The requirements of subsection (a) of this section are illustrated by the example in figure 28 TAC §21.2414(b).

Figure: 28 TAC §21.2414(b).

Facts. A health benefit plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Because of depression, Individual D attempts suicide. As a result, D sustains injuries and is hospitalized for treatment of the injuries. Under the exclusion, the plan denies D benefits for treatment of the injuries.

Conclusion. In this example, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of D's injuries violates the requirements of subsection (a) of this section because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

DIVISION 2. PLAN INFORMATION AND DATA COLLECTION

28 TAC §§21.2421 - 21.2427

STATUTORY AUTHORITY. The Commissioner adopts §§21.2421 - 21.2427 under Insurance Code §§843.151, 846.005, 1202.051, 1251.008, 1271.004, 1355.257, 1355.258, 1501.010, and 36.001.

Insurance Code §843.151, addressing health maintenance organizations' group health plans, provides that the Commissioner may adopt reasonable rules as necessary and proper to meet the requirements of federal law and regulations.

Insurance Code §846.005, addressing multiple employer welfare arrangements' health benefit plans, provides that the Commissioner shall adopt rules necessary to meet the minimum requirements of federal law and regulations.

Insurance Code §1202.051, addressing individual health benefit plans, requires that the Commissioner adopt rules necessary to meet the minimum requirements of federal law, including regulations.

Insurance Code §1251.008, addressing group and blanket health benefit plans, provides that the Commissioner may adopt rules necessary to administer Chapter 1251, concerning Group and Blanket Health Insurance.

Insurance Code §1271.004, addressing health maintenance organizations' individual health care plans, provides that the Commissioner may adopt rules necessary to meet the minimum requirements of federal law, including regulations.

Insurance Code §1355.257 provides that Chapter 1355, Subchapter F, supplements Subchapters A and B of that chapter, and Chapter 1368, and the rules adopted under those statutes. Insurance Code §1355.257 also provides that the legislature intends that Insurance Code Chapter 1355's Subchapter A or B, Chapter 1368, or a department rule

adopted under those statutes, control over Subchapter F in any circumstance in which those statutes or rules require a benefit that is not required by Subchapter F, or require a more extensive benefit than is required by Subchapter F.

Insurance Code §1355.258, addressing coverage for mental health conditions and substance use disorders, requires that the Commissioner adopt rules necessary to implement Chapter 1355, Subchapter F.

Insurance Code §1501.010, addressing employers' group health plans, provides that the Commissioner may adopt rules necessary to meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§21.2421. Definitions - Division 2.

Definitions for Division 2. For purposes of Division 2 of this subchapter, the following terms have the meanings indicated, except where the context clearly indicates otherwise:

(1) Emergency care--A health care service or benefit:

(A) provided in an air, land, or water ambulance, and that is emergency care as defined under Insurance Code Chapter 1201; or

(B) that meets a plan's applicable statutory definition of emergency care in Insurance Code Chapters 843, 1201, or 1301, or emergency care as required in Insurance Code §1271.155, provided in a hospital emergency facility, licensed

freestanding emergency medical care facility, community mental health center, or comparable emergency facility.

(2) In-network--Care covered under the plan's in-network benefit, including care provided by:

(A) an in-network provider; or

(B) an out-of-network provider as required by Insurance Code Chapters 1271 and 1301, and §3.3708 (relating to Payment of Certain Basic Benefit Claims and Related Disclosures), §3.3725 (relating to Payment of Certain Out-of-Network Claims) of this title, and §11.1611 (relating to Out-of-Network Claims; Non-Network Physicians and Providers) of this title.

(3) Inpatient--Care provided on an inpatient basis. Inpatient health care services or benefits are provided in an inpatient facility, including, but not limited to, those identified in CMS Form 1500 POS Codes 21 (Inpatient Hospital (other than psychiatric)), 31 (Skilled Nursing Facility), 32 (Nursing Facility), 34 (Hospice), 51 (Inpatient Psychiatric Facility), 54 (Intermediate Care Facility/Individuals with Intellectual Disabilities), 55 (Residential Substance Abuse Treatment Facility), 56 (Psychiatric Residential Treatment Center), and 61 (Comprehensive Inpatient Rehabilitation Facility).

(4) Office visit--A medical/surgical or mental health/substance use disorder (MH/SUD) service or benefit received in an office, including, but not limited to, those identified in CMS Form 1500 POS Code 11 (Office).

(5) Outpatient--Care provided on an outpatient basis. Outpatient health care services or benefits are provided in an outpatient setting other than an office visit, including, but not limited to, those identified in CMS Form 1500 POS Codes 17 (Walk-in Retail Health Clinic), 18 (Place of Employment/Worksite), 19 (Off Campus - Outpatient

Hospital), 20 (Urgent Care Facility), 22 (On Campus - Outpatient Hospital), 24 (Ambulatory Surgical Center), 49 (Independent Clinic), 52 (Psychiatric Facility - Partial Hospitalization), 53 (Community Mental Health Center), 57 (Non-residential Substance Abuse Treatment Facility), 62 (Comprehensive Outpatient Rehabilitation Facility), 65 (End-Stage Renal Disease Treatment Facility), and 72 (Rural Health Clinic).

(6) Out-of-network--Care covered under the plan's out-of-network benefit, and all care under an indemnity plan or other health benefit plan that has no network of providers. Care provided by an out-of-network provider that is covered under the plan's in-network benefit is not out-of-network care.

§21.2422. Deadline for Reporting Data.

Annual reporting. The information and data an issuer must report as required by Division 2 of this subchapter are due annually.

(1) Each reporting period is a calendar year.

(2) The first reporting date for this subchapter is December 1, 2021, for data from January 1, 2020, through December 31, 2020.

(3) An issuer's annual reports for calendar year 2021 and subsequent reporting periods are due not later than July 1 following the reporting period.

§21.2423. Collecting and Reporting Data.

(a) Requirement to collect and report data. An issuer must collect and report the data required by this division for each applicable health benefit plan using the data collection template titled "MH/SUD Parity Rule Division 2 Data Collection Reporting Form," consisting of multiple worksheets, published on TDI's website.

(b) Separate templates required. For each combination of plan type and market type the issuer offers, the data must be reported in a separate template with its own worksheets.

(c) Example. An example of how subsection (b) of this section would be satisfied is that an issuer offering PPO plans and EPO plans in the individual, small, and large group markets will submit a separate template with its own worksheets for its PPO individual plans, its PPO small group plans, and its PPO large group plans, and another three files for its EPO plans, for a total submission of six templates with their own worksheets.

§21.2424. Issuer and Plan Information.

(a) Identifying issuer information. For each data collection template an issuer provides to TDI under §21.2423 of this title (relating to Collecting and Reporting Data), within the "MH/SUD Parity Rule Division 2 Data Collection Reporting Form" template, in the worksheet titled "Issuer and Plan Information," an issuer must provide the:

(1) issuer name;

(2) NAIC number, or if none, issuer license number;

(3) reporting year;

(4) submission date;

(5) contact name;

(6) title;

(7) phone number; and

(8) email address.

(b) Identifying plan information. In the "Issuer and Plan Information" worksheet, an issuer must identify the:

(1) market type;

(2) plan type;

(3) number of policies or contracts for which data is reported;

(4) number of covered lives for which data is reported; and

(5) premium volume for policies or contracts for which data is reported.

(c) Information on grandfathered coverage. In the "Issuer and Plan Information" worksheet, an issuer must specify whether it has any plans subject to this rule that provide grandfathered coverage, as defined in 45 CFR §147.140 (concerning Preservation of Right to Maintain Existing Coverage). If so, the issuer must identify the:

(1) number of policies or contracts that provide grandfathered coverage;

(2) number of covered lives under grandfathered coverage; and

(3) premium volume for grandfathered policies or contracts.

§21.2425. Claims and Utilization Review: Reporting Classifications.

(a) Separate reporting. Within the "MH/SUD Parity Rule Division 2 Data Collection Reporting Form" template, in the worksheet titled "Claims and Utilization Review," an issuer must separately report claims and requests for utilization review for medical/surgical and MH/SUD.

(b) ICD diagnosis codes. In the worksheet titled "Claims and Utilization Review," all claims and utilization review requests with mental, behavioral, and neurodevelopmental disorder diagnosis codes in the International Classification of Diseases and Related Health Problems should be categorized as MH/SUD. Claims and utilization review requests with all other ICD diagnostic codes should be categorized as medical/surgical.

(c) Reporting classifications. Claims and requests for utilization review are to be identified in the worksheet as belonging in one the following reporting classifications:

(1) inpatient, in-network;

(2) inpatient, out-of-network;

(3) outpatient, in-network, consisting of:

(A) office visits; and

(B) all other;

(4) outpatient, out-of-network, consisting of:

(A) office visits; and

(B) all other;

(5) emergency; and

(6) prescription drugs.

(d) Unneeded information. Where appropriate, an issuer may enter "N/A" in the worksheet. For example, indemnity plans will not have data for in-network classifications, and HMOs with no POS component and EPOs will not have data for out-of-network classifications. An issuer of those plans may therefore enter N/A where that data is requested.

§21.2426. Claims and Utilization Review: Aggregate Data Fields.

Within the "MH/SUD Parity Rule Division 2 Data Collection Reporting Form" template, in the worksheet titled "Claims and Utilization Review," for medical/surgical, MH/SUD, and for each of the classifications listed in §21.2425(c) of this title (relating to Claims and Utilization Review: Reporting Classifications), an issuer must provide the following aggregate claims and utilization review data for the reporting year:

(1) the number of reported claims for services or benefits that have been provided:

(A) in total;

(B) by out-of-network providers that were covered as in-network benefits;

(C) that were approved;

(D) that were administratively denied; and

(E) that were adversely determined;

(2) the number of utilization reviews, including:

(A) preauthorization requests for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(B) preauthorization requests approved for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(C) preauthorization requests that received a peer-to-peer or physician-to-physician review for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(D) preauthorization requests that were subject to a fail-first or step therapy requirement;

(E) preauthorization requests that were adversely determined for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(F) concurrent reviews for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(G) concurrent reviews approved for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(H) concurrent reviews that received a peer-to-peer or physician-to-physician review for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(I) concurrent reviews that were adversely determined for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(J) retrospective reviews for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(K) retrospective reviews that were approved for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(L) retrospective reviews that received a peer-to-peer or physician-to-physician review for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults; and

(M) retrospective reviews that were adversely determined for:

(i) children ages 0 - 12;

(ii) adolescents ages 13 - 17; and

(iii) adults;

(3) the number of adverse determinations that were internally appealed that:

(A) then received a peer-to-peer or physician-to-physician review on internal appeal;

(B) were again adversely determined on internal appeal; and

(C) were reversed on internal appeal; and

(4) the number of adverse determinations independently reviewed that were:

(A) upheld on independent review; and

(B) reversed on independent review.

§21.2427. Plan Reimbursement Rates Compared with Medicare Rates.

(a) Reporting worksheet. An issuer must report the data required by this section within the "MH/SUD Parity Rule Division 2 Data Collection Reporting Form" template in the worksheet titled "Reimbursement Rates."

(b) Categories of providers and billing codes. An issuer must report average plan reimbursement rates separately for in-network and out-of-network providers for services provided by the following categories of providers for the billing codes specified by TDI in the worksheet:

(1) orthopedic surgeons;

(2) cardiologists;

(3) internists;

(4) endocrinologists;

(5) gastroenterologists;

(6) neurologists;

(7) pediatricians;

(8) dermatologists;

(9) psychiatrists;

(10) psychologists;

(11) licensed clinical social workers;

(12) podiatrists;

(13) chiropractors;

(14) occupational therapists; and

(15) physical therapists.

DIVISION 3. COMPLIANCE ANALYSES FOR MH/SUD PARITY
28 TAC §§21.2431 - 21.2441

STATUTORY AUTHORITY. The Commissioner adopts §§21.2431 - 21.2441 under Insurance Code §§1355.257, 1355.258, and 36.001.

Insurance Code §1355.257 provides that Chapter 1355, Subchapter F, supplements Subchapters A and B of that chapter, and Chapter 1368, and the rules adopted under those statutes. Insurance Code §1355.257 also provides that the legislature intends that Insurance Code Chapter 1355's Subchapter A or B, Chapter 1368, or a department rule adopted under those statutes, control over Subchapter F in any circumstance in which those statutes or rules require a benefit that is not required by Subchapter F, or require a more extensive benefit than is required by Subchapter F.

Insurance Code §1355.258, addressing coverage for mental health conditions and substance use disorders, requires that the Commissioner adopt rules necessary to implement Chapter 1355, Subchapter F.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§21.2431. Required Analyses for Quantitative and Nonquantitative Parity; Alternative Tools.

(a) QTL and NQTL templates.

(1) For purposes of this division, "QTL template" is the template titled "Compliance Analysis for Quantitative Parity" and its associated technical instructions, available on TDI's website.

(2) For purposes of this division, "NQTL template" is the template titled Compliance Analysis for Nonquantitative Parity" and its associated technical instructions, available on TDI's website.

(b) Analyses of quantitative and nonquantitative parity.

(1) An issuer must analyze each health benefit plan to determine whether its plan design complies with the quantitative parity requirements in §§21.2433 - 21.2437 of this title (relating to Compliance Analysis for Quantitative Parity: General Requirements, Quantitative Parity Analysis: Issuer and Plan Information, Quantitative Parity Analysis: Methodology for Determining Expected Payments, Quantitative Parity Analysis: Covered Benefits, and Quantitative Parity Analysis: "Substantially All" and "Predominant" Tests), using the QTL template, except as permitted by subsection (c) of this section.

(2) An issuer must analyze each health benefit plan to determine whether its plan design complies with the nonquantitative parity requirements in §§21.2438 - 21.2441 of this title (relating to Compliance Analysis for Nonquantitative Parity: General Instructions, Nonquantitative Treatment Limitations Generally, Nonquantitative Parity Analysis: Issuer and Plan Information, and Four-Step Analysis of Nonquantitative Treatment Limitations), using the NQTL template, except as permitted by subsection (d) of this section.

(c) Alternative tool for quantitative parity analysis. An issuer may use an alternative quantitative parity analysis tool instead of the QTL template if the issuer demonstrates to TDI's satisfaction that it is using a methodology for the "predominant" and "substantially

all" tests that is consistent with §21.2408 of this title (relating to Parity Requirements with Respect to Financial Requirements and Treatment Limitations).

(1) Upon request by TDI, an issuer must produce documentation that provides the same level of specificity as the QTL template.

(2) TDI will assess whether the alternative compliance tool satisfies the requirements of this section at the time TDI requests that the issuer submit its compliance analysis.

(d) Alternative tool for nonquantitative parity analysis. An issuer may use an alternative tool instead of the NQTL template if the issuer demonstrates to TDI's satisfaction that the alternative tool contains the information required for each step of the four-step process stated in §21.2441 of this title.

(1) Upon request by TDI, an issuer must produce documentation that provides the same level of specificity as the NQTL template.

(2) TDI will assess whether the alternative tool satisfies the requirements of this section at the time TDI requests that the issuer submit its compliance analysis.

§21.2432. Due Dates for Analyses.

(a) Deadline for quantitative parity analyses. An issuer must complete the parity analyses of its quantitative treatment limitations (QTLs) required by this division for each existing plan not later than the 180th day after the effective date of this subchapter.

(b) Phase-in for nonquantitative parity analyses. The deadlines for completing the parity analyses of an issuer's nonquantitative treatment limitations (NQTLs) will be phased in over three years, in the following manner:

(1) Not later than June 1, 2022, an issuer must complete its initial analysis of each of its utilization review-related NQTLs, including:

(A) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(C) exclusions based on failure to complete a course of treatment;

(D) preauthorization or ongoing authorization requirements; and

(E) concurrent review standards.

(2) Not later than June 1, 2023, an issuer must complete its initial analysis of each of its network-adequacy-related NQTLs, including:

(A) for plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(B) standards for provider admission to participate in a network, including reimbursement rates;

(C) plan methods for determining usual, customary, and reasonable charges;

(D) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits provided under the plan or coverage; and

(E) standards for providing access to out-of-network providers.

(3) Not later than June 1, 2024, an issuer must complete its initial analysis of all of its remaining NQTLs, including:

(A) formulary design for prescription drugs;

(B) exclusions of specific treatments for certain conditions; and

(C) restrictions on applicable provider billing codes.

(4) Before marketing new plans during the phase-in period, an issuer must have completed its analysis of all NQTLs for which the deadline has passed.

(c) New plans. An issuer must perform both its quantitative and nonquantitative analyses before marketing a new plan.

(d) Modified plans. An issuer must update its analyses within 30 days of each material change to a QTL or an NQTL.

§21.2433. Compliance Analysis for Quantitative Parity: General Requirements.

(a) Template and instructions. Except as provided in §21.2431 of this title (relating to Required Analyses for Quantitative and Nonquantitative Parity; Alternative Tools), an issuer must use the QTL template and associated technical instructions to:

(1) provide the information required by §21.2434 of this title (relating to Quantitative Parity Analysis: Issuer and Plan Information), §21.2435 of this title (relating to Quantitative Parity Analysis: Methodology for Determining Expected Payments), and §21.2436 of this title (relating to Quantitative Parity Analysis: Covered Benefits); and

(2) perform the compliance analysis for quantitative parity required by §21.2437 of this title (relating to Quantitative Parity Analysis: "Substantially All" and "Predominant" Tests).

(b) Template programming. TDI may program the QTL template to populate some information and complete some steps of the analysis automatically.

(c) Compliance analysis for plans with the same plan design. An issuer may complete a single analysis for multiple plans with the same plan design.

(d) Retention of completed template. An issuer must retain its completed quantitative parity analysis for each plan, plan design, or modified plan design. The completed analysis must be available to TDI upon request for any plan or plan design that is available for purchase, and for at least five years after coverage terminates for the last enrollee covered.

(e) Version control. The issuer must use a version control system to ensure that the issuer can provide to TDI upon request the version of the completed analysis that applied to a plan on a given date.

§21.2434. Quantitative Parity Analysis: Issuer and Plan Information.

(a) Identifying issuer information. Within each QTL template, in the worksheet titled "Issuer and Plan Information," an issuer must provide the:

(1) issuer name;

(2) NAIC number, or if none, issuer license number;

(3) date the analysis was completed (analysis completion date);

(4) contact name;

(5) phone number; and

(6) email address.

(b) Identifying plan information. Within each QTL template, in the worksheet titled "Issuer and Plan Information," an issuer must provide the:

(1) unique plan marketing name;

(2) unique plan identifier;

(3) date the plan was first issued (plan issuance date);

(4) market type;

(5) plan type; and

(6) identification number of the filing or filings in which the forms were approved.

(c) Information required where analysis includes multiple plans. If the analysis includes multiple plans, the information required by subsection (b) of this section must be repeated for each of the plans to which the analysis applies.

§21.2435. Quantitative Parity Analysis: Methodology for Determining Expected Payments.

(a) Expected payment methodology. Within each QTL template, in the worksheet titled "Expected Payment Methodology," an issuer must provide an explanation of the methodology that describes the underlying data used to determine the total payments of each benefit in the quantitative analyses, such as the steps, data, and assumptions used to calculate or project expected payments. The description must demonstrate that:

(1) the quantitative analysis is based on the total allowed amounts (not limited to the portion paid by the plan), projected for the applicable plan year;

(2) the quantitative analysis for each classification and subclassification, if applicable, accounts for all expected payments for all covered medical/surgical benefits under the plan or plan design; and

(3) a reasonable method was used to determine the expected payment amount. An issuer must document the assumptions used in choosing a data set and making projections.

(b) Data sources. An issuer must clearly describe the following information, in addition to any other relevant information:

(1) the specific plans or other sources of claims data used to determine the expected payment amounts for the analysis;

(2) the time period of the claims data--for example, calendar years 2018 and 2019; and

(3) what adjustments, if any, were made to the data or payment projections.

(c) Insufficient plan-level data. If data other than plan-level data was used for the analysis, an issuer must submit a separate actuarial certification addressing:

(1) the sufficiency and credibility of plan-level data; and

(2) why the substitute data set used for the analyses is reasonable and actuarially appropriate, including a description of any assumptions used in choosing the data and making projections.

§21.2436. Quantitative Parity Analysis: Covered Benefits.

(a) General information. Within each QTL template, in the worksheet titled "Covered Benefits," an issuer must identify:

(1) whether outpatient benefits are subclassified into "office visit" and "other;"

(2) whether the plan or plan design has a tiered network; and

(3) if the plan or plan design has a tiered network, the number of tiers.

(b) List of covered benefits. In the worksheet titled "Covered Benefits," an issuer must list each benefit covered by the plan or plan design, including all benefits listed in the schedule of benefits and the policy, certificate, evidence of coverage, or contract of insurance. Covered benefits must be repeated as needed to list each benefit on separate lines, based on:

(1) network;

(2) types and levels of applicable financial requirements and QTLs; and

(3) classification or subclassification, as applicable.

(c) Combining covered benefits. Covered benefits that have the same QTLs may be combined for the purposes of the QTL analysis;

(d) Examples. The examples in this subsection illustrate the requirements of subsections (b) and (c) of this section.

(1) Example 1. If a plan or plan design covers the first office visit with $0 cost sharing, and subsequent office visits are subject to coinsurance, then each level of cost sharing must be listed on a separate line.

(2) Example 2. If a plan or plan design covers occupational therapy for both medical/surgical and MH/SUD diagnoses, then occupational therapy must be listed on separate lines for each.

(3) Example 3. If a plan or plan design covers physical therapy, occupational therapy, and speech therapy subject to identical QTLs, then the covered benefits may be combined in a single line.

(4) Example 4. If a plan or plan design applies identical types and levels of QTLs to all in-network medical/surgical and MH/SUD covered benefits, then all in-network medical/surgical covered benefits may be combined in a single line and all in-network

MH/SUD covered benefits may be combined in a single line, for a total of two lines of covered benefits in each classification worksheet.

(e) Categorization, classification, and subclassification of covered benefits. For each covered benefit, the issuer must:

(1) categorize the covered benefit, consistent with the definitions of "medical/surgical benefit," "mental health benefit," and "substance use disorder benefit" in §21.2406 of this title (relating to Definitions), as medical/surgical or MH/SUD;

(2) classify the covered benefit consistent with §21.2408(b)(2)(A)(i) - (vi) of this title (relating to Parity Requirements with Respect to Financial Requirements and Treatment Limitations) as:

(A) inpatient, in-network;

(B) inpatient, out-of-network;

(C) outpatient, in-network;

(D) outpatient, out-of-network; and

(E) emergency care;

(3) if the issuer uses multiple network tiers, add separate subclassifications for in-network classifications, consistent with subparagraph §21.2408(c)(3)(B) of this title; and

(4) if applicable to outpatient benefits, subclassify the covered benefit, consistent with §21.2408(c)(3)(C) of this title, as:

(A) outpatient, in-network including, if applicable, separate identification of:

(i) outpatient in-network office visits; and

(ii) all other outpatient in-network benefits; and

(B) outpatient, out-of-network, including, if applicable, separate identification of:

(i) outpatient out-of-network office visits; and

(ii) all other outpatient out-of-network benefits.

(f) Methodology for categorizing covered benefits. Within the QTL template, in the worksheet titled "Categorization Methodology," an issuer must provide an explanation of the methodology used to categorize a covered benefit as a mental health benefit, medical/surgical benefit, or substance use disorder benefit. If a plan defines a condition as a mental health condition, substance use disorder, or medical or surgical condition, it must categorize benefits for those conditions in the same way for purposes of this rule. For example, if a plan defines unspecified dementia as a mental health condition, it must categorize benefits for unspecified dementia as mental health benefits. An issuer must apply the same categorization for both the QTL and NQTL analyses.

(g) Methodology for classifying and subclassifying covered benefits. Within the QTL template, in the worksheet titled "Classification Methodology," an issuer must provide an explanation of the methodology used to classify and subclassify covered benefits, consistent with §21.2408(b)(2) and (c)(3) of this title. In determining the classification in which a particular benefit belongs, an issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in

residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. An issuer must apply its methodology consistently when classifying covered benefits and use the same classification for both the QTL and NQTL analyses.

§21.2437. Quantitative Parity Analysis: "Substantially All" and "Predominant" Tests.

(a) Separate worksheet and analysis for each classification and subclassification. Within the QTL template are separate worksheets, named for each classification or subclassification (classification worksheets) identified in §21.2436(e) of this title (relating to Quantitative Parity Analysis: Covered Benefits). If an issuer's plan design applies a QTL or financial requirement to a MH/SUD benefit in a given classification or subclassification, the issuer must document, in the applicable classification worksheet, the following:

(1) in Column 1 of each classification worksheet: the dollar amount or per member per month amount of all plan payments expected to be paid under the plan for the plan year consistent with §21.2408(c)(1)(C) - (E) of this title (relating to Parity Requirements with Respect to Financial Requirements and Treatment Limitations);

(2) in Column 2 of each classification worksheet: whether a copay applies and, if applicable, the copay amount;

(3) in Column 3 of each classification worksheet: whether a coinsurance applies and, if applicable, the coinsurance percentage amount;

(4) in Column 4 of each classification worksheet: whether a deductible applies and, if applicable, the deductible amount;

(5) in Column 5 of each classification worksheet: whether a session limit applies and, if applicable, the session limit quantity; and

(6) in Column 6 of each classification worksheet: whether a day limit applies to each service category and, if applicable, the day limit quantity.

(b) "Substantially all" test. Consistent with §21.2408(c)(1)(A) of this title, an issuer must perform the following calculations separately in each classification worksheet to determine whether a QTL or financial requirement that applies to MH/SUD benefits also applies to substantially all medical/surgical benefits.

(1) To calculate the aggregate total of expected plan payments for medical/surgical benefits in the classification worksheet, add the dollar amounts listed in every row of Column 1.

(2) To determine whether a copay applies to substantially all medical/surgical benefits in the classification worksheet:

(A) for every row in Column 2 of the worksheet with a copay amount listed greater than $0, add the expected plan payment amounts for the benefit listed in Column 1 of that row; and

(B) divide the amount in subsection (b)(2)(A) of this section by the aggregate total calculated under subsection (b)(1) of this section.

(3) To determine whether a coinsurance applies to substantially all medical/surgical benefits in the classification worksheet:

(A) for every row in Column 3 of the worksheet with an enrollee coinsurance amount listed greater than $0, add the expected plan payment amounts for the benefit listed in Column 1 of that row; and

(B) divide the amount addressed in subsection (b)(3)(A) of this section by the aggregate total calculated under subsection (b)(1) of this section.

(4) To determine whether a deductible applies to substantially all medical/surgical benefits in the classification worksheet:

(A) for every row in Column 4 of the worksheet with a deductible amount listed greater than $0, add the expected plan payment amounts for the benefit listed in Column 1 of that row; and

(B) divide the amount addressed in subsection (b)(4)(A) of this section by the aggregate total calculated under subsection (b)(1) of this section.

(5) To determine whether a session limit applies to substantially all medical/surgical benefits in the classification worksheet:

(A) for every row in Column 5 of the worksheet with a session limit listed that is less than unlimited, add the expected plan payment amounts for the benefit category listed in Column 1 of that row; and

(B) divide the amount addressed in in subsection (b)(5)(A) of this section by the aggregate total calculated under subsection (b)(1) of this section.

(6) To determine whether a day limit applies to substantially all medical/surgical benefits in the classification worksheet:

(A) for every row in Column 6 of the worksheet with a day limit listed that is less than unlimited, add the expected plan payment amounts for the benefit listed in Column 1 of that row; and

(B) divide the amount addressed in subsection (b)(6)(A) of this section by the aggregate total calculated under subsection (b)(1) of this section.

(7) If the amount calculated under any of the paragraphs in subsections (b)(2) - (b)(6) of this section is less than two-thirds on any of the classification worksheets, the financial requirement or quantitative treatment limitation in that paragraph fails the "substantially all" test under §21.2408(c)(1)(A) of this title and cannot be applied to a MH/SUD benefit.

(c) "Predominant" test. Consistent with §21.2408(c)(1)(B) of this title, the issuer must separately perform the following calculations in each classification worksheet, as applicable, to determine whether the level of a type of quantitative treatment limitation or financial requirement that satisfied the "substantially all" test in subsection (b) of this section is no less favorable than the predominant quantitative treatment limitation or financial requirement that applies to medical/surgical benefits.

(1) Calculate the aggregate total of expected plan payments for medical/surgical benefits within each classification or subclassification that is subject to a particular type of financial requirement or quantitative treatment limitation. Separately, in Columns 2 through 6 of the classification worksheet, for every row with an amount listed, add the expected claim dollar amounts from Column 1 of the worksheet for the benefit listed in that row.

(2) To determine whether the level of a financial requirement or quantitative treatment limitation applied to MH/SUD is not less favorable than the predominant financial requirement or quantitative treatment limitation applied to medical/surgical benefits, follow the instructions in the following subparagraphs for each financial requirement and quantitative treatment limitation identified in Columns 2 through 4 of each classification worksheet.

(A) Rank each level of each type of financial requirement and quantitative treatment limitation from highest to lowest.

(B) For each level of each type of financial requirement and quantitative treatment limitation identified in Columns 2 through 4 of the classification worksheet, add the expected plan payments identified in Column 1 of the worksheet for each benefit to which the level of financial requirement or quantitative treatment limitation applies.

(C) Divide each amount calculated under subsection (c)(2)(B) of this section by the aggregate total addressed in subsection (c)(1) of this section.

(D) Add the amounts calculated under subsection (c)(2)(C) of this section for each level of each type of financial requirement and quantitative treatment limitation identified in Columns 2 through 4 of the classification worksheet, from highest to lowest, until the aggregate total exceeds 50%.

(E) In each of the classification worksheets, the least restrictive level of each type of financial requirement or quantitative treatment limitation calculated under subsection (c)(2)(D) of this section to exceed 50% is the predominant level and the least restrictive level that can be applied to MH/SUD benefits. For example:

(i) for copays, coinsurance, and deductibles, the predominant level is the highest amount that can be applied to MH/SUD benefits; and

(ii) for day limits and session limits, the predominant level is the lowest level of day or session limits that can be applied to MH/SUD benefits.

§21.2438. Compliance Analysis for Nonquantitative Parity: General Instructions.

(a) Template and instructions. Except as provided in §21.2431 of this title (relating to Required Analyses for Quantitative and Nonquantitative Parity; Alternative Tools), an issuer must use the template and its associated technical instructions published on TDI's website, titled "Compliance Analysis for Nonquantitative Parity" (NQTL template), to perform the plan identification and compliance analyses for NQTL parity required by:

(1) §21.2440 of this title (relating to Nonquantitative Parity Analysis: Issuer and Plan Information); and

(2) §21.2441 of this title (relating to Four-Step Analysis of Nonquantitative Treatment Limitations).

(b) Template programming. TDI may program the template to populate some information and complete some steps of the analysis automatically.

(c) Compliance analysis for plans with identical NQTLs. An issuer may complete a single analysis for multiple plans that contain an identical set of NQTLs.

§21.2439. Nonquantitative Treatment Limitations Generally.

(a) NQTLs in general. NQTLs generally are treatment limitations on the scope or duration of benefits for treatment. An issuer is prohibited from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage *as written and in operation*, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification.

(b) Numerical application of NQTLs. While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a

numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. But these standards sometimes rely on numerical standards such as numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards. Therefore, reimbursement rates to which a participating provider must agree are to be evaluated in accordance with the rules for NQTLs.

(c) Examples. The following is an illustrative, non-exhaustive list of NQTLs:

(1) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(2) preauthorization or ongoing authorization requirements;

(3) concurrent review standards;

(4) formulary design for prescription drugs;

(5) for plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(6) standards for provider admission to participate in a network, including reimbursement rates;

(7) plan or issuer methods for determining usual, customary, and reasonable charges;

(8) refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols);

(9) exclusions of specific treatments for certain conditions;

(10) restrictions on applicable provider billing codes;

(11) standards for providing access to out-of-network providers;

(12) exclusions based on failure to complete a course of treatment; and

(13) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits provided under the plan or coverage.

§21.2440. Nonquantitative Parity Analysis: Issuer and Plan Information.

(a) Identifying issuer information. Within the NQTL template, in the worksheet titled "Issuer and Plan Information," an issuer must provide the:

(1) issuer name;

(2) NAIC number, or if none, issuer license number;

(3) date the analysis was completed (completion date);

(4) version control number;

(5) date of the most recent NQTL analysis update (revision date);

(6) contact name;

(7) phone number; and

(8) email address.

(b) Identifying plan information. Within the NQTL template, in the worksheet titled "Issuer and Plan Information," an issuer must provide the following identifying information:

(1) unique plan marketing name;

(2) unique plan identifier;

(3) date the plan design was first issued (issuance date);

(4) market type;

(5) plan type; and

(6) identification number of the filing or filings in which the forms were approved;

(c) Information required where analysis includes multiple plans. If the analysis includes multiple plans, the information required by subsection (b) of this section must be repeated for each of the plans to which the analysis applies.

§21.2441. Four-Step Analysis of Nonquantitative Treatment Limitations.

(a) Four-step analysis. An issuer must complete the four-step analysis detailed in this section for each NQTL contained in the plan documents for each plan. An issuer must report its NQTL analyses separately for each applicable classification or subclassification, using the classification worksheets as described in subsection (b) of this section.

(b) Step 1. Within the NQTL template, in the worksheet titled "NQTL Summary," an issuer must identify each NQTL that applies to MH/SUD or medical/surgical benefits covered by the plan, including, but not limited to, those identified in §21.2439 of this title (relating to Nonquantitative Treatment Limitations Generally).

(1) Within the NQTL Summary worksheet, an issuer must identify, for each NQTL listed:

(A) whether the NQTL does or does not apply to benefits categorized as:

(i) medical/surgical benefits; and

(ii) MH/SUD benefits; and

(B) whether the NQTL does or does not apply to the following classifications and subclassifications:

(i) in-network inpatient;

(ii) out-of-network inpatient;

(iii) in-network outpatient, including, if applicable:

(I) in-network outpatient - office; and

(II) in-network outpatient - all other;

(iv) out-of-network outpatient, including, if applicable:

(I) out-of-network outpatient - office; and

(II) out-of-network outpatient - all other;

(v) emergency care; or

(vi) prescription drugs.

(2) Within the NQTL template, in each classification or subclassification worksheet, an issuer must provide the specific plan document terms, coverage terms, or other relevant terms regarding the NQTL.

(3) Within the NQTL template, in each classification or subclassification worksheet, an issuer must list all MH/SUD and medical/surgical covered benefits to which each NQTL applies, and:

(A) assign covered benefits to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits;

(B) use the same categorization and classification of a given covered benefit for both its QTL and NQTL analyses;

(C) analyze the NQTLs separately for MH/SUD and medical/surgical benefits;

(D) analyze each NQTL separately if a covered benefit includes multiple components (such as outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (such as prior authorization and limits on treatment dosage or duration); and

(E) describe how the requirements for each NQTL are implemented, who makes the decisions, and what the decision maker's qualifications are.

(c) Step 2. Within the NQTL template, in each classification or subclassification worksheet, an issuer must identify each factor considered in the design and application of the NQTL. Illustrative examples of factors are provided in the NQTL template.

(1) If only certain benefits are subject to an NQTL (such as meeting a fail-first protocol or requiring preauthorization), issuers must have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.

(2) An issuer must document whether any factors were given more weight than others and the reasons for doing so, including evaluating the specific data used in the determination (if any).

(d) Step 3. Within the NQTL template, in each classification or subclassification worksheet, an issuer must identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified in Step 2 to design and apply the NQTL. Illustrative examples of sources of factors are provided in the NQTL template.

(1) If an issuer uses these sources of factors, they must apply them comparably to MH/SUD and medical/surgical benefits.

(2) Evidentiary standards and processes that an issuer relies on may include any evidence that the issuer considers in developing its medical management techniques,

including recognized medical literature and professional standards and protocols (such as comparative effectiveness studies and clinical trials), and published research studies.

(3) If there is any variation in the application of a guideline or standard being relied on by the issuer, an issuer must explain the process and factors relied on for establishing that variation.

(4) If an issuer relies on any experts, the issuer must describe the experts' qualifications and whether the expert evaluations in setting recommendations for both MH/SUD and medical/surgical conditions are comparable.

(5) When identifying the sources of the factors considered in designing the NQTL, an issuer must identify any threshold at which each factor will implicate the NQTL. For example, if high cost is identified as a factor used in designing a prior authorization requirement, the issuer would identify and explain:

(A) the threshold dollar amount at which prior authorization will be required for any benefit;

(B) the data used to determine the benefit is "high cost"; and

(C) how, if at all, the amount that is to be considered "high cost" is different for MH/SUD benefit as compared with medical/surgical benefits, and how the issuer justifies this difference.

(6) The NQTL template includes examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs.

(e) Step 4. Within the NQTL template, in each classification or subclassification worksheet, an issuer must provide a comparative analysis demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, as written and in operation, are comparable to and are applied no more

stringently than the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical/surgical benefits. Examples of methods and analyses an issuer could use to substantiate that factors, evidentiary standards, and processes are comparable are included in the NQTL template. When applicable, the comparability analysis must:

(1) demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD benefits and medical/surgical benefits;

(2) if utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits, identify the measures in place to ensure comparable application of utilization review policies to the NQTL;

(3) identify any consequences or penalties that apply to the benefits when the NQTL requirement is not met, such as a reduction in benefits if not preauthorized; and

(4) demonstrate compliance both as written and in operation by:

(A) identifying all exception processes available and when they may be applied;

(B) identifying how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims;

(C) identifying who makes denial determinations and whether the decision makers have comparable expertise with respect to MH/SUD and medical/surgical benefits;

(D) performing and documenting an audit to check sample claims to assess how several NQTLs operate in practice, and whether written processes are correctly carried out;

(E) determining and documenting average denial rates and appeal overturn rates for concurrent review, and assessing the parity between these rates for MH/SUD benefits and medical/surgical benefits; and

(F) demonstrating that there are not arbitrary or discriminatory differences in how the issuer applies underlying processes and strategies to NQTLs with respect to medical/surgical benefits versus MH/SUD benefits.

DIVISION 4. AUTISM SPECTRUM DISORDER
28 TAC §21.2451 and §21.2452

STATUTORY AUTHORITY. The Commissioner adopts §21.2451 and §21.2452 under Insurance Code §§1355.257, 1355.258, and 36.001.

Insurance Code §1355.257 provides that Chapter 1355, Subchapter F, supplements Subchapters A and B of that chapter, and Chapter 1368, and the rules adopted under those statutes. Insurance Code §1355.257 also provides that the legislature intends that Insurance Code Chapter 1355's Subchapter A or B, Chapter 1368, or a department rule adopted under those statutes, control over Subchapter F in any circumstance in which those statutes or rules require a benefit that is not required by Subchapter F, or require a more extensive benefit than is required by Subchapter F.

Insurance Code §1355.258, addressing coverage for mental health conditions and substance use disorders, requires that the Commissioner adopt rules necessary to implement Chapter 1355, Subchapter F.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§21.2451. Applicability.

Applicability. This division applies only to health benefit plans that provide coverage for autism spectrum disorder as required by Insurance Code Chapter 1355, Subchapter A, concerning Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses and Other Disorders.

§21.2452. Coordination of Provisions in Insurance Code Chapter 1355, Concerning Benefits for Certain Mental Disorders.

(a) Applicability. This section applies only to a health benefit plan that is subject to both:

(1) Insurance Code Chapter 1355, Subchapter A, concerning Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses and Other Disorders; and

(2) Insurance Code Chapter 1355, Subchapter F, concerning Coverage for Mental Health Conditions and Substance Use Disorders.

(b) Compliance requirement. If an issuer's health benefit plan includes a quantitative or nonquantitative treatment limitation that is permissible under Insurance Code Chapter 1355, Subchapter A, but does not satisfy Insurance Code §1355.254, concerning Coverage for Mental Health Conditions and Substance Use Disorders, the issuer must modify its plan to ensure that it complies with Insurance Code §1355.254.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on August 18, 2021.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts the repeal of 28 TAC Chapter 21, Subchapter P, §§21.2401 - 21.2407, and 28 TAC Chapter 21, Subchapter JJ, §§21.4401 - 21.4404. The Commissioner also adopts new 28 TAC Chapter 21, Subchapter P (relating to Mental Health and Substance Use Disorder Parity), §§21.2401 - 21.2409, 21.2411, 21.2413, 21.2414, 21.2421 - 21.2427, 21.2431 - 21.2441, §21.2451, and §21.2452.

Commissioner of Insurance

By: DocuSigned by:
Doug Slape
C77A87C8C21B435...

Doug Slape
Chief Deputy Commissioner
Tex. Gov't Code §601.002
Commissioner's Order No. 2018-5528