SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 1. GENERAL PROVISIONS
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REPEAL OF DIVISION 2. STATE-MANDATED HEALTH BENEFITS
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INTRODUCTION. The Texas Department of Insurance proposes changes to 28 TAC Chapter 21, Subchapter AA, relating to consumer choice health benefit plans. Proposed changes are in Division 1, §§21.3501 - 21.3504; Division 3, §21.3530; and Division 4, §21.3542. The proposal also includes proposed new 28 TAC §21.3506 and the proposed repeal of Division 2, §§21.3510 - 21.3518.

The department proposes nonsubstantive changes to §§21.3501 - 21.3504 to conform to agency style and usage guidelines and proposes new §21.3506, relating to State-Mandated Health Benefits in Blanket Indemnity Policies. The new section will replace §21.3514, State-Mandated Health Benefits in Blanket Indemnity Policies, which is proposed for repeal along with the other sections in Division 2. No changes are proposed to the text of §21.3514 as it moves to §21.3506.

The department proposes the repeal of Division 2, §§21.3510 - 21.3518, concerning state-mandated health benefits. The repeal is necessary to remove the list of mandates that may be excluded from consumer choice health benefit plans.

The department proposes amendments to §21.3530, relating to Health Carrier Disclosure; and §21.3542, relating to Offer of State-Mandated Plan. These amendments are necessary to require health carriers to use additional language in the consumer choice health benefit plan written disclosure statement. The disclosure statement assists consumers in making informed decisions, and the proposed amendments ensure that a health carrier provides the disclosure to consumers no later than three business days from the date the health carrier receives the consumer's application from the federal health benefit exchange.

The proposed amendments to §21.3530 and §21.3542 are also necessary to update the information that must be included in a required consumer choice health benefit plan written disclosure

statement form. The existing rule does not contemplate marketing a consumer choice health benefit plan through the electronic medium of the federal health benefit exchange. Because of this, the existing rule only addresses delivery of the required consumer choice health benefit plan written disclosure statement either from a health carrier directly to an applicant or through an agent.

The proposed amendments to §21.3542 update the existing rule to clarify that a health carrier that offers consumers the opportunity to apply for one or more consumer choice health benefit plans must also offer the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that reasonably approximates the consumer choice health benefit plan offered, including state-mandated health benefits and other benefits authorized by the Insurance Code. This change is not a new requirement, but merely a clarification of requirements already in existence.

EXPLANATION. Insurance Code §1507.006 and §1507.056 require health carriers to provide a proposed policy or contract holder, or current policy or contract holder, with a written disclosure statement that the "health benefit plan being purchased does not provide some or all the state-mandated health benefits," and to list the state-mandated health benefits not included in the plan. The disclosure statement enables a consumer to make an informed decision about whether the consumer choice health benefit plan provides sufficient coverage for the consumer's needs. If the health carrier issues a consumer choice health benefit plan to an individual policy or contract holder, the written disclosure statement must include a notice that purchasing the plan may limit their future coverage options in the event the covered person's health changes and needed benefits are not available under the consumer choice health plan.

The proposed amendments will add a new section to 28 TAC Chapter 21, Subchapter AA, Division 1. The new section will be §21.3506, relating to State-Mandated Health Benefits in Blanket Indemnity Policies, and will contain the unmodified text of §21.3514, which is proposed for repeal.

The department also proposes the repeal of 28 TAC §§21.3510 - 21.3518, relating to state-mandated health benefits. The current text of the rule has caused some confusion, as it only lists mandates that may be excluded from consumer choice health benefit plans and does not list what mandates are required in the plans. Insurance Code §1507.002(2) and §1507.053 sufficiently define what constitutes the state-mandated health benefits that may be excluded from consumer choice health benefit plans, and these sections also provide a list of specific state-mandated health benefits that may not be excluded.

Under the proposed amendments, §21.3530 will be revised to require a health carrier to provide each prospective or current policyholder or contract holder a clearly written disclosure statement that provides a sufficient description of the reduced benefits or state-mandated health benefits not included in the consumer choice health benefit plan. This will enable a consumer to make an informed decision about whether the consumer choice health benefit plan under consideration provides sufficient coverage for the consumer's needs. "Health carrier" is defined in §21.3502(7) to include a health insurance carrier, a group hospital corporation under Insurance Code Chapter 842, a health maintenance organization (HMO), and a stipulated premium company.

The proposed amendments to §21.3530 establish an exception for carriers that offer and provide consumer choice health benefit plans through the federal health benefit exchange to provide the required consumer choice health benefit plan written disclosure statement. The amendments to this section would require a health carrier to provide the written disclosure statement to the consumer at the time of application, if the federal health benefit exchange provides a mechanism for it. If the federal exchange does not provide a mechanism, the amendments would require a health carrier to provide the disclosure statement to the consumer no later than three business days from the date the health carrier receives the consumer's application from the federal exchange.

If the health carrier does not provide the written disclosure statement at the time of application under this exception, the health carrier must provide either a link to the written disclosure statement directly on the healthcare.gov website, or a reference and link to the written disclosure statement in either the summary of benefits and coverage or the plan brochure provided on the healthcare.gov website. When the health carrier provides the written disclosure statement under this exception, the proposed amendments require that the health carrier request that the prospective or current policyholder or contract holder sign and return the written disclosure statement, and that the health carrier provide a no-cost method for the prospective or current policyholder or contract holder to return the signed written disclosure statement.

Under the proposed amendments to §21.3530, changes will be made to Form CCP 1 to make it more consumer friendly and easier to understand. The department currently has multiple versions of the form for individual or group coverage. Under this proposal, there will be one consolidated form with variable brackets to enable the health carriers to select "individual" or "group" disclosures. This consolidated form will retain the Form CCP 1 form number, but with the new title of *Texas Department of Insurance*, *Required Disclosure Statement for all Consumer Choice Health Benefit Plans Issued in*

Texas. These form changes will eliminate confusion, ensure that consumers receive adequate information about the reduced benefits or the state-mandated health benefits not included in the plan and enable them to make informed decisions about whether the consumer choice plan offered or purchased will provide sufficient coverage for their needs. Health carriers are currently required to file Form CCP 1 with the department for approval under §21.3543. Health carriers will be required to update and file for approval their written disclosure forms, to conform with the consolidated Form CCP 1 proposed under the amendments to §21.3530 and §21.3542, no later than one year after the effective date of this rule.

The proposal also makes nonsubstantive changes to §21.3530 to update mailing and website addresses.

Section 21.3542(a) is amended by adding language to clarify that a health carrier that offers the opportunity to apply for one or more consumer choice health benefit plans must also offer the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that reasonably approximates the consumer choice health benefit plan offered, including state-mandated health benefits and other benefits authorized by the Insurance Code.

The proposed amendments will also revise §21.3542 to clarify that the requirement in subsection (b)(1) to market a state-mandated plan with any consumer choice plan applies to health carriers who market consumer choice health benefit plans through the electronic medium of the federal health benefit exchange or other online marketplaces. Subsection (b)(1) requires health carriers to use the same sources and methods of distribution to market both the consumer choice health benefit plans and the health benefit plans required by the subsection.

Section 21.3542(b) is also updated by deleting subsection (b)(3)(C), because it is redundant and unnecessary. Subsection (b)(3)(C) requires a health carrier, on request, to provide the person or entity an explanation of each of the policies or evidences of coverage and the differences between the health plan offered under subsection (a) of the section and the consumer choice health benefit plans. Health carriers are required to provide this information to a prospective or current policyholder or contract holder under §21.3530. The information is provided under §21.3530 regardless of whether the prospective or current policyholder or contract holder requests it.

The proposal also makes nonsubstantive changes to §§21.3501 - 21.3504, §21.3530, §21.3542 to conform to agency style and usage guidelines.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Judy Wooten, project manager, Life and Health Regulatory Initiatives Team, Regulatory Policy Division, has determined that during each year of the first five years that the proposed repealed, amended, and new sections are in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering the sections. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE.

Ms. Wooten has determined that for each year of the first five years the repeal of §§21.3510 - 21.3518 is in effect, the public benefit anticipated as a result of administration and enforcement of the repeal is that it will add clarity to the rules by removing the list of mandates that may be excluded from consumer choice health benefit plans, since they do not affirmatively impose requirements. There is no anticipated economic cost to persons who are required to comply with the proposed repeal. There is no anticipated difference in cost of compliance between small and large businesses.

Ms. Wooten has also determined that certain public benefits will result for each year of the first five years the proposed amendments are in effect. The proposed amendments to §21.3530 will ensure that consumers who purchase their health coverage through the federal health benefit exchange receive a required consumer choice health benefit plan written disclosure statement that includes a sufficient description of the health benefit plan being purchased, a list of the reduced benefits, or state-mandated health benefits not included in the plan being purchased. The disclosure is intended to enable a consumer to make an informed decision about whether the consumer choice health benefit plan provides sufficient coverage for the consumer's needs.

The proposed amendments to §21.3530 and §21.3542 may result in additional costs to health carriers offering or providing health coverages through the federal health benefit exchange. Under the proposed amendments, a health carrier offering or providing health coverage through the federal health benefit exchange, as that exchange currently structures its enrollment process, is required to provide a method for a prospective or current policyholder or contract holder to return a signed written disclosure statement to the health carrier at no cost to the prospective or current policyholder or contract holder. The proposed amendments would allow the health carrier to determine the best method for consumers to return the signed written disclosure statement. A health carrier can designate a method that is the most cost efficient for the health carrier to facilitate the return of the signed written disclosure statement.

The department anticipates that a health carrier offering or providing health coverage through the federal health benefit exchange will incur the following costs to comply with the proposed amendments to §21.3530, if the return method used by the health carrier is to send a printed form and provide return postage for it: (i) printing costs to print the written disclosure statement; (ii) the costs for filing the written disclosure statement for approval; (iii) return postage costs for the prospective or current policyholder or contract holder to mail the written disclosure statement to the health carrier; and (iv) the compensation costs for the additional staff time needed to print and mail the written disclosure statement to the prospective or current policyholder or contract holder.

(i) Printing costs. The department's analysis of standard printing and paper costs relies on the following factors. The department estimates that the cost of printing could range from approximately six to eight cents per page for printing and paper. The department anticipates that the health carriers required to comply with the proposed amendments to §21.3530 will have the information necessary to determine their costs, including the number of pages that will need to be printed and whether in-house printing costs or contract printing costs will be incurred. The printing costs may vary, be slightly higher if in-house printing is not used, or both.

(ii) Filing costs. Health carriers must update previously approved written CCP 1 disclosure forms for plans offered, issued, or renewed. Health carriers must file with the department their updated CCP 1 disclosure forms for the department's approval. Health carriers will incur costs for filing the updated written disclosure statement with the department for approval. Filings submitted to the department for approval incur a $100.00 filing fee per filing, plus any additional fee for filing through the SERFF system. The department is unable to provide the SERFF costs with specificity since it is dependent on the number of filings a health carrier may submit through SERFF and whether the carrier elects to pay a fee per filing or purchase a filing block. A health carrier's cost is also dependent on the number of CCP 1 disclosure forms the health carrier may have filed with the department. A health carrier could mitigate the filing fee costs if the written disclosure statement is included as a supplemental form with other policy forms or plan documents and submitted to the department in one filing. A health carrier marketing multiple consumer choice plans could also submit one filing containing multiple variations of the written disclosure statement along with a statement identifying the previously approved policy forms or plan documents with which the written disclosure statements will be used. To help mitigate a health carrier's filing costs, the department is allowing health carriers one year from the effective date of the rule to update and file for approval their written disclosure forms that conform

with the proposed consolidated Form CCP 1. In the interim, health carriers may continue to use their existing stock of previously approved written disclosure forms.

(iii) Mailing costs. The department's analysis of standard mailing costs is based on the following factors. According to the U. S. Postal Service business price calculator, available at dbcalc.usps.com, the cost to bulk mail machinable letters in the automated area distribution center category, in a standard business mail envelope with a weight limit of 3.3 ounces and sent to a standard five-digit ZIP code in the United States, is 29 cents. With the weight limit of 3.3 ounces, a health carrier can mail approximately 18 pages per envelope for the 29-cent cost (this estimate is based on six pages of standard 20-lb printing paper, which weighs one ounce). The department determined that the cost of a standard business envelope is two cents. Accordingly, for each additional mailing that does not exceed 18 pages, the department estimates that the total mailing cost would be no more than 31 cents. The department anticipates that it will cost approximately 31 cents for health carriers to comply with the written disclosure requirement in the proposed amendments to §21.3530. For first-class mailings, the current cost of a first class stamp is 47 cents, and the metered cost for a first-class letter is 46.5 cents for the first ounce, and 21 cents for each additional ounce. The department anticipates that the health carriers required to comply with the postage requirements in the proposed amendments will have the information necessary to determine their individual postage cost, including the number of mailings and the number of pages to be mailed. In addition, the health carrier could eliminate mailing costs entirely if the health carrier uses the e-signature process under Insurance Code Chapter 35. Using the e-signature process will result in cost reduction as the health carriers will not incur printing and copying costs. To the extent there are any other additional mailing costs, those costs should be attributed to the statutory requirements for disclosure under Insurance Code Chapter 1507.

(iv) Staff wages. The number of hours that will be required to comply with the proposed amendments to §21.3530 will be minimal. The department's analysis of the costs for staff wages to perform required compliance tasks is based on information from the Labor Market and Career Information Development Department of the Texas Workforce Commission at the web addresses below.

(I) A general operations manager working in Texas earns a median hourly wage of approximately $61.99, according to: www.texaswages.com/socDetails.aspx?soc=11-1021.

(II) An administrative assistant working in Texas earns a median hourly wage of approximately $15.76, according to: www.texaswages.com/socDetails.aspx?soc=43-6014.

(III) A computer programmer working in Texas earns a median hourly wage of approximately $41.66, according to: www.texaswages.com/socDetails.aspx?soc=15-1131.

(IV) An attorney working in Texas earns a median hourly wage of approximately $68.98, according to: www.texaswages.com/socDetails.aspx?soc=23-1011.

(V) A medical director working in Texas earns a median hourly wage of approximately $94.91, according to: www.texaswages.com/socDetails.aspx?soc=29-1069.

(VI) A registered nurse working in Texas earns a median hourly wage of approximately $33.60, according to: www.texaswages.com/socDetails.aspx?soc=29-1141.

(VII) A desktop publisher working in Texas earns a median hourly wage of approximately $17.25, according to: www.texaswages.com/socDetails.aspx?soc=43-9031.

(VIII) A paralegal working in Texas earns a median hourly wage of approximately $25.57, according to: www.texaswages.com/socDetails.aspx?soc=23-2011.

The department anticipates that the number of hours that will be required to comply with the proposed amendments to §21.3530 will be negligible. Health carriers may be able to reduce or eliminate additional staff hours to comply with the written disclosure requirement if they use the e-signature process under Insurance Code Chapter 35.

The anticipated compliance cost is the cost of printing and return postage for a single page, which the department estimates as approximately 31 - 49 cents per form. Health carriers can mitigate or eliminate the cost of compliance with this requirement by using a cost-efficient method. For example, if a health carrier uses the e-signature process under Insurance Code Chapter 35, the health carrier may be able to reduce the cost for compliance.

The department does not anticipate any cost for compliance with §21.3542 since the amendments to that section are a clarification of existing requirements in the current rule. The department anticipates that any cost a health carrier may incur from the amendments to §21.3542 would be a result of the health carrier's failure to comply with §21.3542 adopted in 2004. In any event, the cost to provide a state-mandated health plan through the federal health benefit exchange would vary from health carrier to health carrier; thus a health carrier would be in the best position to determine those actual costs.

The cost of compliance with the proposal will not vary between large businesses and small or micro businesses based on the size of the business, and the department's cost analysis is equally

applicable to both large and small or micro businesses. There is no anticipated difference in cost of compliance between small or micro businesses and large businesses.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. In accordance with Government Code §2006.002(c), the department has determined that the proposed repeal of §§21.3510 - 21.3518 will not have an adverse economic effect on small or micro business health carriers because it is a repeal of sections that list mandates that may be excluded from consumer choice health benefit plans that do not affirmatively impose any requirements. Therefore, in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis with respect to the repealed sections in the proposed rule.

Adverse Economic Impact on Small and Micro Businesses from Proposed Amendments.

In accordance with Government Code §2006.002(c), the department has determined that the proposed amendments to §21.3530 and §21.3542 may have an adverse economic effect on one to 38 small or micro business health carriers that must comply with the proposed rules.

The proposed amendments to §21.3530 require health carriers to have a prospective or current policyholder or contract holder sign and return a written disclosure statement. The proposed rule requires health carriers to provide a method for the prospective or current policyholder or contract holder to return the signed written disclosure statement to the health carriers at no cost to the prospective or current policyholder or contract holder.

The department anticipates the economic impact to be the cost of printing and return postage for a single page, which the department estimates as approximately 31 - 49 cents per form. The cost of compliance with this amendment will not vary between large businesses and small or micro businesses. The department's cost analysis of this requirement, which can be found in the *Public Benefit/Cost Note* section of this proposal applies equally to small or micro businesses.

Under Government Code §2006.002(c), before adopting a rule that may have an adverse economic effect on small or micro businesses, an agency must prepare a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the proposed rule. For each of the proposed amendments, the department considered other regulatory methods that accomplish the objectives of the proposal, minimize any adverse economic impact on health carriers that qualify as small or micro businesses under Government Code §2006.001(1) and (2), but still protect the health, safety, and environmental and economic welfare of the state.

Regulatory Alternatives Considered - Written Disclosure Requirement under §21.3530

The department considered the following regulatory alternatives for the written disclosure requirement in proposed §21.3530 that are not statutory requirements: (i) not proposing the amendment to §21.3530; (ii) proposing a different disclosure requirement that would apply only to small and micro businesses; and (iii) excluding small and micro businesses from the applicability of the written disclosure requirement under the proposed amendment to §21.3530. However, the department determined that these options would not accomplish the objectives of §21.3530 and would not be consistent with protecting the health, safety, and environmental and economic welfare of the state.

(i) Not proposing the written disclosure *amendment to §21.3530.* The proposed amendments to §21.3530 establish a process for health carriers that market consumer choice health benefit plans through the federal health benefit exchange to provide the required consumer choice health benefit plan written disclosure statement. The proposed amendments require that the health carrier request that the prospective or current policyholder or contract holder sign and return the written disclosure statement, and that the health carrier provide a no-cost method for the prospective or current policyholder or contract holder to return the signed written disclosure statement to the health carrier. The proposed amendments to §21.3530 are necessary to address a gap in the existing rule because it does not contemplate offering or providing a consumer choice health benefit plan through an electronic medium, such as the federal health benefit exchange. Absent the proposed amendments to §21.3530, the existing rule would remain in place, and the section would not address a method for health carriers to provide the notice required by Insurance Code §1507.006 and §1507.056 when the health carrier offers or provides a consumer choice plan through the federal health benefit exchange. For these reasons this alternative was rejected.

(ii) Allowing health carriers flexibility in determining how consumers must return the signed disclosure statement forms. Under Insurance Code §1507.006 and §1507.056, and 28 TAC §21.3530, a health carrier must retain a signed copy of the written disclosure statement required by the respective sections. However, if the consumer does not return the signed copy of the written disclosure statement, the health carrier will not have it to retain. The department believes that a consumer is more likely to return the signed disclosure form if there is no cost to the consumer to return it. So the proposed amendment requires the health carriers to provide a method of returning the signed form at no cost to the consumer.

Initially, the department considered specifying that health carriers comply with the written disclosure requirement by providing return postage for a consumer to use in returning the disclosure form. However, the proposed rule does not specify a method for returning a signed disclosure form as proposed, and health carriers will instead be given flexibility under the rule.

A health carrier is in the best position to determine the most cost-effective way for a consumer to return a signed disclosure form as required by the proposed rule. Permitting each health carrier to determine the method of returning the form creates a flexible approach that could help defray the cost of return postage. For some health carriers, providing return postage may be the most cost-effective method to comply with the proposed amendment. Other health carriers may choose to use an e-signature process under Insurance Code Chapter 35. The department cannot determine a more cost-effective alternative to apply to small or micro businesses to ensure compliance with the disclosure requirements. The flexible approach proposed in the written disclosure amendment to §21.3530 would help alleviate additional cost impact to any health carrier, including small or micro business health carriers, in complying with the requirement to provide a way for consumers return the signed disclosure statement forms. For this reason, the department has incorporated this option in the proposed text.

(iii) Excluding small and micro businesses from the applicability of the written disclosure requirement under the proposed amendments to §21.3530. Exempting small and micro business health carriers from the written disclosure requirement of the proposed amendments could result in consumers of these small and micro businesses failing to receive adequate information about state-mandated health benefits not included in the consumer choice health benefit plan they are purchasing. Differing standards could also result in diminished methods of providing the elaborate notice contemplated under the statute and the rule. Applying the written disclosure requirement to all health carriers, regardless of size, will result in consistent application of the disclosure criteria and oversight review procedures in the statute and the rule. This consistent application will, in turn, ensure that all consumers, including those that use small and micro business health carriers, have the requisite information to obtain necessary services. Requiring all health carriers, regardless of size, to follow the same disclosure requirements eliminates the possibility that the department would have to create a dual tracking system for overseeing compliance with the disclosure process based on a health carrier's business size.

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

REQUEST FOR PUBLIC COMMENT. If you wish to comment on this proposal you must do so in writing no later than 5 p.m. on December 12, 2016. Send your comments either by mail to Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to ChiefClerk@tdi.texas.gov. You must simultaneously submit an additional copy of the comment either my mail to Judy Wooten, project manager, Life and Health Regulatory Initiatives Team, Regulatory Policy Division, Mail Code 106-1D, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to LHLComments@tdi.texas.gov. You must submit any request for a public hearing separately to the Office of Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 1. GENERAL PROVISIONS
28 TAC §§21.3501 – 21.3504 and 21.3506

STATUTORY AUTHORITY. The amendments to §§21.3501 – 21.3504 and the addition of new §21.3506 to Subchapter AA, Consumer Choice Health Benefit Plans, Division 1, General Provisions, is proposed under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The

section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and provide it to department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed new §21.3506 implements Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 1. GENERAL PROVISIONS

§21.3501. Statement of Purpose.

This subchapter implements [~~is intended to implement~~] the provisions of the Texas Consumer Choice of Benefits Health Insurance Plan Act to achieve [~~. The general purpose of the Act and this subchapter is to implement~~] the legislative goal of providing individuals, employers, and other purchasers of health care coverage in this state the opportunity to choose health benefit plans that are more affordable and flexible than plans available in the existing market. To that end, the Legislature [~~legislature~~] has authorized health carriers to issue policies or evidences of coverage that, in whole or in part, do not offer or provide certain state-mandated health benefits.

§21.3502. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) Basic health care services--Health care services that the commissioner determines an enrolled population might reasonably need to maintain [~~be maintained in~~] good health.

(2) Commissioner--The commissioner of insurance.

(3) Consumer choice health benefit plan--A group or individual accident or sickness insurance policy[~~,~~] or evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits, but that provides creditable coverage as defined by [~~the~~] Insurance Code §1205.004(a) or §1501.102(a).

(4) Consumer choice of benefits health insurance plan--A consumer choice health benefit plan.

(5) Department--The Texas Department of Insurance.

(6) HMO--a person defined in Insurance Code §843.002(14).

(7) Health carrier--Any entity authorized under the Insurance Code or another insurance law of this state that provides health benefits in this state, including an insurance company, a group hospital service corporation under the Insurance Code Chapter 842, an HMO [~~a health maintenance organization~~] under the Insurance Code Chapter 843, and a stipulated premium company under the Insurance Code Chapter 884.

(8) Health insurer--Any entity authorized under the Insurance Code[~~this code~~] or another insurance law or regulation of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 842 of the Insurance Code, and a stipulated premium company under Chapter 884 of the Insurance Code.

(9) Standard health benefit plan--A consumer choice health benefit plan.

(10) State-mandated health benefits--

(A) Coverage required under the Insurance Code, the Administrative Code [~~this code~~], or other law of this state to be provided in an individual, blanket, or group policy for accident and health insurance, a contract for coverage of a health-related condition, or an evidence of coverage that:

(i) includes coverage for specific health care services or benefits;

(ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts, including limitations provided in [~~the~~] Insurance Code §1271.151; or

(iii) includes a specific category of licensed health care practitioner from whom an insured or enrollee is entitled to receive care.

(B) Do not include benefits or coverage mandated by federal law, or standard provisions or rights required under the Insurance Code, the Administrative Code [~~this code~~], or other law of this state, to be provided in an individual, blanket, or group policy for accident and health insurance, a contract for coverage of a health-related condition, or an evidence of coverage unrelated to specific health illnesses, injuries, or conditions of an insured or enrollee, including those benefits or coverages enumerated in [~~the~~] Insurance Code §1507.003(b) and §1507.053(b).

§21.3503. Authority to Offer.

A health carrier may offer[~~,~~] one or more consumer choice health benefit plans; however, if the [~~and a~~] health carrier [~~that~~] is [~~also~~] a small employer carrier, it must [~~shall~~] offer[~~,~~] one or more consumer choice health benefit plans in accordance with this subchapter and other applicable law.

§21.3504. Severability.

A holding that any provision of this subchapter or the application thereof to any person or circumstances is for any reason invalid may [~~shall~~] not affect the remainder of the subchapter and the application of its provisions to any persons under other circumstances.

§21.3506. State-Mandated Health Benefits in Blanket Indemnity Policies.

The category of group to which the health carrier is issuing coverage determines which benefits are state-mandated health benefits for blanket indemnity insurance policies.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 2. STATE-MANDATED HEALTH BENEFITS
28 TAC §§21.3510 - 21.3518

STATUTORY AUTHORITY. The repeal of 28 TAC Division 2, §§21.3510 - 21.3518 is proposed under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and to provide it to the department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed repeal of Division 2, §§21.3510 - 21.3518 implements Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 2. STATE-MANDATED HEALTH BENEFITS

§21.3510. State-mandated Health Benefits in Individual Indemnity Policies.

§21.3511. State-mandated Health Benefits in Group Association Indemnity Policies.

§21.3512. State-mandated Health Benefits in Small Employer Indemnity Policies.

§21.3513. State-mandated Health Benefits in Large Employer Indemnity Policies.

§21.3514. State-mandated Health Benefits in Blanket Indemnity Policies.

§21.3515. State-mandated Health Benefits in Individual HMO Plans.

§21.3516. State-mandated Health Benefits in Group HMO Plans.

§21.3517. State-mandated Health Benefits in Small Employer HMO Plans.

§21.3518. State-mandated Health Benefits in Large Employer HMO Plans.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 3. REQUIRED NOTICES
28 TAC §21.3530

STATUTORY AUTHORITY. The amendments to §21.3530 are proposed under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that

the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and provide it to the department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plan to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §21.3530 implement Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 3. REQUIRED NOTICES

§21.3530. Health Carrier Disclosure.

(a) A health carrier offering or providing a consumer choice health benefit plan must provide each prospective or current policyholder or contract holder with a written disclosure statement in the manner prescribed in Form CCP 1 provided by the department for that purpose. The information provided in Form CCP 1 must provide a sufficient description of the reduced benefit or the state-mandated health benefits not included in the plan to enable the consumer to make an informed decision about whether the consumer choice plan being offered or purchased provides sufficient coverage for the consumer's needs. Form CCP 1:

(1) acknowledges that the consumer choice health benefit plan being offered or purchased does not provide some or all state-mandated health benefits;

(2) lists those state-mandated health benefits not included under the consumer choice health benefit plan;

(3) provides a notice that purchase of the plan may limit future coverage options in the event the policyholder's, contract holder's, or certificate holder's health changes and needed benefits are not covered under the consumer choice health benefit plan;

(4) requires the prospective or current policyholder or contract holder to sign an acknowledgment that the prospective or current policyholder or contract holder has [~~he~~] received the written disclosure statement; [~~,~~] and

(5) informs the prospective or current policyholder or contract holder that the prospective or current policyholder or contract holder [~~he~~] has the right to a copy of the written disclosure statement free of charge.

(b) A health carrier may obtain Form CCP 1 by making a request to the Life and Health Lines Office Intake [~~Life and Health/Filings and Operations Division~~], Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701, or by accessing the department's [~~department~~] website at www.tdi.texas.gov [~~www.tdi.state.tx.us~~].

(c) A health carrier must provide [~~tender~~] the written disclosure statement described in subsection (a) of this section:

(1) to a prospective policyholder or contract holder, not later than the time of [~~with~~] the offer of a consumer choice health benefit plan, except as provided by subsection (e) of this section;

(2) to a [~~an~~] current [~~existing~~] policyholder or contract holder, along with any offer to renew the contract or policy.

(d) A health carrier must provide the written disclosure statement described in subsection (a) of this section to a prospective or current policyholder or contract holder applying for coverage through the federal health benefit exchange as follows:

(1) The health carrier must provide a written disclosure statement:

(A) at the time of application, if the federal health benefit exchange provides a mechanism for a health carrier to provide the written disclosure statement at the time of application; or

(B) no later than three business days from the date the health carrier receives the application from the federal health benefit exchange.

(2) If the health carrier does not provide the written disclosure statement at the time of application, the health carrier must provide either a link to the written disclosure statement directly on the healthcare.gov website; or a reference and link to the written disclosure statement in either the summary of benefits and coverage or the plan brochure provided on the healthcare.gov website.

(e) [~~(d)~~] Except as provided by subsection (g) of this section, when [~~Where~~] a health carrier provides [~~tenders~~] the written disclosure statement referenced in subsection (a) of this section to a prospective or current policyholder or contract holder:

(1) through an agent, the agent may not transmit the application to the health carrier for consideration until the agent has secured the signed written disclosure statement from the applicant; and [~~.~~]

(2) directly to the applicant, the health carrier may not process the application until the health carrier has secured the signed written disclosure statement from the applicant.

(f) When a health carrier provides the written disclosure statement described in subsection (a) of this section in the manner described by subsection (e) of this section, the health carrier must:

(1) request that the prospective or current policyholder or contract holder sign and return the written disclosure statement described in subsection (a) of this section, and

(2) provide a method for the prospective or current policyholder or contract holder to return the signed written disclosure statement to the health carrier at no cost to the prospective or current policyholder or contract holder.

(g) [~~(e)~~] The health carrier must, on [~~upon~~] request, provide the prospective or current policyholder or contract holder with a copy of the written disclosure statement.

(h) [~~(f)~~] When [~~Where~~] a health carrier is offering or issuing a consumer choice health benefit plan to an association, the health carrier must satisfy the requirements of subsection (d) [~~(c)~~] of this section by providing [~~tendering~~] the written disclosure statement to prospective or existing certificate holders.

(i) A health carrier offering or issuing a consumer choice health benefit plan to a prospective or current policy holder, contract holder, or an association must update and file with the commissioner, for approval, its written disclosure statement that conforms with Form CCP 1 no later than one year from the effective date of this rule.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 4. ADDITIONAL REQUIREMENTS
28 TAC § 21.3542

STATUTORY AUTHORITY. The amendment to §21.3542 is proposed under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits reduced or not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and provide it to the department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits reduced or not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §21.3542 implement Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 4. ADDITIONAL REQUIREMENTS

§21.3542. Offer of State-Mandated Plan.

(a) A health carrier that offers the opportunity to apply for one or more consumer choice health benefit plans under this section to a person or entity must also, no later than at the time of application,

offer the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that reasonably [~~most closely~~] approximates the consumer choice health benefit plan offered, that includes state-mandated health benefits, and that is otherwise authorized by the Insurance Code.

(b) With regard to health plans required by subsection (a) of this section, a health carrier must [~~shall~~]:

(1) use the same sources and methods of distribution to market both consumer choice health benefit plans and health benefit plans required by this subsection, [~~;~~] and a health carrier that markets consumer choice health benefit plans through the federal health benefit exchange or other online marketplaces must use the same sources and methods of distribution to market both consumer choice health benefit plans and state-mandated health benefit plans required by this subsection;

(2) make the offer of the [~~such~~] health plans, the premium cost of the [~~such~~] plans, as well as any additional details regarding them, contemporaneously with and in the same manner as the offer and premium cost of, and other details regarding, the consumer choice health benefit plan policy or evidence of coverage; and

(3) provide at least the following information:

(A) a description of how the person or entity may apply for or enroll in each offered policy or evidence of coverage; and

(B) the benefits [~~and/~~]or services available, or both, and the premium cost under each offered policy or evidence of coverage.[~~; and~~]

[~~(C) upon request, an explanation of each of the policies or evidences of coverage and the differences between the health plan offered pursuant to subsection (a) of this section and the consumer choice health benefit plans.~~]

(c) A health carrier may [~~shall~~] not apply more stringent or detailed requirements related to the application process for a consumer choice health benefit plan, or for a policy or evidence of coverage offered in accordance [~~compliance~~] with subsection (a) of this section, than it applies for other health benefit plans offered by the health carrier.

(d) A health carrier offering a consumer choice health benefit plan must obtain from each prospective policyholder or contract holder, at or before the time of application, a written affirmation that the health carrier also offered a policy or evidence of coverage in compliance with subsection (a) of this section. A health carrier may combine on a single form this written affirmation and the

acknowledgement of the written disclosure statement required by §21.3530(a)(4) of this subchapter (relating to Health Carrier Disclosure).

CERTIFICATION. This agency certifies that legal counsel has reviewed the proposed repeal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on October 26, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance