Chapter 21. Trade Practices
Subchapter W. Coverage for Acquired Brain Injury
§§21.3101 - 21.3107

1. INTRODUCTION. The Texas Department of Insurance proposes amendments to §§21.3101 - 21.3105 and new §21.3106 and §21.3107, concerning coverage for acquired brain injury. These amendments and new sections are necessary to implement House Bill (HB) 1919, 80th Legislature, Regular Session, effective January 1, 2008, which amended Insurance Code Chapter 1352, relating to required coverage for acquired brain injury. The proposed amendments and new sections: (i) address expanded coverage of acquired brain injury provisions in health benefit plans to include coverage of post-acute care and cognitive rehabilitation for survivors of brain injuries; (ii) distinguish required coverage provisions that do not apply to small business health benefit plans and provide alternative coverage provisions that do apply to small business health benefit plans; (iii) specify the content for a notification of coverage that health benefit plan issuers, other than small business plans, are required to annually provide to insureds or enrollees; and (iv) specify procedures for the distribution of the required notification of coverage. The amendments are also necessary to update statutory citations in existing rules to conform to the non-substantive revised Insurance Code, which are necessary for easier use and readability of the rules.

The proposed amendment to delete §21.3101(a)(4) is necessary because the statutory authority for the provision has expired. The statutory authority for §21.3101(a)(4) in SECTION 2 of Acts 2001, 77th Leg., Ch. 859 required the Sunset Commission to prepare a report and the Department to assist the Sunset Commission as necessary. However, under SECTION 2(d), SECTION 2 expired on September 1,

2007. The proposed amendments to §21.3101(c)(1) are necessary to specify an effective date for the proposed amendments and new sections. The Department is proposing an effective date of October 31, 2008.

The proposed amendments to §21.3101(c)(2) are necessary to make clarifying changes to punctuation within the paragraph.

The proposed amendments to §21.3102 are necessary to add definitions for "outpatient day treatment services" and "post-acute care treatment services," and to redesignate the following paragraphs accordingly.

The proposed amendments to §21.3103 are necessary to expand the section, adding new subsections, paragraphs, and subparagraphs, in order to implement provisions of HB 1919 related to required coverage for acquired brain injury. Additionally, proposed amendments are necessary to re-organize existing subsections into paragraphs and subparagraphs for purposes of better organization and clarity of the proposed and existing rules. Subsection titles are proposed to assist in organization and provide clarity. The proposed amendment to §21.3103(a), which addresses required coverage, is necessary to modify the existing provision concerning coverage for services to conform to the Insurance Code §1352.003, as amended by HB 1919, by adding "outpatient day treatment services or other post-acute care treatment services" to the types of required coverage. Section 21.3103(b) addresses medically necessary and appropriate treatments and services for an acquired brain injury. The proposed amendment to §21.3103(b)(1) that changes the existing reference to "subsection (a) of this section" to "this subchapter" is necessary because the reorganization of §21.3103 and the expansion of the subchapter to implement HB 1919 results in the use of the

terms “necessary” and “medically necessary” in other rules within the subchapter in addition to §21.3103(a). The proposed amendment to §21.3103(b) that adds new subparagraph (2) is consistent with the Insurance Code §1352.007(a) as enacted by HB 1919, which prohibits health benefit plans from denying benefits for the coverage required under Chapter 1352 of the Insurance Code based solely on the fact that the treatment or services are provided at a facility other than a hospital, and mandates that medically necessary treatment and services for an acquired brain injury must be provided under the coverage required by Chapter 1352 at a facility at which appropriate services may be provided. Additionally, in accordance with the Insurance Code §1352.007(a)(1) and (2), the proposed new §21.3103(b)(2) provides examples of such facilities in subparagraphs (A) and (B). The proposed amendment to §21.3103(c)(1) is necessary to specify that the source of the mandated coverage is the Insurance Code Chapter 1352. In accordance with the Insurance Code §1352.003(e), proposed new §21.3103(c)(2) provides that a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, been unresponsive to treatment, and becomes responsive to treatment at a later date. In accordance with the Insurance Code §1352.003(f), proposed §21.3103(c)(2) specifies five factors that are to be used in determining whether expenses related to periodic reevaluation of care are reasonable and must be covered. Section 21.3103(d) addresses annual or lifetime payment limitations, deductibles, copayments, and coinsurance. Proposed new §21.3103(d)(1) is necessary to prohibit a health benefit plan from subjecting the coverage for services required by §21.3103 to payment limitations, deductibles, copayments, and coinsurance

factors that are more restrictive than payment limitations, deductibles, copayments, and coinsurance factors applicable to other similar coverage provided under the health benefit plan.

Proposed new §21.3103(d)(2) is necessary to clarify the Insurance Code §1352.003(c) provisions relating to health benefit plan post acute care treatment limitations. HB 1919 amends §1352.003 of the Insurance Code to add subsection (c) which provides that a health benefit plan may not include, in any lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan. Section 1352.003(c) further provides that any limitation imposed under the plan on days of post-acute care treatment must be separately stated in the plan. Thus, while both sentences in §1352.003(c) address limitations related to days of post-acute care treatment, the first sentence in §1352.003(c) expressly prohibits including any post-acute care treatment covered under the plan in *any lifetime limitation* on the number of days of acute care treatment covered under the plan, and the second sentence provides that *any limitation* imposed under the plan on days of post-acute care treatment must be separately stated in the plan. The reference to *any limitation* in the second sentence clearly includes any lifetime limitation as well as any other type of limitation under a health benefit plan. Limitations on the number of days in a health benefit plan may be annual limitations or lifetime limitations. However, because of the first sentence in §1352.003(c), which addresses only lifetime limitations, it is possible for a health benefit plan to apply the second sentence in §1352.003(c) to provide that only lifetime limitations for post acute care treatment must be stated separately, and another health benefit plan to apply the sentence to provide

that both lifetime and annual limitations for post acute care treatment must be stated separately. This could result in insureds and enrollees of some plans having different acute care and post acute care limitations than insureds and enrollees in other plans, which is not consistent with the intent of the statute. Therefore, it is necessary to provide guidance to ensure consistent implementation of §1352.003(c) so that all insureds and enrollees of health benefit plans are treated uniformly with respect to acute care limitations and post acute care limitations. As a result, the Department is proposing §21.3103(d)(2)(A) to provide that a health benefit plan may not include post-acute care treatment related to acquired brain injury in any coverage provisions under the plan that address annual and/or lifetime limitations on the number of days of post acute care treatment related to acquired brain injury. The Department is also proposing §21.3103(d)(2)(B) to provide, in accordance with the Insurance Code §1352.003(c), that a health benefit plan that includes annual and/or lifetime limitations on coverage for acquired brain injury must provide a separate statement of coverage under the plan for any annual and/or lifetime limitations for post-acute care treatment related to acquired brain injury. These provisions are proposed for the following reasons. The plain language in the first sentence in §1352.003(c) does not expressly address the inclusion or prohibited inclusion of limitations other than lifetime limitations. The first sentence prohibits a health benefit plan that has a lifetime limitation on the number of days of acute care from including in that limitation any post acute care covered under the plan. As previously stated, the reference to *any limitation* in the second sentence clearly includes any lifetime limitation as well as any other type of limitation under health benefit plans. Because the limitations on the number of days in a health benefit plan may be

annual limitations or lifetime limitations, the second sentence provides that any lifetime or annual limitation imposed on the number of days of covered acute care treatment under the plan must be separately stated in the plan. If such limitations must be separately stated, it is anticipated that the plans have such limitations. Because the first sentence in §1352.003(c) does not expressly address any type of limitation other than lifetime limitations, including the prohibition of annual limitations, and because the second sentence anticipates the use of both annual and lifetime limitations for acute care treatment, proposed §21.3103(d)(2)(A) provides that a health benefit plan may not include post-acute care treatment related to acquired brain injury in any coverage provisions under the plan that address annual and/or lifetime limitations on the number of days of post acute care treatment related to acquired brain injury. Proposed §21.3103(d)(2)(B) provides, in accordance with the Insurance Code §1352.003(c), that a health benefit plan that includes annual and/or lifetime limitations on coverage for acquired brain injury must provide a separate statement of coverage under the plan for any annual and/or lifetime limitations for post-acute care treatment related to acquired brain injury.

Section 21.3103(e) addresses other coverage limitations. The proposed amendment to §21.3103(e) is necessary to reflect that the source of the mandated coverage is the Insurance Code Chapter 1352. Section 21.3103(f) addresses permitted coverage exclusions. One of the proposed amendments to §21.3103(f) is necessary to clarify that the term that is defined in §21.3102 is "neurofeedback therapy" rather than the existing referenced term “neurofeedback.” The proposed amendments to §21.3103(f) are necessary to specify that the source of the mandated coverage is the

Insurance Code Chapter 1352. Section 21.3103(g) addresses permitted coverage denials. A proposed amendment in §21.3103(g) that changes the term “an issuer” to “a health benefit plan” is necessary for consistency with the Insurance Code §1352.003. A second proposed amendment in §21.3103(g) that changes the phrase “listed in subsection (a) of this section” to “required under the Insurance Code Chapter 1352” is necessary to specify that the source of the mandated coverage is the Insurance Code Chapter 1352. Proposed new §21.3103(h) is necessary to address the inapplicability of §21.3103 to small employer health benefit plans in accordance with the Insurance Code §§1352.003(h) and 1352.007(b).

Existing §21.3104(c) specifies the minimum training required in order for each issuer to comply with the requirements of §21.3104(c) relating to preauthorization of coverage or utilization review training. The proposed amendment to §21.3104(c)(3) adds the word “and” to the end of that paragraph. This is necessary to clarify that all of the types of training or instruction listed in §21.3104(c)(3)(1) – (4) comprise the total minimum requirements.

Proposed new §21.3106 is necessary to address small employer health benefit plans. The changes in Chapter 1352 of the Insurance Code enacted by HB 1919 are not applicable to small employer health benefit plans; instead, HB 1919 enacts a new §1352.0035 that contains the same requirements of Chapter 1352 that applied to small employer health benefit plans before the enactment of HB 1919. Proposed new §21.3106 is consistent with §1352.0035 of the Insurance Code.

Proposed new §21.3107 is necessary to address the mandatory annual notice of coverage to insureds and enrollees that is required in §1352.005 of the Insurance Code.

Section 1352.005(a) requires a health benefit plan issuer, other than a small employer health benefit plan, to annually notify each insured or enrollee under the plan in writing about the coverages described by 1352.003. As required by §1352.005(b) of the Insurance Code, the proposed notice was prepared in consultation with the Texas Traumatic Brain Injury Advisory Council. Section 1352.005(c) of the Insurance Code specifies the required types of information that must be included in the notice. Proposed new §21.3107(a) specifies the content of the notice in accordance with §1352.005(c). Proposed §21.3107(b) provides a process for distribution of the notice of coverage for acquired brain injury. Proposed §21.3107(c) requires the notice to be printed in at least 12-point type and to comply with the timelines specified in proposed §21.3107(c)(1)(A) and (B). Under the proposed timelines, the notice must be provided within the policy term and no later than the 60th day after the effective date of this section to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the effective date of this section; or within the policy term and no later than the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the effective date of this section. Proposed new §21.3107(c)(2) requires a health benefit plan issuer to deliver the notices to insureds or enrollees through the U.S. Postal Service except as provided in §21.3107(c)(6). Proposed new §21.3107(c)(3) provides that the notice may be delivered with other health benefit plan documents that are delivered through the U.S. Postal Service as long as the time frames in §21.3107(c)(1) are met. For example, the notice may be delivered with the policy, certificate, evidence of coverage, or enrollment/insurance card. Proposed new §21.3107(c)(4) provides that

if the notice is provided to the primary insured's or enrollee's last known address, the requirements of §21.3107 are satisfied with respect to all enrollees or insureds residing at that address. Proposed new §21.3107(c)(5) requires separate notices to be provided to the spouse or the dependent at the spouse's and/or dependent's last known address if the last known address of a covered spouse and/or dependent is different than the primary insured's or enrollee's last known address. Proposed new §21.3107(c)(6) allows the notice to be provided to the group master contract holder for distribution to insureds or enrollees of group health benefit plans if the health benefit plan issuer has an agreement with the group master contract holder that the notice will be delivered in accordance with the timelines specified in §21.3107(c)(1). Proposed §21.3107(c)(6) further provides that in the event the notice is distributed to the group master contract holder, the health benefit plan issuer will be held responsible for ensuring that the notice is provided to the insureds or enrollees. Proposed new §21.3107(d) provides that the section does not apply to a small employer health benefit plan issuer in accordance with §1352.003(a) of the Insurance Code.

Proposed amendments to §§21.3101(a)(3); 21.3102(6) and (7); 21.3103(b)(1); 21.3104(a), (c), and (c)(4); and 21.3105 update statutory citations to conform with the non-substantive revised Insurance Code.

2. FISCAL NOTE. Debra Diaz-Lara, Acting Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division (HWCN), has determined that for each year of the first five years the proposed amendments and new sections will be in effect, there will be no fiscal impact to state and local

governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Diaz-Lara also has determined that for each year of the first five years the proposed amendments and new sections are in effect, the public benefit anticipated as a result of the proposal are rules that implement the Insurance Code Chapter 1352 as amended by HB 1919, 80th Legislature, and provide guidance to health benefit plan issuers on: (i) coverage of post-acute care and cognitive rehabilitation for survivors of brain injuries as required by the Insurance Code §1352.003(c); and (ii) the procedures for distribution to insureds and enrollees of the mandatory annual notification of coverage required by the Insurance Code §1352.005. Also, statutory citations in existing rules are updated to conform to the non-substantive revised Insurance Code, which will result in easier use and readability of the rules.

The Department does not anticipate any additional cost to persons required to comply with the proposal except for implementation of the procedures for distribution to insureds or enrollees of the mandatory annual notification of coverage for acquired brain injury in proposed §21.3107(c). Section 1352.005(a) of the Insurance Code requires a health benefit plan issuer subject to Chapter 1352, other than a small employer health benefit plan, to annually notify each insured or enrollee under the plan in writing about the coverages described by §1352.003 of the Insurance Code. Because the statute does not require a specific means of distribution, the department is proposing

§21.3107(c)(2), which requires that a health benefit plan issuer deliver the notices to insureds or enrollees through the U.S. Postal Service.

Pursuant to §1352.005(a) of the Insurance Code, a small employer health benefit plan issuer is not required to distribute the notification, and therefore, no small employer health benefit plan issuer is subject to proposed §21.3107(c). Pursuant to §1501.002(14) of the Insurance Code, a “small employer” is a person that employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. Pursuant to §1501.002(15) of the Insurance Code, a “small employer health benefit plan" is a health benefit plan developed by the Commissioner under Insurance Code Chapter 1501 Subchapter F or any other health benefit plan offered to a “small employer” in accordance with Insurance Code §1501.252(c) or §1501.255. A “small employer health benefit plan" issuer may be a business of any size. A “small employer” is the purchaser of the health benefit plan whose employees are covered under the small employer health benefit plan. The statutory exemption from the annual notice requirement in §1352.005(a) of the Insurance Code applies to each health benefit plan issuer, regardless of the size of the individual issuer, that issues plans to those employers that meet the statutory definition of “small employer” in §1501.002(14) of the Insurance Code. The exemption does not pertain to the size of the individual health benefit plan issuer. Therefore, persons that are required to distribute the notification are health benefit plan issuers, regardless of size, that provide acquired brain injury coverage to insureds or enrollees under any plan other than a plan that qualifies as a “small employer health benefit plan.” Part of the

costs associated with the notification of insureds and enrollees of coverage for acquired brain injury are the direct result of HB 1919. Section 1352.005 of the Insurance Code requires that the notice of coverage for acquired brain injury be distributed annually in writing to each insured or enrollee under the plan. Section 1352.005(c) specifies the content that must be included in the notice. This content includes: (i) a description of the benefits listed under §1352.003 of the Insurance Code; (ii) a statement that the fact that an acquired brain injury does not result in hospitalization or receipt of a specific treatment or service described by the Insurance Code §1352.003 for acute care treatment does not affect the right of the insured or enrollee to receive benefits described by the Insurance Code §1352.003 commensurate with the condition of the insured or enrollee; and (iii) a statement of the fact that benefits described by the Insurance Code §1352.003 may be provided in a facility listed in the Insurance Code §1352.007. Section 1352.005(b) requires the Commissioner to prescribe the specific contents and wording in the notice in consultation with the Texas Traumatic Brain Injury Advisory Council. The notice contents required pursuant to proposed §21.3107(a) does not contain any information that is not specified in §1352.005(c) of the Insurance Code, either generally as in §1352.005(c)(1) or specifically as provided in §1352.005(c)(2) and (3). The proposal does not require any information to be included in the notice that is additional to that specified in §1352.005(c). Therefore, the annual printing costs associated with preparation of the required notice of coverage for acquired brain are a direct result of the legislative enactment of HB 1919. As previously indicated, the statute, however, does not address the manner of delivery of the required notice. The proposal in §21.3107(c)(2) requires that the notice be delivered through the U.S. Postal

Service. The anticipated cost associated with such delivery is approximately $0.45 per notice. This estimate is based on the fact that a box of 500 pre-stamped window envelopes may be purchased from the U.S. Post Office for $224.90. This amount divided by 500 equals $0.4498. The total actual cost for each issuer will vary depending on how many insureds and enrollees of each issuer must receive the notice. If a health benefit plan issuer opts to use another type of envelope and means of postage, the issuer has the information necessary to estimate the costs of such an option. The Department has attempted to defray the cost resulting from proposed §21.3107(c)(2) through the alternatives in proposed §21.3107(c)(3), which permits health benefit plan issuers to deliver the required notice of coverage for acquired brain injury with other health benefit plan documents (such as the policy, certificate, evidence of coverage, or enrollment/insurance card) and in proposed §21.3107(c)(6), which permits group health benefit plan issuers to provide the notice to the group master contract holder for distribution to insureds or enrollees when the carrier has an agreement with the group master contract holder that the notice will be delivered in accordance with the timelines specified in the proposed rule.

All other costs required to comply with the proposal result from the legislative enactment of HB 1919 and not as a result of the adoption, enforcement, or administration of this proposal.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses,

state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(a)(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(a)(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.001(a)(1) does not specify a maximum level of gross receipts for a "micro business." The Department has determined that the proposal may have an adverse economic impact on approximately 30 - 40 health benefit plan issuers that qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2) and that are required to comply with the proposed rules. The only adverse economic impact of the proposed rules anticipated by the Department on these 30 - 40 health benefit plan issuers is the additional cost required to comply with the procedures for distribution of the mandatory annual notification under proposed §21.3107(c)(2) to insureds and enrollees under any health benefit plan other than a plan that qualifies as a small employer health benefit plan. These 30 – 40 health benefit plan issuers are not necessarily the same health benefit plan issuers as the "small employer health benefit plan issuers" that are statutorily exempt from the annual notice requirements of §1352.005(a) of the Insurance Code and therefore also exempt from proposed §21.3107(c). Pursuant to §1501.002(14) of the Insurance Code, a "small employer" is a

person that employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. Pursuant to §1501.002(15) of the Insurance Code, a “small employer health benefit plan" is a health benefit plan developed by the Commissioner under Insurance Code Chapter 1501 Subchapter F or any other health benefit plan offered to a “small employer” in accordance with Insurance Code §1501.252(c) or §1501.255. A “small employer health benefit plan" issuer may be a business of any size, and a “small employer” is the purchaser of the health benefit plan whose employees are covered under the small employer health benefit plan. The statutory exemption from the requirements in §1352.005 of the Insurance Code applies to health benefit plan issuers, regardless of the size of the individual issuer, that issue plans to those employers that meet the statutory definition of “small employer” in §1501.002(14) of the Insurance Code. The exemption does not pertain to the size of the individual health benefit plan issuer. For example, a health benefit plan issuer that does not qualify as a small or micro business under the Government Code §2006.001(a)(1) and (2) may be the plan issuer for a small employer health benefit plan; in this instance, the health benefit plan issuer would not be subject to §1352.005 of the Insurance Code or proposed §21.3107(c). Or, alternatively, a health benefit plan issuer that qualifies as a small or micro business under the Government Code §2006.001(a)(1) and (2) may be the plan issuer for a small employer benefit plan and also would not be subject to §1352.005 or proposed §21.3107(c), but if the same small or micro business health benefit plan issuer were a plan issuer for a plan other than a plan that qualifies as a “small employer health benefit

plan," the small or micro business plan issuer would be subject to §1352.005 and proposed §21.3107(c). Therefore, those health benefit plan issuers that qualify as a small or micro business under the Government Code §2006.001(a)(1) and (2) that are required to distribute the notification are those small and micro business health benefit plan issuers that provide acquired brain injury coverage to insureds or enrollees under any plan other than a plan that qualifies as a small employer health benefit plan. Any health benefit plan issuer that qualifies as a small or micro business under the Government Code §2006.001(a)(1) and (2) that provides acquired brain injury coverage to insureds or enrollees under a "small employer health benefit plan" is not required by the Insurance Code §1352.003(a) or proposed §21.3107(c) to distribute the annual notification. The Department's cost analysis for the distribution of the annual notice and resulting estimated costs on a per notice basis in the Public Benefit/Cost Note portion of this proposal is equally applicable to those health benefit plan issuers that qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2). As previously indicated, the total actual cost for each issuer, regardless of size, will vary depending on how many insureds and enrollees of each issuer must receive the notice.

In accordance with the Government Code §2006.002(c-1), the Department has considered other regulatory methods to accomplish the objectives of the proposal that will also minimize any adverse impact on the estimated 30 – 40 health benefit plan issuers that qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2).

The Insurance Code §1352.005 requires a health benefit plan issuer that is subject to Chapter 1352, other than a small employer health benefit plan issuer, to

annually notify each insured or enrollee under the plan in writing about the brain injury coverages described in §1352.003 of the Insurance Code. The primary objective of §1352.005 is to ensure that all insureds and enrollees covered under any health benefit plan other than a plan that qualifies as a "small employer health benefit plan" are provided, on an annual basis, essential information about the brain injury coverages under the plan. This includes insureds and enrollees covered under health benefit plans issued by health benefit plan issuers that qualify as a small or micro business under the Government Code §2006.001(a)(1) and (2) when such insureds and enrollees are covered by a health benefit plan other than a plan that qualifies as a "small employer health benefit plan." Proposed §21.3107(c) implements §1352.005 in part by requiring that the health benefit plan issuer, except for the small employer benefit plan issuer, deliver the notices to insureds and enrollees through the U.S. Postal Service. This method of delivery is proposed because it is an efficient method of delivery that is consistent with delivery of notices required by other Department rules. The objective of proposed §21.3107(c) is to establish a standardized method of delivery that is most likely to reach the greatest number of insureds or enrollees.

The other regulatory methods considered by the Department to accomplish the objectives of the statute and the proposal and to minimize any adverse impact on health benefit plan issuers that qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2) include: (i) not adopting the proposed regulation; (ii) implementing different requirements or standards for the estimated 30 – 40 health benefit plan issuers that qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2); and (iii) allowing other alternative methods of delivery.

Not adopting proposed §21.3107(c)(2) If the proposed requirement in §21.3107(c)(2) were not adopted, a health benefit plan issuer that provides acquired brain injury coverage to insureds or enrollees in plans other than small employer health benefit plans and regardless of the size of the health benefit plan issuer would still be statutorily required to distribute an annual notice of coverage for acquired brain injury, but would have no regulatory guidance on procedures for distribution of the notice. Each health benefit plan issuer would have discretion in how the notice was delivered or transmitted to insureds and enrollees. This could result in what could be considered for some insureds and enrollees to be a less reliable and consistent means of notification. For example, a health benefit plan issuer could opt to use methods of notification that not all insureds or enrollees have access to, such as email, fax, or internet posting. The Department, therefore, rejected this approach because the Department could not be sure that it would accomplish the objective of the statute and the rule proposal and, therefore would not be consistent with legislative intent.

Implementing different requirements or standards for health benefit plan issuers that qualify as small and micro businesses. If the proposed requirement in §21.3107(c)(2) that requires a health benefit plan issuer, other than a small employer health benefit plan issuer, to deliver the required notice to insureds and enrollees through the U.S. Postal Service were not made applicable to health benefit plan issuers that qualify as small or micro businesses under the Government Code §2006.001(a)(1) and (2), the proposal would not result in an adverse economic effect on the small or micro business health benefit plan issuers. However, it would also result in the small and micro business health benefit plan issuers having discretion in how the notice was

delivered or transmitted to each plan's insureds or enrollees. This could result in what could be considered for some insureds and enrollees to be a less reliable or consistent means of notification. For example, a small or micro business health benefit plan issuer could opt to use methods of notification that not all insureds or enrollees have access to, such as email, fax, or internet posting. The Department, therefore, rejected this approach because the Department could not be sure that it would accomplish the objective of the statute and the rule proposal and implement the legislative intent, *i.e*., that all insureds and enrollees covered under any health benefit plan other than a plan that qualifies as a small employer health benefit plan, including those covered by health benefit plans issued by an issuer that qualifies as a small or micro business under the Government Code §2006.001(a)(1) and (2), receive essential information, on an annual basis, about the brain injury coverages under the plan.

Allowing alternative methods of delivery. The Department anticipates that costs resulting from the proposed requirement in §21.3107(c)(2) that health benefit plan issuers, except small employer health benefit plan issuers, deliver the required notice to insureds and enrollees through the U.S. Postal Service can be reduced or eliminated through two alternative methods of delivery that may be used by an issuer, including health benefit plan issuers that qualify as small and micro businesses under the Government Code §2006.001(a)(1) and (2): (i) proposed §21.3107(c)(3) allows health benefit plan issuers to distribute the annual notice of coverage for acquired brain injury with other health benefit plan documents that already must be distributed (such as the policy, certificate, evidence of coverage, or enrollment/insurance card), and (ii) proposed §21.3107(c)(6) allows group health benefit plan issuers to provide the annual

notice to the group master contract holder for distribution to insureds or enrollees when the health benefit plan issuer has an agreement with the group master contract holder that the notice will be delivered in accordance with the statutory requirement of annual notice and with the notification requirements specified in proposed §21.3107(c)(1)(A) and (B). The Department has determined that both of these methods will achieve the purpose of the statute and the proposed rule and will be consistent with the legislative intent. Both alternatives will also reduce the economic impact on health benefit plan issuers that qualify as small and micro businesses under the Government Code §2006.001(a)(1) and (2) and that must issue the notice to insureds and enrollees covered under any health benefit plan other than a small employer health benefit plan.

5. 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 the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 25, 2008 to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Debra Diaz-Lara, Manager, HWCN

Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of the proposed amendments and new sections in a public hearing under Docket No. 2692 scheduled for September 25, 2008 at 10:00 a.m. in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The amendments and new sections are proposed pursuant to the Insurance Code §§1352.003(g), 1352.0035(c), 1352.005(b), and 36.001. Section 1352.003(g) provides that the Commissioner shall adopt rules as necessary to implement Insurance Code Chapter 1352, relating to brain injury coverage. Section 1352.0035(c) provides that the Commissioner shall adopt rules as necessary to implement §1352.0035, relating to required brain injury coverage for small employer benefit plans. Section 1352.005(b) provides that the Commissioner, in consultation with the Texas Traumatic Brain Injury Advisory Council, shall prescribe by rule the specific contents and wording of the notice of coverage for acquired brain injury that is required by §1352.005(a). Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§21.3101	Insurance Code §§1352.001 and 1352.002
§21.3102 and 21.3103	Insurance Code §1352.003
§21.3104	Insurance Code §1352.004
§21.3106	Insurance Code §1352.0035
§21.3107	Insurance Code §1352.005

9. TEXT.

§21.3101. General Provisions.

(a) Purpose. The purpose of this subchapter is to:

(1) ensure that enrollees in health benefit plans receive coverage for certain services for acquired brain injury and to facilitate the recovery and progressive rehabilitation of survivors of acquired brain injuries to the extent possible to their pre-injury condition by making available therapies that are medically necessary, clinically proven, goal-oriented, efficacious, based on individualized treatment plans, and provided by, or ordered and provided under the direction of a licensed healthcare practitioner with the goal of returning the individual to, or maintaining the individual in, the most integrated living environment appropriate to the individual;

(2) ensure that an issuer provides coverage for services related to an acquired brain injury under the medical/surgical provisions of the health benefit plan;

(3) require the issuer of a health benefit plan to provide adequate training of individuals responsible for preauthorization of coverage or utilization review under the plan in order to prevent wrongful denial of coverage required under the Insurance Code Chapter 1352[~~Article 21.53Q~~] and this subchapter, and to avoid confusion of medical/surgical benefits with mental/behavioral health benefits; and

[~~(4) gather information to allow the department to cooperate with, and to assist, the Sunset Advisory Commission in determining to what extent the coverage required by Article 21.53Q and this subchapter is being used by enrollees in health benefit plans to which the article and this subchapter apply, and to determine the impact of the required coverage on the cost of those health benefit plans.~~]

(b) (No change.)

(c) Applicability.

(1) Except as otherwise specified in this subchapter:

(A) This subchapter applies [~~These sections apply~~] to all health benefit plans delivered, issued for delivery, or renewed on or after October 31, 2008 [~~January 1, 2002~~].

(B) Health benefit plans delivered, issued for delivery, or renewed prior to October 31, 2008 are subject to the statutes and provisions of this subchapter in effect at the time the health benefit plans were delivered, issued for delivery, or renewed.

(2) Nothing in this subchapter requires the issuer of a health benefit plan to provide coverage for services that are not: medically necessary;[~~,~~] clinically proven;[~~,~~]

goal-oriented;[~~,~~] efficacious;[~~,~~] based on an individualized treatment plan;[~~,~~] or provided by, or ordered and provided under the direction of a licensed healthcare practitioner.

§21.3102. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) - (5) (No change.)

(6) Health benefit plan--As described in the Insurance Code §1352.001 and §1352.002[~~Article 21.53Q, §1~~].

(7) Issuer--Those entities identified in the Insurance Code §1352.001[~~Article 21.53Q, §1(a)(1) - (9)~~].

(8) - (17) (No change.)

(18) Outpatient day treatment services--Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

(19) Post-acute care treatment services--Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

(20)[~~(18)~~] Post-acute transition services--Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

(21)[~~(19)~~] Psychophysiological testing--An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

(22)[~~(20)~~] Psychophysiological treatment--Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

(23)[~~(21)~~] Remediation--The process(es) of restoring or improving a specific function.

(24)[~~(22)~~] Services--The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

(25)[~~(23)~~] Therapy--The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

§21.3103. Coverage for Services.

(a) Required Coverage. Pursuant to the Insurance Code Chapter 1352, a health benefit plan must include[~~An issuer may not exclude~~] coverage for services specified in §1352.003, including [~~for~~] cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and[~~or~~] treatment, neurofeedback therapy, remediation, post-acute transition services and[~~or~~] community reintegration

services, including outpatient day treatment services, or other post-acute care treatment services, if such services are necessary as a result of and related to an acquired brain injury.

(b) Medically Necessary and Appropriate.

(1) For purposes of the Insurance Code §1352.003[~~Article 21.53Q, §2~~] and this subchapter[~~subsection (a) of this section~~], the word "necessary" means "medically necessary."

(2) Pursuant to the Insurance Code §1352.007(a), a health benefit plan may not deny benefits for the coverage required under the Insurance Code Chapter 1352, relating to brain injury, based solely on the fact that the treatment or services are provided at a facility other than a hospital. Medically necessary treatment and services for an acquired brain injury must be provided under the coverage required by Chapter 1352 at a facility at which appropriate services may be provided, which may include:

(A) a hospital regulated under the Health and Safety Code Chapter 241, including an acute or post-acute rehabilitation hospital; and

(B) an assisted living facility regulated under the Health and Safety Code Chapter 247.

(c) Maintenance, Prevention, and Reevaluation of Care.

(1) Treatment goals for services required by the Insurance Code Chapter 1352 [~~subsection (a) of this section~~] may include the maintenance of functioning or the prevention of or slowing of further deterioration.

(2) Pursuant to the Insurance Code §1352.003(e), a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the

care of an individual covered under the plan who has incurred an acquired brain injury, been unresponsive to treatment, and becomes responsive to treatment at a later date. In accordance with the Insurance Code §1352.003(f), factors for determining whether reasonable expenses related to periodic reevaluation of care must be covered may include:

(A) cost;

(B) the time that has expired since the previous evaluation;

(C) any difference in the expertise of the physician or practitioner performing the evaluation;

(D) changes in technology; and

(E) advances in medicine.

(d) Annual or Lifetime Payment Limitations, Deductibles, Copayments, and Coinsurance.

(1) a health benefit plan is prohibited from subjecting the coverage for services required under the Insurance Code Chapter 1352 to payment limitations, deductibles, copayments, and coinsurance factors that are more restrictive than payment limitations, deductibles, copayments, and coinsurance factors [~~The coverage for services required by subsection (a) of this section may be subject to the deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with deductibles, copayments, coinsurance, and annual or maximum payment limits~~] applicable to other similar coverage provided under the health benefit plan.

(2) A health benefit plan that includes annual and/or lifetime limitations on coverage for acquired brain injury:

(A) may not include post-acute care treatment related to acquired brain injury in any coverage provisions under the plan that address annual and/or lifetime limitations on the number of days of acute care treatment related to acquired brain injury, and

(B) must provide a separate statement of coverage under the plan for any annual and/or lifetime limitations for post-acute care treatment related to acquired brain injury.

(e) Other Coverage Limitations. The coverage for services required under the Insurance Code Chapter 1352 [~~by subsection (a) of this section~~] may be subject to limitations and exclusions that are generally applicable to other physical illnesses or injuries under the health benefit plan. These types of exclusions or limitations include, but are not limited to, limitations or exclusions for services that may be limited or excluded because they are solely educational in nature, experimental or investigational, not medically necessary, or services for which the enrollee failed to obtain proper preauthorization under the requirements of the health benefit plan.

(f) Permitted Coverage Exclusions. The types of limitations or exclusions permitted under the Insurance Code §1352.003(d) [~~subsection (d) of this section~~] do not include limitations or exclusions under a health benefit plan which, in and of themselves, meet the definition of a therapy or service required under the Insurance Code Chapter 1352 [~~subsection (a) of this section~~]. For example, if a health benefit plan contains an exclusion for biofeedback therapy, the issuer may deny coverage for biofeedback therapy for any diagnosis except an acquired brain injury diagnosis because biofeedback falls within the definition of "neurofeedback therapy" as defined in §21.3102

[~~§21.3102(12)~~] of this subchapter (relating to Definitions), and for which coverage is required under the Insurance Code Chapter 1352[~~subsection (a) of this section~~]. However, if the same health benefit plan also contains an exclusion for services that are not authorized prior to service, the issuer may, as allowed by subsection (e) of this subsection, deny coverage based upon the prior authorization exclusion.

(g) Permitted Coverage Denials. A health benefit plan [~~An issuer~~] may deny coverage and/or apply a limitation or exclusion in a health benefit plan for a service required under the Insurance Code Chapter 1352 [~~listed in subsection (a) of this section~~] if the service is prescribed for a condition that, although a result of, or related to, an acquired brain injury, was sustained in an activity or occurrence for which other similar coverage under the health benefit plan is limited or excluded (e.g., acts of war, participation in a riot, etc.).

(h) Inapplicability of Section to Small Employer Health Benefit Plan. In accordance with the Insurance Code §§1352.003(h) and 1352.007(b), this section does not apply to a small employer health benefit plan.

§21.3104. Training.

(a) In this section, "preauthorization" has the meaning assigned by the Insurance Code §1352.004(a)[~~Article 21.53Q~~], and includes benefit determinations for proposed medical or health care services.

(b) (No change.)

(c) Each health benefit plan issuer shall ensure that all employees or staff responsible for preauthorization of coverage or utilization review, or any individual

performing these processes, receive training to prevent wrongful denial of coverage required under the Insurance Code Chapter 1352[~~Article 21.53Q~~] and this subchapter, and to avoid confusion of medical/surgical benefits with mental/behavioral health benefits. At a minimum, training shall consist of:

(1) – (2) (No change.)

(3) instruction relating to correctly evaluating requests for services to differentiate between covered medical/surgical benefits versus covered benefits for mental/behavioral health; and

(4) instruction relating to the requirements of the Insurance Code Chapter 1352[~~Article 21.53Q~~] and this subchapter.

(d) - (e) (No change.)

§21.3105. Provision of CPT Codes. Each issuer of a health benefit plan subject to the Insurance Code Chapter 1352[~~Article 21.53Q~~] and this subchapter shall, upon request from the department, submit to the department the list of CPT codes identified by the issuer pursuant to §21.3104(b)(1) of this subchapter (relating to Training).

§21.3106. Small Employer Health Benefit Plans.

(a) Required Coverage. Pursuant to the Insurance Code §1352.0035(a), a small employer health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehaviorial, neurophysiological, neuropsychological, or psychological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or

community reintegration services, if such services are medically necessary as a result of and related to an acquired brain injury.

(b) Deductibles, Copayments, Coinsurance, and Lifetime Limitations. Pursuant to the Insurance Code §1352.0035(b), small employer health benefit plan coverage of acquired brain injury may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits consistent with the deductibles, copayments, coinsurance, or annual or maximum payment limits applicable to other similar coverage provided under the small employer health benefit plan.

(c) Maintenance and Prevention; Treatment Goals. Treatment goals for services required by the Insurance Code §1352.0035 may include the maintenance of functioning or the prevention of or slowing of further deterioration.

(d) Other Coverage Limitations. The coverage for services required by the Insurance Code §1352.0035 may be subject to limitations and exclusions that are generally applicable to other physical illnesses or injuries under the health benefit plan. These types of exclusions or limitations include, but are not limited to, limitations or exclusions for services that may be limited or excluded because they are solely educational in nature, experimental or investigational, not medically necessary, or services for which the enrollee failed to obtain proper preauthorization under the requirements of the health benefit plan.

(e) Permitted Coverage Exclusions. The types of limitations or exclusions permitted under subsection (d) of this section do not include limitations or exclusions under a health benefit plan which, in and of themselves, meet the definition of a therapy or service required under subsection (a) of this section. For example, if a health benefit

plan contains an exclusion for biofeedback therapy, the issuer may deny coverage for biofeedback therapy for any diagnosis except an acquired brain injury diagnosis because biofeedback falls within the definition of "neurofeedback therapy" as defined in §21.3102 of this subchapter (relating to Definitions), and for which coverage is required under subsection (a) of this section. However, if the same health benefit plan also contains an exclusion for services that are not authorized prior to service, the issuer may, as allowed by subsection (d) of this subsection, deny coverage based upon the prior authorization exclusion.

(f) Permitted Coverage Denials. A small employer health benefit plan may deny coverage and/or apply a limitation or exclusion in a health benefit plan for a service required under the Insurance Code Chapter 1352 if the service is prescribed for a condition that, although a result of, or related to, an acquired brain injury, was sustained in an activity or occurrence for which other similar coverage under the health benefit plan is limited or excluded (e.g., acts of war, participation in a riot, etc.).

§21.3107. Mandatory Annual Notice to Insureds and Enrollees.

(a) Pursuant to the Insurance Code §1352.005, health benefit plan issuers shall provide to insureds and enrollees the notification specified in this subsection. A representation of this notification is as follows:

Figure: 28 TAC §21.3107(a)

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

Your health benefit plan coverage for an acquired brain injury includes the following services:

• Cognitive rehabilitation therapy

• cognitive communication therapy

• Neurocognitive therapy and rehabilitation

• Neurobehaviorial, neurophysiological, neuropsychological and psychophysiological testing and treatment

• Neurofeedback therapy and remediation

• Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services

• Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

(b) The notice required by the Insurance Code §1352.005 and subsection (a) of this section is required by the Insurance Code §1352.005 to be issued annually to each insured or enrollee under the plan. In accordance with SECTION 9 of HB 1919, 80th Legislature, the notice shall be issued to each insured or enrollee of a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008.

(c) The notice must be printed in at least 12-point type and must comply with the following requirements;

(1) The notice shall be provided during the policy term for the plan, and no later than:

(A) the 60th day after the effective date of this section to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the effective date of this section; or

(B) the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the effective date of this section.

(2) Except as specified in paragraph (6) of this subsection, a health benefit plan issuer shall deliver the notice to insureds or enrollees through the U.S. Postal Service.

(3) The notice may be delivered with other health benefit plan documents that are delivered through the U.S. postal service as long as the time frames set forth in paragraph (1) of this subsection are met. For example, the notice may be delivered with the policy, certificate, evidence of coverage, or enrollment/insurance card.

(4) If the notice is provided to the primary insured’s or enrollee's last known address, the requirements of this section are satisfied with respect to all insureds or enrollees residing at that address.

(5) If the last known address of a covered spouse and/or dependent is different than the primary insured’s or enrollee’s last known address, separate notices

are required to be provided to the spouse or the dependent at the spouse's and/or dependent's last known address.

(6) For group health benefit plans, the notice may be provided to the group master contract holder for distribution to insureds or enrollees, if the health benefit plan issuer has an agreement with the group master contract holder that the notice will be delivered in accordance with the timelines specified in paragraph (1) of this subsection; however, the health benefit plan issuer will be held responsible for ensuring that the notice is provided to the insureds or enrollees.

(d) In accordance with the Insurance Code §§1352.005(a), this section does not apply to a small employer health benefit plan issuer.