Subchapter AA. Consumer Choice Health Benefit Plans

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1. INTRODUCTION. The Texas Department of Insurance (Department) proposes amendments to §§21.3502, 21.3510 - 21.3513, 21.3515 - 21.3518, 21.3540, and 21.3543, concerning exclusion of certain state-mandated health benefits in consumer choice health benefit plans, and new §§21.4401 - 21.4404, concerning mandated health benefit plan coverage for autism spectrum disorder coverage. The proposed amendments and new sections implement (i) House Bill (HB) 1919, 80th Legislature, Regular Session, effective January 1, 2008, relating to required autism spectrum disorder coverage for certain children; (ii) HB 1485, 79th Legislature, Regular Session, effective September 1, 2005, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans; and (iii) HB 1030, 79th Legislature, Regular Session, effective September 1, 2005, relating to an insured's coinsurance amount applicable to payment to a non-preferred provider. The proposed amendments are necessary to: (i) update existing rules relating to the exclusion of certain state-mandated health benefits in consumer choice

health benefit plans; (ii) update obsolete statutory citations to the Insurance Code as a result of the enactment of the non-substantive revision of the Insurance Code; and (iii) correct citation style errors. Proposed new Subchapter JJ, consisting of §§21.4401 - 21.4404, is necessary to implement §1355.015 of the Insurance Code, which requires that health benefit plans provide autism spectrum disorder coverage for certain children.

HB 1919, relating to required autism spectrum disorder coverage for certain children. HB 1919 amends Insurance Code Chapter 1355, which regulates benefits for certain mental disorders. HB 1919 enacts §1355.015 to include, as a state-mandated benefit, coverage for all generally recognized services prescribed in relation to autism spectrum disorder by an insured's primary care physician in the treatment plan recommended by that physician. Therefore, as a result of the enactment of HB 1919, the Department is proposing new Subchapter JJ, consisting of §§21.4401 - 21.4404, to implement §1355.015. Pursuant to §1355.015(e), Chapter 1507 consumer choice health benefit plans are not required to provide the state-mandated coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. It is, therefore, necessary to amend existing rules regulating consumer choice health benefit plans to provide that the state-mandated coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A, is not required to be offered or provided by these consumer choice health benefit plans.

Proposed new Subchapter JJ consisting of §§21.4401 - 21.4404 is necessary to implement §1355.015 of the Insurance Code. Section 1355.015 requires that health benefit plans provide autism spectrum disorder coverage for certain children. The

proposed new sections simply set forth statutory provisions and provide necessary interpretations of those provisions. The proposed new sections do not impose any new or additional requirements to those in the statute. Proposed new §21.4401 addresses the purpose and applicability of Subchapter JJ. Proposed new §21.4401(a) states that the subchapter implements those provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of the proposed new subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services for certain child enrollees diagnosed with autism spectrum disorder in accordance with the Insurance Code Chapter 1355, Subchapter A. Proposed new §21.4401(b)(1) and (2) addresses the applicability of the subchapter, specifying the types of health benefit plans to which Subchapter JJ does and does not apply.

Proposed new §21.4402 provides definitions of terms used in Subchapter JJ. The terms defined in the section include: “applied behavior analysis,” “autism spectrum disorder,” “enrollee,” “generally recognized services,” “health care practitioner,” “neurobiological disorder,” and “primary care physician.”

Proposed new §21.4403 addresses required coverage for autism spectrum disorder. Proposed new §21.4403(a) specifies the ages of the children covered under the plan who must be provided the required coverage. Section 1355.015(a) of the Insurance Code provides that, at a minimum, a health benefit plan must provide coverage as required by §1355.015 to a child covered under the plan who is “older than two years of age and younger than six years of age” who is diagnosed with autism

spectrum disorder. The Department is proposing new §21.4403(a)(1) to clarify this statutory provision to ensure that all covered children of the requisite statutorily specified age are provided the required coverage consistent with the intent of §1355.015 of the Insurance Code. This clarification is necessary because the Insurance Code §1355.015 does not define what is meant by "older than two years of age." This lack of a definition of what is meant by "older than two years" of age could result in some children of a certain age (for example, two years eight months old) not having coverage under their health benefit plan while other children of that exact same age have coverage under a different health benefit plan. The Department's interpretation is that the phrase "older than two years of age" in §1355.015 applies to children who are "three years of age or older." This interpretation is consistent with both common law and Texas case law. Under both common law and Texas case law, a person is aged a specific year until that person reaches the age of the next year, e.g., a person is two years of age until the person reaches the third anniversary of his or her birth. Under this interpretation, at a minimum, a health benefit plan must provide coverage as required by §1355.015 to an enrollee three years of age or older and younger than six years of age who is diagnosed with autism spectrum disorder. Consistent with §1355.015(a) of the Insurance Code, proposed new §21.4403(a)(2) provides that if an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code. There is no statutory prohibition precluding a

health benefit plan from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for enrollees of other ages. Accordingly, proposed new §21.4403(b) clarifies that a health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for enrollees of other ages. Proposed new §21.4403(c) specifies that in accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. Proposed new §21.4403(d) specifies that pursuant to the Insurance Code §1355.015(d), coverage under the section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

Proposed new §21.4404 addresses health care practitioners. Proposed new §21.4404(a) specifies that, pursuant to the Insurance Code §1355.015(b), a health care practitioner providing treatment for autism spectrum disorder under Chapter 1355, Subchapter A, of the Insurance Code and proposed new Subchapter JJ must meet one of the following requirements: (i) be licensed, certified, or registered by an appropriate agency of this state; (ii) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or (iii) be certified as a provider under the TRICARE military health system. Proposed new §21.4404(b) specifies that a health benefit plan issuer may not deny coverage for services for autism spectrum disorder on

the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by an agency of this state, as long the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).

Existing §§21.3510 - 21.3513 and §§21.3515 - 21.3518 specify state-mandated health benefits that are not required to be included in specific types of consumer choice benefit plans that may be provided under Insurance Code Chapter 1507. The proposed amendments to these sections are necessary to update existing rules relating to the exclusion of certain state-mandated health benefits in consumer choice health benefit plans. The proposed amendments simply reflect statutory provisions and do not impose any new or additional requirements to those in the statute. The Insurance Code in Chapter 1507, which regulates consumer choice health benefit plans, specifies those health benefit plans that are not required to offer or provide state-mandated health benefits, including individual indemnity policies, group association indemnity policies, small employer indemnity policies, large employer indemnity policies, individual HMO plans, group HMO plans, small employer HMO plans, and large employer HMO plans. Pursuant to §1507.001 and §1507.051, Chapter 1507 was enacted in recognition of the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans and health maintenance organization plans that are more affordable and flexible than policies offering accident and sickness insurance coverage and health care plans offered by health maintenance organizations available in the existing market. The purpose of Chapter 1507, therefore, is to increase the availability of health insurance coverage by allowing authorized insurers and health

maintenance organizations to issue health plans that, in whole or in part, do not offer or provide state-mandated health benefits. Because of the §1355.015(e) provision that the statutorily mandated coverage of autism spectrum disorder does not apply to a standard health benefit plan provided under Chapter 1507, it is necessary to amend certain existing rules for consistency with §1355.015(e). The Insurance Code Chapter 1355, Subchapter A, applies to group health benefit plans. There are six types of consumer choice group health benefit plans. However, pursuant to §1355.015(e), no consumer choice health benefit plans are required to include coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A. As a result, the following amendments are proposed to reflect this statutory exemption: (i) §21.3511(23) is proposed to reflect the exemption for group association indemnity consumer choice health benefit plans; (ii) §21.3512(16) is proposed to reflect the exemption for small employer group indemnity consumer choice health benefit plans; (iii) §21.3513(23) is proposed to reflect the exemption for large employer group indemnity consumer choice health benefit plans; (iv) §21.3516(27) is proposed to reflect the exemption for non-employer group HMO consumer choice health benefit plans; (v) §21.3517(20) is proposed to reflect the exemption for small employer group HMO consumer choice health benefit plans; and (vi) §21.3518(27) is proposed to reflect the exemption for large employer group HMO consumer choice health benefit plans.

HB 1485, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans. The

proposed amendments are also necessary to implement HB 1485, enacted by the 79th Legislature to amend former Insurance Code Articles 3.80 §3 and 20A.09N(d). As part of the non-substantive revised Insurance Code by the Texas Legislature, Article 3.80 §3 was adopted without substantive change as the Insurance Code §1507.003 in HB 2018 in the same legislative session in which HB 1485 was enacted. The HB 1485 amendment to Article 3.80 §3 redefined the term "state mandated benefits," as used in the article, to include "coverage for serious mental illness under Subchapter A, Chapter 1355." The amendment also deleted a qualifying phrase that resulted in the definition only applying if the standard health benefit were issued to a large employer. The result of this amendment is: (i) a small employer group indemnity consumer choice health benefit plan must include the offer of serious mental illness under Subchapter A, Chapter 1355; and (ii) a standard health benefit plan issued as part of a group association indemnity policy must include serious mental illness under Subchapter A, Chapter 1355. Also as part of the non-substantive revised Insurance Code, Article 20A.09N(d) was adopted without substantive change as the Insurance Code §1507.053 in HB 2018 in the same legislative session in which HB 1485 was enacted. The HB 1485 amendment to Article 20A.09N(d) redefined the term "state mandated benefits," as used in the section, to include "coverage for serious mental health illness under Subchapter A, Chapter 1355, Insurance Code." The amendment deleted a qualifying phrase that resulted in the definition only applying if the standard health benefit were issued to a large employer. The result of this amendment is: (i) a small employer group Health Maintenance Organization (HMO) consumer choice health benefit plan

must include the offer of serious mental illness under Subchapter A, Chapter 1355; and (ii) a non-employer group HMO consumer choice health benefit plan must include serious mental illness under Subchapter A, Chapter 1355.

Prior to the enactment of HB 1485 and pursuant to Articles 3.80 §3 and 20A.09N(d), four types of consumer choice health benefit plans were not required to include either the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness as required by the Insurance Code Article 3.51-14 (now Chapter 1355, Subchapter A, of the Insurance Code). As a result, these exemptions are reflected in the following four provisions of the existing rules: (i) §21.3511(9) provides that state-mandated health coverage of serious mental illness is not required to be included in a group association indemnity consumer choice health benefit plan; (ii) §21.3512(9) provides that the state-mandated offer of health coverage for serious mental illness is not required to be included in a small employer group indemnity consumer choice health benefit plan; (iii) §21.3516(13) provides that state-mandated health coverage of serious mental illness is not required to be included in a non-employer group HMO consumer choice health benefit plan; and (iv) §21.3517(13) provides that state-mandated offer of health coverage for serious mental illness is not required to be included in a small employer group HMO consumer choice health benefit plan. All four of these exemptions are proposed to be deleted because the exemptions are no longer statutorily authorized. When these state-mandated exemption rules were originally adopted in 2004, the exclusions in §21.3511(9) and §21.3512(9) were consistent with the Insurance Code Article 3.80 §3(b) (now §1507.003 of the Insurance Code). Article

3.80 §3(b) provided: "For purposes of this article, 'state-mandated health benefits' does not include benefits that are mandated by federal law or standard provisions or rights required under this code or other laws of this state to be provided in an individual, blanket, or group policy for accident and health insurance that are unrelated to specific health illnesses, injuries, or conditions of an insured, including provisions related to. . . (7) coverage for serious mental illness under Article 3.51-14 of this code **if the standard health benefit plan is issued to a large employer** as defined by Article 26.02 of this code. . . ." (emphasis added.) When these state-mandated exemptions were originally adopted in 2004, the exclusions in §21.3516(13) and §21.3517(13) were consistent with the Insurance Code Article 20A.09N(d) (now §1507.053 of the Insurance Code). Article 20A.09N(d) provided: "For purposes of this section, 'state-mandated health benefits' does not include benefits that are mandated by federal law or standard provisions or rights required under the Insurance Code or other laws of this state to be provided in an evidence of coverage that are unrelated to specific health illnesses, injuries, or conditions of an insured, including provisions related to. . . (6) coverage for serious mental health illness under Article 3.51-14, Insurance Code, **if the standard health benefit plan is issued to a large employer** as defined in Article 26.02, Insurance Code. . . ." (emphasis added.) Under Article 3.80 §3(b)(7) and Article 20A.09N(d)(6), state-mandated health benefits did not include coverage for serious mental illness under Article 3.51-14 (now Chapter 1355, Subchapter A, of the Insurance Code) in a standard health benefit plan issued to a large employer. However, state-mandated health benefits for serious mental illness under Article 3.51-14 did include: (i)

the offer of coverage for serious mental illness in a standard health benefit plan that was issued to a small employer; (ii) coverage for serious mental illness in a standard health benefit plan that was issued as part of a group association indemnity policy; (iii) the offer of coverage for serious mental illness in a small employer group HMO consumer choice health benefit plan; and (iv) coverage for serious mental illness in a standard health benefit plan that was issued as part of a non-employer group HMO consumer choice health benefit plan. Pursuant to the Insurance Code Article 3.80 §3(b) (now §1507.003 of the Insurance Code), group association indemnity consumer choice health benefit plans and small employer group indemnity consumer choice health benefit plans were not required to provide the state-mandated-offer-of or the state-mandated-coverage-for serious mental illness under Article 3.51-14. As previously stated, existing §21.3511(9) and §21.3512(9) reflect these exemptions for group association indemnity consumer choice health benefit plans and small employer group indemnity consumer choice health benefit plans, respectively. Pursuant to Article 20A.09N(d) (now §1507.053 of the Insurance Code), non-employer group HMO consumer choice health benefit plans and small employer group HMO consumer choice health benefit plans were not required to provide the state-mandated-offer-of or the state-mandated-coverage-for serious mental illness under Article 3.51-14 (now Chapter 1355, Subchapter A, of the Insurance Code). As previously stated, existing §21.3516(13) and §21.3517(13) reflect these exemptions for non-employer group HMO consumer choice health benefit plans and small employer group HMO consumer choice health benefit plans, respectively. However, as a result of the deletion of the qualifying phrase “if the standard health

benefit plan is issued to a large employer" by HB 1485 in the Insurance Code Article 3.80 §3(b)(7), a standard health benefit plan issued to a small employer is required to include the offer of serious mental illness coverage and a standard health benefit plan that is issued as part of a group association indemnity policy is required to include coverage for serious mental illness as required by Chapter 1355, Subchapter A, of the Insurance Code. Also, as a result of the deletion of the same qualifying phrase by HB 1485 in the Insurance Code Article 20A.09N(d) (now §1507.053 of the Insurance Code), a small employer group HMO consumer choice health benefit plan is required to include the offer of serious mental illness coverage and a standard health benefit plan that is issued as part of a non-employer group HMO consumer choice health benefit plan is required to include coverage for serious mental illness as required Chapter 1355, Subchapter A, of the Insurance Code. Therefore, existing §§21.3511(9), 21.3512(9), 21.3516(13) and 21.3517(13) are proposed for deletion. The proposed amendments simply reflect statutory provisions and do not impose any new or additional requirements to those in the statute.

HB 1030, relating to an insured's coinsurance amount applicable to payment to a non-preferred provider. The proposed amendments are also necessary to implement HB 1030 that added §1301.0046 to the Insurance Code. Section 1301.0046 provides that an insured's coinsurance amount applicable to payment to a non-preferred provider may not exceed 50 percent of the total covered amount applicable to the medical or health care services. The §1301.0046 coinsurance limitation is applicable to all preferred provider plans, including those that qualify as

consumer choice health benefit plans. The §1301.0046 coinsurance limitation supersedes the Department's rule in §3.3704(a)(6), relating to Freedom of Choice, Availability of Preferred Providers. Section 3.3704(a)(6) specifies the basic level of coverage that is required in order for a preferred provider benefit plan to not be considered unjust or unfair discrimination under the Insurance Code. An exclusion from the §3.3704(a)(6) requirement is currently in several provisions of the existing consumer choice health benefit plan rules. These exclusions are proposed to be deleted in this proposal.

Prior to the passage of HB 1030, the Insurance Code did not set a specific percentage limit by which an insured's coinsurance amount applicable to payment to a non-preferred provider could exceed the total covered amount applicable to the medical or health care services. Therefore, pursuant to the Insurance Code Article 3.42(i)(2) (now §1701.055(a)(2)), the Department adopted a limit by rule in §3.3704(a)(6). The Department also adopted exemptions to §3.3704(a)(6) for certain consumer choice health benefit plans in the rules regulating those types of plans. These exemptions are reflected in the following four provisions of the consumer choice health benefit plan rules: (i) §21.3510(5) provides the exemption for individual indemnity consumer choice health benefit plans; (ii) §21.3511(5) provides the exemption for group association indemnity consumer choice health benefit plans; (iii) §21.3512(5) provides the exemption for small employer group indemnity consumer choice health benefit plans; (iv) §21.3513(5) provides the exemption for large employer group indemnity consumer choice health benefit plans. All four of these exemptions are proposed to be deleted

because the exemptions are no longer statutorily authorized. Section 3.3704(a)(6) provides that: "A preferred provider benefit plan shall not be considered unjust under the Insurance Code Article 3.42, or unfair discrimination under the Insurance Code Articles 21.21-6 or 21.21-8, or to violate Articles 3.70-2(B) or 21.52 of the Insurance Code provided that . . . (6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 30% less than the higher level of coverage. A reasonable difference in deductibles shall be determined considering the benefits of each individual policy; . . . ." As previously noted, Chapter 1507 of the Insurance Code regulates consumer choice health benefit plans. Section 1507.001 states the purpose of the chapter: "The legislature recognizes the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. The legislature, therefore, seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in this state to issue accident and sickness policies that, in whole or in part, do not offer or provide state-mandated health benefits." The exclusion in §§21.3510(5), 21.3511(5), 21.3512(5), and 21.3513(5) from the §3.3704(a)(6) requirement was based on the legislative purpose stated in §1507.001 of the Insurance Code. However, with the enactment of HB 1030, an insured's coinsurance amount applicable to payment to a non-preferred provider may not exceed 50 percent of the total covered amount applicable to the medical or health care services. As previously noted, the §1301.0046 coinsurance limitation is applicable to all

health benefit plans, including consumer choice health benefit plans. Also, as previously noted, the §1301.0046 coinsurance limitation supersedes the §3.3704(a)(6) requirement. According to the Senate Research Center bill analysis for HB 1030, the purpose of the legislation is to provide more options for employers and individuals looking for affordable health insurance. (SENATE RESEARCH CENTER, BILL ANALYSIS (ENGROSSED), HB 1030, 79TH Legislature, Regular Session effective September 1, 2005.) This purpose is consistent with the purpose of the Insurance Code Chapter 1507 as stated in §1507.001. Therefore, existing §§21.3510(5), 21.3511(5), 21.3512(5), and 21.3513(5), relating to exclusion from the §3.3704(a)(6) requirement, are proposed for deletion.

Update of obsolete statutory citations. Proposed amendments are also necessary to update obsolete statutory citations to the Insurance Code as a result of the enactment of the non-substantive revision of the Insurance Code. This will result in easier use and readability of the rules. Amendments are proposed to the following to update statutory citations to conform with the non-substantive revised Insurance Code: §21.3502(3), (7), (10)(A)(ii) and (B); §21.3510(1) – (4); renumbered §21.3510(5) – (8), (11), and (13); §21.3511(1) – (4); renumbered §21.3511(5) – (7), (8) – (20), and (22); §21.3512(1) – (4); renumbered §21.3512(5) – (7), (8) – (13), and (15); §21.3513(1) – (4); renumbered §21.3513(5) – (20) and (22); §21.3515(1) – (7), (10) – (14), and (16); §21.3516(1) – (7) and (10) – (12); renumbered §21.3516(13) – (24) and (26); §21.3517(1) – (7) and (10) – (12); renumbered §21.3517(13) – (17) and (19); §21.3518(1) – (7), (10) – (24), and (26); §21.3540; and §21.3543(1)(A) and (B).

Proposed amendments are also necessary throughout the proposed amended sections to change references to "Insurance Code" to "the Insurance Code" to conform to current Department citation style.

2. FISCAL NOTE. Debra Diaz-Lara, 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, there will be several public benefits anticipated as a result of the proposal. These benefits include (i) rules that implement the Insurance Code Chapter 1355 as amended by HB 1919, 80th Legislature, and provide guidance to health benefit plans on coverage of autism spectrum disorder as required by the Insurance Code §1355.015; (ii) rules that implement former Insurance Code Articles 3.80 §3(b) and 20A.09N(d) as amended by HB 1485, 79th Legislature, and adopted by the Texas Legislature without substantive change as the Insurance Code §§1507.003(b) and 1507.053(b), respectively, relating to the state-mandated-offer-of or the state-mandated-coverage-of serious mental illness in consumer choice health benefit plans; (iii) rules that accurately reflect the applicability

of the Insurance Code 1301.0046 as added by HB 1030, 79th Legislature, which provides that an insured's coinsurance amount applicable to payment to a non-preferred provider may not exceed 50 percent of the total covered amount applicable to the medical or health care services; and (iv) rules with updated statutory citations that reflect 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 proposed amendments and new sections. Any costs to such persons for each year of the first five years the proposed amendments and new sections will be in effect are the result of the legislative enactment of HB 1919, HB 1485, and HB 1030 and not the result of the adoption, enforcement, or administration of the proposed amendments. The proposed new sections in Subchapter JJ simply set forth statutory provisions and necessary interpretations of those provisions; the proposed new sections do not impose any new or additional requirements to those in the statute.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. In accordance with the Government Code §2006.002(c), the Department has determined that this proposal will not have an adverse economic effect on small business or micro business health benefit plans that are required to comply with the proposal. Because the proposal does not impose any new requirements or costs with which businesses, regardless of size, must comply, any costs to persons required to comply with these proposed amendments and new

sections are the result of the enactment of HB 1919, HB 1485, and HB 1030, and not the result of the adoption, enforcement, or administration of the proposed amendments and new sections. In accordance with the Government Code §2006.002(c), the Department has therefore determined that a regulatory flexibility analysis is not required because the proposal will not have an adverse impact on small or micro businesses.

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 May 4, 2009 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 comments must be simultaneously submitted to Debra Diaz-Lara, Deputy Commissioner, HWCN Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing on the proposal should be submitted separately to the Office of the Chief Clerk before the close of the public comment period. If a hearing is held, 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 §§1355.015, 1507.009, 1507.059, and 36.001. Section 1355.015 establishes the requirement that health benefit plans provide autism spectrum disorder coverage for certain children. Section 1507.009 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter A, related to Consumer Choice of Benefits Health Insurance Plans. Section 1507.059 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1507, Subchapter B, related to Consumer Choice of Benefits Health Maintenance Organization Plans. 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
§§21.3510 - 21.3513	Insurance Code §1507.004 and §1507.009
§§21.3515 - 21.3518	Insurance Code §§1507.054 and §1507.059
§21.3540	Insurance Code §1507.004
§21.3543	Insurance Code §1271.101 and

	§1701.051
§§21.4401, 21.4403, and 21.4404	Insurance Code §1355.015
§21.4402	Insurance Code §1355.001 and §1355.015

9. TEXT.

Subchapter AA. Consumer Choice Health Benefit Plans
Division 1. General Provisions.

§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) - (2) (No change.)

(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) [~~Article 26.035(a) or Article 3.70-1~~].

(4) - (6) (No change.)

(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, a health maintenance organization under the Insurance Code [~~Article 20A~~

~~and~~] Chapter 843, and a stipulated premium company under the Insurance Code Chapter 884.

(8) - (9) (No change.)

(10) State-mandated health benefits--

(A) Coverage required under the Insurance 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) (No change.)

(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[~~Article 20A.09(l) (as added by Section 7, Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997)~~]; or

(iii) (No change.)

(B) Do not include benefits or coverage mandated by federal law, or standard provisions or rights required under the Insurance 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)[~~Articles 3.80, §3(b) and 20A.09N(d)~~].

Division 2. State-Mandated Health Benefits

§21.3510. State-mandated Health Benefits in Individual Indemnity Policies. The following enumerated items are state-mandated health benefits a health insurer does not have to include in an individual indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

[~~(5) limitations or restrictions on coinsurance imposed by §3.3704(a)(6) of this title (relating to Freedom of Choice: Availability of Preferred Providers);~~]

(5) [~~(6)~~] coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B[~~Article 21.52G~~];

(6) [~~(7)~~] coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A[~~Article 21.53D~~];

(7) [~~(8)~~] coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455[~~Article 21.53F~~];

(8) [~~(9)~~] coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A[~~Article 21.53M~~];

(9) [~~(10)~~] coverage of mental/nervous disorders with demonstrable organic disease as required by §3.3057(d) of this title (relating to Standards for Exceptions, Exclusions, and Reductions Provision);

(10) [~~(11)~~] coverage of transplant donor coverage as required by §3.3040(h) of this title (relating to Prohibited Policy Provisions);

(11) [~~(12)~~] offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E[~~Article 21.53F~~];

(12) [~~(13)~~] entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services; and

(13) [~~(14)~~] the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451[~~Article 21.52 and Article 3.70-2~~].

§21.3511. State-mandated Health Benefits in Group Association Indemnity Policies. The following enumerated items are state-mandated health benefits that a health insurer does not have to include in a group association indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

[~~(5) limitations or restrictions on coinsurance imposed by §3.3704(a)(6) of this title (relating to Freedom of Choice: Availability of Preferred Providers);~~]

(5) [~~(6)~~] the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A[~~Article 3.51-6, §3A~~];

(6) [~~(7)~~] coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364[~~Article 3.51-6, §3C~~];

(7) [~~(8)~~] coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368[~~Article 3.51-9~~];

[~~(9) coverage of serious mental illness as required by Insurance Code Article 3.51-14;~~]

(8) [~~(10)~~] the offer of mental or emotional illness coverage as required by the Insurance Code Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(9) [~~(11)~~] coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(10) [~~(12)~~] the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365[~~Article 3.70-2(G)~~];

(11) [~~(13)~~] the offer of home health care coverage as required by the Insurance Code Chapter 1351[~~Article 3.70-3B~~];

(12) [~~(14)~~] coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code Chapter 1355, Subchapter B[~~Article 3.72~~];

(13) [~~(15)~~] coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B[~~Article 21.52G~~];

(14) [~~(16)~~] continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B[~~Article 21.52J~~];

(15) [~~(17)~~] coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360[~~Article 21.53A~~];

(16) [~~(18)~~] coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361[~~Article 21.53C~~];

(17) [~~(19)~~] coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A [~~Article 21.53D~~];

(18) [~~(20)~~] coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455[~~Article 21.53F~~];

(19) [~~(21)~~] coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A[~~Article 21.53M~~];

(20) [~~(22)~~] offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E[~~Article 21.53F~~];

(21) [~~(23)~~] entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;[~~and~~]

(22) [~~(24)~~] the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and [~~Article 21.52 and Article 3.70-2.~~]

(23) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3512. State-mandated Health Benefits in Small Employer Indemnity Policies. The following enumerated items are state-mandated health benefits that a health insurer does not have to include in a small employer group indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

[~~(5) limitations or restrictions on coinsurance imposed by §3.3704(a)(6) of this title (relating to Freedom of Choice: Availability of Preferred Providers);~~]

(5) [~~(6)~~] the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A[~~Article 3.51-6, §3A~~];

(6) [~~(7)~~] coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364[~~Article 3.51-6, §3C~~];

(7) [~~(8)~~] coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368[~~Article 3.51-9~~];

[~~(9) the offer of serious mental illness coverage as required by Insurance Code Article 3.51-14;~~]

(8) [~~(10)~~] the offer of mental or emotional illness coverage as required by the Insurance Code Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(9) [~~(11)~~] coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(10) [~~(12)~~] the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365[~~Article 3.70-2(G)~~];

(11) [~~(13)~~] the offer of home health care coverage as required by the Insurance Code Chapter 1351[~~Article 3.70-3B~~];

(12) [~~(14)~~] coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B[~~Article 3.72~~];

(13) [~~(15)~~] coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361[~~Article 21.53C~~];

(14) [~~(16)~~] entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;[~~and~~]

(15) [~~(17)~~] the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and [~~Article 21.52 and Article 3.70-2.~~]

(16) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3513. State-mandated Health Benefits in Large Employer Indemnity Policies. The following enumerated items are state-mandated health benefits that a health insurer does not have to include in a large employer group indemnity consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(3) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(4) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

[~~(5) limitations or restrictions on coinsurance imposed by §3.3704(a)(6) of this title (relating to Freedom of Choice: Availability of Preferred Providers);~~]

(5) [~~(6)~~] the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A[~~Article 3.51-6, §3A~~];

(6) [~~(7)~~] coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364[~~Article 3.51-6, §3C~~];

(7) [~~(8)~~] coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368[~~Article 3.51-9~~];

(8) [~~(9)~~] the offer of mental or emotional illness coverage as required by the Insurance Code Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(9) [~~(10)~~] coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(10) [~~(11)~~] the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365[~~Article 3.70-2(G)~~];

(11) [~~(12)~~] the offer of home health care coverage as required by the Insurance Code Chapter 1351[~~Article 3.70-3B~~];

(12) [~~(13)~~] coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code Chapter 1355, Subchapter B[~~Article 3.72~~];

(13) [~~(14)~~] coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B[~~Article 21.52G~~];

(14) [~~(15)~~] continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B[~~Article 21.52J~~];

(15) [~~(16)~~] coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360[~~Article 21.53A~~];

(16) [~~(17)~~] coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361[~~Article 21.53C~~];

(17) [~~(18)~~] coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A [~~Article 21.53D~~];

(18) [~~(19)~~] coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455[~~Article 21.53F~~];

(19) [~~(20)~~] coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A[~~Article 21.53M~~];

(20) [~~(21)~~] offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E[~~Article 21.53F~~];

(21) [~~(22)~~] entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;[~~and~~]

(22) [~~(23)~~] the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and [~~Article 21.52 and Article 3.70-2.~~]

(23) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3515. State-mandated Health Benefits in Individual HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in an individual HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053[~~Article 20A.09F~~];

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201[~~Article 20A.09(a)(3)(D)~~];

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156[~~Article 20A.09(a)(4)~~];

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B[~~Article 21.52G~~];

(11) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A [~~Article 21.53D~~];

(12) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455[~~Article 21.53F~~];

(13) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A[~~Article 21.53M~~];

(14) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E[~~Article 21.53F~~];

(15) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services; and

(16) the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451[~~Article 21.52 and Article 3.70-2~~].

§21.3516. State-mandated Health Benefits in Group HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in a non-employer group HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053[~~Article 20A.09F~~];

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201[~~Article 20A.09(a)(3)(D)~~];

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156[~~Article 20A.09(a)(4)~~];

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A[~~Article 3.51-6, §3A~~];

(11) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364[~~Article 3.51-6, §3C~~];

(12) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368[~~Article 3.51-9~~];

[~~(13) coverage of serious mental illness as required by Insurance Code Article 3.51-14;~~]

(13) [~~(14)~~] the offer of mental or emotional illness coverage as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(14) [~~(15)~~] coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(15) [~~(16)~~] the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365[~~Article 3.70-2(G)~~];

(16) [~~(17)~~] coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B[~~Article 3.72~~];

(17) [~~(18)~~] coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B[~~Article 21.52G~~];

(18) [~~(19)~~] continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B[~~Article 21.52J~~];

(19) [~~(20)~~] coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360[~~Article 21.53A~~];

(20) [~~(21)~~] coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361[~~Article 21.53C~~];

(21) [~~(22)~~] coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A [~~Article 21.53D~~];

(22) [~~(23)~~] coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455[~~Article 21.53F~~];

(23) [~~(24)~~] coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A[~~Article 21.53M~~];

(24) [~~(25)~~] offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E[~~Article 21.53F~~];

(25) [~~(26)~~] entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;[~~and~~]

(26) [~~(27)~~] the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and [~~Article 21.52 and Article 3.70-2.~~]

(27) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3517. State-mandated Health Benefits in Small Employer HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in a small employer group HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053[~~Article 20A.09F~~];

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201[~~Article 20A.09(a)(3)(D)~~];

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156[~~Article 20A.09(a)(4)~~];

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A[~~Article 3.51-6, §3A~~];

(11) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364[~~Article 3.51-6, §3C~~];

(12) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368[~~Article 3.51-9~~];

[~~(13) the offer of serious mental illness coverage as required by Insurance Code Article 3.51-14;~~]

(13) [~~(14)~~] the offer of mental or emotional illness coverage as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(14) [~~(15)~~] coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(15) [~~(16)~~] the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365[~~Article 3.70-2(G)~~];

(16) [~~(17)~~] coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B[~~Article 3.72~~];

(17) [~~(18)~~] coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361[~~Article 21.53C~~];

(18) [~~(19)~~] entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services; [~~and~~]

(19) [~~(20)~~] the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and [~~Article 21.52 and Article 3.70-2.~~]

(20) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

§21.3518. State-mandated Health Benefits in Large Employer HMO Plans. The following enumerated items are state-mandated health benefits that an HMO does not have to include in a large employer group HMO consumer choice health benefit plan:

(1) coverage of contraceptive drugs and devices as required by the Insurance Code Chapter 1369, Subchapter C[~~Article 21.52L~~] and §21.404(3) of this title (relating to Underwriting);

(2) coverage of childhood immunizations as required by the Insurance Code §1367.053[~~Article 20A.09F~~];

(3) coverage of a minimum stay for maternity as required by the Insurance Code Chapter 1366, Subchapter B[~~Article 21.53F~~];

(4) coverage of reconstructive surgery incident to mastectomy as required by the Insurance Code Chapter 1357, Subchapter A[~~Article 21.53I~~];

(5) coverage of acquired brain injury treatment/services as required by the Insurance Code Chapter 1352[~~Article 21.53Q~~];

(6) treatment by a non-primary care specialist as a primary care provider as required by the Insurance Code §1271.201[~~Article 20A.09(a)(3)(D)~~];

(7) coverage of rehabilitation therapies as required by the Insurance Code §1271.156[~~Article 20A.09(a)(4)~~];

(8) limitations or restrictions on copayments imposed by §11.506(2)(A) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);

(9) limitations or restrictions on deductibles imposed by §11.506(2)(B) of this title;

(10) the offer of in vitro fertilization coverage as required by the Insurance Code Chapter 1366, Subchapter A[~~Article 3.51-6, §3A~~];

(11) coverage of HIV, AIDS, or HIV-related illnesses as required by the Insurance Code Chapter 1364[~~Article 3.51-6, §3C~~];

(12) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by the Insurance Code Chapter 1368[~~Article 3.51-9~~];

(13) the offer of mental or emotional illness coverage as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(14) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter C[~~Article 3.70-2(F)~~];

(15) the offer of speech and hearing coverage as required by the Insurance Code Chapter 1365[~~Article 3.70-2(G)~~];

(16) coverage of stays in a crisis stabilization unit and/or residential treatment center for children and adolescents as required by the Insurance Code §1271.005 and Chapter 1355, Subchapter B[~~Article 3.72~~];

(17) coverage of a minimum stay for mastectomy treatment/services as required by the Insurance Code Chapter 1357, Subchapter B[~~Article 21.52G~~];

(18) continuation of coverage of certain drugs under a drug formulary as required by the Insurance Code Chapter 1369, Subchapter B[~~Article 21.52J~~];

(19) coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by the Insurance Code Chapter 1360[~~Article 21.53A~~];

(20) coverage of bone mass measurement for osteoporosis as required by the Insurance Code Chapter 1361[~~Article 21.53C~~];

(21) coverage of diabetes care as required by the Insurance Code Chapter 1358, Subchapter A [~~Article 21.53D~~];

(22) coverage of telehealth and telemedicine as required by the Insurance Code Chapter 1455[~~Article 21.53F~~];

(23) coverage of off-label drugs as required by the Insurance Code Chapter 1369, Subchapter A[~~Article 21.53M~~];

(24) offer of coverage for therapies for children with developmental delays as required by the Insurance Code Chapter 1367, Subchapter E[~~Article 21.53F~~];

(25) entitlement to care under the Insurance Code Article 21.52B relating to pharmaceutical services;[~~and~~]

(26) the requirements of the Insurance Code Chapter 1451, Subchapter D[~~Article 21.52D~~] regarding the use of optometrists and ophthalmologists by managed care plans, that exceed the entitlement to select a practitioner under the Insurance Code Chapter 1451; and [~~Article 21.52 and Article 3.70-2.~~]

(27) coverage of autism spectrum disorder as required by the Insurance Code Chapter 1355, Subchapter A.

Division 4. Additional Requirements.

§21.3540. Direct Access to Services. Any consumer choice health benefit plan must include coverage for direct access to the health care services of an obstetrical or gynecological care provider as required by the [~~Texas~~] Insurance Code Chapter 1451, Subchapter F[~~Article 21.53D, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997~~].

§21.3543. Required Plan Filings. A health carrier shall:

(1) file the consumer choice health benefit plan with the Filings and Operations Division in accordance with:

(A) the Insurance Code Chapter 1271[~~Article 20A.09~~] and Chapter 11 of this title (relating to Health Maintenance Organizations) including the filing fee requirements; and

(B) the Insurance Code Chapter 1701[~~Article 3.42~~] and Chapter 3, Subchapter A of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, Endorsements for Life, Accident, and Health Insurance and Annuities) including the filing fee requirements.

(2) (No change.)

Subchapter JJ. Autism Spectrum Disorder Coverage

§21.4401. Purpose and Applicability.

(a) General Purpose. This subchapter implements those provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of this subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services of certain child enrollees diagnosed with autism spectrum disorder, as provided in the Insurance Code Chapter 1355, Subchapter A.

(b) Applicability.

(1) This subchapter applies to:

(A) the health benefit plans specified in the Insurance Code §1355.002; and

(B) small employer health benefit plans offered pursuant to the Insurance Code §1501.252(c).

(2) This subchapter does not apply to:

(A) a standard health benefit plan provided under the Insurance Code Chapter 1507, pursuant to the Insurance Code §1355.015(e);

(B) a health benefit plan issued by a health carrier through a health group cooperative under the Insurance Code §1501.058, pursuant to the Insurance Code §1501.0581(i); or

(C) a health benefit plan specified in the Insurance Code §1355.003(a)(1) – (7).

§21.4402. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) Applied behavior analysis--The design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. Applied behavior analysis includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

(2) Autism spectrum disorder--As defined in the Insurance Code §1355.001(3).

(3) Enrollee--A person covered by a health benefit plan described by the Insurance Code §1355.002.

(4) Generally recognized services--The term includes, but is not limited to, the following services, when such services are prescribed in accordance with the Insurance Code §1355.015(b) and §21.4403(b) of this subchapter (relating to Required Coverage):

(A) evaluation and assessment services;

(B) applied behavior analysis;

(C) behavior training and behavior management;

(D) speech therapy;

(E) occupational therapy;

(F) physical therapy; or

(G) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

(5) Health care practitioner--A physician, advance practice nurse, physician assistant, or other individual appropriately licensed, registered, or certified, or whose professional credential is recognized and accepted as described by the Insurance Code §1355.015(b).

(6) Neurobiological disorder--As defined in the Insurance Code §1355.001(4).

(7) Primary care physician--A physician selected or otherwise designated as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated to develop a treatment plan for the purpose of treating autism spectrum disorder.

§21.4403. Required Coverage.

(a) Certain Children Enrollees.

(1) At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee who is three years of age or older and younger than six years of age and who is diagnosed with autism spectrum disorder.

(2) Pursuant to the Insurance Code §1355.015(a), if an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code.

(b) Enrollees of Other Ages. A health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for enrollees of other ages.

(c) Medical and Surgical Benefit. In accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a

medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.

(d) Deductibles, Copayments, and Coinsurance. Pursuant to the Insurance Code §1355.015(d), coverage under this section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

§21.4404. Health Care Practitioners.

(a) Health Care Practitioner Who Provides Treatment. Pursuant to the Insurance Code §1355.015(b), a health care practitioner providing treatment for autism spectrum disorder under the Insurance Code Chapter 1355, Subchapter A, and this subchapter must:

(1) be licensed, certified, or registered by an appropriate agency of this state;

(2) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or

(3) be certified as a provider under the TRICARE military health system.

(b) Coverage for Applied Behavior Analysis. A health benefit plan issuer may not deny coverage for services for autism spectrum disorder on the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by

an agency of this state, as long the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).