

## Information about Consumer Choice Plans

### What are state mandated benefits and consumer choice plans?

Texas law requires that health insurance and HMO plans cover certain benefits, frequently called “[state mandated health benefits](#).” Different plans are subject to different sets of state mandated benefits.

In order to provide flexibility, Texas allows health insurers and HMOs that offer plans with all the state mandated benefits to also offer “consumer choice plans,” which may exclude or limit certain state mandated benefits.

### How does the federal health care reform law affect consumer choice plans?

Beginning in 2014, the Affordable Care Act now generally requires plans sold to individuals and small businesses to cover a minimum package of “essential health benefits” (EHB) which includes the state mandated benefits. Health plans are now very limited in their ability to offer consumer choice plans that limit the state mandates.

Nevertheless, three of Texas’ requirements for HMO plans exceed federal EHB requirements so they may still be limited in a consumer choice plan:

- [Texas law](#) requires HMOs to provide rehabilitation benefits without limits; federal law allows plans to impose limits. A consumer choice HMO plan may impose limits, such as covering only 25 visits for rehabilitation services per year.
- [Texas law](#) limits HMOs use of copayment, deductible, and coinsurance requirements, but a consumer choice HMO plan may impose such cost-sharing requirements. For example, a consumer choice HMO plan may impose a \$5,000 deductible for in-network services, which would exceed the normal Texas limit.

### What about your plan?

Carriers are required to notify you if you are purchasing a consumer choice plan, identify the benefits that have been limited, and get your acknowledgement. You can also review your Summary of Benefits and Coverage (SBC) to see the cost sharing and limits that apply to each type of service covered under your plan. If you want more detail than is provided in the SBC, Texas law requires health insurers and HMOs to provide a document that includes more specific information regarding benefits, exclusions, terms and conditions, preauthorization requirements, service areas, etc. For this, ask for your plan’s Texas mandated summary plan description. If you want even more information, you can ask for your actual insurance policy/certificate or HMO evidence of coverage.