SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS

DIVISION 3. REQUIRED NOTICES

Repeal of 28 TAC §§21.3525 – 21.3528

28 TAC §21.3530, and §21.3535

DIVISION 4. ADDITIONAL REQUIREMENTS

28 TAC §§21.3542, 21.3543, and 21.3544

INTRODUCTION. The Texas Department of Insurance proposes to repeal 28 TAC §§21.3525 - 21.3528 and to amend §§21.3530, 21.3535, 21.3542, 21.3543, and 21.3544, concerning required notices for consumer choice health benefit plans. The proposed amendments implement Senate Bill 1852, 86th Legislature (2019), remove the requirement that health carriers obtain signed consumer choice disclosure statements on renewal, address other items related to when and how disclosure statements are signed and maintained, and make other modifications to make disclosures easier for consumers to understand.

EXPLANATION. The department proposes amending 21.3530, 21.3535, 21.3542, 21.3543, and 21.3544 to remove the renewal requirement for a carrier to sign a disclosure statement at renewal. A prospective policyholder is only required to sign a disclosure statement when applying for initial coverage. These amendments conform the sections to Insurance Code §1507.006.

The proposed amendments also include nonsubstantive editing changes to use plain language to conform to the agency's current style, and formatting changes to improve the disclosure form's readability.

Descriptions of the proposed amendments to the sections follow.

Repeal of §21.3525 - 21.3528. Insurer Notice on Application, Insurer Notice on Policy, HMO Notice on Application, and HMO Notice on Evidence of Coverage. The repeal of §§21.3525 - 21.3528 removes unnecessary duplication of Insurance Code §1507.005(a).

Section 21.3530. Health Carrier Disclosure. The amendments to §21.3530 clarify the required elements of a written disclosure for consumer choice plans. The changes to subsection (a) clarify that the disclosure should be provided in a manner that enables a consumer to retain a copy. Additionally, the requirements for Form CCP 1 are removed from subsection (a) and similar requirements are proposed in new subsection (c).

Subsection (b) is amended to provide that Form CCP 1 may be used to fulfill the requirements of the section and is available on the department's website.

New subsection (c) incorporates standards of readability into the disclosure forms. Subsection (c) is also drafted to make it clear that Form CCP 1 is not adopted by reference, but can be used by carriers if they so choose. Subsection (c)(1) provides for an acknowledgment that the consumer choice health benefit plan being offered or purchased does not provide some or all state-mandated health benefits. Subsection (c)(2) creates a requirement that the consumer purchasing the health plan be identified on the form. Subsection (c)(3) better describes the type of detail needed to sufficiently describe the difference between the consumer choice plan and a similar plan containing the state-mandate. Subsection (c)(4) creates a requirement that will notify consumers if their state-mandates change on renewal in a way that requires a change to the consumer-signed disclosure form. Subsection (c)(5) specifies the information that must be provided to consumers so they can research a similar health plan that contains all state-mandates, as is required by current §21.3542(d). That requirement is proposed to be removed from §21.3542 and incorporated in to §21.3530(c)(6)(C). Subsection (c)(6) requires insurers to

provide places for consumers to affirm that they understand four things: that the consumer choice plan does not contain the same level of coverage as a state-mandated plan (which brings language similar to what is required in the policies and contracts into the disclosure); that more information about consumer choice health benefit plans is available from the department on the department website or by calling the TDI helpline (an affirmation currently required by §21.3542(d)); that the health carrier has offered the opportunity to purchase a state-mandated plan that contains all Texas-required benefits and coverages; and, for plans issued in the individual market, that if the plan does not meet the consumer's needs, in most cases the consumer will not be able to get a new plan until the next open enrollment period. Subsection (c)(7) requires that a prospective or current policyholder or contract holder be informed that the prospective or current policyholder or contract holder has the right to a copy of the written disclosure statement. In an effort to ensure that consumers are not confused by this disclosure, subsection (c)(8) requires a sentence in English and Spanish that informs consumers they should not sign the form if they do not understand it. Subsection (c)(9) requires that forms provided at the initial purchase must contain a space for the consumer to sign. Subsection (c)(10) requires that the health plan notify the consumer how to access additional information about consumer choice plans from the department.

Current subsections (c) and (d) are redesignated as (d) and (e).

Redesignated subsection (d) is amended to require provision of the written disclosure form at least 60 days before the policy or contract renewal date.

New subsection (f) requires a health carrier to request a signature on the written disclosure form at the time of initial coverage or enrollment and when a policyholder renews coverage under a different plan than that for which the original disclosure statement was signed.

Current subsections (e) - (i) are redesignated as (g) - (k), and citations to these subsections in the other subsections are updated as appropriate to reflect this change.

Redesignated subsection (g) is revised to delete the words "or current" because the provisions in the subsection are only applicable to someone applying for coverage.

Redesignated subsection (h) is amended to provide clarification of who receives a written disclosure. The subsection is also amended to remove references to current policyholders, because the provisions in the subsection are only applicable to someone applying for coverage.

Redesignated subsection (i) is amended to clarify that a health carrier must, on request, provide the prospective or current policyholder or contract holder with a copy of the written disclosure statement free of charge.

Redesignated subsection (k) is amended to provide that disclosure forms must be filed within six months of the effective date of the rules and to conform to current agency style.

Section 21.3535. Retention of Disclosure. Section 21.3535 is amended to provide a five-year retention requirement for signed disclosure forms. Because disclosures are not signed every year, the requirement to retain signed forms for five years after a plan terminates effectively results in a retention period for the same amount of time as the existing requirement.

Subsection (a)(1) is amended to provide that insurers should retain copies of plan documents, because the department cannot confirm that the written disclosure has been filled out properly without knowing the mandates that were excluded from the plan.

Subsection (b) is amended to substitute the term "electronically" for "by facsimile or email transmission."

Subsection (c) is amended to address only renewals where a current policyholder or contract holder is not required to sign a disclosure statement. This change is made because written disclosure forms will no longer be signed on renewal.

Section 21.3542. Offer of State-Mandated Plan. Section 21.3542(d) is deleted because the requirement for a health plan to obtain an affirmation that it offered a plan containing all state mandates on a separate document was moved to the acknowledgments in §21.3530(c)(6)(C). Requiring that this information be in one document will benefit consumers and will create more continuity between health plans.

Section 21.3543. Required Plan Filings. Section 21.3543, which contains the filing rules associated with consumer choice plans, is amended to incorporate the requirement contained in current §21.3530(i) that a disclosure form must be filed for approval. Subsection (1) is amended to clarify that the consumer choice plan must be filed separately from any state-mandated plan. Subsection (2) is amended to require that the disclosure be filed for approval before use, no longer tying the disclosure to the filing of the plan itself. This amendment will make it clearer how to address instances when a health plan makes changes to the disclosure but not the health plan.

Section 21.3544. Required Annual Reporting. Section 21.3544 is amended to change the annual reporting requirements for information on consumer choice plans. Amendments to subsection (a) clarify that Form CCP 2 is adopted by reference, and, therefore, submission of the data must be made using that form. This will help the department gather the information consistently from many health plans. In subsection (a), current paragraphs (3), (5), and (6) are deleted, because the department believes it is of limited benefit for health plans to keep providing the information required by those paragraphs. This information has seldom, if ever, been requested from the department. Existing paragraph (4) is renumbered as paragraph (3), and new paragraph (4) is added as a better way to collect the information previously requested under §21.3543(2)(B). By

changing to the language in paragraph (4), the department should still acquire the information that has been requested in the past by the legislature, with fewer data points.

Current subsection (b) is deleted because it provided a definition for a reporting requirement that was repealed from subsection (a). New subsection (b) is added to establish what constitutes the average premium index rate for the purpose of subsection (a) of the section.

In addition, the proposed amendments include nonsubstantive editorial and formatting changes to conform the sections to the agency's current style and to improve the rule's clarity. These changes include standardizing references to the department's website and the phrasing used to describe the electronic submission of documents; deleting the word "the" where it is unnecessarily placed before Insurance Code citations; and capitalizing the word "Commissioner" where it appears in lowercase, replacing the word "subchapter" with "title" in citations to the Texas Administrative Code, and replacing the word "shall" with "must" to adhere to current agency style.

The department received comments on an informal draft posted on the department's website on July 1, 2020. The department considered those comments when drafting this proposal.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, Director, Regulatory Initiatives for the Life and Health Lines Office, has determined that during each year of the first five years the proposed amendments and repeals are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by statute. Ms. Bowden made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Bowden does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments and repeals are in effect, Ms. Bowden expects that enforcing the proposed amendments and repeals will have the public benefits of ensuring that the department's rules conform to Insurance Code Chapter 1507 and will make disclosures under the rules easier for Texas consumers to understand.

In addition, Ms. Bowden estimates that while some individual costs associated with the repeals and amendments are increased in some cases, the overall cost of complying with the amended rules will be the same as, or lower than, the cost of complying with the current rules. Lower costs will result from the elimination of data reporting that has not proved useful. The costs for obtaining and maintaining disclosure statements should be the same.

The department anticipates that, by amending its disclosure form, a health carrier will incur the following new costs to comply with the proposed amendments to §21.3530: (i) one-time costs for additional staff time needed to develop the written disclosure statement; and (ii) one-time staff wages and filing fees for updated disclosure forms.

The department estimates that it will take an administrative assistant between one and two hours to update the disclosure form and a compliance officer between 1/2 and one hour to review the disclosure form for each consumer choice plan offered by the company. Based on a review of previous filings, the department estimates that a typical carrier will have to update one disclosure form in each applicable market. An issuer may have to update between one and three disclosure forms, depending on whether the issuer offers plans in the individual, small-group, and large-group markets. The department's cost analysis of wages for staff to perform required compliance tasks is based on

information from the Labor Market & Career Information (LCMI) Department of the Texas Workforce Commission at texaswages.com/WDAWages.

Office and administrative support workers in Texas earn a mean hourly wage of $18.54. Compliance officers working in Texas earn a mean hourly wage of $35.91. In total, the department estimates that carriers will spend between $37 and $219 in one-time costs for staff to update the disclosure forms.

Health carriers must file with the department their updated disclosure forms for the department's approval. Under Insurance Code §1701.053 the department is authorized to charge a $100 fee for any form filed by a health carrier with the department. However, the department will not charge this fee for disclosure forms that are filed separately from other forms (health carriers will still incur a transaction fee of up to $34 for filing through the SERFF filings system). A compliance officer will also spend an estimated two hours filing the form with the department. Based on the wage data previously cited, the department estimates that health carriers will incur $72 in wages associated with making the necessary filing. A health carrier's total cost will depend on the number of disclosure forms the health carrier files with the department. A health carrier could avoid the filing fee costs if the written disclosure statement is included as a supplemental form with other policy forms or plan documents and submitted to the department in one filing. A health carrier marketing multiple consumer choice plans could also submit one filing containing multiple variations of the written disclosure statement, along with a statement identifying the previously approved policy forms or plan documents with which the written disclosure statements will be used. To help mitigate a health carrier's filing costs, the department is allowing health carriers six months from the effective date of the rule to update and file for approval their written disclosure forms that conform with the proposed consolidated Form CCP 1.

The department anticipates that some carriers may incur additional filing fees under the amendments to §21.3543, because the amendments require that a consumer choice plan be filed separately from any state-mandated plan. The cost to each health carrier will depend on how many consumer choice plans the carrier offers, how often the carrier makes filings, and whether the carrier has chosen in the past to combine consumer choice plans and state-mandated plans in a single filing. Many health carriers already submit separate filings for consumer choice plans and state-mandated plans. Based on a review of filing data, the department estimates that the average carrier makes one plan filing per year in each market in which they offer a consumer choice plan. Depending on whether an issuer offers consumer choice plans to individuals, small groups, or large groups, an issuer may spend between $134 and $402 on additional filing fees annually, based on a $100 state form filing fee and a $34 fee for using the SERFF filing system.

The department anticipates that any costs resulting from the amendments to §21.3543 will be more than offset by reduction in costs resulting from the amendments to §21.3544 by simplifying reporting under that section. When the current version of this section was proposed in January of 2004, at 29 TexReg 297, the department estimated that the data collection requirements would cost health carriers between $1,000 and $5,000 annually. Adjusted for inflation based on the CPI Inflation Calculator provided by the U.S. Bureau of Labor Statistics available at www.bls.gov/data/inflation_calculator.htm, the department estimates costs in August of 2020 (the most recent month for which data is available) to be between $1,403 and $7,017 annually. Currently, the data collection requires reporting of 240 lines of data. As proposed, the data collection will require reporting of only 96 lines of data, eliminating 60% of the data currently required, including data elements that issuers have reported are more difficult to maintain, such as the number of consumers who were previously uninsured. The department anticipates that this change will result in a cost savings for issuers ranging from $842 to $4,210 annually,

presuming that eliminating 60% of the data will eliminate 60% of the cost of the data collection.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that the proposed amendments and repeals will not have an adverse economic effect or a disproportionate economic impact on small or micro businesses or on rural communities because, as addressed in the cost note, the department estimates that the rules will result in overall cost savings that exceed any new costs imposed by the rules. The cost analysis previously described is not expected to vary for small or micro businesses. Likewise, the anticipated savings from the reduction in data collection requirements is expected to provide the same benefits for small and micro businesses. Considering both new costs and cost savings, the proposed amendments to §21.3530 and §§21.3542 - 21.3544 are expected to slightly reduce the cost of compliance for all carriers, including small or micro businesses. As a result, and in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that, taken together, the proposed amendments and repeal will decrease the total cost imposed on regulated persons. Therefore, no additional rule amendments are required.

GOVERNMENT GROWTH IMPACT STATEMENT. The department has determined that for each year of the first five years that the proposed amendments and repeal are in effect, the proposal:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will limit an existing regulation;

- will not increase or decrease the number of individuals subject to the rules' applicability; and

- will not positively or adversely affect the Texas economy.

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. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. The department will consider any written comments on the proposal that are received by the department no later than 5:00 p.m., central time, on January 4, 2021. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The request for public hearing must be separate from any comments and received by the department no later than 5:00 p.m., central time, on

January 4, 2021. If the department holds a public hearing, the department will consider written and oral comments presented at the hearing.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS

DIVISION 3. REQUIRED NOTICES

Repeal of 28 TAC §§21.3525, 21.3526, 21.3527, and 21.3528

STATUTORY AUTHORITY. The department proposes the repeal of 28 TAC §§21.3525, 21.3526, 21.3527, and 21.3528 under Insurance Code §1507.009 and Insurance Code §36.001.

Insurance Code §1507.009 provides that the Commissioner adopt rules necessary to implement Chapter 1507.

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

TEXT.

§21.3525. Insurer Notice on Application.

§21.3526. Insurer Notice on Policy.

§21.3527. HMO Notice on Application.

§21.3528. HMO Notice on Evidence of Coverage.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS

DIVISION 3. REQUIRED NOTICES

§§21.3530 and 21.3535

STATUTORY AUTHORITY. The department proposes amendments to 28 TAC §21.3530 and §21.3535 under Insurance Code §§36.001, 1507.005, 1507.006, and 1507.009.

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

Insurance Code §1507.005 provides that each written application for participation in a standard health benefit plan must contain certain language.

Insurance Code §1507.006 requires health carriers providing standard health plans to provide a proposed policyholder or policyholder with certain written disclosures. The section also requires each applicant for initial coverage to sign the disclosure statement provided by the health carrier, and it requires the carrier to retain the signed disclosure statement.

Insurance Code §1507.009 provides that the Commissioner adopt rules necessary to implement Chapter 1507.

CROSS-REFERENCE TO STATUTE. Sections 21.3530 and 21.3535 implement Insurance Code §1507.005 and §1507.006.

TEXT.

§21.3530. Health Carrier Disclosure.

(a) A health carrier offering or providing a consumer choice health benefit plan must provide each prospective or current policyholder or contract holder with a written disclosure statement in a manner that gives the policyholder or contract holder the ability

to keep a copy of the disclosure statement [~~prescribed in Form CCP 1 provided by the department for that purpose~~]. The disclosure statement [~~information provided in Form CCP 1~~] must provide a sufficient description of the [~~reduced benefit or the~~] state-mandated health benefits that are reduced or not included in the plan to enable the prospective or current policyholder or contract holder [~~consumer~~] to make an informed decision. [~~about whether the consumer choice plan being offered or purchased provides sufficient coverage for the consumer's needs. Form CCP 1:~~]

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

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

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

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

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

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

(c) If a health carrier chooses to generate its own disclosure statement, it must comply with readability standards applicable to forms reviewed under Chapter 3 of this title (relating to Life, Accident, and Health Insurance and Annuities) and Chapter 11 of this title (relating to Health Maintenance Organizations) and the paper copy must use at least 12-point type. The disclosure statement also must:

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

(2) identify the consumer choice health benefit plan being offered or purchased;

(3) in plain language, list each health benefit or coverage not provided at the state-mandated level in the consumer choice health benefit plan, define the listed health benefit or coverage, describe the level of benefit or coverage in the consumer choice plan being offered, and describe the level of benefit or coverage that would be provided in a state-mandated plan;

(4) when applicable because the health carrier has materially modified a consumer choice plan in a way that necessitates a change to the disclosure, or when the disclosure must be updated to reflect changes in state law, contain the following language, in bold type, directly above the list required by paragraph (3) of this subsection, as applicable:

(A) "The benefits or coverages you are agreeing to on this renewal are different from your current plan."; or

(B) "The benefits required by state law have changed since you first received this disclosure.";

(5) identify the state-mandated plan that is most like the consumer choice health benefit plan being offered, and provide:

(A) a phone number where the consumer can purchase that state-mandated plan; and

(B) a URL that connects the consumer either to the summary of benefits and coverage for that state-mandated plan or, if one is not available, to the outline of coverage, written plan description, or other similar summary document for the state-mandated plan;

(6) contain acknowledgments, which require applicants for initial coverage or enrollment to initial to affirm understanding, of the following:

(A) that the consumer choice health benefit plan does not provide the same level of coverage required in a state-mandated plan;

(B) that more information about consumer choice health benefit plans is available from the department either online at www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the TDI Consumer Help Line at 1-800-252-3439;

(C) that the health carrier offered the opportunity to purchase a state-mandated plan that contains all benefits and coverages required in Texas; and

(D) if the plan is being issued in the individual market, that if the plan does not meet the consumer's needs, in most cases the consumer will not be able to get a new plan until the next open enrollment period;

(7) inform the prospective or current policyholder or contract holder that the prospective or current policyholder or contract holder has the right to a copy of the written disclosure statement;

(8) contain the following language in bold type: "Don't sign this document if you don't understand it. No firme este documento si no lo comprende."; and

(9) for initial coverage or enrollment, provide space for the prospective or current policyholder or contract holder to print and sign their name, and to sign to acknowledge receipt of the disclosure statement.

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

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

(2) to a current policyholder or contract holder, at least 60 days before the policy or contract renewal date [~~along with any offer to renew the contract or policy~~].

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

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

(2) if the health carrier is unable to provide the written disclosure and obtain a signature at the time of application, the health carrier must:

(A) mail the written disclosure statement to the prospective or current policyholder or contract holder no later than three business days from the date the health carrier receives the application from the federal health benefit exchange; and

(B) provide either a link to the written disclosure statement directly on the healthcare.gov website, or a reference and link to the written disclosure statement in the summary of benefits and coverage or the plan brochure provided on the healthcare.gov website.

(f) A health carrier must request a signature on the written disclosure statement:

(1) at the time of initial coverage or enrollment; and

(2) any time a policyholder is renewing coverage under a different consumer choice plan from the plan for which the initial disclosure statement was signed, including instances where the health carrier discontinues a plan, consistent with Insurance Code §1202.051, concerning Renewability and Continuation of Individual Health Insurance Policies; Insurance Code §1271.307, concerning Renewability of Coverage: Individual Health Care Plans and Conversion Contracts; and Insurance Code §1501.109, concerning Refusal to Renew; Discontinuation of Coverage.

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

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

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

(h)[~~(f)~~] When a health carrier provides the written disclosure statement described in subsection (a) of this section in the manner described by subsection (e)(2)[~~(d)(2)~~] of this section to a prospective policyholder or contract holder, the health carrier must:

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

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

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

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

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

§21.3535. Retention of Disclosure.

(a) A health carrier must, for a period of five [~~six~~] years after the date a consumer choice health benefit plan terminates:

(1) retain in the health carrier's records the signed disclosure statement required by §21.3530 of this title [~~subchapter~~] (relating to Health Carrier Disclosure), [~~and~~] the written affirmation required by §21.3542 of this title [~~subchapter~~] (relating to Offer of State-Mandated Plan), and plan documents that show which benefits or coverages were not provided at the state-mandated level in the issued consumer choice health benefit plan; and

(2) on request from the department, provide copies [~~a copy~~] of the retained documents [~~signed disclosure statement and/or written affirmation~~] to the department.

(b) A health carrier may accept receipt of a signed disclosure and [~~or~~] written affirmation electronically [~~by facsimile or electronic transmission~~], but the [~~such~~] carrier remains responsible for compliance with subsection (a)(2) of this section.

(c) For renewals where a current policyholder or contract holder is not required to sign a disclosure statement, [~~If subsequent to the issuance of a policy or evidence of coverage, a policyholder or contract holder does not return the signed disclosure statement to the health carrier,~~] the health carrier may satisfy the requirements of subsection (a)(1) of this section by furnishing proof that the health carrier tendered the disclosure statement [~~, with a request to sign and return it,~~] to the policyholder or contract holder in accordance with §21.3530(d)[~~(c)~~](2) of this title [~~subchapter~~].

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 4. ADDITIONAL REQUIREMENTS
§§21.3542, 21.3543, and 21.3544

STATUTORY AUTHORITY. The department proposes amendments to 28 TAC §§21.3542, 21.3543, and 21.3544 under Insurance Code §§36.001, 1507.006, 1507.007, and 1507.009.

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

Insurance Code §1507.006 requires health carriers providing standard health plans to provide a proposed policyholder or policyholder with certain written disclosures. The section also requires each applicant for initial coverage to sign the disclosure statement provided by the health carrier, and it requires the carrier to retain the signed disclosure statement.

Insurance Code §1507.007 provides that a health carrier that offers one or more standard health plans under Chapter 1507 must also offer at least one accident or sickness insurance policy that provides state-mandated benefits and is otherwise authorized by the Insurance Code.

Insurance Code §1507.009 provides that the Commissioner adopt rules necessary to implement Chapter 1507.

CROSS-REFERENCE TO STATUTE. Section 21.3542 implements Insurance Code §1507.007. Section 21.3543 implements Insurance Code §1507.005 and §1507.006. Section 21.3544 implements Insurance Code § 36.001.

§21.3542. Offer of State-Mandated Plan.

(a) A health carrier that offers the opportunity to apply for one or more consumer choice health benefit plans under this section [~~to a person or entity~~] must also, no later than at the time of application, offer the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that reasonably approximates the consumer choice health benefit plan offered, that includes state-mandated health benefits, and that is otherwise authorized by the Insurance Code.

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

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

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

(3) provide at least the following information:

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

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

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

[~~(d) A health carrier offering a consumer choice health benefit plan must obtain from each prospective policyholder or contract holder, at or before the time of application, a written affirmation that the health carrier also offered a policy or evidence of coverage in compliance with subsection (a) of this section. A health carrier may combine on a single form this written affirmation and the acknowledgement of the written disclosure statement required by §21.3530(a)(4) of this subchapter (relating to Health Carrier Disclosure).~~]

§21.3543. Required Plan Filings.

A health carrier must [~~shall~~]:

(1) file the consumer choice health benefit plan separate from any state-mandated health benefit plan with the department [~~Filings and Operations Division~~] in accordance with:

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

(B) [~~the~~] Insurance Code Chapter 1701 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) before use, file for approval with the department its: [~~include with the filing of a consumer choice health benefit plan :~~]

[~~(A)~~] disclosures required by §21.3530 of this title [~~subchapter~~] (relating to Health Carrier Disclosure) and[~~;~~]

[~~(B) a statement of the reduction in premium resulting from the differences in coverage and design between the consumer choice health benefit plan and an identical plan providing all state-mandated health benefits;~~]

[~~(C)~~] certification of compliance with §21.3542 of this title [~~subchapter~~] (relating to Offer of State-Mandated Plan); and

(3) file, [~~(D)~~] for informational purposes, the rates to be used with a consumer choice health benefit plan.

§21.3544. Required Annual Reporting.

(a) Health carriers offering a consumer choice health benefit plan must [~~shall~~] file annually with the department a data certification, not later than April 1 of each year, [~~in the manner prescribed~~] on Form CCP 2, Consumer Choice Health Benefit Plans Data Certification, Rev. 05/20. The data certification includes the following, each set out by plan type [~~provided by the department, a certification stating the following~~]:

(1) the total number of consumer choice health benefit plans newly issued and renewed covering Texas lives [~~by type of plan~~];

(2) the total number of Texas lives (including members/employees, spouses, and dependents) covered under newly issued and renewed consumer choice health benefit plans;

(3) [~~the total number of consumer choice health benefit plans covering Texas lives that were cancelled or non-renewed during the previous calendar year (and were not in effect after December 31), as well as the total number of Texas lives covered under those plans, and gross premiums paid for coverage of Texas lives under those plans;~~]

[~~(4)~~] the gross premiums received for newly issued and renewed consumer choice health benefit plans covering Texas lives; and

(4) the average premium index rate for consumer choice plans and state-mandated plans.

(b) For the purpose of subsection (a) of this section, the average premium index rate is the earned premium divided by the member months for each set of plans, given per member per month, where member months is the number of people enrolled in a plan times the months of enrollment. For projected average premium index rates, the earned premium and member months should reflect a best estimate.

[~~(5) the number of consumer choice health benefit plans covering individuals and groups in Texas that were uninsured for at least two months prior to issue, and the number of Texas lives covered under those plans; and~~]

[~~(6) the number of consumer choice health benefit plans in force in Texas on December 31, and the number of Texas lives covered under those plans, based on the first three digits of the five-digit ZIP Code of:~~]

[~~(A) the employer's principal place of business in Texas, for any employer-based plan; and~~]

[~~(B) the individual's place of residence, for individual or group non-employer based plans.~~]

[~~(b) For purposes of this subsection, gross premiums shall be the total amount of monies collected by the health carrier for health benefit plans during the applicable calendar year or the applicable calendar quarter. Gross premiums shall include premiums collected for individual and group consumer choice health benefit plans. Gross premiums shall also include premiums collected under group certificates issued or delivered to individuals (in this state), regardless of where the health carrier issues or delivers the master policy.~~]

(c) Form CCP 2 is available on [~~can be obtained from the Texas Department of Insurance, Filings and Operations Division, MC 106-1E, P.O. Box 149104, Austin, Texas 78714-9104. The form can also be obtained from~~] the department's website at www.tdi.texas.gov [~~internet web site @ www.tdi.state.tx.us~~].

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

Issued in Austin, Texas, on November 12, 2020.

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