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

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §§21.3101 - 21.3105 and new §21.3106 and §21.3107, concerning coverage for acquired brain injury. The amendments to §§21.3101, 21.3103 and new §21.3107 are adopted with changes to the proposed text published in the August 22, 2008 issue of the *Texas Register* (33 TexReg 6714). The amendments to §§21.3102, 21.3104, and 21.3105, and new §21.3106 are adopted without changes.

2. REASONED JUSTIFICATION. These amendments and new sections are necessary to implement House Bill (HB) 1919, 80th Legislature, Regular Session, effective January 1, 2008. HB 1919 amended Insurance Code Chapter 1352, relating to required coverage for acquired brain injury. The amendments and new sections: (i) address expanded coverage of acquired brain injury provisions in health benefit plans to include coverage of post-acute care and cognitive rehabilitation for survivors of brain injuries; (ii) distinguish required coverage provisions that do not apply to small business health benefit plans and provide alternative coverage provisions that do apply to small business health benefit plans; (iii) specify the content of the statutorily required notification of coverage that health benefit plan issuers, other than small business health benefit plans, are required to annually provide to insureds or enrollees; and (iv)

specify procedures for the distribution of the statutorily required notification of coverage. The amendments are also necessary to update statutory citations in existing rules to conform to the non-substantive revised Insurance Code. These updates are necessary for easier use and readability of the rules.

As required by §1352.005(b) of the Insurance Code, the notice included in adopted §21.3107 was prepared in consultation with the Texas Traumatic Brain Injury Advisory Council. The Department posted an informal working draft of the proposed amendments and new sections on the Department's internet website from June 11, 2008 to June 23, 2008. The Department formally proposed the amendments and new sections in the August 22, 2008 issue of the *Texas Register* (33 TexReg 6714).

A public hearing on the rule proposal was held on September 25, 2008. In response to written comments on the published proposal and comments made at the hearing, the Department has changed some of the proposed language in the text of the rule as adopted. Additionally, this adoption includes minor editorial corrections in three provisions. None of the changes made to the proposed text, either as a result of comments or as a result of necessary clarification, materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

The following changes are made to the proposed text as a result of comments.

The Department has revised §21.3101(c)(1)(A) and (B) as adopted to specify that these rules apply to all health benefit plans delivered, issued for delivery, or renewed on or after March 31, 2009. Health benefit plans delivered, issued for delivery,

or renewed prior to March 31, 2009 are subject to the statutes and rules in effect at the time the health benefit plans were delivered, issued for delivery, or renewed. The March 31, 2009 date is in lieu of the proposed October 31, 2008 applicability date. This change is the result both of a commenter objecting to the proposed applicability date of October 31, 2008, and as a result of the effective date of this adoption. According to the commenter, as proposed, the applicability date of October 31, 2008 would not have been a realistic date because it would not have provided sufficient time for health benefit plans to prepare for compliance with the new rules. The Department has determined that these rules will apply to all health benefit plans delivered, issued for delivery, or renewed on or after March 31, 2009. The Department believes that this will provide sufficient time for insurers to take the necessary action to comply with the new requirements. As a result of this change in the applicability date to March 31, 2009, the Department has also changed the date in §21.3107(c)(1)(A) and (B) for the distribution of the Insurance Code §1352.005 mandatory notice to insureds and enrollees. As adopted, §21.3107(c)(1)(A) and (B) read: "(1) The notice shall be provided during the policy term for the plan, and no later than: (A) March 31, 2009 to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the March 31, 2009 applicability date of this subchapter; or (B) the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the March 31, 2009 applicability date of this subchapter." The proposed date for distribution of the notice was "no later than: (A) the 60th day after the effective date of this section to insureds or enrollees whose plans

were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the effective date of this section; or (B) the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the effective date of this section." Consistent with the intent of the proposal, the change in §21.3107(c)(1)(A) to "no later than March 31, 2009" is necessary to ensure that the notices will be distributed in a timely manner to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the March 31, 2009 applicability date. This change is necessary because of the necessary delay in applicability of the new rules to March 31, 2009. The references to "effective date" in proposed §21.3107(c)(1)(A) and (B) have been changed to "March 31, 2009 applicability date" for purposes of clarification and consistency in implementation.

Adopted §21.3103(d) has been revised to closely follow the statutory language of §1352.003(c) of the Insurance Code. As adopted, §21.3103(d) addresses lifetime payment limitations, deductibles, copayments, and coinsurance. Section 21.3103(d) as adopted: (i) prohibits a health benefit plan from subjecting the coverage required under the Insurance Code Chapter 1352 to payment limitations, deductibles, copayments, and coinsurance factors that are more restrictive than payment limitations, deductibles, copayments, and coinsurance factors applicable to other similar coverage provided under the health benefit plan; (ii) prohibits a health benefit plan that includes lifetime limitations on coverage required under the Insurance Code Chapter 1352 from including any post acute care treatment for such coverage in any lifetime limitation on the number

of days of acute care treatment covered under the plan; and (iii) requires a health benefit plan to separately state in the plan any lifetime limitation imposed under the plan on days of post-acute care treatment for the coverage required under the Insurance Code Chapter 1352. These changes to §21.3103(d) are the result of a commenter who objected to proposed §21.3103(d)(2) as being inconsistent with §1352.003(c) of the Insurance Code. The commenter stated that the statute, at §1352.003(c), indicates that a carrier may not apply *lifetime* limitations regarding acute care treatment to post-acute care treatment, but that there is no mention of *annual* limitations. The commenter asserted that the proposed rule added the term *annual*, despite the fact that the statute does not contain or authorize this prohibition. The commenter asserted that the use of generally applicable *annual* limitations is allowed by the statute and should not be prohibited by the rule.

The Department has also made non-substantive editorial changes to (i) re-locate a misplaced “and”; (ii) remove an incorrect comma; (iii) correct singular words that should be plural; and (iv) capitalize certain words. Adopted §21.3101(a)(2) and (3) have been revised to correct the placement of the word “and” in the paragraph (1) – (3) listings. As proposed, existing §21.3101(a)(4) was deleted because authority for the provision no longer exists. However, the “and” at the end of §21.3101(a)(3) was not removed, despite the fact that there would no longer be a fourth paragraph following §21.3101(a)(3). This inadvertent error has been corrected by placing the word “and” at the end of §21.3101(a)(2). The Department has also deleted an incorrect comma in §21.3107(c)(6) as adopted. Proposed §21.3107(c)(6) contained a comma between the

words “or enrollees” and “if the health benefit plan issuer. . . .” Section 21.3107(c)(6) as adopted reads: “(6) For group health benefit plans, the notice may be provided to the group master contract holder for distribution to insureds or enrollees if the health benefit plan issuer has an agreement with the group master contract holder that the notice will be delivered in accordance with the timelines specified in paragraph (1) of this subsection; however, the health benefit plan issuer will be held responsible for ensuring that the notice is provided to the insureds or enrollees.” In §21.3101(a) as adopted, the words “purpose” and “is” in the introductory sentence have been changed to “purposes” and “are” to reflect the fact that there are multiple purposes stated in §21.3101(a). The introductory sentence in adopted §21.3101(a) reads: “(a) Purpose. The purposes of this subchapter are to: . . . .” The words “postal service” in §21.3107(c)(3) have been capitalized to read U.S. Postal Service.”

A correction of error notice was published in the September 5, 2008 issue of the *Texas Register* (33 TexReg 7624) to add a colon that was inadvertently omitted after the word "not" in §21.3101(c)(2). In accordance with this notice, proposed §21.3101(c)(2) is adopted without changes and reads: "(2) Nothing in this subchapter requires the issuer of a health benefit plan to provide coverage for services that are not: medically necessary; clinically proven; goal-oriented; efficacious; based on an individualized treatment plan; or provided by, or ordered and provided under the direction of a licensed healthcare practitioner."

The following paragraphs provide a brief summary as well as an analysis of the reasons for the adopted amendments and new sections.

The adopted amendment to §21.3101(c)(1) is necessary to specify an applicability date for the adopted amendments and new sections. Adopted §21.101(c)(1)(A) and (B) specify that, except as otherwise specified within the subchapter, these rules apply to all health benefit plans delivered, issued for delivery, or renewed on or after March 31, 2009. Health benefit plans delivered, issued for delivery, or renewed prior to March 31, 2009, are subject to the statutes and rules in effect at the time the health benefit plans were delivered, issued for delivery, or renewed. The Department anticipates that the March 31 applicability date will provide sufficient time for insurers to take the necessary action to comply with the new requirements, including preparing to provide the notice required by §21.3107.

The adopted amendments to §21.3102 are necessary to add definitions for the terms “outpatient day treatment services” and “post-acute care treatment services” in paragraphs (18) and (19). These are terms used in the new rules and in Chapter 1352 of the Insurance Code. The adopted amendments also redesignate the remaining definitions accordingly.

The adopted amendments to §21.3103 are necessary to expand the section, adding new subsections, paragraphs, and subparagraphs, in order to implement provisions of HB 1919 related to required coverage for acquired brain injury. Additionally, adopted amendments are necessary to re-organize existing subsections into paragraphs and subparagraphs for purposes of better organization and clarity of the adopted and existing rules. Subsection titles are adopted to assist in organization and provide clarity.

Section 21.3103(a) addresses required coverage for an acquired brain injury in accordance with Chapter 1352 of the Insurance Code. The adopted amendment to §21.3103(a) is necessary to add “outpatient day treatment services or other post-acute care treatment services” to the types of required coverage. This type of coverage is required by the Insurance Code §1352.003, as amended by HB 1919.

Section 21.3103(b) addresses medically necessary and appropriate treatments and services for an acquired brain injury in accordance with Chapter 1352 of the Insurance Code. The reorganization of §21.3103 and the expansion of the subchapter to implement HB 1919 results in the use of the terms “necessary” and “medically necessary” in other rules within the subchapter in addition to §21.3103(a). Therefore, the adopted amendment to §21.3103(b)(1) is necessary to change the reference to “subsection (a) of this section” to “this subchapter.” The adopted amendment to §21.3103(b) that adds new paragraph (2) is necessary to prohibit health benefit plans from denying benefits for the coverage required under Chapter 1352 of the Insurance Code based solely on the fact that the treatment or services are provided at a facility other than a hospital. Adopted §21.3103(b)(2) is also necessary to mandate that medically necessary treatment and services for an acquired brain injury must be provided under the coverage required by Chapter 1352 at a facility at which appropriate services may be provided. Additionally, new §21.3103(b)(2)(A) and (B) are necessary to specify examples of such facilities in accordance with the Insurance Code §1352.007(a)(1) and (2).

Section 21.3103 addresses maintenance, prevention, and reevaluation of care. The adopted amendment to §21.3103(c)(1) is necessary to specify that the source of the mandated coverage is the Insurance Code Chapter 1352. In accordance with the Insurance Code §1352.003(e), adopted new §21.3103(c)(2) provides that a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, been unresponsive to treatment, and becomes responsive to treatment at a later date. In accordance with the Insurance Code §1352.003(f), adopted §21.3103(c)(2) specifies five factors that are to be used in determining whether expenses related to periodic reevaluation of care are reasonable and must be covered.

Section 21.3103(d) addresses lifetime payment limitations, deductibles, copayments, and coinsurance. Adopted new §21.3103(d)(1) is necessary to prohibit a health benefit plan from subjecting the coverage required under the Insurance Code Chapter 1352 to payment limitations, deductibles, copayments, and coinsurance factors that are more restrictive than payment limitations, deductibles, copayments, and coinsurance factors applicable to other similar coverage provided under the health benefit plan. Adopted new §21.3103(d)(2) is necessary to prohibit a health benefit plan that includes lifetime limitations on coverage required under the Insurance Code Chapter 1352 from including any post acute care treatment for such coverage in any lifetime limitation on the number of days of acute care treatment covered under the plan. Adopted new §21.3103(d)(3) is necessary to require a health benefit plan to separately state in the plan any lifetime limitation imposed under the plan on days of post-acute

care treatment for the coverage required under the Insurance Code Chapter 1352. These provisions closely follow the statutory language of §1352.003(c) of the Insurance Code. Section 1352.003(c) of the Insurance Code states that a carrier may not apply *lifetime* limitations regarding acute care treatment to post-acute care treatment.

Section 21.3103(e) addresses other coverage limitations. The adopted amendment to §21.3103(e) is necessary to reflect that the source of the mandated coverage is the Insurance Code Chapter 1352.

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

Section 21.3103(g) addresses permitted coverage denials. The adopted amendment in §21.3103(g) that changes the term “an issuer” to “a health benefit plan” is necessary for consistency with the Insurance Code §1352.003. The adopted amendment in §21.3103(g) that changes the phrase “listed in subsection (a) of this section” to “required under the Insurance Code Chapter 1352” is necessary to specify that the source of the mandated coverage is the Insurance Code Chapter 1352.

Adopted new §21.3103(h) is necessary to address the inapplicability of §21.3103 to small employer health benefit plans in accordance with the Insurance Code §§1352.003(h) and 1352.007(b).

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

Adopted new §21.3106 is necessary to address small employer health benefit plans. The changes in Chapter 1352 of the Insurance Code enacted by HB 1919 are not applicable to small employer health benefit plans; instead, HB 1919 enacts a new §1352.0035 that contains the same requirements of Chapter 1352 that applied to small employer health benefit plans before the enactment of HB 1919. Adopted new §21.3106 is consistent with §1352.0035 of the Insurance Code. Adopted new §21.3106 addresses the following areas of regulation for small employer health benefit plans: (i) required coverage; (ii) deductibles, copayments, coinsurance, and lifetime limitations; (iii) maintenance and prevention and treatment goals; (iv) other coverage limitations; (v) permitted coverage exclusions; and (vi) permitted coverage denials.

Adopted new §21.3107 is necessary to address the mandatory annual notice of coverage to insureds and enrollees that is required in §1352.005 of the Insurance Code. Section 1352.005(a) requires a health benefit plan issuer, other than a small employer health benefit plan, to annually notify each insured or enrollee under the plan in writing about the coverages described by §1352.003. As required by §1352.005(b) of the Insurance Code, the adopted notice was prepared in consultation with the Texas

Traumatic Brain Injury Advisory Council. Section 1352.005(c) of the Insurance Code specifies the required types of information that must be included in the notice. Adopted new §21.3107(a) is necessary to specify the content of the notice in accordance with §1352.005(c). Adopted §21.3107(b) is necessary to provide a process for distribution of the notice of coverage for acquired brain injury. Adopted §21.3107(c) requires the notice to be printed in at least 12-point type and to comply with the timelines specified in adopted §21.3107(c)(1)(A) and (B). Under the adopted timelines, the notice must be provided (i) within the policy term and no later than March 31, 2009, to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the March 31, 2009 applicability date of the new rules; or (ii) within the policy term and no later than the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the March 31, 2009 applicability date of the new rules. Adopted new §21.3107(c)(2) requires a health benefit plan issuer to deliver the notices to insureds or enrollees through the U.S. Postal Service except as provided in §21.3107(c)(6). Adopted new §21.3107(c)(3) provides that the notice may be delivered with other health benefit plan documents that are delivered through the U.S. Postal Service as long as the time frames in §21.3107(c)(1) are met. For example, the notice may be delivered with the policy, certificate, evidence of coverage, or enrollment/insurance card. Adopted new §21.3107(c)(4) provides that if the notice is provided to the primary insured's or enrollee's last known address, the requirements of §21.3107 are satisfied with respect to all enrollees or insureds residing at that address. Adopted new §21.3107(c)(5)

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

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

3. HOW THE SECTIONS WILL FUNCTION.

§21.3101. General Provisions. Section 21.3101 addresses general subchapter provisions, including purpose in subsection (a), severability in subsection (b), and applicability in subsection (c). The adopted amendment to §21.3101(a)(3) updates the obsolete citation to Article 21.53Q, which is now Chapter 1352 of the Insurance Code,

as a result of the legislative enactment of the non-substantive Insurance Code revision. The adopted amendment to §21.3101(a) which removes subsection (a)(4) deletes an obsolete statement of purpose. There are no further substantive changes to existing subsection (a) in this adoption. There are no changes to the existing severability provisions in §21.3101(b). Under the adopted amendments to §21.3101(c)(1), the applicability date of these adopted rules is March 31, 2009, unless specified otherwise in the rules. Adopted §21.3101(c)(1)(A) provides that, except as otherwise specified in the subchapter, the rules apply to all health benefit plans delivered, issued for delivery, or renewed on or after March 31, 2009. Adopted §21.3101(c)(1)(B) provides that, except as otherwise specified in the subchapter, health benefit plans delivered, issued for delivery, or renewed prior to March 31, 2009, are subject to the statutes and provisions of this subchapter in effect at the time the health benefit plans were delivered, issued for delivery, or renewed. The adopted amendments to §21.3101(c)(2) change the punctuation for purposes of clarification of the six separate elements. Health benefit plan issuers are not required to provide coverage for services that are not: (i) medically necessary; (ii) clinically proven; (iii) goal-oriented; (iv) efficacious; (v) based on an individualized treatment plan; or (vi) provided by, or ordered and provided under the direction of a licensed healthcare practitioner.

§21.3102. Definitions. The adopted amendments to §21.3102 add definitions for the terms “outpatient day treatment services” and “post-acute care treatment services” in paragraphs (18) and (19) and redesignate the remaining definitions accordingly.

§21.3103. Coverage for Services. Section 21.3103(a) addresses required coverage for an acquired brain injury in accordance with Chapter 1352 of the Insurance Code. The adopted amendment to §21.3103(a) adds "outpatient day treatment services or other post-acute care treatment services" to the types of required coverage.

Section 21.3103(b) addresses medically necessary and appropriate treatments and services for an acquired brain injury in accordance with Chapter 1352 of the Insurance Code. The reorganization of §21.3103 and the expansion of the subchapter to implement HB 1919 results in the use of the terms "necessary" and "medically necessary" in other rules within the subchapter in addition to §21.3103(a). Therefore, the adopted amendment to §21.3103(b)(1) changes the reference to "subsection (a) of this section," which is in the existing rules prior to this adoption, to "this subchapter." Under the adopted amendment to §21.3103(b) that adds new paragraph (2), health benefit plans are prohibited from denying benefits for the coverage required under Chapter 1352 of the Insurance Code based solely on the fact that the treatment or services are provided at a facility other than a hospital. Adopted §21.3103(b)(2) also mandates that medically necessary treatment and services for an acquired brain injury must be provided under the coverage required by Chapter 1352 at a facility at which appropriate services may be provided. Additionally, in accordance with the Insurance Code §1352.007(a)(1) and (2), examples of such facilities are specified in subparagraphs (A) and (B) of the new §21.3103(b)(2).

Section 21.3103(c) addresses maintenance, prevention, and reevaluation of care. New §21.3103(c)(2), consistent with the Insurance Code §1352.003(e), requires a

health benefit plan to include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who (i) has incurred an acquired brain injury, (ii) been unresponsive to treatment, and (iii) becomes responsive to treatment at a later date. Five factors that are to be used by health benefit plans in determining whether expenses related to periodic reevaluation of care are reasonable and must be covered are specified in adopted §21.3103(c)(2). These five factors are consistent with the Insurance Code §1352.003(f).

Adopted §21.3103(d) addresses lifetime payment limitations, deductibles, copayments, and coinsurance. Under new §21.3103(d)(1) a health benefit plan is prohibited from subjecting the coverage required by §21.3103 to payment limitations, deductibles, copayments, and coinsurance factors that are more restrictive than payment limitations, deductibles, copayments, and coinsurance factors applicable to other similar coverage provided under the health benefit plan. Under new §21.3103(d)(2), a health benefit plan that includes lifetime limitations on coverage required under the Insurance Code Chapter 1352 is prohibited from including any post acute care treatment for such coverage in any lifetime limitation on the number of days of acute care treatment covered under the plan. Under new §21.3103(d)(2) a health benefit plan is required to separately state in the plan any lifetime limitation imposed under the plan on days of post-acute care treatment for the coverage required under the Insurance Code Chapter 1352.

Section 21.3103(e) addresses other coverage limitations. These limitations are the same as the limitations specified in existing 21.3103(e) prior to this adoption. The

adopted amendment to §21.3103(e) is non-substantive and reflects that the source of the mandated coverage is the Insurance Code Chapter 1352.

Section 21.3103(f) addresses permitted coverage exclusions. These exclusions are the same as the exclusions specified in existing §21.3103(f) prior to this adoption. The adopted amendments to §21.3103(f) are non-substantive and (i) clarify that the term that is defined in §21.3102 is "neurofeedback therapy" rather than the existing referenced term “neurofeedback”; and (ii) specify that the source of the mandated coverage is the Insurance Code Chapter 1352.

Section 21.3103(g) addresses permitted coverage denials. These permitted coverage denials are the same as those specified in existing §21.3103(g) prior to this adoption. The adopted amendments to §21.3103(g) are non-substantive and (i) change the term “an issuer” to “a health benefit plan” for consistency with the Insurance Code §1352.003; and (ii) change the phrase “listed in subsection (a) of this section” to “required under the Insurance Code Chapter 1352” to correctly specify the source of the mandated coverage.

New §21.3103(h) specifies the inapplicability of §21.3103 to small employer health benefit plans in accordance with the Insurance Code §1352.003(h) and §1352.007(b).

§21.3104. Training. Existing §21.3104(c) specifies the minimum training required in order for each issuer to comply with the requirements of §21.3104(c) relating to preauthorization of coverage or utilization review training. The adopted amendment to §21.3104(c)(3) adds the word “and” to the end of that paragraph to clarify that all of

the types of training or instruction listed in §21.3104(c)(3)(1) – (4) comprise the total minimum requirements.

§21.3105. Provision of CPT Codes. The requirements of §21.3105 are the same as those specified in existing §21.3105 prior to this adoption. The adopted amendments to this section are non-substantive and replace the obsolete citation to Article 21.53Q with the updated citation (the Insurance Code Chapter 1352).

§21.3106. Small Employer Health Benefit Plans. New §21.3106 addresses small employer health benefit plans. The changes in Chapter 1352 of the Insurance Code enacted by HB 1919 are not applicable to small employer health benefit plans; instead, HB 1919 enacts a new §1352.0035 that contains the same requirements of Chapter 1352 that applied to small employer health benefit plans before the enactment of HB 1919. Adopted new §21.3106 is consistent with §1352.0035 of the Insurance Code. Adopted new §21.3106 addresses the following areas of regulation for small employer health benefit plans: (i) required coverage; (ii) deductibles, copayments, coinsurance, and lifetime limitations; (iii) maintenance and prevention and treatment goals; (iv) other coverage limitations; (v) permitted coverage exclusions; and (vi) permitted coverage denials.

§21.3107. Mandatory Annual Notice to Insureds and Enrollees. New §21.3107 addresses the mandatory annual notice of coverage to insureds and enrollees that is required in §1352.005 of the Insurance Code. Section 1352.005(a) requires a health benefit plan issuer, other than a small employer health benefit plan, to annually notify each insured or enrollee under the plan in writing about the coverages described

by §1352.003. Section 1352.005(c) of the Insurance Code specifies the required types of information that must be included in the notice. New adopted §21.3107(a) specifies the content of the notice in accordance with §1352.005(c). The process for distribution of the notice of coverage is specified in adopted §21.3107(b). Under adopted §21.3107(c) health benefit plan issuers must print the notice in at least 12-point type and comply with the timelines specified in §21.3107(c)(1)(A) and (B). Under the adopted timelines, the notice must be provided (i) within the policy term and no later than March 31, 2009, to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the March 31, 2009 applicability date of the new rules; or (ii) within the policy term and no later than the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the March 31, 2009 applicability date of the new rules. Under new §21.3107(c)(2), a health benefit plan issuer must deliver the notices to insureds or enrollees through the U.S. Postal Service except as provided in §21.3107(c)(6). New §21.3107(c)(6) allows the notice to be provided to the group master contract holder for distribution to insureds or enrollees of group health benefit plans if the health benefit plan issuer has an agreement with the group master contract holder that the notice will be delivered in accordance with the timelines specified in §21.3107(c)(1). Adopted §21.3107(c)(6) further provides that in the event the notice is distributed to the group master contract holder, the health benefit plan issuer will be held responsible for ensuring that the notice is provided to the insureds or enrollees. Under new §21.3107(c)(3) a health benefit plan issuer may deliver the notice

with other health benefit plan documents that are delivered through the U.S. Postal Service as long as the time frames in §21.3107(c)(1) are met. For example, the notice may be delivered with the policy, certificate, evidence of coverage, or enrollment/insurance card. New §21.3107(c)(4) provides that if the notice is provided to the primary insured's or enrollee's last known address, the requirements of §21.3107 are satisfied with respect to all enrollees or insureds residing at that address. New §21.3107(c)(5) requires separate notices to be provided to the spouse or the dependent at the spouse's and/or dependent's last known address if the last known address of a covered spouse and/or dependent is different than the primary insured's or enrollee's last known address. New §21.3107(d) specifies that the provisions of §21.3107 do not apply to a small employer health benefit plan issuer. This is in accordance with §1352.003(a) of the Insurance Code.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General

Comment: One commenter endorses the Department's proposed rules. Another commenter expresses appreciation for the Department's work implementing the requirements of HB 1919 regarding treatment for certain brain injuries and general support for adoption of the rules.

Agency Response: The Department appreciates the commenters' endorsement and support.

Comment: Four commenters assert that some providers are not being paid for the necessary care being provided to their patients. One of the commenters states that despite the law some companies continue to put up barriers and deny legitimate claims. According to the commenter, these barriers have either resulted in a very restricted form of their covered benefits or outright denial. The commenter states that the intent of HB 1919 is to guarantee that policyholders receive full benefits from their health plans, but that despite such efforts, enrollees and insureds are still being denied coverage based on reasoning that contradicts the law. Another commenter expresses concern that some patients are being denied coverage for a continuum of treatments offered in non-hospital settings in disregard of the current law. The commenter expresses hope that the promulgation of rules implementing HB 1919 will remove any and all confusion about what treatments are allowed and where such treatments can be offered.

Agency Response: The Department agrees that services may be provided in facilities at which appropriate services may be provided, even if such facilities are non-hospital settings. This is addressed in the Insurance Code §1352.007(a) and §21.3103(b)(2) which is adopted without change. However, the Department disagrees with the comments, insofar as they suggest that benefits should be provided without permissible contractual limitations. The Department does not have the authority to require coverage in excess of that mandated by HB 1919 and cannot prevent the application of contractual limits permitted by the Insurance Code. If a provider, insured, or enrollee believes that claims are improperly denied, the incident should be reported to the

Department so that the Department may conduct an investigation and take proper action.

§21.3101(c). Applicability

Comment: One commenter suggests an effective date of at least December 1, 2008, in lieu of the proposed October 31 effective date. The commenter states that the effective date of October 31 is not a realistic date. The commenter's reasons include: (i) the proposed rule includes requirements that the commenter says are not consistent with the statute and which will therefore require filings for policy and certificate amendments; (ii) even if the rule were adopted by the Commissioner on the first possible date, it would not allow a health plan sufficient time to develop policy language amendments, file with the Department and receive Department approval in time for the amended policy language to be issued with new coverage documents issued on or after October 1, 2008; and (iii) the Department has a 60-day deemer period in which to review the forms and the proposed effective date is overly optimistic.

Agency Response: Because of the effective date of this adoption, the Department agrees that the October 1 effective date is not viable. While the Department agrees in part with the commenter's reasons for the need to have a later effective date, the Department disagrees that the proposed rule includes requirements that are not consistent with the statute. The rule in proposed §21.3103(d)(2)(A) and (B) included an interpretation of the Insurance Code §1352.003(c). The Insurance Code §1352.003(c) prohibits a health benefit plan from including in any lifetime limitation on the number of

days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan. It further requires that any limitation imposed under the plan on days of post-acute care treatment must be separately stated in the plan. The interpretation implemented in proposed §21.3103(d)(2)(A) and (B) may have necessitated the re-filing of policy language by some health benefit plans. The Department has determined that the applicability date of the adopted rules is March 31, 2009. Proposed §21.3101(c)(1) is revised accordingly in this adoption. The Department believes that this March 31 applicability date will provide sufficient time for insurers to take the necessary action to comply with the new requirements. As a result of this change in the applicability date to March 31, 2009, the Department has also changed the date in §21.3107(c)(1)(A) and (B) for the distribution of the Insurance Code §1352.005 mandatory notice to insureds and enrollees. As adopted, §21.3107(c)(1)(A) and (B) read: "(1) The notice shall be provided during the policy term for the plan, and no later than: (A) March 31, 2009 to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the March 31, 2009 applicability date of this subchapter; or (B) the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the March 31, 2009 applicability date of this subchapter." Consistent with the intent of the proposal, the change in §21.3107(c)(1)(A) to "no later than March 31, 2009" is necessary to ensure that the notices will be distributed in a timely manner to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the March 31, 2009 applicability

date. The references to “effective date” in proposed §21.3107(c)(1)(A) and (B) have been changed to “March 31, 2009 applicability date” for purposes of clarification and consistency in implementation.

Comment: A commenter requests that the Department include clarifying language in the adoption order indicating the impact of the rule on services delivered prior to the effective date of the adopted rules. According to the commenter, issues are raised concerning the effective date of the rule and the Department’s interpretation of provisions in HB 1919 and Insurance Code Chapter 1352 that relate to events that have occurred between the effective date of the statute and the eventual effective date of the rule. The commenter states that services have been delivered, payments have been made, limits have been imposed, and complaints have been filed that relate to the impact of the changes made by HB 1919 and the Department's interpretation of those changes. According to the commenter, in addition to the rule text addressing applicability of the rule, a clearer statement as to the Department's intent to make use of the rule's post-HB 1919 statutory interpretation is necessary because the changes to the statute made by HB 1919 were effective well before the effective date of the rule. The commenter inquires whether the required separate statement of limitations, including limitations other than lifetime limitations specifically referenced in the statute, is applicable to health benefit plans issued or renewed prior to the effective date of the rule, and if not, would generally applicable limitations otherwise apply.

Agency Response: Beginning on January 1, 2008, all health plans subject to regulation under Chapter 1352 of the Insurance Code were required to be in compliance

with the new HB 1919 requirements for coverage related to acquired brain injury. In reviewing forms filed by health benefit plans, the Department has been enforcing these statutory requirements since January 1, 2008, and will continue to do so. The Insurance Code §1352.003(c) specifies "A health benefit plan may not include, in any lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan. *Any limitation imposed under the plan on days of post-acute care treatment must be separately stated in the plan.*" (emphasis added) Therefore, as of January 1, 2008, plans have been statutorily required to include separate statements for any limitations imposed under the plan on days of post-acute care treatment. Under adopted §21.3101(c)(1)(B), health benefit plans delivered, issued for delivery, or renewed prior to the effective date of the rules are subject to the statutes and provisions of the new rules in effect at the time the health benefit plans were delivered, issued for delivery, or renewed, except as otherwise specified in the subchapter. Adopted §21.3107(c) implements the delivery of notice requirement in §1352.003 of the Insurance Code. This requirement is applicable to all health benefit plans regardless of the date of issuance, delivery, or renewal of the plan. Adopted §21.3107(c) specifies the notice content and requires the delivery of the notice during the policy term for the plan and (i) no later than March 31, 2009, to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008 and before the March 31, 2009 applicability date of the new rules; or (ii) no later than the 60th day after enrollment and/or renewal to insureds or enrollees

whose plans are delivered, issued for delivery, or renewed on or after the March 31, 2009 applicability date of the new rules.

§21.3102(18). Definition of "Outpatient day treatment services"

Comment: A commenter objects to the definition of "outpatient day treatment services" in proposed §21.3102(18). According to the commenter, the proposed definition includes services that are delivered in "transitional residential" settings. The commenter states that the statute does not provide authority to include residential settings in the definition of a service that is intended to be delivered on an outpatient basis.

Agency Response: The Department disagrees. It is the Department's interpretation that authority for the definition of "outpatient day treatment services" is derived from the Insurance Code §1352.007. Section 1352.007 provides that "A health benefit plan may not deny coverage under this chapter based solely on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at a facility at which appropriate services may be provided. . . ." Therefore, if a facility can appropriately provide services that constitute outpatient day treatment services, the coverage required by Chapter 1352 of the Insurance Code cannot be denied merely because the facility is a residential facility.

§21.3102(18), §21.3103(a) and Figure: 28 TAC §21.3107(a). Replacement of the term "outpatient day treatment services" with newly defined terms

Comment: Four commenters recommend revising §21.3102(18) by changing the defined term from “outpatient day treatment services” into two defined terms: “outpatient treatment services” and “day treatment services.” The commenters also recommend adding as a new defined term “transitional residential services.” The commenters assert that the purpose of Insurance Code §1352.003(b) is to spell out the continuum of care traditionally utilized in the post acute care treatment of persons with brain injuries, from most intensive to least: transitional residential, day treatment and outpatient. According to the commenters, although the terms for outpatient and day treatment were combined into “outpatient day treatment services” in HB 1919 to describe the continuum of care, in everyday practical application by providers the services are separate. The commenters request that these services be broken out separately and written as “outpatient treatment services” and “day treatment services” because there is an appropriate distinction between the two terms. Three of these commenters recommend that “outpatient day treatment services” be defined as follows: “Structured services provided 1 - 3 hours per day, one to five days per week, to address functional deficits in physiological, behavioral, and/or cognitive functions to address the need for physical therapy, occupational therapy, speech/language therapy, neuropsychology, medicine and case management. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.” These three commenters also recommend that “day treatment services” be defined as follows: “Structured services provided 4 – 6 hours per day, five days per week, to address the need for medical treatment, medical rehabilitation and disease

management to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration or non-residential treatment settings." Additionally, these three commenters recommend that the term "transitional residential services" be defined as "Post-acute transitional rehabilitation services providing medically or behaviorally complex medical treatment, medical rehabilitation and disease management services 24 hours a day, seven days a week."

The three commenters also suggest how to use the newly defined terms, recommending that the proposed words "including outpatient day treatment services" in §21.3103(a) be changed to "including transitional rehabilitation services, outpatient treatment services, day treatment services;" and the commenters suggest changing the words "including outpatient day treatment services" in the sixth bullet in Figure: 28 TAC §21.3107(a) to "including transitional rehabilitation services, outpatient treatment services, day treatment services."

A fifth commenter also recommends that the definition of "outpatient day treatment service" be modified to ensure that payment is made for all categories of day treatment and the full number of hours of treatment provided. The fifth commenter does not offer alternative terms, but does assert that at a minimum the Department should initiate an investigation of companies that are improperly denying these claims.

Agency Response: The Department declines to divide the term "outpatient day treatment services" into the two terms of "outpatient treatment services" and "day treatment services" and add a third term "transitional residential services." The

Insurance Code §1352.003(b) as enacted by HB 1919 requires a health benefit plan to "include coverage for post-acute transition services or community reintegration services, including *outpatient day treatment services*, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury." (emphasis added) Therefore, the Department does not have the statutory authority to adopt rules that require limits to be expanded to encompass each type of treatment that may exist in a continuum of care. The Insurance Code §1352.003(c) addresses two categories to which a plan may apply global limits on days of coverage: acute care and post-acute care. Pursuant to the Insurance Code §1352.003(c), a health benefit plan may apply limits on acute care and post-acute care, with the only restrictions being: (i) that a plan may not include any days of post acute care treatment covered under the plan in a lifetime limitation on the number of days of acute care treatment covered under the plan, and (ii) that a plan must separately state any limitation imposed under the plan on days of post-acute care treatment. The Insurance Code §1352.003 does not address any sub-levels of acute care treatment and post-acute care treatment or require that a certain number of days be allocated to specific types of treatment within these two categories of treatment. Section 1352.003(g) of the Insurance Code authorizes the Department to adopt rules as necessary to implement the Insurance Code Chapter 1352. It is the Department's position that this rulemaking authority does not authorize the Department to require limits to be expanded to address sub-levels of acute care treatment and post-acute care treatment or require that a certain number of days be allocated to specific types of treatment within these two categories of treatment.

In regard to the request made by the fifth commenter that the Department initiate an investigation of companies that are improperly denying claims, the Department investigates every complaint that is filed with the Department. This includes any complaint that relates to the improper denial of coverage required by Insurance Code Chapter 1352 and these rules.

§21.3102(19). Definition of "post-acute care treatment services"

Comment: A commenter asserts that in §21.3102(19), the definition of "post-acute care treatment services" should make clear that inpatient residential treatment does not qualify. According to the commenter, inpatient residential services are generally considered to be long-term care and thus subject to coverage terms, if any, of long-term care in the policy.

Agency Response: The Department disagrees. The Insurance Code §1352.003(b) states: "A health benefit plan must include coverage for post-acute transition services, community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury." Additionally, the Insurance Code §1352.007 states: "A health benefit plan may not deny coverage under this chapter based solely on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at a facility at which appropriate services may be provided. . . ." Therefore, if the services are provided for post-acute transition or community reintegration, or constitute other post-

acute care treatment services necessary as a result of and related to an acquired brain injury, coverage for those services cannot be denied merely because they are provided at an inpatient residential facility.

§21.3103(b). Medically Necessary and Appropriate: Facility at which appropriate services may be provided

Comment: A commenter asserts that even though the revised statutes recognize that post acute-care services may be provided in facilities other than a traditional hospital setting, some health benefit plans continue to put up barriers to treatment rather than recognize that the revised statute specifically permits post acute-care services provided in facilities other than a traditional hospital setting.

Agency Response: The Department agrees that while the Insurance Code Chapter 1352 does not use the phrase "facilities other than a traditional hospital setting," the Insurance Code §1352.007 states: "A health benefit plan may not deny coverage under this chapter based solely on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at a facility at which appropriate services may be provided. . . ." The Insurance Code Chapter 1352 does not mandate that services provided as required by Chapter 1352 only be provided in hospitals. The language in Insurance Code §1352.007 is reflected in proposed §21.3103(b)(2), which is adopted without change.

Comment: Three commenters suggest deleting the term "post-acute rehabilitation hospital" from §21.3103(b)(2)(A). According to the commenters, within the health care community there is no such entity as a "post-acute rehabilitation hospital."

Agency Response: The Department disagrees and declines to make the requested change. The term "post-acute rehabilitation hospital" is used in Insurance Code §1352.007(a), which provides, in part: "Treatment for an acquired brain injury may be provided under the coverage required by this chapter, as appropriate, and may be provided at a facility at which appropriate services may be provided, including: (a) a hospital regulated under Chapter 241, Health and Safety Code, including an acute or *post acute rehabilitation hospital*. . . ." (emphasis added) Additionally, an internet search for the term "post-acute rehabilitation hospital" identified links to facilities that refer to themselves as "post-acute rehabilitation hospitals." Therefore, the term appears to be used to some degree in the health care community.

Comment: Three commenters recommend changing the words in proposed §21.3103(b)(2)(B) from "an assisted living facility regulated under the Health and Safety Code Chapter 247" to "an assisted living facility serving as a transitional rehabilitation facility as regulated under the Health and Safety Code Chapter 247." The commenters did not provide an explanation for the requested change.

Agency Response: The Department disagrees. The requested term "transitional rehabilitation facility" is not used within the Health and Safety Code Chapter 247. The Department declines to use terminology that is inconsistent with the statute. The use of

such inconsistent terminology is not within the Department's rulemaking authority and could result in ambiguity and confusion.

Comment: A commenter requests that the rule clarify that coverage of services provided at an assisted living facility is limited to the actual services and not to costs associated with room and board at such a facility. The commenter points out that proposed §21.3103(b)(2) provides that coverage for the services required under HB 1919, related to acquired brain injury, may not be denied solely on the basis that the services are provided at a facility other than a hospital. The commenter further notes that the rule offers assisted living facilities as an example. According to the commenter, there exists confusion regarding payment for room and board services when rendered by an assisted living facility. As a result, if the rule examples in §21.3103(b)(2)(A) and (B) are not further clarified, there is a great potential for misunderstanding and for numerous unnecessary requests for clarification after the rule is adopted. The commenter states that the rule example could further clarify that reference to assisted living facilities does not imply that all services provided by an assisted living facility in connection with acquired brain injury are covered services mandated by the rule or statute.

Agency Response: Pursuant to the Insurance Code §1352.003(b), coverage must be provided for "post-acute care treatment services necessary as a result of and related to an acquired brain injury. . . ." Pursuant to the Insurance Code §1352.007, "A health benefit plan may not deny coverage under this chapter based solely on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an

acquired brain injury may be provided under the coverage required by this chapter, as appropriate, at a facility at which appropriate services may be provided. . . ." Therefore, if a facility, such as an assisted living facility, can appropriately provide services that constitute post-acute care treatment services, payment for those services cannot be denied merely because the facility is an assisted living facility. The Department therefore disagrees that further clarification of the example in proposed §21.3103(b)(2)(A) and (B) within the rule text is necessary. With regard to the comment about confusion regarding payment for services, the Insurance Code §1352.003(b) only requires coverage for post-acute care treatment services that are necessary as a result of and related to an acquired brain injury. Therefore, a health benefit plan under Chapter 1352 can deny coverage for services that are not medically necessary. For example, if a victim of acquired brain injury is capable of living at home and only needs a structured day program to address mild to moderate functional deficits following acquired brain injuries, 24-hour care may be found to not be medically necessary.

§21.3103(c). Maintenance, Prevention, and Reevaluation of Care

Comment: One commenter requests clarification regarding whether health plans may simply subject coverage of reasonable expenses for periodic reevaluation to the utilization review process. According to the commenter, the list of factors specified in the proposed rule that can be used to determine whether reasonable expenses for periodic reevaluation must be covered are very similar to the factors currently weighed in most health plans' utilization review process. Additionally, the commenter notes that

§21.3103(c)(2) provides that health plans "must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, been unresponsive to treatment, and becomes responsive to treatment at a later date." According to the commenter, it is unclear what constitutes "responsive." The commenter raises the concern that any number of signs could meet the definition of being responsive even if it does not meet a definition of making progress.

Agency Response: The Department agrees that a health benefit plan may submit coverage of reasonable expenses for periodic reevaluation to the utilization review process. The Department does not agree that any clarification of what constitutes "responsive" in §21.3103(c)(2) is necessary. This is an issue for an enrollee or insured's provider to determine. Every victim of an acquired brain injury is impacted by the injury in a different way; therefore, it is necessary for the medical provider to determine the effect of the injury on the individual.

§21.3103(d). Lifetime Payment Limitations, Deductibles, Copayments, and Coinsurance

Comment: One commenter requests clarification in §21.3103(d) of the parameters of the separate statement of limitations applicable to post-acute care treatment services. According to the commenter, although the proposed rule requires a separate statement of limitations applicable to post-acute care treatment services, the parameters of the separate statement are unclear. The commenter asks whether the separate statement

of limitations can simply indicate that the generally applicable benefits and limitations will apply to these services, or whether the Department interprets the separate statement of limitations requirement to also include a completely separate benefit for post-acute care treatment services. The commenter suggests that the latter result appears to be a significant departure from prior interpretations of this mandate and the statute itself. The commenter asks if, in a situation where a health benefit plan has an existing rehabilitation benefit and limitation, whether the separate statement may simply reference the benefit and limitation as the coverage for post-acute care treatment services.

Agency Response: Pursuant to the Insurance Code §1352.003(c), the required separate statement of limitations cannot simply indicate that the generally applicable benefits and limitations will apply to post-acute care treatment services and cannot simply reference the benefit and limitation as the coverage for post-acute care treatment services. The Insurance Code §1352.003(c) clearly provides that "any limitation imposed under the plan on days of post-acute care treatment must be separately stated in the plan." Therefore, a separate statement of limitations with a completely separate benefit for post-acute care treatment services is required to comply with the statute. Additionally, the Department does not agree that this interpretation of the statutory requirement in §1352.003(c) significantly departs from prior interpretations. The Department has included a requirement for a separate statement of limitations based on the Insurance Code §1352.003(c) in the prior draft versions of this adopted rule.

Comment: A commenter objects to proposed §21.3103(d)(2) as being inconsistent with §1352.003(c) of the Insurance Code. The commenter states that the statute, at §1352.003(c), indicates that a carrier may not apply *lifetime* limitations regarding acute care treatment to post-acute care treatment, but that there is no mention of *annual* limitations. The commenter asserts that the proposed rule adds the term *annual*, despite the fact that the statute does not contain or authorize this prohibition. The commenter asserts that the use of generally applicable *annual* limitations is allowed by the statute and should not be prohibited by the rule.

Agency Response: The Department agrees. Therefore, proposed §21.3103(d)(1) – (3) have been revised accordingly in this adoption. Adopted §21.3103(d)(1) – (3) read as follows: "(d) Lifetime Payment Limitations, Deductibles, Copayments, and Coinsurance. (1) A health benefit plan is prohibited from subjecting the coverage required under the Insurance Code Chapter 1352 to payment limitations, deductibles, copayments, and coinsurance factors that are more restrictive than payment limitations, deductibles, copayments, and coinsurance factors applicable to other similar coverage provided under the health benefit plan. (2) A health benefit plan that includes lifetime limitations on coverage required under the Insurance Code Chapter 1352 is prohibited from including any post acute care treatment for such coverage in any lifetime limitation on the number of days of acute care treatment covered under the plan. (3) A health benefit plan must separately state in the plan any lifetime limitation imposed under the plan on days of post-acute care treatment for the coverage required under the Insurance Code Chapter 1352."

Comment: A commenter suggests that §21.3103(d)(2) be clarified as follows: "If the coverage imposes a lifetime limit on acute care treatment for acquired brain injury, that lifetime limit may not include post-acute care treatment nor may any lifetime limit on post-acute care treatment be less than the lifetime limit provided for acute care treatment of acquired brain injury. If the coverage contains an overall lifetime limit on coverage for all illnesses or injuries, both acute care and post-acute care treatment for acquired brain injury may be subject to that lifetime limitation." This clarification is necessary, according to the commenter, because the language in the Insurance Code §1352.002(c) on the lifetime cap is not clear. The commenter states that §1352.002(c) could be read as permitting insurers to adopt a lower lifetime cap for acute care treatment of ABI than would be provided for treatment of any other illness or injury, with the one caveat, that whatever lifetime cap is applied for acute care of ABI could not include post-acute care for ABI. The commenter opines that the intent of the statutory language is not to carve out ABI from the normal lifetime maximum benefit of the overall coverage, which could mean a lower lifetime cap for ABI benefits than that provided for other medical conditions, but rather to prevent the use of a lifetime cap for acute care for ABI to cut off further post-acute care.

Agency Response: The Department disagrees and declines to make the change. The recommended clarification is not consistent with the statutory language. The Insurance Code §1352.003(c) provides: "A health benefit plan may not include, in any lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan. Any limitation imposed under the

plan on days of post-acute care treatment must be separately stated in the plan." The plain language of this provision appears to require health benefit plans to provide a lifetime limit for post-acute care treatment services for an acquired brain injury that is separate from any lifetime limitation on the number of days of acute care treatment for other physical illnesses or injuries covered under the plan. The provision does not specify a total lifetime limit for post-acute care treatment services that treat an acquired brain injury. Pursuant to §21.3103(e), the coverage required by the Insurance Code Chapter 1352 may be subject to limitations and exclusions that are generally applicable to other physical illnesses or injuries under the health benefit plan. For example, these may include limitations or exclusions for services that are solely educational in nature, experimental or investigational, not medically necessary, or services for which the enrollee failed to obtain proper preauthorization under the requirements of the health benefit plan.

Comment: One commenter opines that the proposed §21.3103(d) appears to require every insurer to file a policy amendment with the Department adding a separate statement of coverage related to acquired brain injury (ABI) post-acute care services, even if that statement does nothing more than indicate that such services are limited in the same manner as any other services covered under the policy. The commenter requests that the Department provide further clarification as to the separate statement of coverage requirement in Insurance Code §1352.003(c) and what exactly will qualify as a separate statement of coverage. The commenter asserts that although the statute includes language indicating that post-acute care limitations should be separately stated

in the coverage document, that language logically relates to the prior sentence in the statute regarding the inapplicability of lifetime acute care limitations to post-acute care services. According to the commenter, if a plan does not attempt to apply any acute care limitation to post-acute care services, and instead treats post-acute care treatment services as it would services for any other illness or injury, the statutory standard would be met. This is because the post-acute care limitation is not a part of the acute care limitation and is stated separately.

Agency Response: Pursuant to the Insurance Code §1352.003(c), a separate statement of coverage is required if a health benefit plan intends to apply lifetime limits on the number of days of post-acute care treatment. While §21.3103(d) does not address this issue, §1352.003(c) provides in relevant part: "Any limitation imposed under the plan on days of post-acute care treatment must be separately stated in the plan." If a health benefit plan imposes a lifetime limitation on the number of days of post-acute care treatment, it is not sufficient for compliance with the Insurance Code §1352.003(c) for the plan to merely state that post-acute care services are limited in the same manner as any other services covered under the policy. The plan should state the number of days that comprise the lifetime limitation on post-acute care treatment.

§21.3103(e). Other Coverage Limitations.

Comment: A commenter inquires about the statutory basis of the language in proposed §21.3103(e) relating to other coverage limitations. Another commenter requests clarification regarding whether services deemed experimental or

investigational may be excluded. The commenter states that, currently, most health plans exclude coverage of services deemed to be experimental or investigational.

Agency Response: Section 21.3103(e) is existing language and was not proposed for amendment in this proposal except for the subsection title and the citation update. The adoption of the substantive language in §21.3103(e) was published in August 23, 2002 issue of the Texas Register (27 TexReg 7814), effective August 26, 2002. Section 21.3103(e) is based on the form filing and review provisions contained in the Insurance Code Chapter 1271, Subchapter C, relating to Commissioner approval, and Chapter 1701, Subchapter B, relating to filing requirements. One way the Department ensures that health benefit plans comply with the mandated benefit requirements of the Insurance Code Chapter 1352 is to verify that the mandated coverage is included where appropriate in forms filed with the Department. However, pursuant to Insurance Code §1271.102(a), the Commissioner must "approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of this chapter [Chapter 1271]." Pursuant to Insurance Code §1701.055(a), the Commissioner may only disapprove a form filed under Chapter 1701 if it violates the Insurance Code, a rule of the Commissioner, or any other law, or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. A health benefit plan must provide the coverage mandated by the Insurance Code Chapter 1352, but the plan is not prohibited from including limitations and exclusions in its policy forms that do not violate the Insurance Code, Department rules, or other laws. The Insurance Code does not prohibit a health benefit plan from limiting

or excluding services because they are solely educational in nature, experimental or investigational, not medically necessary, or those for which the enrollee failed to obtain proper preauthorization under the requirements of the health benefit plan. Therefore, the Department cannot prohibit a health benefit plan from including such limitations and exclusions in its forms. Section 21.3103(e) addresses these types of limitations or exclusions.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For, with changes: Brain Injury Alliance of Texas, Texas Traumatic Brain Injury Advisory Council, Office of Public Insurance Counsel, Texas Association of Health Plans, one legislator, and two members of the public.

Against: None.

6. STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1352.003(g), 1352.0035(c), 1352.005(b), and §36.001. Section 1352.003(g) provides that the Commissioner shall adopt rules as necessary to implement Insurance Code Chapter 1352, relating to brain injury coverage. Section 1352.0035(c) provides that the Commissioner shall adopt rules as necessary to implement §1352.0035, relating to required brain injury coverage for small employer benefit plans. Section 1352.005(b) provides that the Commissioner, in consultation with the Texas Traumatic Brain Injury Advisory Council, shall prescribe by rule the specific contents and wording of the notice of coverage for acquired brain injury

that is required by §1352.005(a). Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§21.3101. General Provisions.

(a) Purpose. The purposes of this subchapter are to:

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

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

(3) require the issuer of a health benefit plan to provide adequate training of individuals responsible for preauthorization of coverage or utilization review under the plan in order to prevent wrongful denial of coverage required under the Insurance Code

Chapter 1352 and this subchapter, and to avoid confusion of medical/surgical benefits with mental/behavioral health benefits.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter is inconsistent with any statutes of this state, is unconstitutional, or for any other reason is invalid, the remaining provisions shall remain in full effect. If a court of competent jurisdiction holds that the application of any provision of this subchapter to particular persons, or in particular circumstances, is inconsistent with any statutes of this state, is unconstitutional, or for any other reason is invalid, the provision shall remain in full effect as to other persons or circumstances.

(c) Applicability.

(1) Except as otherwise specified in this subchapter:

(A) This subchapter applies to all health benefit plans delivered, issued for delivery, or renewed on or after March 31, 2009.

(B) Health benefit plans delivered, issued for delivery, or renewed prior to March 31, 2009, are subject to the statutes and provisions of this subchapter in effect at the time the health benefit plans were delivered, issued for delivery, or renewed.

(2) Nothing in this subchapter requires the issuer of a health benefit plan to provide coverage for services that are not: medically necessary; clinically proven; goal-oriented; efficacious; based on an individualized treatment plan; or provided by, or ordered and provided under the direction of a licensed healthcare practitioner.

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

(1) Acquired brain injury--A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

(2) Cognitive communication therapy--Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

(3) Cognitive rehabilitation therapy--Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

(4) Community reintegration services--Services that facilitate the continuum of care as an affected individual transitions into the community.

(5) Enrollee--A person covered by a health benefit plan.

(6) Health benefit plan--As described in the Insurance Code §1352.001 and §1352.002.

(7) Issuer--Those entities identified in the Insurance Code §1352.001.

(8) Neurobehavioral testing--An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between

behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

(9) Neurobehavioral treatment--Interventions that focus on behavior and the variables that control behavior.

(10) Neurocognitive rehabilitation--Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

(11) Neurocognitive therapy--Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

(12) Neurofeedback therapy--Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

(13) Neurophysiological testing--An evaluation of the functions of the nervous system.

(14) Neurophysiological treatment--Interventions that focus on the functions of the nervous system.

(15) Neuropsychological testing--The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

(16) Neuropsychological treatment--Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

(17) Other similar coverage--The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.

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

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

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

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

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

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

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

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

§21.3103. Coverage for Services.

(a) Required Coverage. Pursuant to the Insurance Code Chapter 1352, a health benefit plan must include coverage for services specified in §1352.003, including cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or other post-acute care treatment services, if such services are necessary as a result of and related to an acquired brain injury.

(b) Medically Necessary and Appropriate.

(1) For purposes of the Insurance Code §1352.003 and this subchapter, the word "necessary" means "medically necessary."

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

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

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

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

(1) Treatment goals for services required by the Insurance Code Chapter 1352 may include the maintenance of functioning or the prevention of or slowing of further deterioration.

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

reasonable expenses related to periodic reevaluation of care must be covered may include:

(A) cost;

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

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

(D) changes in technology; and

(E) advances in medicine.

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

(1) A health benefit plan is prohibited from subjecting the coverage required under the Insurance Code Chapter 1352 to payment limitations, deductibles, copayments, and coinsurance factors that are more restrictive than payment limitations, deductibles, copayments, and coinsurance factors applicable to other similar coverage provided under the health benefit plan.

(2) A health benefit plan that includes lifetime limitations on coverage required under the Insurance Code Chapter 1352 is prohibited from including any post acute care treatment for such coverage in any lifetime limitation on the number of days of acute care treatment covered under the plan.

(3) A health benefit plan must separately state in the plan any lifetime limitation imposed under the plan on days of post-acute care treatment for the coverage required under the Insurance Code Chapter 1352.

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

(f) Permitted Coverage Exclusions. The types of limitations or exclusions permitted under the Insurance Code §1352.003(d) do not include limitations or exclusions under a health benefit plan which, in and of themselves, meet the definition of a therapy or service required under the Insurance Code Chapter 1352. For example, if a health benefit plan contains an exclusion for biofeedback therapy, the issuer may deny coverage for biofeedback therapy for any diagnosis except an acquired brain injury diagnosis because biofeedback falls within the definition of "neurofeedback therapy" as defined in §21.3102 of this subchapter (relating to Definitions), and for which coverage is required under the Insurance Code Chapter 1352. However, if the same health benefit plan also contains an exclusion for services that are not authorized prior to service, the issuer may, as allowed by subsection (e) of this subsection, deny coverage based upon the prior authorization exclusion.

(g) Permitted Coverage Denials. A health benefit plan may deny coverage and/or apply a limitation or exclusion in a health benefit plan for a service required

under the Insurance Code Chapter 1352 if the service is prescribed for a condition that, although a result of, or related to, an acquired brain injury, was sustained in an activity or occurrence for which other similar coverage under the health benefit plan is limited or excluded (e.g., acts of war, participation in a riot, etc.).

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

§21.3104. Training.

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

(b) Each issuer shall develop written preauthorization and utilization review policies and procedures for the purpose of identifying services to be covered for acquired brain injury to be utilized by any individual responsible for preauthorization of coverage or utilization review. Such policies and procedures shall include:

(1) identification of all current Common Procedural Terminology (CPT) codes associated with services for acquired brain injury; and

(2) a means to identify an enrollee initially diagnosed with an acquired brain injury.

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

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

(1) identification of services likely to be requested in treating an enrollee with an acquired brain injury;

(2) identification of specific therapies currently used in treating an enrollee with an acquired brain injury;

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

(4) instruction relating to the requirements of the Insurance Code Chapter 1352 and this subchapter.

(d) At a minimum, training shall be accomplished by attendance at an initial orientation, inservice, or continuing education program relating to acquired brain injuries and their treatments, provided that such training shall be consistent with the requirements of subsections (a) and (b) of this section.

(1) Documentation and verification of training shall be maintained for each employee or staff member responsible for preauthorization of coverage, utilization review, or any individual performing these processes.

(2) Upon request, any documentation and verification required by paragraph (1) of this subsection shall be provided to the issuer with whom the employee, staff member, or individual is employed or contracted.

(3) Upon request, any documentation and verification required by paragraph (1) of this subsection shall be provided to the department for review.

(e) The requirements of this section shall also apply to any contracted entity of an issuer to the extent the contracted entity is responsible for preauthorization, or utilization review.

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

§21.3106. Small Employer Health Benefit Plans.

(a) Required Coverage. Pursuant to the Insurance Code §1352.0035(a), a small employer health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehaviorial, neurophysiological, neuropsychological, or psychological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services, if such services are medically necessary as a result of and related to an acquired brain injury.

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

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

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

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

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

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

§21.3107. Mandatory Annual Notice to Insureds and Enrollees.

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

Figure: 28 TAC §21.3107(a):

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

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

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehaviorial, neurophysiological, neuropsychological and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

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

(b) The notice required by the Insurance Code §1352.005 and subsection (a) of this section is required by the Insurance Code §1352.005 to be issued annually to each insured or enrollee under the plan. In accordance with SECTION 9 of HB 1919, 80th

Legislature, the notice shall be issued to each insured or enrollee of a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2008.

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

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

(A) March 31, 2009, to insureds or enrollees whose plans were delivered, issued for delivery, or renewed on or after January 1, 2008, and before the March 31, 2009 applicability date of this subchapter ; or

(B) the 60th day after enrollment and/or renewal to insureds or enrollees whose plans are delivered, issued for delivery, or renewed on or after the March 31, 2009 applicability date of this subchapter.

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

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

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

(5) If the last known address of a covered spouse and/or dependent is different than the primary insured's or enrollee's last known address, separate notices are required to be provided to the spouse or the dependent at the spouse's and/or dependent's last known address.

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

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

CERTIFICATION. This agency hereby certifies that the adopted amendments and new sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 30, 2009.

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§21.3101 - 21.3105 and new §21.3106 and §21.3107 specified herein, concerning coverage for acquired brain injury, are adopted.

AND IT IS SO ORDERED.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO. 09-0071

FEB 02 2009