SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 1. GENERAL PROVISIONS
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INTRODUCTION. The Texas Department of Insurance adopts amendments to §§21.3501 – 21.3504, §21.3530, and §21.3542; new §21.3506; and the repeal of §§21.3510 – 21.3518 concerning consumer choice health benefit plans. Sections 21.3501, 21.3503, 21.3504, and §21.3506; and the repeal of Division 2, §§21.3510 - 21.3518 are adopted without changes to the proposed text. Sections 21.3502, 21.3530, and 21.3542 are adopted with non-substantive changes to the proposed text as published in the November 11, 2016, issue of the *Texas Register* (41 TexReg 8986). In addition to posting the proposed changes in the *Texas Register,* the department held a public hearing on the proposal on January 26, 2017.

The department adopts §21.3502 with a change to the punctuation as proposed, changing a period to a colon in the first sentence of the section.

The department adopts amendments to §21.3530(d) and (f) with minor changes to the proposed text in response to public comment.

The department combined §21.3530(d)(1)(B) and (d)(2) as proposed to make clear that a health carrier that provides a consumer choice plan through the federal exchange must provide the written disclosure statement at the time of application if the federal health benefit exchange provides a mechanism for a health carrier to provide the written disclosure statement and obtain a signature. If the federal health benefit exchange does not provide a mechanism, the carrier must mail a copy of the disclosure and ensure that consumers have access to the disclosure at the time of purchase by providing a link to the written disclosure statement directly on the healthcare.gov website or a reference and link to the written disclosure statement in the plan documentation provided on the healthcare.gov website, such as in the summary of benefits and coverage or the plan brochure.

Sections §21.3530(c)(1) and (f) incorrectly referenced subsection (e) of the section, rather than subsection (d). The department corrected the proposed text to reference subsection (d), which addresses situations in which a plan is purchased through the federal health benefit exchange and the carrier is unable to provide the disclosure and obtain a signature at the time of application. Subsection (e) and its requirement that an application cannot be processed without the signed disclosure statement only applies to those instances where a health carrier uses an agent or direct markets to an applicant outside the federal health benefit exchange. Since the federal health benefit exchange requires carriers to immediately process all applications, and does not allow a carrier to hold an application pending the prospective or current policyholder or contract holder's return of the signed disclosure statement, §21.3530(f) requires that the health carrier request that the prospective or current policyholder or contract holder sign and return the written disclosure statement and provide a no-cost method for the prospective or current policyholder or contract holder to return the signed written disclosure statement.

The department changes the proposed text of §21.3530(i) by removing the space in the phrase "policy holder."

The department adopts §21.3542 with changes to the proposed text of subsection (b)(1). As originally proposed, amendments update subsection (b)(1) to address instances when a consumer choice plan is marketed through the federal health benefit exchange or other online marketplaces. As originally proposed, it would have expanded the existing requirement for fully mandated health plans to be marketed using the same sources and methods of distribution as those used to market the consumer choice health benefit plans. However, in response to comment and because of the uncertainty with respect to a possible repeal, replacement, or modification of the federal Affordable Care Act (ACA), the department has modified subsection (b)(1) as proposed to exempt plans marketed through the federal health benefit exchange from the requirement.

REASONED JUSTIFICATION. The adopted amendments, new section, and repealed sections are necessary to ensure compliance with Insurance Code Chapter 1507. Insurance Code §1507.006 and §1507.056 require health carriers to provide a proposed policyholder or contract holder or a current policyholder or contract holder with a written disclosure statement that acknowledges that "the standard health benefit plan being purchased does not provide some or all state-mandated health benefits," and to list the state-mandated health benefits not included in the plan. The disclosure statement enables a consumer to make an informed decision about whether the consumer choice health benefit plan provides sufficient coverage for the consumer's needs. If the health

carrier issues a consumer choice health benefit plan to a proposed policyholder or contract holder or a current policyholder or contract holder, the written disclosure statement must include a notice that purchasing the plan may limit their future coverage options in the event the covered person's health changes and needed benefits are not available under the consumer choice health plan.

The amendments add new 28 TAC Chapter 21, Subchapter AA, Division 1, §21.3506, which contains text identical to §21.3514.

The department repeals 28 TAC Chapter 21, Subchapter AA, Division 2, §§21.3510 – 21.3518, relating to state-mandated health benefits. The current text of the rule has caused some confusion, as it only lists mandates that may be excluded from consumer choice health benefit plans and does not list what mandates are required in the plans. Insurance Code §1507.003 and §1507.053 sufficiently define what constitutes the state-mandated health benefits that may be excluded from consumer choice health benefit plans, and these sections also provide a list of specific state-mandated health benefits that may not be excluded. The repeal of Division 2 included §21.3514. The text of this section has been duplicated in new §21.3506, relating to State-Mandated Health Benefits in Blanket Indemnity Policies, to preserve its continuing usefulness and application.

The adopted amendments to 28 TAC Chapter 21, Subchapter AA, Division 3, §21.3530 require a health carrier to provide each prospective or current policyholder or contract holder a clearly written disclosure statement that provides a sufficient description of the reduced benefits or state-mandated health benefits not included in the consumer choice health benefit plan. This will enable a consumer to make an informed decision about whether the consumer choice health benefit plan under consideration provides sufficient coverage for the consumer's needs.

The amendments to §21.3530 establish an exception for carriers that offer and provide consumer choice health benefit plans through the federal health benefit exchange to provide the required consumer choice health benefit plan written disclosure statement. Minor changes were made to clarify §21.3530(d) as proposed. Subsections (d)(1)(B) (d)(2) were combined to make clear that if the healthcare.gov website does not allow the carrier to provide the disclosure and obtain a signature as part of the application process, the carrier must mail a copy of the disclosure statement to the prospective or current policyholder or contract holder no later than three business days from the date of application and ensure that the prospective or current policyholders or contract holders have access to the disclosure at the time of purchase by providing a link to the written disclosure statement in the plan documentation provided on the healthcare.gov website, such as in the summary of benefits and coverage or the plan brochure. When the health carrier provides the written disclosure

statement under this exception, the amendments require that the health carrier request that the prospective or current policyholder or contract holder sign and return the written disclosure statement and that the health carrier provide a no-cost method for the prospective or current policyholder or contract holder to return the signed written disclosure statement.

Also, §21.3530(c)(1) and (f) incorrectly referenced subsection (e), rather than subsection (d). As adopted, the subsections were modified to reference subsection (d), which addresses situations when a plan is purchased through the federal health benefit exchange and the health carrier is unable to provide the disclosure and obtain a signature at the time of application. Since the federal health benefit exchange requires health carriers to immediately process all applications and does not allow a carrier to hold an application pending the consumer's return of the signed disclosure statement, §21.3530(f) requires the carrier to provide a no-cost method for the consumer to return the signed disclosure statement.

Under the adopted amendments to §21.3530, Form CCP 1 was revised to make it more consumer friendly and easier to understand. The department currently has multiple online versions of the form for individual or group coverage. The department adopts one consolidated Form CCP 1 with variable brackets to enable the health carriers to select "individual" or "group" disclosures. This consolidated form retains the Form CCP 1 form number, but with the new title of *Texas Department of Insurance*, *Required Disclosure Statement for all Consumer Choice Health Benefit Plans Issued in Texas*. Revisions to the form will eliminate confusion, ensure that consumers receive adequate information about the reduced benefits or the state-mandated health benefits not included in the plan, and enable them to make informed decisions about whether the consumer choice plan offered or purchased will provide sufficient coverage for their needs. Under §21.3543, health carriers are currently required to file Form CCP 1 with the department for approval. Health carriers will be required to update and file for approval their written disclosure forms, to conform with the adopted consolidated Form CCP 1 under the amendments to §21.3530 and §21.3542, no later than one year after the effective date of this rule.

The amendment to 28 TAC Chapter 21, Subchapter AA, Division 4, §21.3542(a) clarifies that a health carrier that offers the opportunity to apply for one or more consumer choice health benefit plans must also offer the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that reasonably approximates the consumer choice health benefit plan offered, including state-mandated health benefits and other benefits authorized by the Insurance Code.

As originally proposed, this rulemaking was intended to update §21.3542(b)(1) to specifically address instances where the consumer choice plan is marketed through the federal health benefit exchange or other

online marketplaces. However, in response to comment and because of the uncertainty with respect to the possible repeal, replacement, or modification of the ACA, the department has modified subsection (b)(1) to exempt plans marketed through the federal health benefit exchange from the requirement. The adoption amends §21.3542 (b)(1) to exclude the federal health benefit exchange plans from the requirement that health carriers use the same sources and methods of distribution to market both the consumer choice health benefit plans and the health benefit plans required by the subsection.

The department adopts an amendment to §21.3542(b) by deleting subsection (b)(3)(C) because it is redundant and unnecessary. Subsection (b)(3)(C) requires a health carrier, on request, to provide the person or entity an explanation of each of the policies or evidences of coverage and the differences between the health plan offered under §21.3542(a) and the consumer choice health benefit plans. Health carriers are required to provide this information to a prospective or current policyholder or contract holder under §21.3530. The information is provided under §21.3530 regardless of whether the prospective or current policyholder or contract holder requests it.

SUMMARY OF COMMENTS AND AGENCY RESPONSE TO COMMENTS.

Commenter: The department received written and oral comments from only one commenter, the Texas Association of Health Plans.

General Comments.

Comment. The commenter expressed appreciation and supports the department's efforts in updating the consumer choice regulations.

Agency Response to Comment. The department appreciates the commenter's support for updating the consumer choice health benefit plans rule.

Comment. The commenter stated that adoption of the proposed rules would reduce, not increase, coverage in the individual market. It stated that the purpose of the consumer choice laws is to increase the availability of health insurance coverage and provide opportunities for individuals and employers to choose health benefit plans that are more affordable and flexible.

Agency Response to Comment. The department disagrees with this comment and declines to make a change based on it. The consumer choice health benefit plan rules give consumers more coverage options as authorized

by Insurance Code §1507.001 and §1507.051. The disclosure requirement requires health carriers to give policyholders and contract holders adequate information to make informed decisions about their health coverage. Form CCP 1 provides the medium to ensure health carriers communicate all available coverage options to the consumers.

Comment. The commenter called the department's attention to its comments on the HMO rule proposal regarding deductibles. The commenter stated that it strongly opposes as unauthorized by statute the department's position that only consumer choice HMO plans may include deductibles and requested that the HMO rules and the consumer choice rules clarify that non-consumer choice HMO plans are not prohibited from including deductibles.

Agency Response to Comment. The amendments to the consumer choice health benefit plans adopted by this order do not address deductibles. This adoption order does not apply to non-consumer choice health plans, therefore it is not appropriate to address non-consumer choice health plans in this order. The commenter's comments relating to deductibles in the HMO rules have been addressed in the response to comments in the HMO rules adoption order.

Comment. The commenter strongly urges the department to delay considering any amendments to the consumer choice rules affecting the individual market until more information is available regarding how that market will be impacted by possible changes to federal law.

Agency Response to Comment. This adoption order implements state statutes and clarifies state regulations relating to consumer choice health benefit plans under Insurance Code §§1507.002, 1507.003(b), 1507.052, and 1507.053(b) in order to ensure that consumers are given information needed to make purchasing decisions, and that all carriers comply with clear marketing standards. This adoption order does not impact the application of federal laws relating to the individual market. Delaying adoption until more information is available regarding how possible changes to federal law could impact the individual market is unwarranted. The department will continue to monitor changes in federal law and propose future rule changes if necessary.

Section-by-Section Comments.

Comment on §21.3530(a). The commenter expressed objections to the proposed new approval requirement for each plan's Form CCP 1 as imposing an unnecessary administrative burden.

Agency Response to Comment on §21.3530(a). The department disagrees with the comment and declines to make a change. The department has received consumer complaints that indicate health plans are providing generic disclosures that are not specific to the plan being offered or purchased, which leaves consumers confused about which benefit standards the consumer choice plan does not have, as compared to a state-mandated plan. As a result, the department added language to clarify that the disclosure must provide a sufficient description of the reduced or excluded benefit. This has been the requirement since the enactment of Insurance Code §1507.006 and §1507.056.

The revised Form CCP 1 does not impose an unnecessary administrative burden. The form does not contain new requirements. As explained in the proposal, the revisions to the form make it more consumer friendly and easier to understand, and they consolidate the multiple online versions of the form into one form with variable brackets to enable health carriers to select "individual" or "group" disclosures. The usage of one form will eliminate confusion, ensure that consumers receive adequate information about the reduced benefits or the state-mandated health benefits not included in the plan being offered or sold to them, and enable consumers to make informed decisions about whether the consumer choice plan provides sufficient coverage for their needs.

Health carriers are currently required to file Form CCP 1 with the department for approval under §21.3543. Filing this form for approval is not a new requirement under the adopted rules and as such does not impose a new burden. However, health carriers will be required to update and file for approval the written disclosure forms to conform with the revised Form CCP 1 adopted under the amendments to §21.3530 and §21.3542. The rule provides flexibility to allow health carriers up to one year after the effective date of the rule to update and file the revised form.

Comment on §21.3530(d). The commenter opposes adoption of §21.3530(d) of the proposal requiring certain procedures and disclosures on the healthcare.gov website. The commenter argues that compliance may not be possible, as such procedures and disclosures are either mandated by or must be approved by the U.S. Centers for Medicare & Medicaid Services (CMS).

Agency Response to Comment on §21.3530(d). The department disagrees with the comment; however, the department makes clarifying changes to the text as proposed. The disclosure requirements included in the proposed rule are authorized by Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, and 1507.059. CMS approval is not needed for the state to include a disclosure requirement in this rule.

As originally proposed, §21.3530(d)(2) provides an alternative mechanism for health carriers to provide the written disclosure statement to consumers if the exchange does not facilitate the provision of the written disclosure statement, with the ability to obtain a signature at the time of application. In this situation, health carriers must provide the disclosure by mail within three business days of receiving the application, and ensure that consumers have access to the disclosure at the time of purchase by providing a link to the written disclosure statement directly on the healthcare.gov website; or a reference and link to the written disclosure statement in the plan documentation provided on the healthcare.gov website, such as in the summary of benefits and coverage or the plan brochure.

This section was modified to combine §21.3530(d)(1)(B) and §21.3530(d)(2) to clarify the requirements if the federal health benefit exchange is not set up to facilitate the provision of the disclosure statement at the time of application. The various options for making the information available provides flexibility to health carriers and recognizes the potential logistical constraints associated with the exchange. For example, if a health carrier is not able to include the information in the summary of benefits and coverage due to space constraints, it could include the information in the plan brochure, which is not space limited. Requiring health carriers to provide a link to the written disclosure statement will enable consumers to make informed decisions about the health coverage they are purchasing.

The disclosure requirement in §21.3530(d) does not raise a preemption question. Under §1321(d) of the ACA, state laws that do not prevent the application of the provisions of Title I of the ACA are not preempted. States have the authority to enact laws that affect programs established under the provisions of Title I of the ACA, as long as the state laws do not prevent the application of the Act. See Department of Health and Human Services interpretation of the preemption provisions of the Affordable Care Act in *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond*, 79 Fed.Reg 30240 (May 27, 2014). See also, *St. Louis Effort for AIDs v. Huff*, 782 F.3d 1016 (8th Cir. 2015).

Comment on §21.3530(f). The commenter stated that the department should clarify that proposed new §21.3530(f) is intended to provide an exception to the requirement that an application cannot be processed without the signed statement where the application is submitted through the federal exchange.

Agency Response to Comment on §21.3530(f). The department agrees with this comment and has amended §21.3530(f) to reference subsection (d)(2), rather than subsection (e). The department proposed §21.3530(f) to address situations when a plan is purchased through the exchange and the carrier is unable to provide the

disclosure and obtain a signature at the time of application. Since the exchange requires carriers to immediately process all applications, and does not allow a carrier to hold an application pending the consumer's return of the signed disclosure statement, this section requires the carrier to provide a no-cost method for the consumer to return the signed disclosure statement.

Comment on §21.3542(a) and (b)(1). The commenter stated that it opposes the new requirement in §21.3542(b)(1) that a health carrier to use the same sources and methods of distribution to market both consumer choice health benefit plans and health benefit plans required by §21.3542(a). The commenter is also opposed to the twin requirement in §21.3542(b)(1) requiring a health carrier that markets consumer choice health benefit plans through the federal health benefit exchange or other online marketplaces to use the same sources and methods of distribution to market both consumer choice health benefit plans and state-mandated health benefit plans required by subsection (a). The commenter suggested that there is no statutory authority for these requirements. The commenter stated further that requiring fully mandated plans to be sold on the exchange would create huge product and pricing issues for carriers, exacerbating the uncertainty and instability of the individual market. The commenter explained that it would be extremely difficult for carriers to develop plan designs, benefits, and rates for fully mandated plans to be sold on the exchange and gain the necessary regulatory approvals by the Spring 2017 deadline for 2018 exchange products.

The commenter stated that qualified health plans sold on the federal exchange are governed by federal law, that the commenter believes that the proposed rules requiring that certain plans be offered on the exchange are preempted by federal law, and that the department lacks jurisdiction to enforce them. The commenter explained that any new fully mandated plans sold on the exchange must be approved by CMS and the applicable rates reviewed by CMS, and it may be impossible for carriers to comply with this.

Agency Response to Comment on §21.3542(a) and (b)(1). The requirement in §21.3542(b)(1) to use the same sources and methods of distribution to market both consumer choice health benefit plans and other health benefit plans has been in the rule since 2004, before the ACA was enacted. The proposed amendments to this section were intended to update §21.3542(b)(1) to specifically reflect that the department views online marketplaces, including the federal health benefit exchange created under the ACA, as the type of source and method of distribution that §21.3542(b)(1) addresses. However, in response to public comment and because of the uncertainty with respect to the possible repeal, replacement, or modification of the ACA, the department has modified §21.3542(b)(1) to exempt application of the rule to plans marketed through the federal health

benefit exchange. Accordingly, §21.3542 has been revised to clarify that the requirement in subsection (b)(1) to market consumer choice plans with at least a state-mandated plan applies to health carriers that market consumer choice health benefit plans through electronic medium and online marketplaces other than the federal health benefit exchange set up in furtherance of the ACA.

The department has statutory authority to adopt, amend, and enforce §21.3542(b)(1) under Insurance Code §§1507.007, 1507.009, 1507.057, and 1507.059. Insurance products are increasingly being offered online in different platforms, such as online marketplaces and the federal health benefit exchange created under the ACA. Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits. Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits. This rulemaking simply updates §21.3542(b)(1) to specifically reflect the existing reality that electronic medium and online marketplaces are sources used to market and distribute insurance products under §21.3542(b)(1). Section 1507.009 grants the commissioner authority to adopt rules necessary to implement §1507.007, and §1507.059 grants the commissioner authority to adopt rules necessary to implement §1507.057 of the statute.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 1. GENERAL PROVISIONS
28 TAC §§21.3501 – 21.3504 and 21.3506

STATUTORY AUTHORITY. The department adopts the amendments to §§21.3501 – 21.3504 and new §21.3506 under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and provide it to the department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed new §21.3506 implements Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 1. GENERAL PROVISIONS

§21.3501. Statement of Purpose.

This subchapter implements the provisions of the Texas Consumer Choice of Benefits Health Insurance Plan Act to achieve the legislative goal of providing individuals, employers, and other purchasers of health care coverage in this state the opportunity to choose health benefit plans that are more affordable and flexible than

plans available in the existing market. To that end, the Legislature has authorized health carriers to issue policies or evidences of coverage that, in whole or in part, do not offer or provide certain state-mandated health benefits.

§21.3502. Definitions.

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

(1) Basic health care services--Health care services that the commissioner determines an enrolled population might reasonably need to maintain good health.

(2) Commissioner--The commissioner of insurance.

(3) Consumer choice health benefit plan--A group or individual accident or sickness insurance policy or evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits, but that provides creditable coverage as defined by Insurance Code §1205.004(a) or §1501.102(a).

(4) Consumer choice of benefits health insurance plan--A consumer choice health benefit plan.

(5) Department--The Texas Department of Insurance.

(6) HMO--a person defined in Insurance Code §843.002(14).

(7) Health carrier--Any entity authorized under the Insurance Code or another insurance law of this state that provides health benefits in this state, including an insurance company, a group hospital service corporation under the Insurance Code Chapter 842, an HMO under the Insurance Code Chapter 843, and a stipulated premium company under the Insurance Code Chapter 884.

(8) Health insurer--Any entity authorized under the Insurance Code or another insurance law or regulation of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 842 of the Insurance Code, and a stipulated premium company under Chapter 884 of the Insurance Code.

(9) Standard health benefit plan--A consumer choice health benefit plan.

(10) State-mandated health benefits--

(A) Coverage required under the Insurance Code, the Administrative Code, or other law of this state to be provided in an individual, blanket, or group policy for accident and health insurance, a contract for coverage of a health-related condition, or an evidence of coverage that:

(i) includes coverage for specific health care services or benefits;

(ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts, including limitations provided in Insurance Code §1271.151; or

(iii) includes a specific category of licensed health care practitioner from whom an insured or enrollee is entitled to receive care.

(B) Do not include benefits or coverage mandated by federal law, or standard provisions or rights required under the Insurance Code, the Administrative Code, or other law of this state, to be provided in an individual, blanket, or group policy for accident and health insurance, a contract for coverage of a health-related condition, or an evidence of coverage unrelated to specific health illnesses, injuries, or conditions of an insured or enrollee, including those benefits or coverages enumerated in Insurance Code §1507.003(b) and §1507.053(b).

§21.3503. Authority to Offer.

A health carrier may offer one or more consumer choice health benefit plans; however, if the health carrier is a small employer carrier, it must offer one or more consumer choice health benefit plans in accordance with this subchapter and other applicable law.

§21.3504. Severability.

A holding that any provision of this subchapter or the application thereof to any person or circumstances is for any reason invalid may not affect the remainder of the subchapter and the application of its provisions to any persons under other circumstances.

§21.3506. State-Mandated Health Benefits in Blanket Indemnity Policies.

The category of group to which the health carrier is issuing coverage determines which benefits are state-mandated health benefits for blanket indemnity insurance policies.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 2. STATE-MANDATED HEALTH BENEFITS
28 TAC §§21.3510 - 21.3518

STATUTORY AUTHORITY. The department adopts the repeal of 28 TAC Division 2, §§21.3510 – 21.3518 under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and to provide it to the department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed repeal of Division 2, §§21.3510 – 21.3518 implements Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 2. STATE-MANDATED HEALTH BENEFITS

§21.3510. State-mandated Health Benefits in Individual Indemnity Policies.

§21.3511. State-mandated Health Benefits in Group Association Indemnity Policies.

§21.3512. State-mandated Health Benefits in Small Employer Indemnity Policies.

§21.3513. State-mandated Health Benefits in Large Employer Indemnity Policies.

§21.3514. State-mandated Health Benefits in Blanket Indemnity Policies.

§21.3515. State-mandated Health Benefits in Individual HMO Plans.

§21.3516. State-mandated Health Benefits in Group HMO Plans.

§21.3517. State-mandated Health Benefits in Small Employer HMO Plans.

§21.3518. State-mandated Health Benefits in Large Employer HMO Plans.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 3. REQUIRED NOTICES
28 TAC §21.3530

STATUTORY AUTHORITY. The department adopts the amendments to §21.3530 under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and provide it to the department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §21.3530 implement Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 3. REQUIRED NOTICES

§21.3530. Health Carrier Disclosure.

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

prescribed in Form CCP 1 provided by the department for that purpose. The information provided in Form CCP 1 must provide a sufficient description of the reduced benefit or the state-mandated health benefits not included in the plan to enable the consumer to make an informed decision about whether the consumer choice plan being offered or purchased provides sufficient coverage for the consumer's needs. Form CCP 1:

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

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

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

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

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

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

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

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

(2) to a current policyholder or contract holder, along with any offer to renew the contract or policy.

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

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

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

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

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

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

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

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

(f) When a health carrier provides the written disclosure statement described in subsection (a) of this section in the manner described by subsection (d)(2) of this section, the health carrier must:

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

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

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

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

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

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 4. ADDITIONAL REQUIREMENTS
28 TAC § 21.3542

STATUTORY AUTHORITY. The department adopts the amendments to §21.3542 under Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

Section 1507.006 requires a health carrier selling a standard health benefit plan to a proposed policyholder or a current policyholder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits reduced or not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires a health carrier to retain the signed written disclosure statement in the health carrier's records and provide it to the department on request by the commissioner.

Section 1507.007 requires a health carrier offering one or more consumer choice health benefit plans to also offer at least one accident or sickness plan that provides the state-mandated health benefits.

Section 1507.009 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter A.

Section 1507.056 requires an HMO providing a standard health benefit plan to a proposed contract holder or a contract holder to provide a written disclosure statement that acknowledges that the standard health benefit plan being purchased does not provide some or all state-mandated health benefits; lists those state-mandated health benefits reduced or not included in the standard health benefit plan; and, if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan. The section also requires an HMO to

retain the signed disclosure statement in the HMO's records and provide it to the department on request by the commissioner.

Section 1507.057 requires an HMO offering one or more standard health benefit plans to also offer at least one evidence of coverage that provides the state-mandated health benefits.

Section 1507.059 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1507, Subchapter B.

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §21.3542 implement Insurance Code §§1507.006, 1507.007, 1507.009, 1507.056, 1507.057, 1507.059, and 36.001.

TEXT.

DIVISION 4. ADDITIONAL REQUIREMENTS

§21.3542. Offer of State-Mandated Plan.

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

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

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

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

(3) provide at least the following information:

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

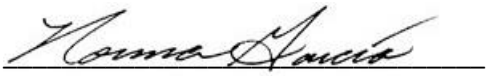
(B) the benefits or services available, or both, and the premium cost under each offered policy or evidence of coverage.

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

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

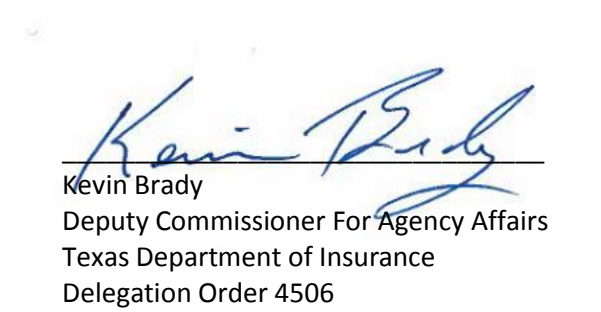
CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on May 4, 2017.



Norma Garcia
General Counsel
Texas Department of Insurance

The department adopts the amendments to §§21.3501 – 21.3504; 21.3530; and §21.3542; the new §21.3506; and the repeal of 28 TAC Division 2, §§21.3510 - 21.3518.



Kevin Brady
Deputy Commissioner For Agency Affairs
Texas Department of Insurance
Delegation Order 4506

COMMISSIONER'S ORDER NO. **2017-5063**