SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

AMENDMENTS TO 28 TAC §§21.2101 - 21.2103 and 21.2105 - 21.2107

REPEAL OF §21.2104

INTRODUCTION. The Texas Department of Insurance (TDI) proposes amendments to 28 TAC §§21.2101 - 21.2103 and §§21.2105 - 21.2107, and proposes the repeal of §21.2104, concerning Mandatory Benefits Notice Requirements. The proposed amendments and repeal are necessary to require the extension of ovarian cancer screening due to the passage of HB 2813, 84th Legislature, Regular Session, 2015, and change the use of the term "hospital confinement" as it relates to SB 979, 84th Legislature, Regular Session, 2015.

EXPLANATION. HB 2813 amended Insurance Code §1370.002 and §1370.003, concerning Certain Tests for Detection of Human Papillomavirus and Cervical Cancer. The amendments require the inclusion of an annual diagnostic screening test for early detection of ovarian cancer, specifically the CA 125 blood test. Section 1370.004 requires that a health plan carrier must provide written notice of the coverage required under Chapter 1370.

SB 979 amended Insurance Code §1201.104 to expand one category of individual accident and health insurance policy from "hospital confinement indemnity" to "hospital indemnity or other fixed indemnity." The amendments make conforming changes to the text of Chapter 21, Subchapter M.

Section 21.2101 is amended to remove notice requirements related to date limitations that are no longer relevant, and §21.2102 is amended to clarify definitions. The amendments to §21.2103 require the mandatory benefit notice to include language related to ovarian cancer.

If a plan is not required to provide a benefit for ovarian cancer screening due to the exception in Insurance Code §1370.002(b), the notice may be modified to omit the references to ovarian cancer and the CA 125 blood test. Section 21.2103(b) is amended to clarify that any notice that includes "substantially similar language," issued after the effective date of these amendments, must be filed with TDI for review and approval by the commissioner. Existing subsection (d) is deleted because the grandfathering language is no longer necessary. This section also requires that the notices be printed in no less than 10-point type. Section 21.2104 is repealed because its 10-point type requirement is moved to §21.2103 and §21.2107.

The amendments to §21.2105 remove date requirements that are no longer relevant. Section 21.2106 is amended to update the TDI website address and provide for language regarding ovarian cancer to be added to the notice. The amendments to §21.2107 clarify language and include the relocated requirement that notices must be printed in no less than 10-point type.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Patricia Brewer, team lead for the Life and Health Regulatory Initiatives Program, has determined that for each year of the first five years the proposed amendments and repeal will be in effect, there will be no fiscal impact to state or local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. Ms. Brewer has also determined that for each year of the first five years the amendments and repeal are in effect, the public benefits anticipated as a result of the proposed amendments and repeal will be that consumers will have notice that the test for ovarian cancer is part of their mandatory benefits.

TDI has determined that the proposed amendments and repeal of §21.2104 may have an adverse economic effect; however, TDI has no discretion in proposing the extension of a notice to include ovarian cancer because TDI, in accordance with Insurance Code §1370.004, must adopt rules requiring health benefit plan carriers to provide notice of the coverage required under Chapter 1370.

The rule also clarifies that all notices issued after the effective date of these amendments are required to be filed with TDI for review and approval by the commissioner unless the carrier uses the TDI promulgated notices. There will be no filing costs if carriers use the adopted notices. Carriers using "substantially similar" notices will incur a $100 fee per filing.

Carriers may also incur a cost to update the language in their notices to include ovarian cancer screenings. If the business has existing stock of notices and has not reprinted since the passage of HB 2813, the costs required to comply with the proposal may include administrative and computer programming costs to update and print new notices to reflect the changed information. Carriers may calculate the total cost of labor for each category by multiplying the number of estimated hours for each cost component by the median hourly wage for each category of labor. The Texas statewide median hourly wage for each category is published online by the Texas Workforce Commission at www.texaswages.com and is as follows:

(a) a computer programmer: $75,539 per year, divided by 2080 hours per year equals $36.32

(b) an administrative assistant: $30,477 per year, divided by 2080 hours per year equals $14.65.

There is no additional postage cost because notices are already required to be issued within 60 days of the plan's issuance or renewal. It is not feasible for TDI to estimate the total increased printing attributable to compliance with this proposal because there are numerous factors involved that are not suited to reliable quantification. TDI estimates that printing or copying costs between $.08 and $.12 per page.

TDI estimates that preparation of the changes to the notice information will likely require a one-time cost of approximately one hour of administrative staff time. The cost will vary depending on whether an administrative assistant or a computer programmer, or a combination of both positions, perform this function.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

Economic Impact Statement. As required by Government Code §2006.002(c), TDI has determined that the proposal may have an adverse economic effect on small or micro businesses that must comply with the rules. The adverse economic impact will result from amending their current notices. The cost of compliance with these proposed rules will not vary between large businesses and small or micro businesses, and TDI's cost analysis and resulting estimated costs in the Public Benefit and Cost Note portion of this proposal are equally applicable to large businesses and small or micro businesses.

Regulatory Flexibility Analysis. Government Code §2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Government Code §2006.002(c)(1) requires that the analysis consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses.

The requirement for carriers to file the notices that have "substantially similar language" will have the same effect on all carriers. Small and micro business carriers may eliminate the cost by using the promulgated notice.

TDI considered the following three additional regulatory alternatives: (i) not proposing the new requirements; (ii) proposing different requirements for small and micro businesses; and (iii) exempting small and micro businesses. For the following reasons, TDI rejected each of these alternatives.

Not Proposing the New Requirements. The primary objective of the proposal is to provide consumers with complete and easily understood notice information consistent with HB 2813. This mandate applies to all health benefit plan carriers subject to Insurance Code Chapter 1370, including small and micro businesses. The rule also clarifies that all notices issued after the effective date of these amendments are required to be filed with TDI for review and approval by the commissioner unless the carrier uses the exact wording of the TDI promulgated notices. This requirement promotes consistency and clarity in notices.

Proposing Different Requirements for Small and Micro Businesses. As previously noted, a purpose of the proposal is to provide consistency and clarity in notices. The same consumer protection reasons exist for all notices. Requiring all health plans to file notices with "substantially similar" language facilitates understanding of the coverage provided. There is no reason why one notice should be distinguished from another. The notices would not be consistent if TDI required something different for small or micro business health benefit plan carriers.

Exempting Small and Micro Businesses. Finally, TDI considered not requiring small and micro businesses to file notices that have "substantially similar" language; however, TDI has determined that the importance of consistency applies equally to large and small carriers and that such an exemption could result in some consumers being unaware of their rights under the statute. Without filing, TDI does not have any insight on the contents of the notice and cannot proactively protect consumers by verifying compliance with the statutes.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI invites the public and affected persons to comment on this proposal. Submit your written comments on the proposal no later than 5 p.m., Central time on June 13, 2016. Send written comments by mail to the Texas Department of Insurance, Office of the Chief Clerk, Mail Code 113-2A, P.O. Box 149104, Austin, Texas 78714-9104; or by email to chiefclerk@tdi.texas.gov. You must simultaneously submit an additional copy of the comment by mail to Patricia Brewer, Team Lead, Texas Department of Insurance, Life and Health Regulatory Initiatives Program, Mail Code 106-1D, P.O. Box 149104, Austin, Texas 78714-9104; or by email to LHLComments@tdi.texas.gov. You must submit any request for a public hearing separately to the Office of the Chief Clerk, Mail Code 113-2A, P.O. Box 149104, Austin, Texas 78714-9104; or by email to chiefclerk@tdi.texas.gov before the close of the public comment period. If a hearing is held, written comments and public testimony presented at the hearing will be considered.

SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

AMENDMENTS TO 28 TAC §§21.2101 - 21.2103 and 21.2105 - 21.2107

STATUTORY AUTHORITY. The amendments to 28 TAC §§21.2101 - 21.2103 and §§21.2105 - 21.2107 are proposed under Insurance Code §1357.006, which requires notice of coverage for reconstructive surgery following a mastectomy; §1357.056, which requires notice of coverage required for hospital stays after mastectomies; §1362.004, which requires notice of coverage for detection of prostate cancer; §1363.004, which requires notice of coverage for detection of colorectal cancer; §1366.058, which requires notice of coverage for maternity, childbirth, and in-home postdelivery care; and §1370.004, which requires notice of coverage for human papillomavirus, ovarian cancer, and cervical cancer screening. Insurance Code §1201.104 requires TDI to adopt rules establishing minimum benefit standards for individual accident and health insurance policies. Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

CROSS-REFERENCE TO STATUTE. The amendments implement Insurance Code §§1370.001, 1370.004, and 1201.104, and Insurance Code Chapters 843, 1271, and 1701.

§21.2101. Scope.

The purpose of this subchapter is:

(1) to require notice to enrollees in a health benefit plan of coverage <u>or</u> [~~and/or~~] benefits for<u>:</u>

<u>(A)</u> prostate cancer examinations;

<u>(B)</u> minimum inpatient stays for maternity and childbirth;

<u>(C)</u> minimum inpatient stays for mastectomy or lymph node dissection;

(D) reconstructive surgery after mastectomy;

(E) certain diagnostic screening tests for early detection of human papillomavirus, ovarian cancer, and cervical cancer;[,] and

(F) certain tests for the detection of colorectal cancer; and [~~. With the exception of notice for reconstructive surgery after mastectomy, notice for certain diagnostic screening tests for early detection of human papillomavirus and cervical cancer, and notice for colorectal cancer detection, §§21.2102 - 21.2106 of this subchapter apply to all carriers issuing, delivering, or renewing health benefit plans as defined in this subchapter as of January 1, 1998. For state notice requirements pertaining to reconstructive surgery after mastectomy, §§21.2102 - 21.2106 of this subchapter apply to all carriers issuing, delivering, or renewing health benefit plans as defined in this subchapter as of June 18, 1999. For notice requirements pertaining to tests for colorectal cancer detection, §§21.2102 - 21.2106 of this subchapter apply to all carriers issuing, delivering, or renewing health benefit plans as defined in this subchapter as of January 1, 2002. For notice requirements pertaining to diagnostic screening tests for early detection of human papillomavirus and cervical cancer, §§21.2102 - 21.2106 of this subchapter apply on or after January 1, 2006, to all carriers issuing, delivering, or renewing health benefit plans as defined in this subchapter.~~]

(2) to require notice to individuals who become eligible for certain protections regarding Medicare supplement coverage under [~~pursuant to~~] §3.3312 of this title (relating to Guaranteed Issue for Eligible Persons). [~~Section 21.2107 of this subchapter applies to all entities, as defined in §3.3312 of this title, that terminate coverage or have covered individuals who cease coverage on or after July 1, 1998, as described in §3.3312 of this title.~~]

§21.2102. Definitions.

The following words and terms, when used in this subchapter [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) Another limited benefit--A plan that provides coverage, singularly or in combination, for benefits for a specifically named disease, accident, or combination of diseases or accidents, including, but not limited to:

(A) heart attack;

(B) stroke;

(C) AIDS; or

(D) travel, farm, or occupational accident.

(2) Carrier--The term includes:

(A) an [~~An~~] insurance company, a group hospital service corporation, a fraternal benefit society, a stipulated premium insurance company, a health maintenance organization, a multiple employer welfare arrangement that holds a certificate of authority under Insurance Code Chapter 846, or an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Insurance Code Chapter 844;[~~.~~]

(B) [~~In addition,~~] for the purposes of paragraph (4)(B) [~~(3)(B)~~] and (F) of this section, [~~the term also includes~~] a reciprocal exchange operating under Insurance Code Chapter 942;

(C) for purposes of paragraph (4)(E) [~~(3)(E)~~] and (F) of this section, [~~the term also includes~~] a Lloyds plan operating under Insurance Code, Chapter 941; and

(D) for purposes of paragraph (4)(E) [~~(3)(E)~~] of this section, [~~the term also includes~~] a risk pool created under Chapter 172, Local Government Code.

(3) [~~(2)~~] Enrollee--A person enrolled in and entitled to coverage under a health benefit plan, including covered dependents.

(4) [~~(3)~~] Health Benefit Plan--Subject to subparagraphs (A), (B), (C), (D), (E), and (F) of this paragraph, a plan that is offered by a carrier and provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness including an individual, group, blanket, or franchise insurance policy or insurance agreement;[,] a group hospital service contract;[,] an individual or group evidence of coverage;[,] or any similar coverage document. The term does not include a plan that provides coverage only for accidental death or dismemberment, disability income, supplement to liability insurance, Medicare supplement, workers' [~~workers~~] compensation, medical payment insurance issued as a part of a motor vehicle insurance policy, or a long-term care policy.

(A) For the inpatient mastectomy coverage notice required by §21.2103(a)(1) [~~subsection (a)(1) of §21.2103~~] of this title (relating to Mandatory Benefit Notices), the definition of health benefit plan includes a plan that provides coverage only for a specific disease or condition for the treatment of breast cancer or for hospitalization. The term does not include a small employer health benefit plan issued under [~~the~~] Insurance Code Chapter 1501, Subchapters A - H (concerning Health Insurance Portability and Availability Act).

(B) For the reconstructive surgery after mastectomy notices required by §21.2103(a)(2) [~~subsection (a)(2) of §21.2103~~] of this title, the definition of health benefit plan does not include:

(i) a plan that provides coverage for a specified disease or another [~~other~~] limited benefit except for cancer;[,]

(ii) a plan that provides only credit insurance;[,]

(iii) a plan that provides coverage only for dental or vision care;[,] or

(iv) a plan that provides coverage only for [~~indemnity for~~] hospital indemnity or other fixed indemnity [~~confinement~~].

(C) For the prostate cancer examination notice required by §21.2103(a)(3) [~~subsection (a)(3) of §21.2103~~] of this title, the definition of health benefit plan does not include:

(i) a small employer health benefit plan written under [~~the~~] Insurance Code Chapter 1501, Subchapters A - H;[~~,~~]

(ii) a plan that provides coverage only for a specified disease or another [~~other~~] limited benefit;[~~,~~] or

(iii) a plan that provides coverage only for [~~indemnity for~~] hospital indemnity or other fixed indemnity [~~confinement~~].

(D) For the inpatient maternity and childbirth coverage notice required by §21.2103(a)(4) and (5) [~~subsection (a)(4) and (5) of §21.2103~~] of this title, the definition of health benefit plan does not include:

(i) a plan that provides only credit insurance;[~~,~~]

(ii) a plan that provides coverage only for a specified disease or another [~~other~~] limited benefit;[~~,~~]

(iii) a plan that provides coverage only for dental or vision care;[~~,~~] or

(iv) a plan that provides coverage only for [~~indemnity for~~] hospital indemnity or other fixed indemnity [~~confinement~~].

(E) For the detection of colorectal cancer screening coverage notice required by §21.2103(a)(6) [~~subsection (a)(6) of §21.2103~~] of this title, the definition of health benefit plan does not include:

(i) a small employer health benefit plan written under [~~the~~] Insurance Code Chapter 1501, Subchapters A - H;[~~, or~~]

(ii) a plan that provides coverage only for a specified disease or another [~~other~~] limited benefit; or

(iii) a plan that provides coverage only for [~~indemnity for~~] hospital indemnity or other fixed indemnity [~~confinement~~].

(F) For the detection of human papillomavirus and cervical cancer screening notice required by §21.2103(a)(7) [~~subsection (a)(7) of §21.2103~~] of this title, the definition of ["]health benefit plan["] includes a small employer health benefit plan written under Insurance Code Chapter 1501, but does not include:

(i) a plan that provides coverage only for a specified disease or another [~~other~~] limited benefit, other than a plan that provides benefits for cancer treatment or similar services;

(ii) a plan that provides coverage only for dental or vision care;

(iii) a plan that provides coverage only for indemnity or for hospital indemnity or other fixed indemnity [~~confinement~~];

(iv) a credit insurance policy; or

(v) a limited benefit policy that does not provide coverage for physical examinations or wellness exams.

[~~(4) Other limited benefit--A plan that provides coverage singularly or in combination, for benefits for a specifically named disease, accident or combination of diseases or accidents, including but not limited to heart attack, stroke, AIDS, and travel, farm or occupational accident.~~]

(5) Primary Enrollee--For group coverage, the covered member or employee of the group. For individual coverage, the person first named on the application or [~~and/or~~] enrollment form.

§21.2103. Mandatory Benefit Notices.

(a) Prescribed mandatory benefit notices consist of the following:

(1) For a health benefit plan that provides coverage or [~~and/or~~] benefits for the treatment of breast cancer, a carrier must [~~shall~~] issue a notice that [~~which~~] includes the language provided in Figure 1 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number 349 Mastectomy).

(2) For a health benefit plan that provides coverage or [~~and/or~~] benefits for a mastectomy, a carrier must [~~shall~~] issue:

(A) an enrollment notice that [~~which~~] includes the language provided in Figure 2 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number 1764 Reconstructive Surgery After Mastectomy-Enrollment); and

(B) an annual notice, that [~~which~~] includes either:

(i) the language provided in Figure 3 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number 1764 Reconstructive Surgery After Mastectomy-Annual); or

(ii) the language provided in Figure 2 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number 1764 Reconstructive Surgery after Mastectomy-Enrollment).

(3) For a health benefit plan that provides coverage or [~~and/or~~] benefits for diagnostic medical procedures, a carrier must [~~shall~~] issue a notice that [~~which~~] includes the language provided in Figure 4 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number 258 Prostate).

(4) For a health benefit plan that provides coverage or [~~and/or~~] benefits for maternity, including benefits for childbirth, a carrier must [~~shall~~] issue a notice that [~~which~~] includes the language

provided in Figure 5 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number 102 Maternity).

(5) If the health benefit plan described in paragraph 4 of this subsection includes benefits or [~~and/or~~] coverage for in-home postdelivery care, the following language, or substantially similar language, must [~~shall~~] be inserted immediately before the "Prohibitions" portion of the notice language in [~~at~~] Figure 5 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title [~~(relating to Forms)~~]: "Since we provide in-home postdelivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary or (b) the mother requests the inpatient stay."

(6) For a health benefit plan that provides coverage or [~~and/or~~] benefits for medical screening procedures, a carrier must [~~shall~~] issue a notice that [~~which~~] includes the language provided in Figure 6 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number 1467 Colorectal Cancer Screening).

(7) For a health benefit plan that provides coverage or [~~and/or~~] benefits for medical screening procedures, a carrier must [~~shall~~] issue a notice that [~~which~~] includes the language provided in Figure 7 §21.2106(b) [~~of subsection (b) of §21.2106~~] of this title (relating to Forms, Form Number LHL391 Human Papillomavirus, Ovarian Cancer, and Cervical Cancer Screening). If a plan is not required to provide a benefit for ovarian cancer screening due to the exception in Insurance Code §1370.002(b) (concerning Exceptions), the notice may be modified to omit the references to ovarian cancer and the CA 125 blood test.

(b) Instead [~~In lieu~~] of the prescribed notices outlined in subsection (a) of this section, a carrier may opt to provide notices with substantially similar language rather than the notices contained in §21.2106(b) [~~subsection (b) of §21.2106~~] of this title. Any substantially similar language notice issued

after the effective date of this amendment must be filed for review and approval by the commissioner under Insurance Code Chapters 843 (concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), and 1701 (concerning Policy Forms). The substantially similar language must be in a readable and understandable format, and must include a clear, complete, and accurate description of these items in the following order:

(1) a heading in bold print and all capital letters indicating the information in the notice relates to mandated benefits;

(2) a statement that the notice is being provided to advise the enrollee of the appropriate coverage or [and/or] benefits, including the carrier's complete licensed name;

(3) a heading in bold print describing the coverage or [and/or] benefits being provided, for example, Examinations for Detection of Prostate Cancer;

(4) a description of the coverage or [and/or] benefits for which the notice is being provided;[.]

(5) for [For] a carrier who issues a health benefit plan that provides coverage or [and/or] benefits for a mastectomy, the following requirements [shall also] apply:

(A) the enrollment notice required by subsection (a)(2)(A) of this section must [shall] disclose that the coverage or [and/or] benefits must [shall] be provided in a manner determined to be appropriate, in consultation with the attending physician and the enrollee, and [shall] state the specific deductibles, copayments, and [and/or] coinsurance, which may not be greater than the deductibles, copayments, and [and/or] coinsurance applicable to other benefits under the health benefit plan; and

(B) the annual notice required by subsection (a)(2)(B) of this section must, [~~shall~~] at a minimum, describe that the health benefit plan provides coverage or [~~and/or~~] benefits for reconstructive surgery after mastectomy, surgery and reconstruction of the other breast for symmetry, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema);[~~.~~]

(6) [~~(5)~~] for the notice required by subsection (a)(1), (2)(A), and (4) of this section, the heading "Prohibitions" in bold, followed by a summary of the prohibited acts by a carrier in providing the coverage or [~~and/or~~] benefits for which the notice is being provided; and

(7) [~~(6)~~] a statement identifying the carrier, and providing a phone number and address to which an enrollee may direct questions regarding the coverage or [~~and/or~~] benefits for which the notice is being provided.

(c) If a health benefit plan provides coverage or [~~and/or~~] benefits of more than one of the required notices described in subsection (a) of this section, the carrier may combine the language of the required notices into one notice.

(d) The notices must be printed in no less than 10-point type. [~~If, before the effective date of the amendments to this subchapter relating to a notice listed in paragraphs (1) - (3) of this subsection, a carrier has provided to its enrollees notice(s) that contains the information concerning the required coverage or benefit, such notice(s) shall be deemed to comply with the requirements of this subchapter as to those enrollees;~~]

[~~(1) reconstructive surgery after mastectomy as required by subsection (a)(2) or (b) of this section;~~]

[~~(2) tests for detection of colorectal cancer as required by subsection (a)(6) or (b) of this section; and~~]

[~~(3) tests for detection of human papillomavirus and cervical cancer as required by subsection (a)(7) or (b) of this section.~~]

§21.2105. Delivery of Mandatory Benefit Notices.

(a) The notices required by §21.2103(a)(1), (3), and (4) of this title (relating to Mandatory Benefit Notices) must [~~shall~~] be issued to enrollees of a health benefit plan within 60 days of the plan's issuance or renewal. [~~that is delivered, issued for delivery, or renewed on or after January 1, 1998, and shall be provided according to the following paragraphs:~~]

(1) [~~The notice shall be provided:~~]

[~~(A) within 60 days of March 29, 1998 to enrollees whose plans were renewed or issued between January 1, 1998 and March 29, 1998;~~]

[~~(B) within 60 days of enrollment to new enrollees, whether in a newly issued or newly delivered health benefit plan, or an existing plan which is renewed after March 29, 1998; or~~]

[~~(C) within 60 days of renewal date to existing enrollees of an existing plan which is renewed after March 29, 1998.~~]

[~~(2)~~] Except as specified in paragraph (5)[~~(6)~~] of this subsection, a carrier must [~~shall~~] deliver the notices to enrollees through the U.S. Postal Service or, as permitted by state law, electronically.

(2)[~~(3)~~] The notice may be delivered with other health benefit plan documents within 60 days of the plan's issuance or renewal. [~~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 the enrollment or insurance [~~enrollment/insurance~~] card.

(3)[~~(4)~~] If the notices are provided to the primary enrollee's last known address, the requirements of this section are satisfied with respect to all enrollees residing at that address.

(4)[~~(5)~~] If a covered spouse or dependent's last known address is different than the primary enrollee, separate notices are required to be provided to the spouse or the dependent at the spouse's or dependent's last known address.

(5)[~~(6)~~] For group health benefit plans, the notice may be provided to the group master contract holder for distribution to enrollees if the carrier has an agreement with the group master contract holder that the notice will be delivered within 60 days of the plan's issuance or renewal [~~in accordance with the timelines specified in paragraph (1) of this subsection~~]; however, TDI will hold the carrier [~~will be held~~] responsible for ensuring that notice is provided to the enrollees.

(b) The notices required by §21.2103(a)(2) of this title must [~~shall~~] be issued to enrollees of a health benefit plan and [~~shall~~] be provided according to the following paragraphs:[~~.~~]

(1) the [~~The~~] enrollment notice required by §21.2103(a)(2)(A) of this title must [~~shall~~] be issued to each enrollee upon enrollment in the health benefit plan;[~~.~~]

(2) the [~~The~~] annual notice required by §21.2103(a)(2)(B) of this title must [~~shall~~] be issued to each enrollee annually; and [~~.~~]

(3) notwithstanding [~~Notwithstanding~~] §21.2103(a)(2) of this title, a carrier may elect to issue the enrollment notice required by §21.2103(a)(2)(A) of this title to satisfy the annual notice requirements set forth in §21.2103(a)(2)(B) of this title.

[~~(4) The provisions of subsection (a)(2) - (6) of this section shall also apply to these notices, except for the timeline requirements of subsection (a)(1) of this section.~~]

[~~(c) A carrier shall issue the notices required by §21.2103(a)(6) and (7) of this title to enrollees of a health benefit plan, and subsections (a)(2) - (6) of this section shall also apply to the notices, except for the timeline requirements of subsection (a)(1) of this section.~~]

§21.2106. Forms.

(a) The forms identified in §21.2103 of this title (relating to Mandatory Benefit Notices) [~~for notices of mandatory benefits~~] are included in subsection (b) of this section in their entirety [~~and have been filed with the Office of the Secretary of State~~]. The forms can be obtained from the Texas Department of Insurance [~~, Life/Health Division, MC 106-1A~~], P.O. Box 149104, Austin, Texas 78714-9104, or from the TDI website, www.tdi.texas.gov [~~department's Web site, www.tdi.state.tx.us~~].

(b) The forms referenced in this chapter are [~~as follow~~]:

(1) - (6)(No change.)

(7) Figure Number 7: Form Number LHL391 Human Papillomavirus, Ovarian Cancer, and Cervical Cancer Screening: Attached Graphic

Figure: 28 TAC §21.2106(b)(7)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage or [~~and/or~~] benefits provided by your contract with ([~~†~~]name of carrier)[~~†~~].

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided[~~,~~] for each woman enrolled in the plan who is 18 years of age or older[~~,~~] for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA [~~United States Food and Drug Administration~~], alone or in combination with a test approved by the FDA [~~United States Food and Drug Administration~~] for the detection of the human papillomavirus.

§21.2107. Right To Medicare Supplement Coverage Notice.

(a) At the time of an event described in §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons) that causes [~~because of which~~] an individual to lose [~~loses~~] coverage or benefits due to the termination of a contract, agreement, policy, or plan, the entity, as defined in [~~and pursuant to~~] §3.3312 of this title, must:

(1) [~~shall~~] notify the individual of his or her rights under §3.3312(a), (c), (d), and (e) of this title, and of the obligations of issuers of Medicare supplement policies under §3.3312(a) of this title; and [~~. The entity shall~~]

(2) communicate this [~~such~~] notice [~~contemporaneous with~~] at the same time as the notification of termination.

(b) At the time of an event described in §3.3312(b) of this title that causes [~~because of which~~] an individual to cease [~~ceases~~] enrollment under a contract, agreement, policy, or plan, the entity, as defined in §3.3312 of this title, that [~~which~~] offers the contract or agreement, regardless of the basis for the cessation of enrollment, [~~the entity offering the plan,~~] or the licensed third party administrator of the plan, must: [~~, respectively, shall~~]

(1) notify the individual of his or her rights under §3.3312(a), (c), (d), and (e) of this title, and of the obligations of issuers of Medicare supplement policies under §3.3312(a) of this title; and[~~.~~ ~~The entity shall~~ (2) communicate this [~~such~~] notice within 10 working days of the entity's receipt of notification of disenrollment.

(c) The notices must be printed in no less than 10-point type.

SUBCHAPTER M.MANDATORY BENEFIT NOTICE REQUIREMENTS

Repeal of §21.2104

STATUTORY AUTHORITY. The repeal is proposed under Insurance Code §1357.006, which requires notice of coverage for mastectomies; §1357.056, which requires notice of coverage required for hospital stays after mastectomies; §1362.004, which requires notice of coverage for detection of prostate cancer; §1363.004, which requires notice of coverage for detection of colorectal cancer; §1366.058, which requires notice of coverage for maternity, childbirth, and in-home postdelivery care; and §1370.004, which requires notice of coverage for human papillomavirus, ovarian cancer, and cervical cancer screening. Insurance Code §1201.104 requires TDI to adopt rules establishing minimum benefit standards for individual accident and health insurance policies. Insurance Code §36.001 provides that

the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

CROSS-REFERENCE TO STATUTE. The repeal implements Insurance Code §§1370.001, 1370.004, and 1201.104.

§21.2104. Print Size of Notices.

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

Issued at Austin, Texas, on April 25, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance