SUBCHAPTER W. MISCELLANEOUS RULES FOR GROUP AND INDIVIDUAL ACCIDENT AND HEALTH INSURANCE
28 TAC §3.3602

INTRODUCTION. The Commissioner of Insurance adopts new 28 TAC §3.3602, relating to requirements for short-term limited-duration coverage. Section 3.3602 implements Senate Bill 1852, 86th Legislature, Regular Session (2019). The new section also provides consumer protections related to renewability and provides consumers notice of the protections they have when purchasing such products. The new section is adopted with changes to the proposed text published in the November 8, 2019, issue of the *Texas Register* (44 TexReg 45). The changes to the proposed text are made in response to public comments and also include other minor changes to add clarity and consistency in the rule text and form and conform with the department's current writing style. These changes do not materially alter issues raised in the proposal, introduce new subject matter, or affect people other than those previously on notice.

The department revised Figure: 28 TAC §3.3602(e) to clarify the instructions in paragraph 6 stating the maximum amount the policy will pay within the policy term, or if applicable, on a lifetime basis. This change was necessary to provide consistent language to describe policy limits.

The department revised Figure: 28 TAC §3.3602(e) to clarify in paragraph 8 that the term "PPO" refers to a preferred provider benefit plan and the term "EPO" refers to an exclusive provider benefit plan.

The department revised Figure: 28 TAC §3.3602(e) to reword the question in paragraph 9. The department replaced "What services does the plan cover?" with "What type of care will this plan cover?" to conform to other language in the form.

In response to a comment, the department revised §3.3602(d)(2) to clarify that renewal does not permit new underwriting.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to include the plan marketing name and the name of the insurer that is underwriting the coverage above paragraph 1. The department made conforming changes to §3.3602(f)(5)(A), which requires issuers to include these elements in a combined disclosure form.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to use plain language in its terminology in paragraph 1. The department changed paragraph 1, to remove language stating that "ACA plans cover hospital, medical, and surgical expenses due to an injury or sickness." The department reformatted the information using bullets and added language to indicate that, unlike ACA plans, a short-term limited-duration plan may not cover all injuries or sicknesses a prospective enrollee had before applying, and it does not allow a prospective enrollee to get federal assistance with premiums or out-of-pocket costs, such as tax credits and cost-sharing reductions.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to add the word "to" between the words "right" and "renew" in paragraph 3.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to add information about applying for an ACA plan outside of the open enrollment period. The department changed paragraph 4 of the disclosure form to provide information on how to find out about a qualifying life event and provided examples of such events.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to clarify the instructions in paragraph 7 to state that if the deductible can reset more frequently than annually, then issuers must disclose that information.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to inform consumers in paragraph 8 about the potential of balance billing in an indemnity plan.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to require issuers to include in paragraph 8 a website address to the plan directory or other information on how to locate providers, for any plan that has a provider network.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to clarify in paragraph 9 that short-term limited-duration plans limit coverage for some types of care.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to instruct the consumer in paragraph 9 to ask the agent for cost-sharing information if it is not included in the chart.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to clarify that the chart in paragraph 9 must include any applicable benefit maximums.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to clarify that row (o) of the chart in paragraph 9 relates to outpatient drug coverage. The department clarified the instructions for row (o) to specify that if prescription drug coverage is limited by a formulary, that information must be stated, and a link to the formulary must be provided. The department also clarified that a discount plan should not be represented as prescription drug coverage.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to include a statement in Spanish and English in paragraph 10 before the signature line. This statement instructs the prospective enrollee not to sign the document if they do not understand it.

In response to a comment, the department revised Figure: 28 §3.3602(e) to include information in the affirmation statement in paragraph 10 about receiving the disclosure form in writing before completing the application or making any payment.

In response to a comment, the department revised Figure: 28 TAC §3.3602(e) to include the department's consumer help line phone number and website address under paragraph 11 so that consumers know who to contact if they experience problems with the plan. The addition of this information necessitated that the federal notice to be renumbered as paragraph 12. The department also revised §3.3602(f)(5)(G) to clarify that a combined disclosure form and outline of coverage must include paragraph 12 of the disclosure form about the federal notice. This change was necessary due to the addition of the department's contact information in paragraph 11 of the disclosure form.

In response to a comment, the department revised §3.3602(f)(5)(A) to clarify that a combined disclosure form must include the title of the form.

REASONED JUSTIFICATION. New §3.3602 is necessary to implement SB 1852. Insurance Code §1509.002(a) requires the Commissioner, by rule, to prescribe a disclosure form to be provided with a short-term limited-duration insurance policy and application. Insurance Code §1509.002(c) also requires an insurer issuing a short-term limited-duration insurance policy to adopt procedures in accordance with the rule to obtain a signed form from the insured acknowledging that the insured received the disclosure form. Section 1509.002(c) requires the rule to allow for electronic acknowledgment.

Section 3.3602(a). New §3.3602(a) describes the purpose of the section, which is to define short-term limited-duration insurance and requirements for short-term limited-duration coverage. New §3.3602(a) also provides that the section applies to any individual

or group accident and health insurance policy or certificate issued under Insurance Code Chapter 1201 or 1251.

Section 3.3602(b). New §3.3602(b) provides that, for purposes of 28 TAC Chapters 3, 21, and 26, short-term limited-duration insurance has the meaning given in Insurance Code §1509.001. Insurance Code §1509.001 states that, in Chapter 1509, "short-term limited-duration insurance" has the meaning assigned by 26 C.F.R. §54.9801-2. Title 26 C.F.R. §54.9801-2, which defines "short-term, limited-duration insurance" to mean "health insurance coverage provided pursuant to a contract with an issuer that: [h]as an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total," and displays a specified notice along with any additional information required by state law.

Section 3.3602(c). New §3.3602(c) provides that a policy or certificate must provide benefits consistent with the minimum standards for the type of coverage offered, and it clarifies that the rules in the subchapter are not inclusive of all requirements that apply to short-term limited-duration plans. For example, many requirements in Title 8 of the Insurance Code (concerning Health Insurance and Other Health Coverages) apply, including general provisions in Chapters 1201 and 1251, and mandated benefit requirements under Title 8, Subtitle E.

Section 3.3602(d). New §3.3602(d) provides the requirements for individual and group short-term limited-duration coverage.

New §3.3602(d)(1) provides that short-term limited-duration coverage may not be marketed as guaranteed renewable because, by definition, under Insurance Code §1509.001, short-term limited-duration insurance cannot be renewed for a total duration that exceeds 36 months. Since the term "guaranteed renewable" implies a continuous

right to renew, use of the term with short-term limited-duration insurance would be misleading.

New §3.3602(d)(2) provides that short-term limited-duration coverage must be marketed either as "nonrenewable," or as "renewable (without new underwriting)" at the option of the policyholder or enrollee, if the enrollee contributes to the premium. Section 3.3602(d)(2) allows issuers to choose whether to issue short-term limited-duration plans that are either nonrenewable or renewable and ensures that plans are marketed consistent with the terms of the policy. To avoid misleading prospective enrollees, if an issuer opts to permit renewability it must do so at the option of the policyholder. In a group policy in which the enrollee contributes to the premium, the enrollee controls the renewal option.

New §3.3602(d)(3) provides that short-term limited-duration coverage must clearly state the duration of the initial term and the total maximum duration, including renewal options. Section 3.3602(d)(3) helps ensure that prospective enrollees are fully informed regarding how long they can keep the coverage.

New §3.3602(d)(4) provides that short-term limited-duration coverage may not be modified after the date of issue, except by signed acceptance of the enrollee. Section 3.3602(d)(4) ensures that the enrollee is informed and accepts the changes in coverage, and also ensures that an issuer does not circumvent the policy terms of renewability by unilaterally modifying the coverage.

New §3.3602(d)(5) provides requirements for renewable, short-term limited-duration coverage. Section 3.3602(d)(5)(A) provides that a short-term limited-duration individual policy or group certificate must include a statement that the enrollee has a right to continue the coverage in force by timely payment of premiums for the number of terms

listed. Section 3.3602(d)(5)(A) also provides for the enrollee to be informed about the enrollee's right to continue coverage when timely premium payments are made.

New §3.3602(d)(5)(B) provides that a short-term limited-duration individual policy or group certificate must include a statement that the issuer will not increase premium rates or make changes in provisions in the policy or certificate on renewal based on individual health status. Section 3.3602(d)(5)(B) ensures that coverage that is marketed as renewable at the option of the enrollee does not require additional underwriting or change the terms of coverage at renewal.

New §3.3602(d)(5)(C) provides that, if applicable, a short-term limited-duration individual policy or group certificate must include a statement that the issuer retains the right, at the time of policy renewal, to make changes to premium rates by class. Section 3.3602(d)(5)(C) makes clear that a renewable policy is not subject to individual rating adjustments at renewal. The statement would not be required when an issuer chooses to offer a fixed premium for the life of the policy.

New §3.3602(d)(5)(D) provides that if a short-term limited-duration individual policy or group certificate is renewable, it must include a statement that the issuer, at the time of renewal, may not deny renewal based on individual health status. Section 3.3602(d)(5)(D) helps ensure that coverage that is marketed as renewable at the option of the enrollee provides contractual terms that are consistent with that marketing.

Section 3.3602(e). New §3.3602(e) provides that an issuer offering short-term limited-duration insurance must include a written disclosure form that is consistent with the form in Figure: 28 TAC §3.3602(e) and the requirements of §3.3602. Section 3.3602(e) is necessary because Insurance Code §1509.002(a) requires the Commissioner by rule to prescribe a disclosure form to be provided with a short-term limited-duration insurance policy and application.

In addition to the elements specifically required by Insurance Code §1509.002(b), the disclosure form includes a statement that the plan is exempt from the federal Affordable Care Act (ACA) and may not cover all necessary care. This information informs prospective enrollees about possible benefit limitations.

Along with information about renewability, the form states that "[t]he amount of your premium payment might change after you renew this plan. But the amount can't go up because of a change in your health. A change in your health can't affect your benefits or your right to renew." These statements are included for consistency with new §3.3602(d)(2) and (5).

Along with the open enrollment information, the form includes an explanation that prospective enrollees can sign up for a plan not covered by the ACA at any time, but that they can be denied for health reasons when they sign up for a new plan. This information is provided to inform prospective enrollees about underwriting that may occur during the initial application for short-term limited-duration coverage.

The form also references Healthcare.gov. This information provides prospective enrollees with a resource to research open enrollment information, including eligibility information about qualifying life events for enrollment at other times.

Following information on the plan's deductible, the form includes information on whether the plan uses a provider network and how to access the provider directory, if applicable. This information helps to ensure prospective enrollees understand the nature of coverage and whether limits apply based on their choice of provider. For indemnity plans, the form also clarifies that providers have not agreed to a set price with the plan and can charge the consumer for any amount not paid by the plan.

The form uses a chart to describe covered services and any limits that apply to those services. This information is necessary because Insurance Code §1509.002(b)(7)(A)-

(H) and (8) require that the disclosure form state whether certain health care services are covered, specifically: prescription drug coverage, mental health services, substance abuse treatment, maternity care, hospitalization, surgery, emergency health care, preventive health care, and any other information the Commissioner determines is important for a purchaser of a short-term limited-duration policy.

Within the chart of covered services, the form expands categories required under Insurance Code §1509.002(b)(7)(B), (C), (D), (E), and (F) in order to separate coverage for facility fees and physician fees. In describing maternity care coverage, the form also separates prenatal visits from physician services at delivery. The form expands on emergency health care to identify coverage for urgent care and ambulance services. The form adds primary care and specialist care office visits.

Issuers are permitted, but not required, to include cost-sharing information in the benefits chart. This flexibility allows an issuer to incorporate key plan summary information within the disclosure document, rather than producing and delivering a separate document that may be repetitive. If the issuers do not include cost-sharing information, the form instructs the consumer that they may request the information.

The form includes the department's contact information through which a consumer can file a complaint or verify an agent's license number. The form also includes a signature line on which the consumer verifies that they received the form before applying or paying for coverage and that they understand the information.

The form also includes the text of the federally required notice. This is included because Insurance Code §1509.001 defines short-term limited-duration insurance based on the federal definition, at 45 C.F.R. Section 54.9801-2. The federal regulation defining "short-term, limited-duration insurance" includes the requirement to provide a specific notice.

Section 3.3602(f). New §3.3602(f) provides the disclosure form requirements. Section 3.3602(f) is necessary because Insurance Code §1509.002(b) provides the information that the disclosure form must include.

New §3.3602(f) provides that in creating the disclosure form, issuers must follow all instructions in the subsection. Section 3.3602(f) ensures that issuers produce the disclosure form correctly and accurately.

New §3.3602(f)(1) provides that a disclosure form must be produced for each plan option that the issuer makes available and reflect the specific terms of the plan. New §3.3602(f)(1) is included because the nature of the information required by Insurance Code §1509.002(b) varies across plan offerings. For example, the plan's duration, renewal options, benefits, deductible, coverage maximum, and coverage for preexisting conditions can vary across different issuers and plans offered by an individual issuer. In order to accurately educate the prospective enrollee regarding the plan or plans available, a single disclosure form should not be used to reflect multiple plans.

New §3.3602(f)(2) provides that the disclosure form must accurately represent the short-term limited-duration coverage. Section 3.3602(f)(2) is provided to fully inform the prospective enrollee about the coverage offered.

New §3.3602(f)(3) provides that if the disclosure form in new Figure 28 TAC §3.3602(e) does not accurately represent the plan being offered, the issuer may modify the form as necessary. When filing the form with the department, the issuer must clearly identify any changes made and explain the reason for modifying the form. Section 3.3602(f)(3) provides flexibility to ensure the disclosure form does not provide inaccurate information. In reviewing filed disclosures, the department will ensure that the changes made accurately represent the terms of the plan.

New §3.3602(f)(4) provides that the chart under disclosure form paragraph (9) may be supplemented to include cost-sharing information for each benefit. Section 3.3602(f)(4) provides flexibility for issuers that wish to use the disclosure form as a primary plan summary document, rather than creating a separate document that may duplicate much of the information in the form.

New §3.3602(f)(5) provides that the disclosure form in Figure: 28 TAC §3.3602(e) may be combined with the outline of coverage required under Insurance Code §1201.107 and 28 TAC §3.3093(4), if certain requirements are met. Section 3.3602(f)(5) provides flexibility for issuers in the individual market, which are required to provide an outline of coverage document that includes much of the same information that is contained in the disclosure form. Allowing issuers to combine the documents eliminates what would otherwise be duplicative disclosure requirements and enables a more streamlined approach.

Section 3.3602(g). New §3.3602(g)(1) provides that the disclosure form must be filed with the department for review before use, consistent with filing procedures in 28 TAC Chapter 3, Subchapter A.

New §3.3602(g)(2) requires that a disclosure form must be provided in writing to a prospective enrollee before the individual completes an application or makes an initial premium payment, application fee, or other fee; and again at the time the policy or certificate is issued. This makes clear that the disclosure should be available in writing before, and not after, a prospective enrollee submits an application. Section 3.3602(g)(2) is necessary because Insurance Code §1509.00(2)(a) requires a disclosure form to be provided with a short-term limited-duration policy and application.

New §3.3602(g)(3) provides that the disclosure form must be signed by the enrollee to acknowledge receipt at the time of application. An electronic signature is acceptable if the issuer's procedures comply with Insurance Code Chapter 35.

New §3.3602(g)(1) through (3) are necessary because Insurance Code §1509.002(c) provides that an issuer issuing a short-term limited-duration insurance policy adopt procedures in accordance with the rule to obtain a signed form from the enrollee acknowledging that the enrollee received the disclosure form. Insurance Code §1509.002(c) also provides that the rule must allow for electronic acknowledgment.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received three written comments, and two oral comments. Commenters in support of the proposal with changes were: AARP Texas; American Cancer Society Cancer Action Network, Inc.; American Diabetes Association; American Lung Association; Center for Public Policy Priorities; Children's Defense Fund-Texas; National Association of Social Workers, Texas Chapter; National Multiple Sclerosis Society; The Leukemia & Lymphoma Society; UnidosUS; and Young Invincibles.

Comment on §3.3602.

A commenter appreciates the department's commitment to the use of plain language to promote transparency.

Agency Response.

The department appreciates the support.

Comment on §3.3602.

A commenter cites a study that found that consumers have "significant difficulty in understanding short-term limited-duration plans cost implications." The commenter encourages the department to develop educational resources for short-term limited-duration plans similar to its "Health Insurance Shopping Guide" and to provide the link to the resource on the disclosure form.

Agency Response.

The department appreciates the comment and will take it into consideration. The department does agree that it is important to connect consumers with educational resources to improve health insurance literacy. The department declines to develop a shopping guide as part of this rulemaking, since it is outside the scope of Insurance Code §1509.002(a), which requires the Commissioner, by rule, to prescribe a disclosure form to be provided with a short-term limited-duration insurance policy and application.

Comment on 3.3602(d)(2).

A commenter states that plans sold as renewable should not engage in medical underwriting or deny coverage at renewal.

Agency Response.

The department agrees that a fair understanding of the right to renew should not expose an individual to additional underwriting. The department changed §3.3602(d)(2) to clarify that renewal does not permit new underwriting.

Comment on 3.3602(d)(5)(B).

A commenter states that while premium rates may not increase based on a change to an individual's health status, other criteria, like occupation and gender, could still be used as factors to modify rates. Another commenter stated that plans sold as renewable

should not change the premium rate or policy terms based on individual risk characteristics. A commenter states that the department should provide more explicit guidelines for premium rate and policy changes to protect the value of these products to those consumers who purchase them.

Agency Response.

The department agrees that a fair understanding of the right to renew is that renewal should not expose an individual to additional underwriting. The department modified §3.3602(d)(2) to clarify that renewal does not permit new underwriting.

Comment on §3.3602(e).

A commenter states that the requirement that all companies selling short-term limited-duration plans must comply with the disclosure forms should remain in the adopted rule. The commenter states that this requirement maintains a level playing field for the benefit of consumers.

Agency Response.

The department appreciates the support.

Comment on Figure: 28 TAC §3.3602(e).

A commenter states that the heading for the disclosure form ("Is this short-term health insurance plan right for me?"), should remain in the adopted rule. The commenter states that question is at the core of the disclosure form itself.

Agency Response.

The department appreciates the support.

Comment on Figure: 28 TAC §3.3602(e).

A commenter recommends adding information to the disclosure form that will help the applicant understand any fees in addition to the monthly premium that may be charged for the plan, such as application fees, association membership fees, and miscellaneous administrative fees.

Agency Response.

The department declines to add this information to the form at this time, because it appears that current marketing practices provide consumers with sufficient information about how much their coverage will cost. The department will monitor the issue and consider future changes to the rule if complaints are received.

Comment on Figure: 28 TAC §3.3602(e).

A commenter recommends that the form have a required space for the name of the insurer, the marketing name of the plan, and the agent's name and license number.

Agency Response.

The department agrees in part and modifies the disclosure form to include the plan marketing name and the name of the issuer that is underwriting the coverage above paragraph 1. The department declines to require the agent's name and license number at this time, due to the administrative complexity and cost that would add. The department will continue to monitor this issue. In addition, the department modified paragraph 11 to provide the department's contact information and how to check if an agent has a license.

Comment on Figure: 28 TAC §3.3602(e).

A commenter recommends that paragraph 1 of the disclosure use more plain language to describe the differences between ACA plans and short-term plans. The commenter suggested alternate language to state, "ACA plans cover preexisting

conditions and comprehensive health benefits such as hospitalization, emergency services, maternity care, preventive care, prescription drugs and mental health and substance use disorder services," or "ACA plans have comprehensive coverage."

Agency Response.

The department agrees that paragraph 1 of the disclosure form should use more plain language in its terminology. The department changed paragraph 1 to explain that, unlike ACA plans, a short-term limited-duration plan may not cover all injuries or sicknesses, including any that a prospective enrollee may have before applying. The department also reformatted the information using bullets and added a statement to indicate that short-term plans don't qualify for tax credits and cost-sharing reductions.

Comment on Figure: 28 TAC §3.3602(e).

A commenter raises a concern that the language in paragraph 3 concerning an individual's right to renew a plan and protection against health-based rate increases may blur the lines between short-term limited-duration insurance and qualified health plan coverage.

Agency Response.

The department disagrees and declines to make a change to the disclosure form. The language as written accurately describes the protections put in place under §3.3602(d). Paragraph 1 of the form highlights key differences between short-term limited-duration insurance and ACA plans and paragraphs 4, 9, and 12 also clarify how the short-term limited-duration insurance plan is different from an ACA plan.

Comment on Figure: 28 TAC §3.3602(e).

Two commenters suggest informing consumers that subsidies may be available for consumers to enroll in an ACA plan.

Agency Response.

The department agrees and changed paragraph 1 of the disclosure form to indicate that short-term limited-duration plans are not eligible for federal assistance.

Comment on Figure: 28 TAC §3.3602(e).

A commenter states that the word "to" is missing in paragraph 3 between the words "right" and "renew."

Agency Response.

The department agrees and added the word "to."

Comment on Figure: 28 TAC §3.3602(e).

One commenter recommends including more information on qualifying life events that enable an individual to get an ACA plan, special enrollment periods, and subsidies. The commenter also recommends adding information to better understand about a potential gap in coverage. The commenter recommends language that states "If you want to sign up for a health plan covered by ACA laws: You can sign up for another plan only during open enrollment or if you have a qualifying life event, such as losing coverage from a job or having a baby. You may be able to get extra help paying for premiums and out-of-pockets costs that are not available with short-term plans. The next open enrollment dates for ACA plans are: (dates listed). When you sign up for a plan during HealthCare.gov open enrollment dates, your insurance coverage will start on the following January 1. To find out if you have a qualifying life event (such as losing coverage through your job, parent or spouse or changes to your family like getting married or having a baby) talk to

your insurance agent or go to HealthCare.gov. The end of this short-term plan is not a qualifying life event, so you may have to wait until the next open enrollment period to sign up for an ACA plan."

Agency Response.

The department agrees that additional information about applying for an ACA plan outside of the open enrollment period is important information for a consumer to understand. The department changed paragraph 4 of the disclosure form to provide information on how to find out about a qualifying life event and examples of those events.

Comment on Figure: 28 TAC §3.3602(e).

Two commenters emphasize the importance of helping consumers understand the risk of balance billing in indemnity plans. Another commenter states the importance of balance billing information with respect to "(m) primary care" and a "(n) specialist office visit." One commenter also states that the first and third answers fail to provide consumers with information regarding the fact that their provider or specialty facility may be entirely out-of-network, leaving the consumer with the responsibility of paying the entire cost of care. One commenter recommends language for paragraph 8 in the disclosure form that states, "No. Your coverage is the same, no matter what doctor/provider you use. No providers have agreed in advance to accept the reimbursement from this short-term plan as payment in full. Doctors/providers can bill you directly for any amount the plan does not pay."

Agency Response.

The department agrees that it's important that consumers understand the potential of balance billing in an indemnity plan and changed the information in Section 8. Other disclosure requirements regarding balance billing apply to short term plans that

constitute preferred provider benefit plans (PPOs) and exclusive provider benefit plans (EPOs) under 28 TAC §3.3705 and Insurance Code Chapters 1301 and 1456.

Comment on Figure: 28 TAC §3.3602(e).

A commenter states that Section 8 of the disclosure form requires insurers to state whether a provider network exists for a given plan, but it does not tell consumers where to look for more information about the comprehensiveness of the networks. The commenter states that the department should require insurers to make information about provider networks available prior to purchase, which could include a link to their online provider-lookup tool. Two commenters recommend requiring issuers to include information about provider networks and the URL to the online provider directory within the disclosure form.

Agency Response.

The department agrees that this is important information for a consumer purchasing a short-term limited-duration plan and notes that Insurance Code §1451.505 requires health plans to provide an online directory and to include a link to the directory in the electronic summary of benefits and coverage. Since federal law does not require a short-term limited-duration plan to provide a summary of benefits and coverage, it is appropriate to include the network information in this disclosure document.

Comment on Figure: 28 TAC §3.3602(e).

A commenter expresses concern for the question asking about the maximum amount the plan will pay for services. The commenter explains that this question can be misleading to consumers. As an example, the commenter explains that many short-term limited-duration plans may have a maximum cap of $2 million for covered services, which

will sound reasonable to a consumer. However, the commenter states that it is unlikely that any consumer would ever reach that cap due to the inadequacy of the plan's benefit design and likelihood that a consumer would pay for most of their care out-of-pocket if diagnosed with a serious illness.

Agency Response.

The department declines to make a change to paragraph 6, because this information is required by Insurance Code §1509.002(b)(5). The information in the chart in paragraph 9 provides more detailed information about plan limits and the department clarified that the chart must include any applicable benefit maximums.

Comment on Figure: 28 TAC §3.3602(e).

One commenter states that it should be clear to the consumer whether the deductible applies for the term of the plan or on an annual basis. The commenter also states that consumers should be informed if the deductible resets during the plan's duration.

Agency Response.

The department agrees and clarified the instructions to state that if the deductible can reset more frequently than annually, this must be disclosed.

Comment on Figure: 28 TAC §3.3602(e).

A commenter raises concern about consumers understanding that in some cases the consumer would be responsible for the entire cost of care if their provider, or specialty facility, is entirely out-of-network.

Agency Response.

The department declines to make a change. The EPO statement makes clear that the plan covers care only from in-network providers, with the exception of emergency care and some other situations.

Comment on Figure: 28 TAC §3.3602(e).

A commenter recommends that insurers be instructed to include any specific dollar cap on per-service reimbursement within the table. For example, if a plan will cover only $100 per day for a hospital stay and cover only a total of $1,500 per confinement, the table must indicate that.

Agency Response.

The department agrees and modified the instructions in the chart to clarify that applicable limitations include benefit maximums.

Comment on Figure: 28 TAC §3.3602(e).

A commenter states that several short-term limited-duration plans only cover prescription drugs during an inpatient hospitalization, and recommends that the language for row (o) clarify that the coverage in question is for outpatient prescription drugs. Two commenters recommend requiring formulary information, including a URL link to the formulary, to be included in the chart. One commenter recommends that if the plan uses a discount card or similar model, the consumer must be informed that they may be responsible for out-of-pocket costs.

Agency Response.

The department agrees and expands the description for row (o) to read "drugs ordered by your doctor (outpatient prescription drugs)." The department clarifies that if the outpatient drug coverage is limited by a formulary, that information must be stated,

and a link to the formulary must be provided. Since a discount card is not insurance coverage, the instructions clarify that it should not be represented as such, but the availability of the discount plan may be stated.

Comment on Figure: 28 TAC §3.3602(e).

A commenter states that, although short-term limited-duration plans do offer prescription drug coverage, the cap can be as low as seven thousand dollars for the duration of the plan. The cost of a drug for cancer treatment could easily reach that cap in a month. The commenter recommends requiring issuers to provide dollar amounts and certain types of contextual details in the disclosure plan.

Agency Response.

The department declines to make this change to row (o) in the chart. The disclosure form requires issuers to explain any applicable limitations, exceptions, or other important information about the nature of coverage. The department added clarification to the instructions for the chart explaining that applicable limitations includes benefit maximums.

Comment on Figure: 28 TAC §3.3602(e).

A commenter references paragraph 9 of the disclosure form, which states that "[w]hile ACA plans cover all listed benefits with few limits, this plan may limit coverage for some types of care." The commenter states that considering that every short-term limited-duration plan on the market in Texas limits some aspect of coverage, and says the department should change "may limit" to "limits."

Agency Response.

The department agrees with the recommendation and has modified paragraph 9 by replacing "may limit" with "limits."

Comment on Figure: 28 TAC §3.3602(e).

A commenter recommends requiring issuers to include cost-sharing information in the chart for each benefit. The commenter notes that as proposed, including cost-sharing information in the disclosure document is optional.

Agency Response.

The department declines to require inclusion of cost-sharing information, since issuers may use other documents to describe the coverage. However, the department did change paragraph 9 to inform the consumer that they may ask for this information if it is not included in the chart. Issuers are also permitted to include cost-sharing information and to combine the disclosure form with the outline of coverage under new 28 TAC §3.3602(f)(4) and (5).

Comment on Figure: 28 §3.3602(e), §3.3602(g)(2), and (3).

A commenter states support for the requirement to provide the disclosure form to the prospective enrollee in writing before the individual completes an application or makes an initial payment. The commenter recommends that either, as part of the affirmation that a consumer read and understood the disclosure form, or separately, a consumer should affirm that they received the disclosure form in writing before they completed the application or made any payment.

Agency Response.

The department appreciates the support. The department also agrees about the affirmation and changed paragraph 10 of the disclosure form to include information

about receiving the disclosure form in writing before completing the application or making any payment.

Comment on Figure: 28 TAC §3.3602(e).

A commenter urges the department to include the department's contact information on the disclosure form so that consumers know who to contact if they experience problems with the plan.

Agency Response.

The department agrees with the recommendation and has modified the disclosure form to include the department's consumer help line phone number and website address under paragraph 11.

Comment on Figure: 28 TAC §3.3602(e).

A commenter requests that the department ensure language access as part of the disclosure rule, by: translating the final disclosure to Spanish and requiring insurers to complete and make the disclosure available in Spanish, at a minimum; on the English-language form, including a short note in Spanish that the consumer may request the alternate Spanish-language disclosure; and requiring agents who are communicating with a consumer in a language other than English to automatically provide the disclosure in that language without the consumer having to request it, if the department has made a disclosure form in that language available.

Agency Response.

The department agrees in part and has modified the disclosure to include a statement in Spanish and English before the signature line that states, "Don't sign this document if you don't understand it." The department also encourages issuers to produce

and file translated versions of the form and to ensure agents provide appropriate assistance to consumers. Consistent with §3.4004(h), foreign language versions of a previously approved form can be filed on an exempt basis.

Comment on §3.3602(f)(1).

Two commenters state that the requirement of one disclosure form for each plan option should remain. A commenter states that this requirement will help reduce confusion as consumers compare products.

Agency Response.

The department appreciates the support.

Comment on §3.3602(f)(3).

A commenter states that the requirement in §3.3602(f)(3) providing that if a carrier modifies the disclosure form it must clearly identify and explain changes to facilitate the department's review should remain.

Agency Response.

The department appreciates the support.

Comment on §3.3602(f)(3).

A commenter raises concern that the ability of issuers to modify the disclosure form could lead to confusion for consumers. The commenter requests that the department remove the modification provision or, if the provision must be kept, to allow form modifications only during a predetermined annual period, to require public disclosure of requested modifications, and to clarify the factors to be used in evaluating modification requests.

Agency Response.

The department declines to make a change. Since the form must be filed for review, the department can ensure that modifications only serve to more accurately describe the coverage, and do not create confusion for consumers.

Comment on §3.3602(f)(5).

A commenter states that the requirement in §3.3602(f)(5) providing the required order of a combined disclosure and outline of coverage should remain.

Agency Response.

The department appreciates the support.

Comment on §3.3602(f)(5).

A commenter recommends clarifying the title from the short-term plan disclosure on any combined document.

Agency Response.

The department agrees to make a change, and it has changed the instructions in §3.3602(f)(5)(A) for combining the forms, to include the title, the plan marketing name, and name of the issuer. This change clarifies that this information must precede paragraph 1 of the outline of coverage.

Comment on §3.3602(g)(1).

A commenter states that the requirement to file the disclosure form for department review before use should remain.

Agency Response.

The department appreciates the support.

Comment on §3.3602(g)(2).

A commenter states that the requirement to provide a disclosure form in writing to a prospective enrollee before completing an application or paying any fees should remain.

Agency Response.

The department appreciates the support.

Comment on §3.3602(g)(3).

A commenter states that the requirement for the enrollee's signature on the disclosure at application should remain.

Agency Response.

The department appreciates the support.

SUBCHAPTER W. MISCELLANEOUS RULES FOR GROUP AND INDIVIDUAL ACCIDENT AND HEALTH INSURANCE

28 TAC §3.3602

STATUTORY AUTHORITY. The Commissioner adopts 28 TAC §3.3602 under Insurance Code §§1201.006, 1201.101(a), 1201.108(b), 1202.051, 1251.008, 1509.002, and 36.001.

Insurance Code §1201.006 provides that the Commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Chapter 1201.

Insurance Code §1201.101(a) provides that the Commissioner adopt reasonable rules establishing specific standards for the content of an individual accident and health

insurance policy and the manner of sale of an individual accident and health insurance policy, including disclosures required to be made in connection with the sale.

Insurance Code §1201.108(b) provides that the Commissioner prescribe the format and content of an outline of coverage required by §1201.107.

Insurance Code §1202.051(d) provides that the Commissioner adopt rules necessary to implement §1202.051 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1251.008 provides that the Commissioner may adopt rules necessary to administer Chapter 1251.

Insurance Code §1509.002 provides that the Commissioner by rule prescribe a disclosure form to be provided with a short-term limited-duration insurance policy and application, that the disclosure form prescribed by rule may include any other information the Commissioner determines is important for a purchaser of a short-term limited-duration insurance policy, and that the rule must allow for electronic acknowledgement.

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

TEXT.

§3.3602. Requirements for Short-Term Limited-Duration Coverage.

(a) The purpose of this section is to define short-term limited-duration insurance and address requirements for short-term limited-duration coverage. This section applies to any individual or group accident and health insurance policy or certificate issued under Insurance Code Chapters 1201 or 1251.

(b) For the purposes of Chapters 3, 21, and 26 of this title, "short-term limited-duration insurance" has the meaning given in Insurance Code §1509.001.

(c) An individual policy or group certificate of short-term limited-duration insurance must provide benefits consistent with the minimum standards for the type of coverage offered.

(d) Short-term limited-duration coverage, including individual policies and group certificates:

(1) may not be marketed as guaranteed renewable;

(2) must be marketed either as nonrenewable, or renewable (without new underwriting) at the option of the policyholder or enrollee, if the enrollee contributes to the premium;

(3) must clearly state the duration of the initial term and the total maximum duration including any renewal options;

(4) may not be modified after the date of issue, except by signed acceptance of the policyholder or the enrollee, if the enrollee contributes to the premium; and

(5) if coverage is renewable, a short-term limited-duration individual policy or group certificate must:

(A) include a statement that the enrollee has a right to continue the coverage in force by timely payment of premiums for the number of terms listed;

(B) include a statement that the issuer will not increase premium rates or make changes in provisions in the policy, or certificate, on renewal based on individual health status;

(C) if applicable, include a statement that the issuer retains the right, at the time of policy renewal, to make changes to premium rates by class; and

(D) include a statement that the issuer, at the time of renewal, may not deny renewal based on individual health status.

(e) An issuer offering short-term limited-duration insurance must include an accurate written disclosure form that is consistent with the form and instructions prescribed in Figure: 28 TAC §3.3602(e) and the requirements of this section.

Figure: 28 TAC §3.3602(e):

"Is this short-term health insurance plan right for me?"

"** You must read and sign this form. **"

<< Instructions to issuers:

- Required text is in quotation marks—remove quotation marks on your form.
- Except for contents of quotation marks, do not print the text inside two chevrons ('<<' and '>>') on the form you give to consumers.
- Content in brackets contain options. You must choose one of the options. Remove brackets on the form you give to consumers.
- Paragraph numbers and letters that are not within quotation marks and that are in bold font and enclosed in parenthesis like this **(X)** are for reference purposes only. Do not print the paragraph numbers and letters on the form you give to consumers.
- The mark X indicates the places you need to enter a number.
- The mark YYYY indicates the places you need to enter a year.
- You must use spacing of six points or more between bullets and paragraphs.
- You must bold text as indicated.
- Per statute, this form must be printed in 14-point font. >>

"**Plan name:**" <<Enter the plan marketing name>>

"**Offered by:**" <<Enter the name of issuer that is underwriting the coverage>>

(1) "This plan does not need to follow federal Affordable Care Act (ACA) rules. Unlike ACA plans, this short-term plan:

- May not cover all injuries or sicknesses, including any you have before applying.
- May not pay for some medical care you might need.
- Doesn't allow you to get federal help with premiums or out-of-pocket costs (tax credits and cost-sharing reductions).

Carefully read the information below so you know this plan's coverage limits and your rights under this plan."

(2) "How long will this plan cover me?"

<< Enter the number of days or months coverage will last under the initial term without any action by the consumer, assuming no fraud, misrepresentations, or failure to pay premiums. >>

"X ['days' or 'months']"

(3) "Can I renew or extend this plan?"

<< If the answer is 'No,' use: >>

"No."

<< Or, if the answer is 'Yes,' use: >>

"Yes. You have the right to renew the plan X times. But the total amount of time you can be covered by this plan is limited to X ['days,' 'months,' or 'years']. The amount of your premium payment might change after you renew this plan. But the amount can't go up because of a change in your health. A change in your health can't affect your benefits or your right to renew."

<< Also explain any other option to extend the plan. >>

(4) "When this plan ends, can I sign up for another insurance plan?

- **If you want to sign up for another short-term health plan or another plan not covered by ACA laws:** You can sign up for another plan at any time. But a short-term health plan can deny you for health reasons. The amount of your premium payment might change.
- **If you want to sign up for a health plan covered by ACA laws:** You can sign up for another plan only during open enrollment or if you have a qualifying life event (like losing coverage from your job or having a baby). To find out if you have a qualifying life event, talk to your insurance agent or go to HealthCare.gov."
    - The next open enrollment dates for ACA plans are:" << To the extent possible, enter the dates of the next three open enrollment periods following the date the initial term of the policy expires. Enter the dates using the format shown below. >>

      "**YYYY:** [Month] [day] to [Month] [day]

      YYYY: [Month] [day] to [Month] [day]

      YYYY: [Month] [day] to [Month] [day]
    - When you sign up for a plan during HealthCare.gov open enrollment dates, your insurance coverage will start January 1.
    - **The end of this plan is not a qualifying life event. You may have to wait until the next open enrollment period to sign up for an ACA plan.**"

(5) "Am I covered for an injury, illness, or disease I had before I applied for this plan (a preexisting condition)?"

"Yes." << If the answer is 'Yes' and there are limitations or exclusions, explain them here. >>

<< If the answer is 'No'—preexisting conditions are excluded in full or in part, use: >>

"No.

- You must tell the truth when answering questions about your health.
- We can deny claims for any injury, illness, or disease you had before signing up for this plan (whether or not you tell us about your condition)."

(6) "What is the most (maximum) this plan will pay for services?"

<< Provide the policy term amount and, if applicable, provide the lifetime limit amount.

If there is only a policy term amount, use: >>

"$X"

<< If there is a policy term amount and a lifetime limit amount, use: >>

"Policy term: $X

Lifetime limit: $X"

(7) "What is the deductible (the amount I must pay for services before this plan starts paying)?"

<< If the plan is not a PPO, use: >>

"You must pay $X (plus your premiums) before the plan will start paying for services."

<< Specify any services that are exempt from the deductible or that have different deductibles. If the deductible can reset more frequently than annually, this must be disclosed.

If the plan is a PPO, use: >>

"You must pay the following (plus your premiums) before the plan starts paying for services:

- $X for in-network services.
- $X for out-of-network services."

<< Specify any services that are exempt from the deductible or that have different deductibles. If the deductible can reset more frequently than annually, this must be disclosed. >>

(8) "Does this plan use a network of doctors / providers?"

<< Choose the applicable answer below. >>

"Yes, the plan is a PPO (preferred provider benefit plan) and has a network of doctors / providers. You can get care from in-network and out-of-network providers. Your costs are usually lower when you use in-network providers.

View the plan's list of in-network doctors / providers:" << Provide a website address to the plan directory or provide other information on how to locate providers. >>

<< or >>

"Yes, the plan is an EPO (exclusive provider benefit plan) and has a network of doctors / providers. Except for emergency care and some other situations, the plan covers care only from in-network providers.

View the plan's list of in-network doctors / providers:" << Provide a website address to the plan directory or provide other information on how to locate providers. >>"

<< or >>

"No. Your coverage is the same, no matter what doctor / provider you use. But the amounts the plan will pay might be less than providers charge for

care. Doctors / providers can bill you directly for any amount the plan does not pay."

<< As applicable, include either: >>

"No providers have agreed in advance to give care at a set price with this plan."

<< or >>"The plan has a network of providers, but you are not limited by this list. If you choose an in-network provider, they will charge you a discounted price. View the plan's list of in-network doctors / providers:" << Provide a website address to the plan directory or other information on how to locate providers. >>

(9) "What type of care will this plan cover?"

"Review the chart below to know which benefits are covered by this plan. ACA plans cover all listed benefits with few limits, but this plan limits coverage for some types of care."

<< The chart below may be supplemented to include cost-sharing information for each benefit. If cost-sharing is not included, state: >>

"The chart below does not include your copay and coinsurance amounts. Ask your agent or the plan for this information."

"Type of care"	**"Is it covered?"**
<< This row is only for instructions. Remove this row on the copy you give to consumers. >>	<< For each benefit listed in the rows below, choose the applicable language: >> "Yes, coverage is like ACA plans." << or >> "Yes, but there are some limits." << or >> "No" << Explain any applicable limitations (including benefit maximums), exceptions, or other important information about the nature of coverage. >>
(a) "Emergency room visit"	<< Use the same instructions given in the first row of this column. >>
(b) "Urgent care"	<< Use the same instructions given in the first row of this column. >>
(c) "Ambulance"	<< Use the same instructions given in the first row of this column. >>
(d) "Hospital stay – facility fee (inpatient – overnight stay)"	<< Use the same instructions given in the first row of this column. >>

"Type of care"	**"Is it covered?"**
(e) "Hospital stay – doctor services (inpatient – overnight stay)"	<< Use the same instructions given in the first row of this column. >>
(f) "Day surgery – facility fee (outpatient – no overnight stay)"	<< Use the same instructions given in the first row of this column. >>
(g) "Day surgery – doctor services (outpatient – no overnight stay)"	<< Use the same instructions given in the first row of this column. >>
(h) "Mental health services (inpatient – overnight stay)"	<< Use the same instructions given in the first row of this column. >>
(i) "Mental health services (outpatient – no overnight stay)"	<< Use the same instructions given in the first row of this column. >>
(j) "Alcohol / drug / substance abuse services (inpatient – overnight stay)"	<< Use the same instructions given in the first row of this column. >>
(k) "Alcohol / drug / substance abuse services (outpatient – no overnight stay)"	<< Use the same instructions given in the first row of this column. >>

"Type of care"	**"Is it covered?"**
(l) "Preventive care (includes regular checkups, and some screenings and vaccines)"	<< Use the same instructions given in the first row of this column. >>
(m) "Primary care (office visit to treat an injury or illness)"	<< Use the same instructions given in the first row of this column. >>
(n) "Specialist care office visit" (Doctors who treat one type of health issue. Examples: cancer, skin issues, allergies, heart issues, or kidney issues.)	<< Use the same instructions given in the first row of this column. >>
(o) "Drugs ordered by your doctor (outpatient prescription drugs)"	<< Use the same instructions given in the first row of this column. And if the answer is 'yes' and coverage is limited to a formulary, include: >> "View the plan's list of covered drugs:" << Provide a website address to the list of covered drugs or provide information on how to get the list. And if answer is 'no,' but a discount plan is offered, that may be stated but it should not be represented as coverage. >>

"Type of care"	**"Is it covered?"**
(p) "Services for a pregnant woman: prenatal office visits"	<< Use the same instructions given in the first row of this column. >>
(q) "Services for a pregnant woman: delivery – doctor services"	<< Use the same instructions given in the first row of this column. >>
(r) "Services for a pregnant woman: delivery – facility fee"	<< Use the same instructions given in the first row of this column. >>

(10) "You must confirm you read and understand this form:"

"Did you read and understand the limited benefits offered by this plan before you applied or paid for coverage?

☐ Yes, I read and understand the benefits and limits of this plan. I was not required to make a payment or apply for this policy before getting this disclosure form.

Don't sign this document if you don't understand it.
No firme este documento si no lo comprende."

"Type or sign your name:

_____

Date:

_____"

(11) "Have a complaint or need help?

To check if an agent has a license or to file a complaint, go to the Texas Department of Insurance's website at **www.tdi.texas.gov** or call 1-800-252-3439."

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(12) "Federal notice: This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."

(f) In creating a disclosure form, issuers must follow all instructions provided in this subsection:

(1) The disclosure must be produced for each plan option that the issuer makes available and reflect the specific terms of the plan.

(2) The disclosure form must accurately represent the short-term limited-duration coverage being provided.

(3) If the disclosure form provided in Figure 28 TAC §3.3602(e) does not accurately represent the plan being offered, the issuer may modify the form as necessary. When filing the form with the department, the issuer must clearly identify any changes made and explain the reason for modifying the form.

(4) The chart under disclosure form paragraph (9) may be supplemented to include cost-sharing information for each benefit.

(5) The disclosure form provided in Figure 28 TAC §3.3602(e) (the disclosure form) may be combined with the outline of coverage required under §3.3093(4) of this title (the outline of coverage) only if the combined disclosure form and outline of coverage is assembled and combined in the following order:

(A) "Is this short-term health insurance plan right for me?" followed by the plan marketing name, name of issuer, and paragraph (1) of the outline of coverage;

(B) paragraph (2) of the outline of coverage is replaced with paragraphs (1) through (8) of the disclosure form;

(C) paragraph (3) of the outline of coverage is combined with paragraph (9) of the disclosure form, using as a minimum, the information contained in the chart in paragraph (9) of the disclosure form;

(D) paragraph (4) of the outline of coverage;

(E) paragraph (5) of the outline of coverage may be removed, as it is addressed in paragraph (3) of the disclosure form;

(F) paragraph (6) of the outline of coverage; and

(G) paragraphs (10), (11), and (12) of the disclosure form.

(g) A disclosure form under this section must be:

(1) filed with the department for review before use, consistent with filing procedures in Subchapter A of this chapter;

(2) provided in writing to a prospective enrollee:

(A) before the individual completes an application or makes an initial premium payment, application fee, or other fee; and

(B) at the time the policy or certificate, is issued; and

(3) signed by the enrollee to acknowledge receipt at the time of application. An electronic signature is acceptable if the issuer's procedures comply with Insurance Code Chapter 35.

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

Issued at Austin, Texas, on December 27, 2019.

/s/ Justin Beam
Justin Beam
Chief Clerk and Assistant General Counsel
Texas Department of Insurance

The Commissioner adopts new 28 TAC §3.3602.

/s/ Kent C. Sullivan
Kent C. Sullivan
Commissioner of Insurance

Commissioner's Order No. **2019-6189**