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

INTRODUCTION. The Texas Department of Insurance proposes 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 proposed section also provides consumer protections related to renewability and provides consumers notice of the protections they have when purchasing such products.

EXPLANATION. Proposed 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). Proposed new §3.3602(a) describes the purpose of the proposed new section, which is to define short-term limited-duration insurance and requirements for short-term limited-duration coverage. Proposed new §3.3602(a) also provides that the proposed new 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). Proposed 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 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). Proposed new §3.3602(c) provides that a policy or certificate must provide benefits consistent with the minimum standards for the type of coverage offered. Proposed new §3.3602(c) is included to clarify 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). Proposed new §3.3602(d) provides the requirements for individual and group short-term limited-duration coverage.

Proposed new §3.3602(d)(1) provides that short-term limited-duration coverage may not be marketed as guaranteed renewable. Proposed new §3.3602(d)(1) is included 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.

Proposed new §3.3602(d)(2) provides that short-term limited-duration coverage must be marketed either as nonrenewable, or as renewable at the option of the policyholder or enrollee, if the enrollee contributes to the premium. Proposed new §3.3602(d)(2) allows issuers to choose whether to issue short-term limited-duration plans that are either nonrenewable or renewable and to ensure 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.

Proposed 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. Proposed new §3.3602(d)(3) helps ensure that prospective enrollees are fully informed regarding how long they can keep the coverage.

Proposed 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. Proposed new §3.3602(d)(4) ensures that the enrollee is informed and accepts the changes in coverage. Proposed new §3.3602(d)(4) also ensures that an issuer does not circumvent the policy terms of renewability by unilaterally modifying the coverage.

Proposed new §3.3602(d)(5) provides requirements for renewable, short-term limited-duration coverage. Proposed new §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. Proposed new §3.3602(d)(5)(A) provides for the enrollee to be informed about the enrollee's right to continue coverage when timely premium payments are made.

Proposed 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. Proposed new §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.

Proposed 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. Proposed new §3.3602(d)(5)(C) is included to make 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.

Proposed 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. Proposed new §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). Proposed 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 proposed Figure: 28 TAC §3.3602(e) and the requirements of this proposed section. Proposed new §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 proposed disclosure form includes a statement that the plan is exempt from the federal Affordable Care Act and may not cover all necessary care. This information informs prospective enrollees about possible benefit limitations.

Along with information about renewability, the proposed form states that "[t]he amount of your premium payment might change after you renew your 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 proposed new §3.3602(d)(2) and (5).

Along with the open enrollment information, the proposed 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 proposed 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 proposed form includes information on whether the plan uses a provider network. This information helps to ensure prospective enrollees understand the nature of coverage and whether limits apply based on their choice of provider.

The proposed 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 proposed 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. Finally, the form includes the text of the federally-required notice.

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.

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

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

Proposed 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. Proposed 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 plan options.

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

Proposed new §3.3602(f)(3) provides that if the disclosure form in proposed 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. Proposed new §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.

Proposed 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. Proposed new §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.

Proposed 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 §3.3093(4) of this title if certain requirements are met. Proposed new §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. The ability to combine the documents eliminates what would otherwise be duplicative disclosure requirements and enables a more streamlined approach.

Section 3.3602(g). Proposed 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.

Proposed 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 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. Proposed new §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.

Proposed 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.

Proposed 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 to 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.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, manager of the Life and Health Lines Office, has determined that during each year of the first five years the proposed new section is in effect, there will not be a fiscal impact on state and local governments as a result of enforcing or administering the section, other than that imposed by the statute. This determination was made because the proposed new section does not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed new section.

Ms. Bowden anticipates no measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new section is in effect, Ms. Bowden expects that administering the proposed section will have the public benefit of ensuring that the department's rules conform to Insurance Code Chapter 1509. The proposed section also provides consumer protections related to renewability. Finally, the proposed section gives prospective enrollees adequate notices of their protections concerning short-term limited-duration insurance.

Ms. Bowden expects that the proposed new section will impose an economic cost on persons required to comply with the new section. The cost of compliance results from disclosure and acknowledgment requirements under Insurance Code §1509.002(a) and (c). It is not clear how much of an economic cost the rule will impose on persons required to comply with the new section. Before January 1, 2020, issuers in Texas will not be permitted to sell short-term health insurance products that could last, including any renewals, beyond a year. Under Insurance Code Chapter 1509, issuers will be able to modify their products to be renewed up to a total of three years. Although this results in a benefit to issuers, they will also incur a new cost by following signed disclosure requirements prescribed by the department.

Issuers could face some administrative computer programming costs associated with drafting the content of the disclosure information and integrating it into their electronic systems, distributing it with policies and applications, and obtaining and retaining enrollee signatures. Issuers might also have to modify their marketing materials. Although the department will not impose a filing fee, a fee of up to $13.50 will apply when the disclosure form is filed with the department through the System for Electronic Rate and Form Filings (SERFF).

Issuers' staff costs may vary depending on the skill level required, the number of staff required, and the geographic location where the work is done. The 2018 median

hourly wages for workers in Texas are reported by the Texas Wages and Employment Projections database and developed and maintained by the Labor Market and Career Information Development Department of the Texas Workforce Commission. The department used this information to estimate labor costs. This information can be found at www.texaswages.com/WDAWages.

Issuers may calculate the total cost of labor for each category by multiplying the number of estimated hours for each component by the median hourly wage for each category of labor. The median hourly wage for a computer programmer is $40.86. The median hourly wage for an administrative assistant is $16.47.

Administrative expenditures could also include postage and the cost of printing new disclosure forms or revising outlines of coverage forms that include the disclosure information. It is not feasible for the department to estimate the total increased printing, copying, mailing, and transmitting costs related to compliance with this proposal because there are many factors involved that are not quantifiable by the department. But according to the United States Postal Service business price calculator, available at www.dbcalc.usps.gov, the current cost to mail a machinable letter in a single standard business mail envelope with a weight of 3.5 ounces to a standard five-digit ZIP code in the United States is $1.15. The department estimates that a standard business envelope costs 1.6 cents. The department further estimates that printing or copying costs between six to eight cents per page. The department believes that mailing costs can be avoided by providing the disclosure information with the outline of coverage at the time of issuance or renewal.

The department estimates that preparing the disclosure form as a stand-alone document or changing the outline of coverage form to include the disclosure information will likely require a one-time cost for approximately two to 10 hours of administrative staff

time. The cost will vary depending on whether an administrative assistant, a computer programmer, or a combination of both positions, perform these functions.

Additionally, issuers that choose to permit renewals will be required to allow renewal at the option of the enrollee, without increasing rates based on individual health status. This could be expected to minimally increase expected claims costs when compared to making renewal at the option of the issuer. However, the department is unaware of any issuers currently that do not give the renewal option to the enrollee. If this is correct, there will be no additional cost to those issuers.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that the proposed new section will not have an adverse economic effect or a disproportionate economic impact on rural communities. As a result, and in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis to address them.

The department has determined that the proposed new section may have an adverse economic effect or a disproportionate economic impact on small or micro businesses. The cost analysis in the Public Benefit and Cost Note section of this proposal also applies to these small and micro businesses. The department estimates that the proposed new section may affect at least thirteen issuers that currently offer short-term limited-duration coverage, including an estimated one to three small or micro businesses. In 2018, only one of the affected issuers had less than $6 million in premium revenue, and only two issuers were independently owned. The primary objectives of this proposal are to require disclosures and protections related to short-term health insurance products. The department considered the following alternatives to minimize any adverse impact on small and micro businesses while accomplishing the proposal's objectives:

(1) The department considered not proposing the new section. This would not comply with Insurance Code §1509.002(a), which requires the Commissioner to adopt a disclosure form by a rule. Not requiring the filing of the disclosure would violate Insurance Code §31.002(3), which requires the department to ensure that the Insurance Code is executed. If the department permitted policies advertised as renewable to be renewed only at the discretion of the issuer, the department's rules would not comply with Insurance Code §31.002(4), which requires the department to protect and ensure the fair treatment of consumers.

(2) The department also considered exempting small or micro businesses from the requirements of the rule. This would also prevent compliance with Insurance Code §1509.002(a), which applies regardless of the size of the regulated entity, and this would result in some prospective enrollees not receiving the disclosure required by the proposed section.

(3) The department also considered imposing different requirements on small or micro businesses. The department considered a shorter disclosure form for small or micro businesses, but this would provide less consumer protection without any material reduction of costs, because it would still impose costs similar or equal to those for the proposed disclosure form. The disclosure will likely only need to be filed once because it can be filed with variable language, allowing the filed disclosure to be produced for use with many different policies. Regarding the requirements related to renewability under proposed §3.3602(d), the department considered providing a longer implementation period for small or micro businesses, but rejected this option because it does not appear that any issuer, including any small or micro business, is currently offering policies renewable only at the option of the issuer. Given that issuers currently allow renewability at the option of the enrollee, small and micro business issuers may not need any additional implementation time.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that this proposal does impose a possible cost on regulated persons. However, no rule repeal or rule amendments are required under Government Code §2001.0045 because the proposed 28 TAC §3.3602 is necessary to implement legislation, which meets the exception under Government Code §2001.0045(c)(9). Specifically, the proposed rule implements Insurance Code §1509.002(a) and (c), as added by SB 1852, 86th Legislature, 2019.

Insurance Code §1509.002(a) and (b) requires that the Commissioner adopt by rule a disclosure form that contains specific information, including any other information the Commissioner determines is important for a purchaser of a short-term limited-duration insurance policy. The department has attempted to minimize the cost by not charging a state filing fee for the disclosure form.

The department does not believe the renewability requirement imposes a cost on issuers because issuers are currently unable to permit renewal beyond 12 months. Those that currently offer renewal of three- or six-month policies appear to do so at the option of the enrollee, consistent with what is proposed here. The department notes that the section gives an issuer the option to allow renewal, but at the option of the policyholder, or enrollee, if the enrollee contributes to the premium. The section does not restrict an issuer's ability to fully underwrite before the initial issuance of the policy, or to increase rates at renewal on a class basis. Even if giving this option to the prospective enrollee were to cause a cost for issuers, this protection for policyholders is necessary to protect the health, safety, and welfare of the residents of this state under §2001.0045(c)(6), because prospective enrollees could be left without health insurance coverage for significant periods of time. For example, a prospective enrollee could purchase a short-term policy on June 1, 2020, relying on the fact that the coverage could be renewed to

June 1, 2022, with the intent that they would change to major medical coverage during open enrollment in December of 2020 or 2021, if necessary. If a prospective enrollee becomes seriously ill on February 1, 2021, and the issuer has the option to deny renewal on June 1, 2021, the prospective enrollee could be without health insurance until January 1st, 2022, potentially resulting in significant harm to their health, safety, and welfare. The proposed section would give the prospective enrollee certainty in their planning. If the issuer offers a renewal option, the prospective enrollee will be able to take it if they need it.

GOVERNMENT GROWTH IMPACT STATEMENT. The department has determined that for each year of the first five years that the proposed new section is in effect the proposed rule:

- will not create or eliminate a government program;

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

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

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

- will create a new regulation;

- will not limit an existing regulation;

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

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or

limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. The department will consider any written comments on the proposal that are received by the department no later than 5:00 p.m., Central time, on December 9, 2019. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will also consider written and oral comments on the proposal in a public hearing under Docket No. 2817 at 10:00 a.m. Central time on November 15, 2019 in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

STATUTORY AUTHORITY. The department proposes §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.

CROSS-REFERENCE TO STATUTE. Section 3.3602 implements Insurance Code Chapter 1509, enacted by SB 1852, 86th Legislature, Regular Session (2019).

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 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. >>

(1) "This plan does not need to follow federal Affordable Care Act (ACA) rules. ACA plans cover hospital, medical, and surgical expenses due to an injury or sickness. Compared to ACA plans, this short-term plan may: (1) not cover all injuries or sicknesses, and (2) not pay for some medical care you might need. 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 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.
    - The next open enrollment dates 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.
- To find out if you have a qualifying life event, talk to your insurance agent or go to HealthCare.gov. **The end of this plan is not a qualifying life event.**"

(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, write: >>

"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?"

<< Include both the policy term amount and lifetime limit amount, if applicable. >>

(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 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. >>

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

<< Choose the applicable answer below. >>

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

<< or >>

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

<< or >>

"No. Your coverage is the same, no matter what doctor / provider you use." << If applicable, include: >> "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."

(9) "What services does the plan cover?"

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

<< The chart below may be supplemented to include cost-sharing information for each benefit. >>

"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, 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. >>
(l) "Preventive care (includes regular checkups, and some screenings and vaccines)"	<< Use the same instructions given in the first row of this column. >>

"Type of care"	"Is it covered?"
(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 (prescription drugs)"	<< Use the same instructions given in the first row of this column. >>
(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?

☐ Yes, I read and understand the benefits and limits of this plan."

"Type or sign your name:

_____

Date:

_____"

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(11) "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) 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) and (11) 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 in Austin, Texas, on October 28, 2019.

/s/ James Person
James Person, General Counsel
Texas Department of Insurance