SUBCHAPTER AA.
CONSUMER CHOICE HEALTH BENEFIT PLANS
DIVISION 3.
REQUIRED NOTICES
Repeal of 28 TAC §§21.3525 - 21.3528
28 TAC §21.3530 and §21.3535
DIVISION 4. ADDITIONAL REQUIREMENTS
28 TAC §§21.3542, 21.3543, and 21.3544

INTRODUCTION. The Commissioner of Insurance adopts the repeal of 28 TAC §§21.3525 - 21.3528 and the amendment of §§21.3530, 21.3535, 21.3542, 21.3543, and 21.3544, concerning required notices for consumer choice health benefit plans. The department adopts the repeal of §§21.3525 - 21.3528 and the amendments to §21.3542 and §21.3543 without changes to the proposed text published in the *Texas Register* on December 4, 2020, at 45 TexReg 8729. The department changed proposed §21.3530 and §21.3535 in response to public comments and made additional changes to these sections and §21.3544 to provide corrections and clarification and to improve conformity between sections.

REASONED JUSTIFICATION. The amended sections implement Insurance Code §1507.006, remove the renewal requirement for a consumer to sign a disclosure statement at renewal, remove the text of rules that duplicate statutory language, use plain language consistent with the agency's current style, simplify disclosure forms, and improve the disclosure forms' readability and usability. The amended sections also help address areas of consumer confusion that result from the current disclosure form.

Descriptions of the amendments to the sections follow.

Repeal of §§21.3525 - 21.3528. Insurer Notice on Application, Insurer Notice on Policy, HMO Notice on Application, and HMO Notice on Evidence of Coverage. The repeal of §§21.3525 - 21.3528 removes unnecessary duplication of Insurance Code §1507.005 and §1507.055.

Section 21.3530. Health Carrier Disclosure. The amendments to §21.3530 clarify the required elements of a written disclosure for consumer choice plans; provide that the disclosure should be provided in a manner that enables a consumer to retain a copy; remove the requirements for Form CCP 1 from subsection (a) and provide similar requirements in new subsection (c); provide that Form CCP 1 may be used to fulfill the requirements of the section and is available on the department's website; incorporate standards of readability into the disclosure forms; provide that Form CCP 1 is not adopted by reference, but can be used by carriers if they choose; contain the written affirmation moved from §21.3542; require a disclosure form signature for initial coverage or enrollment; use plain language consistent with the agency's current style; and redesignate parts of the section to conform to amendments. In response to comment, §21.350(a) as proposed has been modified to replace "sufficient description" with "sufficiently detailed description."

In response to comment, §21.3530(c) as proposed has been modified to provide more useful information in the disclosure statement; instruct consumers to refer to the Summary of Benefits and Coverage for more information; refer consumers to a health carrier's state-mandated plan if there is one available; allow for disclosures on the federal exchange to be delivered in the plan brochure on the healthcare.gov website and acknowledged by signing an application to enroll in a plan; substitute the phrase

"enrolling in coverage" for "renewing coverage;" and change internal designations and a reference to conform to the changes.

In addition, in response to comment, §21.3530(d) as proposed has been modified to remove the requirement that a disclosure statement be delivered at least 60 days before the renewal date.

Finally, in response to comment, §21.3530(e) as proposed has been modified to allow a health carrier in some instances to include the disclosure statement as the first page in the plan brochure provided on the healthcare.gov website.

In addition to the changes made to the proposed text in response to comment, the department has made the following changes to provide additional clarity, correct errors, and provide conformity within the text:

- eliminated a reference to a "paper copy" in proposed §21.3530(c) to conform with amendments allowing electronic copies;

- revised a reference in proposed §21.3530(c)(4) to correct a reference to a redesignated provision;

- eliminated a reference to a "current" policyholder in §21.3530(c)(4), since a signature is not required when coverage is renewed, and corrected a reference to conform to other changes made in subsection (c);

- revised §21.3530(c)(6) to remove the acknowledgment that the health carrier offered a state-mandated plan, and redesignate part of the paragraph, because this information is duplicative of the revised §21.3530(c)(5) and §21.3542;

- revised §21.3530(c)(8)- (9) and §21.3530(e)(2) to conform to revisions made to lessen confusion for consumers on the federal marketplace;

- added the word "and" to the end of §21.3530(d)(1);

- revised a reference in proposed §21.3530(g) to conform to revisions in §21.3530(e); and

- redesignated proposed §21.3530(i) - (k) as §21.3530(h) - (j) to conform to the elimination of proposed §21.3530(h).

Section 21.3535. Retention of Disclosure. The amendments to §21.3535 provide for retention of signed disclosure forms for five years; provide that insurers must retain copies of plan documents; substitute the term "electronically" for "by facsimile or email transmission;" and eliminate signatures on renewals where a current policyholder or contract holder is not required to sign a disclosure statement. In response to comment, §21.3535 as proposed has been modified to correct a reference to the written affirmation moved from §21.3542 to §21.3530.

Section 21.3542. Offer of State-Mandated Plan. Section 21.3542(d) is deleted because the requirement for a health plan to obtain an affirmation that it offered a plan containing all state mandates on a separate document was moved to the acknowledgments in §21.3530(c)(6).

Section 21.3543. Required Plan Filings. The amendments to §21.3543 incorporate a requirement similar to that in former §21.3530(i) that a disclosure form must be filed for approval; clarify that a consumer choice plan must be filed separately from any state-mandated plan; require that disclosures be separately filed for approval before use; and simplify the disclosure form.

Section 21.3544. Required Annual Reporting. Section 21.3544 is amended to change the annual reporting requirements for information on consumer choice plans and provide that data submission must be made on Form CCP 2. In subsection (a), the previous paragraphs (3), (5), and (6) are deleted. Previous paragraph (4) is renumbered as

paragraph (3), and new paragraph (4) is added as a better way to collect the information previously requested under §21.3543(2)(B). Also, the previous subsection (b) is deleted because it provided a definition for a reporting requirement that was repealed from subsection (a). New subsection (b) is added to establish what constitutes the average premium index rate for the purpose of subsection (a) of the section.

In addition, the department made the following changes to the proposed text to allow additional time for compliance with the amendments and to correct errors within the text:

- inserted the designator for paragraph (3) in §21.3544(a) to correct its inadvertent omission from the published proposal;

- revised proposed §21.3544 to change the reporting date to June 1 to provide additional time for health carriers to implement the modifications, to ensure data is complete and is aligned with the historical data provided on the federal Unified Rate Review Template, and to avoid more concurrent data calls for health carriers and staff; and

- revised proposed §21.3544 to clarify the data to be reported and to remove a form revision date inadvertently contained in the proposal.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: A commenter in support of the proposal was Every Texan. A commenter in support of the proposal with changes was the Texas Medical Association. Commenters against the proposal were the Texas Association of Health Plans and the Texas Association of Life & Health Insurers.

Comments on the Proposal in General

Comment. One commenter says it appreciates the department's efforts to draft a more understandable disclosure form. The commenter notes that the plain language in the new form is a big improvement over the previous version and that the wording within the table itself is far more likely to be understood and empower a consumer to make an informed choice. The commenter encourages the department to move forward with the proposed form update for the large-employer market and grandfathered individual and small-group plans only.

The same commenter notes that for many consumers on the federal exchange, the disclosure form will tell them they could pay more to get a different plan with less coverage during the next open enrollment period almost a year away. The commenter found this information to not be useful and not worth the confusion and alarm that some consumers report. The commenter also notes that for federal exchange consumers, the timing of the disclosure form causes it to be delivered after, rather than before, the close of the open enrollment period, and thus to not be useful in making a choice of plans. The commenter notes that given how fundamentally individual and small-group plans have changed since the Affordable Care Act (ACA), it would make sense to re-envision any consumer choice plan disclosure to reflect realities in the post-ACA world. The commenter offers several suggestions to develop a different approach to revising the disclosure form, including legislative changes and a stakeholder meeting to discuss alternate approaches. The commenter also recommends that the department revise the proposed rules to reduce consumer confusion by letting federal marketplace consumers know:

- that a plan is compliant with the ACA and contains all essential health benefits; and

- whether a state-mandated benefit plan referenced is available on or off of the federal marketplace, whether they could use any premium subsidy or cost sharing reduction (CSR) for that plan, and when and how they could switch to it if desired.

Another commenter says that the only change made by Senate Bill 1852, 86th Legislature, 2019 to Insurance Code Chapter 1507 was to eliminate the signature requirement for the consumer choice disclosure statement on renewal. The commenter says that the proposed amendments make unnecessary and unreasonable changes to a process that is working well, has not created unreasonable compliance challenges, and has not been the subject of consumer complaints. The commenter says that the proposed amendments would require extensive planning by health carriers and introduce needless expenses and challenges. The commenter says that the current consumer choice rules do not need to be updated because the provisions of SB 1852 are clear, and the commenter recommends that any new rulemaking be strictly limited to implementation of SB 1852.

A third commenter also says that the proposed amendments make unnecessary and unreasonable changes to a process that is working well. The commenter says that the proposed changes would create undue burdens on health carriers and are more likely to create more consumer confusion. The commenter notes that the disclosures can cause confusion among consumers on the federal marketplace.

Finally, all three commenters say that this confusion occurs particularly because of department rules providing that HMOs may have only deductibles in consumer choice plans.

Agency Response. The department appreciates the support for the proposed amendments.

The department has addressed the revisions suggested by the second and third commenters in its responses to comments on §21.3530(c)(1) and §21.3530(c)(5)(C), and by the revisions to §21.3530(e)(2) described in the following paragraphs. Since the signature requirement has been removed, it is unnecessary to advise federal marketplace consumers that a failure to sign and return the form under §21.3530(c)(8) will not result in a loss of coverage or subsidy.

In general, the department disagrees with the second and third commenters on the utility of the proposed amendments. Updating the disclosure requirements results in a more understandable and usable disclosure form, eliminates consumer confusion, and fits within the requirements of Insurance Code §§1507.005, 1507.006, and 1507.009 without creating undue burdens on health carriers.

The department agrees that the current disclosure statement and its timing may cause confusion for some consumers on the federal exchange and has revised proposed §21.3530(e)(2) and deleted proposed §21.3530(h) in response. The revisions eliminate requirements to mail a disclosure statement to be signed after the consumer has already applied for and become enrolled in a plan on the federal exchange and provide a link to the disclosure statement. Instead, the revised text allows health carriers to include the disclosure statement as the first page in the plan brochure provided on the Healthcare.gov website.

The department agrees with the first commenter's suggestions for improving the disclosure form and has expanded §21.3530(c)(1) to add language explaining, if applicable, that the plan includes federally required essential health benefits and complies with the ACA. The department also added §21.3530(c)(5)(C), which informs the consumer

whether the state-mandated plan is available on Healthcare.gov and explains whether the state-mandated plan will qualify for reduced premiums and cost sharing.

Comment on repeal of §§21.3525 - 21.3528

Comment. One commenter says that while the underlying statutory provisions (i.e., Insurance Code §1507.005 and §1507.055) contain the required statements that are proposed for repeal, retaining the language in the rules promotes health carrier compliance and consumer understanding of the requirements imposed on health carriers by presenting all the relevant language in one location, rather than requiring toggling back and forth between the Insurance Code and regulations. The commenter says that the current rules offer greater consumer protection than the statutory language because they impose a minimum font-size requirement for the required application and policy/evidence of coverage statements (i.e., no less than 12-point type), which is not expressly stated in the statute. The commenter says that if the department repeals §§21.3525 - 21.3528, health carriers may start reducing the font size of these important notices, resulting in fine-print notices that undermine both the conspicuousness and readability of the required statements.

Agency Response. The department disagrees with the commenter and declines to withdraw the repeal of §§21.3525 - 21.3528. The proposed amendments will not adversely affect health plan compliance or consumer understanding, but will instead make the disclosures easier to comprehend. Further, eliminating repetition of statutory requirements in the rules will aid health carrier compliance and consumer understanding, because this repetition has in the past caused statutes and rules to conflict and caused

confusion when the former are amended and the latter were not. The department also notes that requirements in 28 TAC §3.602 will prevent fine-print disclosures, since policies and applications must use at least a 10-point font size. Section 21.3530(c) also requires the disclosure form to use at least a 12-point font size.

Comment on §21.3530(a)

Comment. One commenter requests that Form CCP 1 be made mandatory and that the department modify the language in the proposed amendments and the form to also include a reference to Form CCP 1 in §21.3530(a). The commenter recommends that the department strike "sufficient" as the modifier of the description of state-mandated benefits that are reduced or not included in the plan and replace it with a requirement for a "sufficiently detailed" description to ensure that consumers receive all necessary information.

Two other commenters ask that the department confirm and clarify that the disclosure statement may be provided electronically, which will allow the applicant to print and keep a paper copy or retain an electronic copy.

Agency Response. The department declines to make Form CCP 1 mandatory. The department does not want to prevent health carriers from customizing disclosures to accurately describe their plans. The amendments to §21.3543 make clear that plans must file disclosures with the department for approval. This review ensures that disclosures will not be modified in a way that violates the rules or misleads consumers.

The department agrees that "sufficiently detailed" conveys the requirement the department proposed and has changed the text of §21.3530(a) as proposed to clarify the

subsection and make it clear the disclosure statement may be provided electronically. The department has made these revisions.

Comment on §21.3530(b) and (c)

Comment. One commenter notes that the department proposes to make the use of Form CCP 1 optional, though with some conditions. The commenter strongly objects, stating that the use of Form CCP 1 should be mandatory with no option to use a different disclosure form, because a single, uniform disclosure form would be more user friendly. The commenter says that a single, standard form would allow consumers to more easily compare disclosure forms from initial coverage to renewal and from plan to plan. The commenter says that discerning differences in health carrier coverage can be a difficult task, even for experts in the health care field, and the department should standardize the required form to remove any extra layers of difficulty associated with consumer reviews of these health carriers.

Agency Response. As previously noted, the department does not want to prevent health carriers from customizing disclosures to accurately describe their plans. The department wants to be flexible, while still requiring, as these amendments do, health carriers to provide sufficient information for consumers to be able to make intelligent decisions. Plans are required to be filed before use, which gives the department time to review and approve them, and this should sufficiently protect the ability of consumers to get the information they need. The department declines to make the requested revisions.

Comments on §21.3530(c)

Comment. One commenter asks that §21.3530(c) be modified to include the elements of the disclosure statement as required elements in Form CCP 1, and that the amendment at the beginning of the sentence to permit a health-plan-generated disclosure statement be rejected.

Agency Response. The department agrees that all substantive elements in Form CCP 1 should be required. However, these elements are already present in the requirements of §21.3530(c) as amended, so it is not necessary to further revise the provision and the department declines to make a change.

Comment. One commenter recommends that the department revise the proposed amendments to §21.3530(c)(1)-(3) to reduce consumer confusion by telling federal marketplace consumers that a plan is compliant with the ACA and contains all essential health benefits.

Another commenter supports requiring plans to identify the consumer choice benefit plan being offered or purchased. The commenter says that this is basic information, which is useful to the consumer for multiple reasons, including supplying the consumer with information needed to enable him or her to ask the department relevant questions about the plan and to comparison shop.

Agency Response. The department believes the information required here effectively identifies the plan being offered or purchased and makes it easy to compare plans and understand the benefits that are not available in a consumer choice plan. The description should clearly explain the nature of a reduced benefit, such as coverage that is subject to visit limits, and Form CCP 1 provides examples of how health issuers can explain reduced or excluded benefits. Instructing consumers to refer to the Summary of Benefits and

Coverage to see the specific level of benefits provided by the plan should resolve the commenters' concerns and allow consumers to obtain the information needed, and the department has changed the text of §21.3530(c)(3) as proposed to include such an instruction.

The department agrees that it would reduce consumer confusion if federal marketplace consumers were told whether a plan is ACA compliant and contains all essential health benefits, and it has changed the text of §21.3530(c)(1) as proposed accordingly.

Comment. One commenter says that the proposed amendments are overly burdensome with no corresponding increase in consumer protection.

That commenter and a second commenter say that the proposed amendments to §21.3530(c)(1) are burdensome, overly detailed, and contain unnecessary new requirements. The commenters say that requiring a unique disclosure form for every plan offered--with each copay, coinsurance, deductible, etc., option being a separate "plan"--is overly burdensome.

The second commenter also says that the proposed amendments go beyond what Insurance Code §1507.006 currently requires.

Both commenters say that the proposed requirements are especially problematic for individual plans offered on the federal exchange, where the majority of plans offered are consumer choice plans. The commenters say that because the process is typically entirely electronic, mandating multiple changes to the disclosure and plan selection process would require massive changes to the current electronic workflow and "shopping cart" process. The commenters ask the department to confirm that the form could include

several variations within one disclosure document. For example, that the form could indicate "Plan 001 has a $200 Deductible; Plan 002 has a $400 Deductible; and Plan 003 has a $500 Deductible."

The commenters say that the proposed requirement to have unique disclosure forms for each plan variation creates a tremendous increase in the work necessary to comply with the regulations, and that one large health carrier estimated it would be required to update and file for approval over 100 forms in order to cover each plan combination, and that such additional requirements act as a barrier to entry in the Texas individual exchange market. The commenters say that the proposal's cost note does not account for this volume and that the proposal creates requirements for additional filings with CMS. The commenters say that the volume of unique forms also creates opportunity for error because of the need to match each distinct disclosure form with the appropriate application form.

Agency Response. The department understands the concerns about unique disclosures, and it has changed the text of §21.3530(c) as proposed to require a sufficient amount of detail on how the plan varies from the state-mandated plan, while not requiring the disclosure to include the specific level of benefits provided by the plan. The department believes this will allow more general disclosures that can describe multiple plans, rather than requiring unique disclosures for every plan variation offered. This change will resolve the difficulties expressed by the commenters.

Comment. One commenter requests that §21.3530(c)(2) be revised to require identification of the consumer choice benefit plan being offered or purchased. The commenter says this is basic information, which is useful to the consumer for multiple

reasons, including supplying the consumer with information needed to enable him or her to ask the department relevant questions about the plan and to comparison shop.

Agency Response. The department disagrees, because consumers can rely on health carrier applications and the federally required summary of benefits and coverage when comparison shopping, and this should provide them with the information they need to comparison shop. The primary purpose of the disclosure form is to help consumers understand that the plan has reduced or excluded one or more benefits that would be required in a state-mandated plan, and ensure they understand where they can find a plan with all state-mandated benefits. To reduce the burden of creating more detailed disclosures, the department has revised subsection (c)(2) as proposed. As adopted, subsection (c)(2) requires detailed benefits information and new subsection (c)(3) instructs consumers to refer to the Summary of Benefits and Coverage to see the specific level of benefits the plan provides.

Comment. One commenter supports the language in §21.3530(c)(3) as proposed, saying that it is more detailed than the language in subsection (a)(2), which it appears to replace, and provides information that should be useful to consumers in evaluating whether to select a plan. The commenter suggests that rather than merely listing each health benefit or coverage, the department require a clear comparison between the state-mandated benefit level and a consumer choice health benefit plan, and the commenter suggests language to that effect. The commenter suggests that to enhance consumers' decision-making prior to enrolling in a consumer choice health benefit plan, the disclosure statement should provide tangible examples of what it means for a plan to offer a "reduced" benefit rather than no coverage at all.

Agency Response. The department appreciates the support for the proposed language. The department has adopted language enabling comparisons, including comparisons of "reduced" benefits and coverage, in subsections (c)(2) and (c)(3). The information required by the adopted subsections will make it easier for a consumer to compare plans and understand the benefits that are not available in a consumer choice plan. The description required should clearly explain the nature of a reduced benefit, such as coverage that is subject to visit limits, and Form CCP 1 provides examples of how health carriers can explain reduced or excluded benefits.

Comment. One commenter strongly supports the proposed language in §21.3530(c)(4) to aid in putting consumers on notice when a state-mandated benefit is modified on renewal. The commenter recommends that the language be made more conspicuous by requiring health carriers to include this language in all capital letters and specifically itemize the changes from their last plans. The commenter also recommends inclusion of language explaining that choosing a consumer choice of benefit plan may result in unanticipated out-of-pocket costs if the policyholder requires excluded services during the benefit year.

Agency Response. The department appreciates the support for the proposed amendment, but it declines to require capital letters or itemized changes from previous plans, because the plan references in the remainder of the subsection will provide sufficient information for consumers to be able to intelligently evaluate plans without including more warning language. The department has also corrected a reference to conform to changes made to subsection (c).

Comment. One commenter recommends that the department reduce consumer confusion by revising proposed §21.3530(c)(5) to require that the disclosure statement tell federal marketplace consumers whether a referenced state-mandated benefit plan is available on or off of the federal marketplace, whether consumers could use any premium subsidy or CSR for that plan, and when and how consumers could switch to the plan if desired.

Another commenter supports the proposed language.

A third commenter says that the language as proposed is ambiguous because it suggests that insurer may have to offer state-mandated plans other than those plans offered by the insurer.

A fourth commenter says that the rules should clarify that health carriers are not required to identify plans offered by other health carriers.

The third and fourth commenters say that the proposed amendments require the disclosure to identify the state-mandated plan that is most like the consumer choice health benefit plan being offered, and provide: "... (B) a URL that connect the consumer either to the summary of benefits and coverage for that state-mandated plan..." The commenters say that this requirement is extremely burdensome for each of the distinct plan variations and will require extensive manual labor as well as computer programing expenses.

Agency Response. The department appreciates the support for the proposed language. The department agrees it will reduce consumer confusion to revise the proposed rules to require that the disclosure statement tell individual market consumers whether the state-mandated benefit plan is available on or off of the federal marketplace and whether they could use any premium subsidy or CSR for that plan, and the department has changed

§21.3530(c)(5)(C) as proposed to require this. Due to the range of timing and circumstances, the department declines to require that the disclosure form include information on how consumers can switch plans, but does require the disclosure to include an acknowledgement in §21.3530(c)(6)(C) that, in most cases the consumer will not be able to get a new plan until the next open enrollment period.

The department has changed the language as proposed in this subsection to require the health carrier to identify one or more state-mandated plans it offers and require a URL that connects to the health carrier's website where the state-mandated plan is available for purchase. This requirement should be less burdensome for health carriers, while continuing to ensure that consumers are able to access the state-mandated plan. The adopted language makes clear that health carriers are required to only provide information about the state-mandated plans they offer and does not require health carriers to identify plans offered by their competitors.

Comment. One commenter supports the proposed language in §21.3530(c)(6), but asks that the department clarify that these acknowledgements must be included in all disclosure forms since the statutory language in Insurance Code §1507.006(a)(3) and §1507.056(a)(3) requires the disclosure form, regardless of whether it is the initial enrollment or renewal, to include for individual policyholders a "notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan."

The commenter says that it appears that the department intends for subsection (c)(6)(D) to replace the previous subsection (a)(3), which required this information in all

disclosure forms, consistent with the underlying statutory language. The commenter says the only distinction that the department is attempting to make in subsection (c)(6) is to provide that the policyholder's or contract holder's initials are not required to be obtained on the renewal disclosure form, since the requirement for the renewal to be signed was removed with the passage of SB 1852.

The commenter requests that, if the department moves forward with the language in proposed §21.3530(f), which would require the health carrier to request a signature on the written disclosure statement any time a policyholder is renewing coverage under a different consumer choice plan from the plan for which the initial disclosure was signed, the department also modify the proposed requirement to seek initials for the acknowledgements contained in proposed subsection (c)(6) to include those renewal disclosure forms as well.

Another commenter notes that the proposed amendments add a requirement that the applicant initial "to affirm understanding." The commenter says that adding the words "to affirm understanding" is unnecessary and could be ambiguous in such a manner as to lead to disputes after the fact. The commenter said that this could lead to unnecessary litigation, both with applicants and health carriers, and to unnecessary disputes with department examiners and enforcement personnel. The commenter says that these three words are not necessary, and an acknowledgement should speak for itself. The commenter also says that the requirement to "affirm understanding" is not required in Insurance Code Chapter 1507 and was not required by the changes contemplated by SB 1852.

Agency Response. The department appreciates the support for the proposed language. The department agrees that the required acknowledgements should be included on all

disclosure forms provided both to applicants for initial coverage and upon renewal. The department agrees that the requirement to "initial to affirm understanding" has caused some confusion, and it has changed the language in subsection (c)(6) as adopted to eliminate the requirement. The department has also changed §21.3530(f) as proposed to clarify that a signature on the disclosure is required only when a policyholder is enrolling in a particular plan for the first time, so it is unnecessary to make the change suggested by the first commenter.

The department has eliminated the proposed requirement in §21.3530(c)(6)(C) for an acknowledgment that the health carrier offer a state-mandated plan, because this requirement is duplicative of the adopted §21.3530(c)(5) and §21.3542. Proposed §21.3530(c)(6)(D) has been redesignated §21.3530(c)(6)(C) as a result.

Comment. One commenter notes that the proposed language in §21.3530(c)(7) largely tracks previous subsection (a)(5), but says that the proposed language omits the requirement for the disclosure to state that the right to the copy is to be free of charge. The commenter recommends that the department include that language so that subsection (c)(7) reads "inform the prospective or current policyholder or contract holder that the prospective or current contract holder has the right to a copy of the written disclosure statement free of charge." The commenter says it presumes that the department struck the "free of charge" language because it was added to proposed subsection (i). However, the commenter says that it is important to have that language in both places, because the language in subsection (c)(7) is to inform the policyholders and contract holders of their rights, while the language in (i) requires the health carrier to follow through with provision of the copy free of charge.

Agency Response. The department disagrees and declines to make the requested change because the requirement adopted in subsection (h), which was proposed as subsection (i), is sufficient to require the provision of copies free of charge. The department has changed the text of §21.3530(c)(7) as proposed and Form CCP 1 to state that a "health carrier must provide" a copy of the written disclosure statement "upon request." The department has omitted the "free of charge," language for the sake of plain language and brevity, and also because it is unlikely a consumer would think a fee would be required to obtain a copy of the statement.

Comment. One commenter recommends that the department reduce consumer confusion by revising proposed §21.3530(c)(8) to require that the disclosure tell federal marketplace consumers they will not lose their coverage or subsidy if they do not sign and return the form.

A second commenter supports the requirement for the disclosure to include the "don't sign this document" language in proposed subsection (c)(8), to encourage those who do not understand the contents of the document to seek additional information prior to signing.

A third commenter says that the proposed amendment requires language about not signing the disclosure statement that is not required by statute, and it appears to be an attempt by the department to legislate requirements by rule. The commenter says this has never been required for consumer choice plans since they were originally authorized in 2005, and that no statutory authority exists to add this requirement. The commenter says adding this now seems intended to make it more difficult for compliance and more

difficult to complete the sale of consumer choice plans. The commenter recommends the proposed amendments to §21.3530(c)(8) not be adopted.

Agency Response. The department believes the changes made to §21.3530(c)(8) and (9) and (e)(2) as proposed and the exclusion of proposed §21.3530(h) address the issue of federal marketplace consumers being concerned that they will lose their coverage or subsidy if they do not sign the form. As adopted, §21.3530(c)(8) requires the disclosure to inform federal marketplace consumers that their application to enroll provides acknowledgement of the disclosure. As adopted, §21.3530(c)(8) does not require a signature line on the disclosure statement for federal marketplace consumers, but provides that signing the application there constitutes an acknowledgment. This resolves the concerns of the second and third commenters.

The department disagrees with the third commenter; the "don't sign this document" language is reasonable and consistent with the department's rulemaking authority, particularly since the disclosure and signature required by the statute make little sense if the disclosure is not understood, and the department believes health carriers and agents want their consumers to properly understand the products being sold and the benefits that are and are not included in those products. As adopted, the "don't sign this document" language has been moved to §21.3530(c)(9).

Comment. One commenter says that the language in proposed §21.3530(c)(9) requiring a signature space on initial enrollment appears to conflict with proposed new language in §21.3530(f), which would require a carrier to request a signature on the written disclosure statement any time a policyholder renews coverage under a different consumer choice plan from the plan for which the initial disclosure statement was signed. The

commenter asks that this language be modified to more clearly include these disclosure form signatures, as well as initial coverage or enrollment signatures, if the department moves forward with subsection (f).

Agency Response. The department has changed the text of §21.3530(c)(9) as proposed to clarify when and how the disclosure form requires a signature. The department eliminated the reference to a "current" policyholder, since a signature is not required when coverage is renewed. As adopted, §21.3530(c)(9) does not require a signature line on the disclosure statement for federal marketplace consumers when a disclosure is delivered consistent with §21.3530(e)(2). Section 21.3530(c)(9) does not conflict with adopted subsection (f), which requires a signature when a consumer enrolls under a different plan. As adopted, the subsection contains the "don't sign this document" language proposed in §21.3530(c)(8).

Comment. One commenter supports proposed §21.3530(d) requiring notice of the disclosure form prior to renewal to allow for comparison shopping, particularly if the 60-day window falls within an open enrollment period for marketplace and individual plans. However, the commenter says that receipt of the offer of renewal may be necessary to better assess the value of the plan when comparison shopping and some consumers may misplace the disclosure form if it is not received along with the offer of renewal. The commenter recommends that the health carrier be required to send an additional copy of the disclosure form along with the renewal offer if the renewal offer is sent fewer than 60 days before the renewal date.

Two more commenters say that subsection (d) requires that the mandated disclosure be provided at least 60 days before the renewal date. The commenters says

that the proposed provision is likely based on an assumption that all benefit changes are made by the health carrier, but the commenters point out that is not always the case. The commenters say employer-based groups may choose to make minor benefit changes, and they often do not make their final renewal decisions until very late in the plan year, so the proposed requirement hampers consumer choice. The commenters say the 60-day advance notice requirement is presumably based on the "guaranteed renewability" provisions of Insurance Code §1501.108, which require 60 days' advance notice only for changes made at the direction of the plan, but does not apply to changes made at the policyholder's request. The commenters note that 28 TAC §3.3038 also allows health carriers to make modifications to individual plans at a policyholder's request. The commenters say §21.3530 should likewise not mandate a 60-day-notice requirement for changes to consumer choice plans made at the request of the policyholder.

Agency Response. The department agrees with the second and third commenters and not with the first. Furnishing a copy of the disclosure form along with the renewal offer is more conducive to consumer understanding than mandating 60 days' advance notice. However, one copy of the disclosure should be sufficient and avoid unnecessary duplication. The department agrees with the second and third commenters on notices for changes made at the request of the policyholder and has removed the 60-day language.

Comment. One commenter supports the proposed language in §21.3530(f), because it helps address the underlying policy concern of reducing the administrative burden of obtaining a signature on an unchanged renewal policy, while continuing to acknowledge that consumers need to be informed of policies or contracts when renewing under a

different consumer choice plan, because there may be material differences from the prior disclosure form.

The commenter suggests that the proposed language be changed to require that the health carrier not only request but also obtain the policyholder's or contract holder's signature on the disclosure statement. The commenter notes that proposed §21.3530(f) and §21.3530(c)(4) work in concert to help ensure that a policyholder or contract holder is notified of the material changes when renewing a policy or contract, and asked that the department adhere to its historically strong consumer protection stance and include both of these provisions in the final rule. The commenter says it is not administratively burdensome for health carriers to be required to include the single sentence in the disclosure form that is required under proposed §21.3530(c)(4), and notes that the requirement to obtain a signature for disclosures on policies or contracts when a policyholder is renewing coverage under a different consumer choice plan is still a significant reduction of administrative burden over the prior statutory requirement to obtain signatures on all renewal disclosure forms. The commenter says it makes sense to adopt both of these proposed rule provisions.

Agency Response. The department appreciates the support for the proposal, but disagrees with the suggested change because under Insurance Code §1507.006 and the section as adopted, a signature is not required on renewal. "Enrolling in" differs from "renewal" in that the former clearly entails a new or different plan, while the latter does not. The department has changed the language proposed in §21.3530(f) to refer to "enrolling in," rather than "renewing."

Comment. One commenter objects to the proposed amendment to §21.3530(f)(2), which it says would require health carriers to "request a signature" on disclosure statements when there is a "material change" in a policy on renewal. The commenter says this was a continuation of the signature requirement on renewal eliminated by SB 1852.

Another commenter objects to the proposed amendments, which it says require a signature any time a policyholder is renewing coverage under a different consumer choice plan, including "discontinuation and replacement" scenarios that may occur because of federal or state requirements unrelated to "mandated benefits." The commenter says that both state and federal law require at least 90 days' advance notice of such changes, so a signature should not be required.

A third commenter says it is confused about why a requirement to "request a signature" is meaningful.

Agency Response. As noted in response to previous comments, the department has adopted language different from what was proposed in §21.3530(f) to refer to "enrolling in," rather than "renewing," because a signature is no longer required on renewal. Thus, "renewal" is not at issue in the rule. This should resolve the expressed objections.

With regard to requesting a signature, Insurance Code §21.3530 requires disclosure forms to be signed and retained. The requirement to request a signature works in conjunction with the statute and §21.3530(g), to ensure that applicants receive and sign the disclosure.

Comment. One commenter suggests that, in accord with its suggestion to require obtaining signatures for renewals referenced under proposed subsection (f)(2), subsection (f) retain the references to current policyholder or contract holders and instead modify

the introductory clause of §21.3530(g) to read as follows: "Except as provided by subsection (i) of this section or for renewals falling outside of subsection (f)(2), … . "

Agency Response. As adopted, the section does not require a signature on renewal, so the department declines to make the change suggested by the commenter. Instead, the department has changed the introductory clause to conform to adopted changes in §21.3530(e).

Comment. One commenter recommends that §21.3530(h) retain references to current policyholders or contract holders.

Agency Response. The subsection dealt with the delivery of notice. The department has deleted the subsection to conform to the changes in §21.3530(e)(2), to which this subsection referred. Section 21.3530(e)(2) now contains the references to current policyholders or contract holders. As a result, the reference to current policyholders or contract holders is no longer necessary here.

Comments on §21.3535

Comment. One commenter recommends that in §21.3535(a) the department require retention of the disclosure form only, or at least clarify that the coverage documents do not need to be retained together with the coverage documents. The commenter says that requiring retention of the plan documents as well creates an unnecessary administrative burden for health carriers, since the department should be able to compare the notice with form filings made by the health carrier if necessary.

Another commenter says that the proposed amendments change the retention period from five to six years and states no opposition to that. However, the commenter

says the proposed amendments also potentially add confusion to the record-keeping requirement by adding the following language: "after the date a consumer choice health benefit plan terminates." The commenter asks whether this means each plan offered to a specific group or individual, or whether it instead refers to the various plans that may be offered by a health carrier.

Agency Response. The amendments to §21.3535(a) do not materially change the retention period, since retaining documents for five years after a plan terminates is equivalent to retaining them for six years after the disclosure is signed, and since the previous rules required a signature at each renewal. The retention period applies to plans offered to a specific group or individual. The department agrees that retaining the disclosure statement is sufficient to allow the department to review the statements, so it has changed §21.3535 as proposed to require retention of only the disclosure statement.

Comment. One commenter says that amendments to §21.3535(b) increase the documents required to be maintained by adding: "and plan documents that show which benefits or coverages were not provided at the state-mandated level in the issued consumer choice health benefit plan."

The commenter says the applicable statutory provisions only require maintenance of the signed disclosure statement, but that the proposed amendments add additional requirements not addressed in Insurance Code Chapter 1507 and are vague and ambiguous. The commenter asks whether the proposed amendments refer to the plan documents shown in each signed disclosure, or more broadly to state-mandated coverages a particular health carrier offers at the time a consumer choice plan is chosen by an applicant. The commenter says that this may substantially increase record keeping

and other requirements, because some changes in state-mandated plans are made by the Texas Legislature and others by changes at the federal level. The commenter opposes the proposed amendment to §21.3535(b).

Agency Response. The department agrees that retaining the disclosure statement is sufficient to allow the department to review the statements, if necessary, so it has made that change in the section to §21.3535 as proposed.

Comments on §21.3543

Comment. One commenter asks the department to clarify what "separate" means in the proposed amendments to §21.3543(1): i.e., two different SERFF filings or two different sets of forms?

Agency Response. "Separate" in the proposed amendments to §21.3543(1) means two different forms or sets of forms, with distinct form numbers, that are submitted in separate SERFF filings.

Comment. One commenter opposes the proposed deletion of the requirement in §21.3543(2)(B) to submit a statement of the reduction in premium resulting from the differences in coverage and design between the consumer choice health benefit plan and an identical plan providing all state-mandated health benefits. The commenter says this information is necessary for state policy makers, the public, and the department to better evaluate the effect of consumer choice plans on health care costs and coverage.

Agency Response. The department agrees that the information might ideally be useful at times, but declines to make the suggested change. As it is currently collected with form filings, the data is not submitted in a uniform format or in a way that allows the

department to aggregate the data. Additionally, the amendment to §21.3544(a)(4) will require substantively the same information in a consistent data format that can be better understood and shared with policy makers.

Comment on §21.3544 and Form CCP 2

Comment. One commenter opposes deleting some of the annual reporting data elements in §21.3544. The commenter says that on their face, these data elements appear to be useful for assessment of the impact of these plans on Texans. The commenter recommends retaining the required data elements. The commenter says that the frequency of data elements being requested should not be the sole determinant of their value to the department or the Texas Legislature for future regulatory efforts directed at these plans.

A second commenter says that current and proposed §21.3543 require health carriers to file the rates to be used with a consumer choice plan with the department, and the commenter objects to the proposed requirement for an additional annual filing of the average premium index rate as unnecessary and overly burdensome.

A third commenter says that the proposed requirement for health carriers to calculate and report average premium indexes for both consumer choice and state-mandated plans appears to be inconsistent with Insurance Code §551.008 by requiring separate calculations. The commenter says that Insurance Code Chapter 1507 only requires filing of rates for consumer choice plans regulated under the chapter, yet the proposed amendments require similar calculations and filings as data for both state-mandated and consumer choice plans.

A fourth commenter says several of its members have asked why Form CCP 2 needs to be changed. The commenter says that data elements have been programmed and reported consistently since the inception of the consumer choice plans, and changes now will require significant reprogramming and IT costs for every health carrier.

Agency Response. The department agrees that some of the old annual reporting data elements might ideally be useful at times. However, the department declines to make the change suggested by the first commenter because the data collected under the section were not being used, and the section merely imposed a reporting burden without a corresponding benefit. The amendments to §21.3544 retain the collection of information that is most relevant to policymakers, while reducing the reporting burden by eliminating data elements that are of limited value.

The proposed requirement for health carriers to provide premium index rates for consumer choice and state-mandated plans replaces the requirement to provide a statement of the reduction in premium resulting from the differences in coverage and design between the consumer choice health benefit plan and an identical plan providing all state-mandated health benefits, which has been removed from §21.3543. Both requirements are derived from the health carrier's rates, and the new language does not require a health carrier to develop information it does not already have readily available. The adopted requirement allows the department to aggregate this information and present it in a uniform format, without increasing the reporting burden.

The department assumes the third commenter's reference to Insurance Code §551.008, which does not exist, should actually be to Insurance Code §1507.008. The department does not agree that the proposed rule is inconsistent with §1507.008, which requires an informational rate filing. Section 21.3544 and Form CCP 2 instead requires an

additional data element as a part of a larger data filing requirement relating to data covering a number of aspects of consumer choice plans.

The department has made changes to §21.3544 as proposed. First, the reporting date has been changed to June 1 to provide additional time for health carriers to implement modifications necessary due to the amendments, to ensure data is complete and aligns with the historical data provided on the federal Unified Rate Review Template, and to avoid more concurrent data calls for health carriers and staff. Second, the department understands that the term "premium index rate" does not have a common meaning for plans that are not required to use the federal Unified Rate Review Template. Therefore, that term has been changed to "average premium rate." Third, to simplify reporting, the department has added clarification on how a health carrier should report the average premium rate, depending on whether health carriers are required to develop rates using the federal Unified Rate Review Template definition. Health carriers with such a requirement may simply use the average plan-adjusted index rate they have already submitted. Health carriers that do not have such a requirement would report average rates based on per member per month earned premiums as proposed. Finally, the instruction regarding projected rates has been removed, since the report is due June 1 for plans sold in the previous calendar year.

The department does not agree that reducing the data elements will cause significant IT costs, because the revised requirements are less burdensome than those under the previous rule.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS

DIVISION 3. REQUIRED NOTICES

Repeal of 28 TAC §§21.3525, 21.3526, 21.3527, and 21.3528

STATUTORY AUTHORITY. The department adopts the repeal of 28 TAC §§21.3525, 21.3526, 21.3527, and 21.3528 under Insurance Code §1507.009 and §36.001.

Insurance Code §1507.009 provides that the Commissioner shall adopt rules necessary to implement Chapter 1507.

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.

§21.3525. Insurer Notice on Application.

§21.3526. Insurer Notice on Policy.

§21.3527. HMO Notice on Application.

§21.3528. HMO Notice on Evidence of Coverage.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS

DIVISION 3. REQUIRED NOTICES

§§21.3530 and 21.3535

STATUTORY AUTHORITY. The department adopts amendments to 28 TAC §21.3530 and §21.3535 under Insurance Code §§36.001, 1507.005, 1507.006, and 1507.009.

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.

Insurance Code §1507.005 provides that each written application for participation in a standard health benefit plan must contain certain language.

Insurance Code §1507.006 requires health carriers providing standard health plans to provide a proposed policyholder or policyholder with certain written disclosures. The section also requires each applicant for initial coverage to sign the disclosure statement provided by the health carrier, and it requires the health carrier to retain the signed disclosure statement.

Insurance Code §1507.009 provides that the Commissioner adopt rules necessary to implement Chapter 1507.

TEXT.

§21.3530. Health Carrier Disclosure.

(a) A health carrier offering or providing a consumer choice health benefit plan must provide each prospective or current policyholder or contract holder with a written or electronic disclosure statement in a manner that gives the policyholder or contract holder the ability to keep a copy of the disclosure statement. The disclosure statement must provide a sufficiently detailed description of the state-mandated health benefits that are reduced or not included in the plan to enable the prospective or current policyholder or contract holder to make an informed decision.

(b) Form CCP 1 fulfills the requirements of this section and is available on the department's website at www.tdi.texas.gov.

(c) If a health carrier chooses to generate its own disclosure statement, it must comply with readability standards applicable to forms reviewed under Chapter 3 of this title (relating to Life, Accident, and Health Insurance and Annuities) and Chapter 11 of this title (relating to Health Maintenance Organizations) and the statement must use at least 12-point type. The disclosure statement also must:

(1) acknowledge that the consumer choice health benefit plan being offered or purchased does not provide some or all state-mandated health benefits and explain, if applicable, that the plan does include all health benefits required by the Affordable Care Act;

(2) in plain language, list each health benefit or coverage not provided at the state-mandated level in the consumer choice health benefit plan, define the listed health benefit or coverage, describe the benefit or coverage in the consumer choice plan being offered, and describe the benefit or coverage that would be provided in a state-mandated plan;

(3) instruct consumers to refer to the Summary of Benefits and Coverage to see the specific level of benefits provided by the plan;

(4) when applicable because the health carrier has materially modified a consumer choice plan in a way that necessitates a change to the disclosure, or when the disclosure must be updated to reflect changes in state law, contain the following language, in bold type, directly above the list required by paragraph (2) of this subsection, as applicable:

(A) "The benefits or coverages you are agreeing to on this renewal are different from your current plan."; or

(B) "The benefits required by state law have changed since you first received this disclosure.";

(5) explain that the health carrier offers one or more state-mandated plans and provide:

(A) a phone number where the consumer can purchase the state-mandated plan;

(B) a URL that connects the consumer to the health carrier's website where the state-mandated plan is available for purchase; and

(C) for individual market plans, indicate whether the state-mandated plan is available on the federal health benefit exchange and if it is not, explain that the plan will not qualify for reduced premiums or cost-sharing;

(6) contain acknowledgments of the following:

(A) that the consumer choice health benefit plan does not provide the same level of coverage required in a state-mandated plan;

(B) that more information about consumer choice health benefit plans is available from the department either online at www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the TDI Consumer Help Line at 1-800-252-3439; and

(C) if the plan is being issued in the individual market, that if the plan does not meet the consumer's needs, in most cases the consumer will not be able to get a new plan until the next open enrollment period;

(7) inform the prospective or current policyholder or contract holder that the health carrier must provide a copy of the written disclosure statement upon request;

(8) for a disclosure being delivered consistent with subsection (e)(2) of this section, include the following language in bold type, directly above the acknowledgements in paragraph (6) of this subsection: "By signing your application to enroll in this plan, you acknowledge the following:"; and

(9) for initial coverage or enrollment, other than for a disclosure being delivered consistent with subsection (e)(2) of this section, provide space for the prospective policyholder or contract holder to print and sign their name, and to sign to acknowledge receipt of the disclosure statement, accompanied by the following language in bold type: "Don't sign this document if you don't understand it. No firme este documento si no lo comprende."

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

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

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

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

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

(2) if the health carrier is unable to provide the written disclosure and obtain a signature at the time of application, the health carrier must include the disclosure statement as the first page in the plan brochure provided on the healthcare.gov website.

(f) A health carrier must request a signature on the written disclosure statement:

(1) at the time of initial coverage or enrollment; and

(2) any time a policyholder is enrolling in coverage under a different consumer choice plan from the plan for which the initial disclosure statement was signed, including instances where the health carrier discontinues a plan, consistent with Insurance Code §1202.051, concerning Renewability and Continuation of Individual Health Insurance Policies; Insurance Code §1271.307, concerning Renewability of Coverage: Individual Health Care Plans and Conversion Contracts; and Insurance Code §1501.109, concerning Refusal to Renew; Discontinuation of Coverage.

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

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

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

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

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

(j) A health carrier offering or issuing a consumer choice health benefit plan to a prospective or current policyholder, contract holder, or an association must update and file with the Commissioner, for approval, its written disclosure statement that conforms with this section no later than six months from the effective date of this section.

§21.3535. Retention of Disclosure.

(a) A health carrier must, for a period of five years after the date a consumer choice health benefit plan terminates:

(1) retain in the health carrier's records the signed disclosure statement required by §21.3530 of this title (relating to Health Carrier Disclosure); and

(2) on request from the department, provide copies of the retained documents to the department.

(b) A health carrier may accept receipt of a signed disclosure and written affirmation electronically, but the carrier remains responsible for compliance with subsection (a)(2) of this section.

(c) For renewals where a current policyholder or contract holder is not required to sign a disclosure statement, the health carrier may satisfy the requirements of subsection

(a)(1) of this section by furnishing proof that the health carrier tendered the disclosure statement to the policyholder or contract holder in accordance with §21.3530(d)(2) of this title.

SUBCHAPTER AA. CONSUMER CHOICE HEALTH BENEFIT PLANS

DIVISION 4. ADDITIONAL REQUIREMENTS

§§21.3542 - 21.3544

STATUTORY AUTHORITY. The department adopts amendments to 28 TAC §§21.3542 - 21.3544 under Insurance Code §§36.001, 1507.006, 1507.007, and 1507.009.

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.

Insurance Code §1507.006 requires health carriers providing standard health plans to provide a proposed policyholder or policyholder with certain written disclosures. The section also requires each applicant for initial coverage to sign the disclosure statement provided by the health carrier, and it requires the health carrier to retain the signed disclosure statement.

Insurance Code §1507.007 provides that a health carrier that offers one or more standard health plans under Chapter 1507 must also offer at least one accident or sickness insurance policy that provides state-mandated benefits and is otherwise authorized by the Insurance Code.

Insurance Code §1507.009 provides that the Commissioner adopt rules necessary to implement Chapter 1507.

TEXT.

§21.3542. Offer of State-Mandated Plan.

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

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

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

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

(3) provide at least the following information:

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

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

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

§21.3543. Required Plan Filings.

A health carrier must:

(1) file the consumer choice health benefit plan separate from any state-mandated health benefit plan with the department in accordance with:

(A) Insurance Code Chapter 1271 and Chapter 11 of this title (relating to Health Maintenance Organizations) including the filing fee requirements; and

(B) Insurance Code Chapter 1701 and Chapter 3, Subchapter A of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, Endorsements for Life, Accident, and Health Insurance and Annuities) including the filing fee requirements;

(2) before use, file for approval with the department its disclosures required by §21.3530 of this title (relating to Health Carrier Disclosure) and certification of compliance with §21.3542 of this title (relating to Offer of State-Mandated Plan); and

(3) file, for informational purposes, the rates to be used with a consumer choice health benefit plan.

§21.3544. Required Annual Reporting.

(a) Health carriers offering a consumer choice health benefit plan must file annually with the department a data certification, not later than June 1 of each year, on Form CCP 2, Consumer Choice Health Benefit Plans Data Certification. The data certification includes the following, each set out by plan type:

(1) the total number of consumer choice health benefit plans newly issued and renewed covering Texas lives;

(2) the total number of Texas lives (including members/employees, spouses, and dependents) covered under newly issued and renewed consumer choice health benefit plans;

(3) the gross premiums received for newly issued and renewed consumer choice health benefit plans covering Texas lives; and

(4) the average premium rate for consumer choice plans and state-mandated plans.

(b) For the purpose of subsection (a) of this section:

(1) for plans that are required to develop rates using the federal Unified Rate Review Template, the average premium rate is the average plan-adjusted index rate for each set of plans as submitted for the previous calendar year;

(2) for plans that are not required to develop rates using the federal Unified Rate Review Template, the average premium rate is the earned premium divided by the member months for each set of plans, given per member per month, where member months is the number of people enrolled in a plan times the months of enrollment.

(c) Form CCP 2 is available on the department's website at www.tdi.texas.gov.

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

Issued at Austin, Texas, on May 17, 2021.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance

The Commissioner repeals 28 TAC §§21.3525 - 21.3528 and adopts amendments to 28 TAC §21.3530, §21.3535, and §§21.3542 - 21.3544.

Commissioner of Insurance

By: DocuSigned by:
Doug Slape
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Doug Slape
Chief Deputy Commissioner
Tex. Gov't Code §601.002
Commissioner's Order No. 2018-5528