

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE G. HEALTH COVERAGE AVAILABILITY

CHAPTER 1507. CONSUMER CHOICE OF BENEFITS PLANS

SUBCHAPTER A. CONSUMER CHOICE OF BENEFITS HEALTH INSURANCE PLANS

Sec. 1507.001. PURPOSE. The legislature recognizes the need for individuals, employers, and other purchasers of coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. The legislature, therefore, seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in this state to issue accident and sickness policies that, in whole or in part, do not offer or provide state-mandated health benefits.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.002. DEFINITIONS. In this subchapter:

(1) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state. The term includes an insurance company, a group hospital service corporation under Chapter 842, and a stipulated premium company under Chapter 884.

(2) "Standard health benefit plan" means an accident or sickness insurance policy that, in whole or in part, does not offer or provide state-mandated health benefits, but that provides creditable coverage as defined by Section 1205.004(a) or 1501.102(a).

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.003. STATE-MANDATED HEALTH BENEFITS. (a) For purposes of this subchapter, "state-mandated health benefits"

means coverage required under this code or other laws of this state to be provided in an individual, blanket, or group policy for accident and health insurance or a contract for a health-related condition that:

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

(2) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

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

(b) For purposes of this subchapter, "state-mandated health benefits" does not include benefits that are mandated by federal law or standard provisions or rights required under this code or other laws of this state to be provided in an individual, blanket, or group policy for accident and health insurance that are unrelated to a specific health illness, injury, or condition of an insured, including provisions related to:

(1) continuation of coverage under:

(A) Subchapters F and G, Chapter 1251;

(B) Section 1201.059; and

(C) Subchapter B, Chapter 1253;

(2) termination of coverage under Sections 1202.051 and 1501.108;

(3) preexisting conditions under Subchapter D, Chapter 1201, and Sections 1501.102-1501.105;

(4) coverage of children, including newborn or adopted children, under:

(A) Subchapter D, Chapter 1251;

(B) Sections 1201.053, 1201.061, 1201.063-1201.065, and Subchapter A, Chapter 1367;

(C) Chapter 1504;

(D) Chapter 1503;

(E) Section 1501.157;

(F) Section 1501.158; and

(G) Sections 1501.607-1501.609;

(5) services of practitioners under:

- (A) Subchapters A, B, and C, Chapter 1451; or
- (B) Section 1301.052;
- (6) supplies and services associated with the treatment of diabetes under Subchapter B, Chapter 1358;
- (7) coverage for serious mental illness under Subchapter A, Chapter 1355;
- (8) coverage for childhood immunizations and hearing screening as required by Subchapters B and C, Chapter 1367, other than Section 1367.053(c) and Chapter 1353;
- (9) coverage for reconstructive surgery for certain craniofacial abnormalities of children as required by Subchapter D, Chapter 1367;
- (10) coverage for the dietary treatment of phenylketonuria as required by Chapter 1359;
- (11) coverage for referral to a non-network physician or provider when medically necessary covered services are not available through network physicians or providers, as required by Section 1271.055; and
- (12) coverage for cancer screenings under:
 - (A) Chapter 1356;
 - (B) Chapter 1362;
 - (C) Chapter 1363; and
 - (D) Chapter 1370.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.029(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.029(a), eff. September 1, 2007.

Sec. 1507.004. STANDARD HEALTH BENEFIT PLANS AUTHORIZED; MINIMUM REQUIREMENT. (a) A health carrier may offer one or more standard health benefit plans.

(b) Any standard health benefit plan must include coverage for direct services to an obstetrical or gynecological care provider as required by Subchapter F, Chapter 1451.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.005. NOTICE TO POLICYHOLDER. (a) Each written application for participation in a standard health benefit plan must contain the following language at the beginning of the document in bold type:

"You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy."

(b) Each standard health benefit plan must contain the following language at the beginning of the document in bold type:

"This Consumer Choice of Benefits Health Insurance Plan, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy."

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.006. DISCLOSURE STATEMENT. (a) A health carrier providing a standard health benefit plan must provide a proposed

policyholder or policyholder with a written disclosure statement that:

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

(2) lists those state-mandated health benefits not included in the standard health benefit plan; and

(3) if the standard health benefit plan is issued to an individual policyholder, provides a notice that purchase of the plan may limit the policyholder's future coverage options in the event the policyholder's health changes and needed benefits are not available under the standard health benefit plan.

(b) Each applicant for initial coverage must sign the disclosure statement provided by the health carrier under Subsection (a) and return the statement to the health carrier. Under a group policy or contract, the term "applicant" means the employer.

(c) A health carrier must:

(1) retain the signed disclosure statement in the health carrier's records; and

(2) on request from the commissioner, provide the signed disclosure statement to the department.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 657 (S.B. [1852](#)), Sec. 1, eff. September 1, 2019.

Sec. 1507.007. ADDITIONAL POLICIES. A health carrier that offers one or more standard health benefit plans under this subchapter must also offer at least one accident or sickness insurance policy that provides state-mandated health benefits and is otherwise authorized by this code.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.008. RATES. A health carrier shall file for

informational purposes the rates to be used with a standard health benefit plan. Nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any individual accident and sickness insurance policy or policies.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.009. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

SUBCHAPTER B. CONSUMER CHOICE OF BENEFITS HEALTH MAINTENANCE
ORGANIZATION PLANS

Sec. 1507.051. PURPOSE. The legislature recognizes the need for individuals and employers in this state to have the opportunity to choose health maintenance organization plans that are more affordable and flexible than existing market health care plans offered by health maintenance organizations. The legislature, therefore, seeks to increase the availability of health care plans by allowing health maintenance organizations authorized to operate health maintenance organizations in this state to issue group or individual evidences of coverage that, in whole or in part, do not offer or provide state-mandated health benefits.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.052. DEFINITIONS. (a) In this subchapter, "standard health benefit plan" means a group or individual evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits but that provides creditable coverage as defined by Section 1205.004(a) or 1501.102(a).

(b) In this subchapter, terms defined by Section 843.002 have the meanings assigned by that section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.053. STATE-MANDATED HEALTH BENEFITS. (a) For purposes of this subchapter, "state-mandated health benefits" means coverage required under this code or other laws of this state to be provided in an evidence of coverage that:

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

(2) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts, including limitations provided in Section 1271.151; or

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

(b) For purposes of this subchapter, "state-mandated health benefits" does not include coverage that is mandated by federal law or standard provisions or rights required under this code or other laws of this state to be provided in an evidence of coverage that are unrelated to a specific health illness, injury, or condition of an enrollee, including provisions related to:

(1) continuation of coverage under Subchapter G, Chapter 1251;

(2) termination of coverage under Sections 1202.051 and 1501.108;

(3) preexisting conditions under Subchapter D, Chapter 1201, and Sections 1501.102-1501.105;

(4) coverage of children, including newborn or adopted children, under:

(A) Chapter 1504;

(B) Chapter 1503;

(C) Section 1501.157;

(D) Section 1501.158; and

(E) Sections 1501.607-1501.609;

(5) services of providers under Section 843.304;

(6) coverage for serious mental health illness under

Subchapter A, Chapter 1355; and

- (7) coverage for cancer screenings under:
 - (A) Chapter 1356;
 - (B) Chapter 1362;
 - (C) Chapter 1363; and
 - (D) Chapter 1370.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.030(a), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.030(a), eff. September 1, 2007.

Sec. 1507.054. STANDARD HEALTH BENEFIT PLANS AUTHORIZED. A health maintenance organization authorized to issue an evidence of coverage in this state may offer one or more standard health benefit plans.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.055. NOTICE TO ENROLLEES. (a) Each written application for enrollment in a standard health benefit plan must contain the following language at the beginning of the document in bold type:

"You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage."

(b) Each standard health benefit plan must contain the following language at the beginning of the document in bold type:

"This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage."

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.056. DISCLOSURE STATEMENT. (a) A health maintenance organization providing a standard health benefit plan must provide a proposed contract holder or a contract holder with a written disclosure statement that:

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

(2) lists those state-mandated health benefits not included in the standard health benefit plan; and

(3) if the standard health benefit plan is issued to an individual certificate holder, provides a notice that purchase of the plan may limit the certificate holder's future coverage options in the event the certificate holder's health changes and needed benefits are not available under the standard health benefit plan.

(b) Each applicant for initial enrollment must sign the disclosure statement provided by the health maintenance organization under Subsection (a) and return the statement to the health maintenance organization. Under a group evidence of coverage, the term "applicant" means the employer.

(c) A health maintenance organization must:

(1) retain the signed disclosure statement in the organization's records; and

(2) on request from the commissioner, provide the signed disclosure statement to the department.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 657 (S.B. 1852), Sec. 2, eff. September 1, 2019.

Sec. 1507.057. ADDITIONAL EVIDENCES OF COVERAGE. A health maintenance organization that offers one or more standard health benefit plans under this subchapter must also offer at least one evidence of coverage that provides state-mandated health benefits and is otherwise authorized by this code.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.058. RATES. A health maintenance organization shall file for informational purposes the rates to be used with a standard health benefit plan. Nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any evidence of coverage.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.

Sec. 1507.059. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(a), eff. September 1, 2005.