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1. INTRODUCTION. The Commissioner of Insurance adopts new Subchapter E, §§26.501, 26.502, 26.511 - 26.517, 26.521, 26.522, 26.531 - 26.538, 26.551 - 26.553, and 26.561 - 26.564, concerning provisions essential to the operation of the Healthy Texas Program and changes in law made by the Insurance Code Chapter 1508, added pursuant to Senate Bill (SB) 78, 81st Legislature, Regular Session. Sections 26.512 - 26.514, 26.521, 26.522, 26.533, and 26.551 are adopted with changes to the proposed text published in the November 20, 2009 issue of the *Texas Register* (34 TexReg 8181). Sections 26.501, 26.502, 26.511, 26.515 - 26.517, 26.531, 26.532, 26.534 - 26.538, 26.552 , 26.553, and 26.561 - 26.564 are adopted without changes.

A correction of error notice was published in the December 11, 2009 *Texas Register* (34 TexReg 9024) to correct errors in the proposal published in the November 20, 2009 issue. The following errors were corrected:

In the Introduction, the reference to "Proposed new §26.515 set forth. . . ." was

corrected to read: "Proposed new §26.515 sets forth. . . ." and the reference to "Proposed new §26.521 also provides that a qualifying small employer may not have provided group health insurance covering any of their employees. . . ." was corrected to read: "Proposed new §26.521 also provides that a qualifying small employer may not have provided group health insurance covering any of its employees. . . ."

In the proposed text, the following corrections were made:

In §26.521(e): "(e) Qualifying small employers must, in accordance with the Insurance Code §1.508.051 and §1.508.063. . . ." was corrected to read: "(e) Qualifying small employers must, in accordance with the Insurance Code §1.508.051 and §1.508.053. . . ."

In §26.521(e)(3): "(3) At least one eligible employee earning annual wages . . . United States Department of Health and Human Services as adjusted by the commissioner . . . ." was corrected to read: "(3) At least one eligible employee earning annual wages . . . United States Department of Health and Human Services or as adjusted by the commissioner . . . ."

In §26.535(b)(2): "(2) an annual per-individual and per-family maximum financial requirement. . . ." was corrected to read: "(2) an annual maximum financial requirement. . . ."

In §26.535(c)(1): "(1) meet the small employer participation provisions of §26.521(a) - (e)(1) and (g) - (k) of this subchapter. . . ." was corrected to read: "(1) meet the small employer participation provisions of §26.521(a), (b), (d), (e)(1) and (g) - (k) of this subchapter. . . ."

2. REASONED JUSTIFICATION. The new sections are necessary to implement SB 78, which amended the Insurance Code by adding Chapter 1508 to establish the Healthy Texas Program to provide access to quality small employer health benefit plans at an affordable price and to encourage small employers to offer health benefit plan coverage to employees and to dependents of employees. The sections are essential to help ensure that the Healthy Texas Program is fully operational in a manner permitting participating health benefit plan issuers to issue qualified small employer health benefit plans and utilize the Healthy Texas Premium Stabilization Fund, and make the first annual request for reimbursement January 1, 2011.

Three Department-sponsored stakeholders meetings in 2009 centered on discussion of SB 78 implementation with interested parties, including public comments and questions about prospective Department rules to implement SB 78. The Department posted draft text of the proposed new rules on the Department's internet website from October 7 to October 14, 2009, and invited informal comment. The Department received several written comments on the posted rule text, which were considered and integrated to the extent possible into the proposed rules published for formal comment in the *Texas Register* (34 TexReg 8181).

The Commissioner conducted a public hearing on the published rule proposal on December 2, 2009, under Docket Number 2707. In response to written comments on the published proposal and comments made at the hearing, the Department has changed some of the proposed language in the text of the rule as adopted. None of the

changes to the proposed text materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

The following changes are made to the proposed text.

Section 26.512(a) is changed in response to comment to clarify that the date and time record requirement is to document and acknowledge submission and receipt of an application, but not necessarily one that is in all respects a complete application that includes necessary verifications.

Section 26.512(c) is changed in response to comment to make it clear that the basis of verification is review of the certification and, as appropriate, any supporting documentation requested and received by the issuer.

Section 26.513(b) is changed in response to comment to clarify that the Commissioner may prescribe a standardized health benefit plan renewal certification form to be utilized for employer renewal certification purposes.

Section 26.514(b)(3) is changed in response to comment to clarify that nonrenewal is permitted in the situation where the small employer has not complied with a provision of the health benefit plan relating to premium contribution, group size, or participation requirements as set forth in the Insurance Code Chapter 1508 and this subchapter.

Section 26.514(e) is changed in response to comment to specify that a qualifying group health benefit plan is subject to the continuation of coverage provisions of the Insurance Code, Chapter 1251, Subchapters F and G, except that a plan issued by a participating health benefit plan issuer that elects to discontinue Healthy Texas

coverage by withdrawing from participation in the Healthy Texas Program pursuant to §26.515 of the subchapter (relating to Notice of Discontinuance of Health Plan; Issuer Withdrawal from Participation) is not subject to such continuation of coverage provisions.

Section 26.522(a) is changed as a result of comment to provide that in order for a small employer to qualify for coverage under the Healthy Texas Program, eligible employees of the employer must, as a group, satisfy income criteria set forth in the Insurance Code §1508.051(a)(2).

Section 26.533(b) is changed to correctly reflect the name of an internal reference.

Section 26.551(a) is changed in response to comments by designating its second sentence as paragraph (1); adding a paragraph (2) to provide that pursuant to the Insurance Code §1508.202(d) a health benefit plan issuer may use the geographic location of the employer's primary place of business as an additional criterion in setting premium rates for a qualifying health benefit plan; and adding a paragraph (3) to provide that a health benefit plan issuer may not use a "health status related factor" as defined in the Insurance Code §1501.002(7) in setting premium rates for a qualifying health benefit plan.

Section 26.551(b) is changed in response to comment to provide that a participating group health benefit plan issuer may rely on available annual reported and published data concerning Healthy Texas enrollment and operations, and other available data communicated by the Commissioner on an ongoing basis in establishing

premium rates that consider availability of reimbursement from the fund.

3. HOW THE SECTIONS WILL FUNCTION. The sections provide the essential provisions for the establishment and operation of the Healthy Texas Program as set forth in the Insurance Code Chapter 1508, and are composed of six separate divisions, as follows.

Division 1. General Provisions

Section 26.501 states the purpose of the subchapter, including the objectives of providing access to quality small employer health benefit plans at an affordable price and encouraging small employers to offer health benefit plan coverage to employees and dependents of employees.

Section 26.502 provides definitions of essential words and terms used in the subchapter. *Dependent* has the meaning assigned by the Insurance Code §1501.002(2). *Eligible employee* has the meaning assigned by the Insurance Code §1501.002(3). *Fund* is defined as the Healthy Texas small employer premium stabilization fund established under the Insurance Code Chapter 1508, Subchapter F. *Health benefit plan* has the meaning assigned by the Insurance Code §1501.002(5). *Health benefit plan issuer* has the meaning assigned by the Insurance Code §1501.002(6). *Participating health benefit plan issuer* is defined as a health benefit plan issuer that has elected to participate in the Healthy Texas Program in accordance with the Insurance Code Chapter 1508 and this subchapter. *Qualifying group health benefit plan* is defined as a health benefit plan that provides benefits for health care services in

the manner described by the Insurance Code Chapter 1508, and as approved by the Commissioner. *Small employer* has the meaning assigned by the Insurance Code §1501.002(14).

Division 2. Participation by Health Benefit Plan Issuers

Section 26.511 outlines the essential elements for health benefit plan issuer participation, including submission of an application to be a participating issuer, issuer compliance with the Insurance Code Chapter 1508 and this subchapter, and offering only qualifying group health benefit plans to small employers participating in the Healthy Texas Program. It includes a statement of Commissioner determination that limitation concerning which health benefit plan issuers may participate in the Healthy Texas Program is necessary to achieve the purposes of the program, and that the Commissioner will, in accordance with the Insurance Code §1508.101(c), contract on a competitive procurement basis with one or more health benefit plan issuers to provide qualifying health benefit plan coverage.

Section 26.512 details provisions relating to the enrollment process for obtaining coverage under a qualified group health benefit plan, including the application process, initial eligibility certification and verification process, acceptance and issuance-of-coverage provisions, enrollment periods, and enrollment-related documents to be created and transmitted or maintained by participating issuers.

Section 26.513 specifies provisions relating to annual recertification of eligibility of employers and enrollees participating in the Healthy Texas Program, and potential consequences of failure to provide recertification.

Section 26.514 details provisions for health plan renewal and provides that a qualifying group health benefit plan is renewable at the option of a participating small employer so long as the eligibility and certification or recertification provisions of the Insurance Code Chapter 1508 and applicable provisions of §§26.512, 26.513, and 26.521 continue to be met. It also provides that a qualifying group health benefit plan is renewable at the option of a participating small employer unless any one of the four circumstances described in §26.514(b) is present. Section 26.514(b)(3) has been changed to clarify that nonrenewal is permitted in the situation where the small employer has not complied with a provision of the health benefit plan relating to premium contribution, group size, or participation requirements as set forth in the Insurance Code Chapter 1508 and this subchapter. Section 26.514 also contains the notice requirements for nonrenewal or termination. Section 26.514(e) has been changed to specify that a qualifying group health benefit plan is subject to the continuation of coverage provisions of the Insurance Code, Chapter 1251, Subchapters F and G, except that a plan issued by a participating health benefit plan issuer that elects to discontinue Healthy Texas coverage by withdrawing from participation in the Healthy Texas Program pursuant to §26.515 of the subchapter (relating to Notice of Discontinuance of Health Plan; Issuer Withdrawal from Participation) is not subject to such continuation of coverage provisions.

Section 26.515 sets forth notice and administrative requirements for group health benefit plan discontinuance resulting from a participating health benefit plan issuer's election to withdraw from participation in the Healthy Texas Program, including the

timing, content and recipients of the notice; the uniformity qualifications applicable to the discontinuance; and the continuing requirement that the health benefit plan issuer comply with all other applicable legal provisions.

Section 26.516 requires a 30-day grace period for payment of premiums.

Section 26.517 lists the participating health plan issuer contact information, and revisions or updates to such contact information, that must be submitted to the Department by a participating health benefit plan issuer. Information required includes the name, mailing and email address, and telephone number of a health plan issuer contact person assigned to the Healthy Texas Program, the mailing and email address and toll-free telephone number to which consumer inquiries about the program are to be directed, and the service area in which the program will be available.

Division 3. Participation by Small Employers

Section 26.521 specifies the mandatory and discretionary provisions relating to small employer participation in the program. The section restates statutory criteria for qualification as a small employer. It specifies that a small employer must offer coverage to all eligible employees and requires that 30 percent of eligible employees meet wage criteria described in Chapter 1508 of the Insurance Code. The section also mandates an offer of coverage to each dependent of an eligible employee; it permits small employers to offer coverage to part-time employees working at least 20 hours per week, as well as their dependents, but clarifies that part-time employees or dependents who are offered coverage are not eligible employees for purposes of determining a small employer's eligibility to purchase a qualifying group health benefit plan. The section

also details premium contribution requirements for employers and participation requirements for eligible employees, and clarifies that employers are not required to contribute to the premium paid to a group health benefit plan issuer for either dependent or part-time employee coverage. The section also provides that the small employer's place of business must be located within the State of Texas in order for the small employer to qualify to purchase a qualifying group health benefit plan. Section 26.521 also provides that a qualifying small employer may not have provided group health insurance covering any of its employees at any time during the 12-month period preceding application for a Healthy Texas plan, subject to a *de minimis* per-employee contribution amount or baseline annual maximum benefit threshold. The section provides that mid-year fluctuations in group size, wage levels and employee participation are not bases for termination of a Healthy Texas plan. The section also provides that a small employer may impose waiting periods which newly hired workers must satisfy in advance of obtaining coverage, so long as the waiting period is no longer than 90 days from date of hire and is the same for all newly hired workers.

Section 26.522 provides for the verification of income upon which qualification for coverage is based, in accordance with the Insurance Code §1508.051. The language of §26.522(a) is changed as a result of comment to provide that in order for a small employer to qualify for coverage under the Healthy Texas Program, eligible employees of the employer must, as a group, satisfy income criteria set forth in the Insurance Code §1508.051(a)(2).

Division 4. Participation by Regional and Local Health Care Programs

Section 26.531 states the purpose of the division. The section also contains a brief description of regional and local health care programs.

Section 26.532 sets forth the applicability and scope of the division, providing that existing or newly formed regional or local health care programs may elect to participate in the Healthy Texas Program.

Section 26.533 addresses the submission requirements for participation by such regional or local health care programs, including submission of an election on an application form for participation in the Healthy Texas Program. The section details the options for participation available to regional or local health care programs. It also references participation requirements to be met by such programs.

Section 26.534 details the provisions for participation in the Healthy Texas Program by a regional or local health care program through direct purchase of a health benefit plan. The Health and Safety Code §75.102(a)(3) provides that a regional or local health care program may provide health care benefits to employees of small employers by purchasing or facilitating purchase of health benefit plan coverage for those employees from a health benefit plan issuer, including coverage under any other health benefit plan available in this state, in lieu of choosing to purchase or facilitate purchase of a Chapter 1501 small employer health benefit plan or Chapter 1507 standard health benefit plan. The section includes employer and employee eligibility provisions and requirements that must be satisfied on an individual small employer basis.

Section 26.535 specifies the provisions for participation through the

implementation of a regional or local health care program containing benefit, operational and administrative provisions that meet or exceed standards established by the Commissioner for benefit and service level categories described in the section. The section includes continuing employer eligibility provisions for participating regional or local health care programs, including employer premium or program health care cost contribution requirements and employee participation requirements. It also provides that a regional or local health care program must meet claims eligibility provisions of §26.562, as well as the response to information request provisions of §26.563(b), and the data filing requirements of §26.564 that apply to health benefit plan issuers. The section includes provisions directed to financial soundness and solvency of regional and local health care programs participating in the Healthy Texas Program.

Section 26.536 addresses the matter of withdrawal from participation in the Healthy Texas Program by a regional or local health care program, and the provision of necessary notice and disclosure to the Commissioner and to program enrollees concerning such withdrawal by a regional or local health care program.

Section 26.537 specifies the program certification provisions, including initial and renewal certification, for small employers that are members of a regional or local health care program that is participating in Healthy Texas under either of the two options described in §26.534 and §26.535.

Section 26.538 provides that except as expressly provided in Division 4 of the subchapter, the provisions of Division 3 of the subchapter apply to small employers and the employees of those employers that participate in a regional or local health care

program that elects to participate in the Healthy Texas Program.

Division 5. Rating of Qualified Health Benefit Plans

Section 26.551 provides for premium rates and rating of plans eligible for claim reimbursement under the Healthy Texas Program. The section provides for review and approval of premium rates and restricts issuers to the use of age and gender as case characteristics in accordance with the Insurance Code §1508.202(c). The section requires that premium rates consider availability of reimbursement from the fund. It also requires: that rating factors be applied consistently for employers in the same class of business; that the claims expense component used for calculating loss ratios, premium rates and premium rate adjustments be adjusted based on reimbursement from the fund; and that initial rate submissions and rate adjustment applications contain information prescribed by the Commissioner as necessary to assist in determination of anticipated premium rate impact on availability of fund reimbursement. Section 26.551(a) is changed by designating its second sentence as paragraph (1); adding a paragraph (2) to provide that pursuant to the Insurance Code §1508.202(d) a health benefit plan issuer may use the geographic location of the employer's primary place of business as an additional criterion in setting premium rates for a qualifying health benefit plan; and adding a paragraph (3) to provide that a health benefit plan issuer may not use a "health status related factor" as defined in the Insurance Code §1501.002(7) in setting premium rates for a qualifying health benefit plan. In addition, §26.551(b) is changed to provide that a participating group health benefit plan issuer may rely on available annual reported and published data concerning Healthy Texas enrollment and

operations, and other available data communicated by the Commissioner on an ongoing basis in establishing premium rates that consider availability of reimbursement from the fund.

Section 26.552 permits participating health benefit plan issuers to reinsure their Healthy Texas business in whole or in part if such action would favorably impact premium rates.

Section 26.553 requires that a health benefit plan issuer, not later than 30 days from the effective date of any amendment to this subchapter, submit policy form amendments and premium rate adjustments necessitated by the amendments.

Division 6. Healthy Texas Small Employer Premium Stabilization Fund

Section 26.561 defines terms essential to the Healthy Texas small employer premium stabilization fund provisions of the subchapter. *Claims corridor* is defined as claims paid on behalf of a covered person in excess of $5,000 and less than $75,000 per calendar year. *Claims paid* is defined as claims paid by a participating health benefit plan issuer pursuant to a qualifying health benefit plan issued under the Healthy Texas Program as determined by the date of payment rather than the date of service or date the claim was incurred. *Claims threshold* is defined as the aggregate amount that a participating health benefit plan issuer must pay out as claims paid before reaching the claims corridor and becoming eligible for reimbursement on behalf of an enrollee in a given calendar year.

Section 26.562 specifies the eligibility provisions relating to reimbursement from the fund for claims paid. In accordance with the Insurance Code §1508.252, the section

provides that fund reimbursement shall be calculated on a per-covered-person aggregated basis. It provides that reimbursement eligibility is limited to 80 percent of eligible claims paid on behalf of a covered person under a qualifying health plan. It further provides that an issuer is not entitled to any reimbursement on behalf of an enrollee whose paid claims do not in the aggregate reach the claims threshold for a given calendar year. The section also provides that claims paid are determined by the date of payment rather than the date of service or date the claim was incurred and prohibits delay of claim payment solely to assure that the payment date will fall in a subsequent calendar year. The section also provides that: claims paid shall not include interest paid by an issuer in connection with any claim; claims paid in a calendar year must be submitted for reimbursement before April 1 of the subsequent calendar year to be eligible for fund reimbursement; and claims paid shall not include claims paid prior to January 1, 2010.

Section 26.563 addresses fund establishment and administration. It describes some of the oversight functions of the Commissioner, as well as the requirement for health benefit plan issuer response to requests for information from the Commissioner.

Section 26.564 specifies the provisions relating to data filing requirements, including necessary claims data in connection with an issuer's annual submission of requests for reimbursement from the fund. It describes some of the categories and elements of data to be submitted by issuers; provides for data reporting periods that may be other than a calendar year and with a frequency that might be monthly if determined by the Commissioner to be necessary; requires that claims payment data

clearly state both the date the claim was incurred and the date it was paid; and requires plan issuers to use a coding system to ensure the privacy of all covered individuals.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Comments directed to the examination of employer eligibility certifications and supporting documentation to verify that applicants meet eligibility requirements. Two comments are directed to examination of eligibility certifications.

Comment: A commenter urges that consistency in eligibility verification methodology across health plans with respect to employer eligibility certification submissions is essential to ensuring appropriate and uniform access to the Healthy Texas Program. The commenter notes that a streamlined approach to the certification process by utilizing a uniform and standardized approach to application form development and design is desirable. The commenter states such an approach is accommodated by provisions of §§26.512(d) and 26.513(b). The commenter further states that a certification structure could be pursued which would obviate the need for employers to submit payroll or income supporting documentation to health plans, in which case all references to the term “supporting documentation” could properly be removed from §§26.512(c) and (g), 26.521(j) and 26.522(b).

Agency Response: The Department appreciates the comment but does not make a change to the provisions of the subchapter as a result of the comment regarding removal of the term “supporting documentation” for the following reasons. The Department agrees with the commenter that the intent of provisions of §§26.512(d) and

26.513(b) is to facilitate and accommodate uniform and standardized forms for use by participating health benefit plan issuers in order to effectively and efficiently administer the Healthy Texas Program, including the utilization of certification forms which both fulfill their purpose and contribute to efficient program administration. In response to the comment on §26.513(b), a change is made to the subsection to provide that the Commissioner may prescribe a standardized health benefit plan renewal certification form to be utilized for employer renewal certification purposes. However, the rules implemented pursuant to the Insurance Code Chapter 1508 also must acknowledge and recognize those situations anticipated by §1508.151(c), which provides that a participating health benefit plan issuer may require a small employer to submit appropriate documentation in support of either an initial certification or a recertification at time of plan renewal. Because Chapter 1508 provides for the acquisition of supporting documentation in connection with employer certification in appropriate circumstances, parallel provisions in the rules are necessary to implement the permissive authority Chapter 1508 provides to plan issuers, notwithstanding efforts to develop a process and standardized forms to diminish and possibly eliminate the practical necessity for issuers to obtain supporting documentation as part of the employer certification process.

Comment: A commenter expresses concern that §26.512(c) could be interpreted to require issuers to determine the veracity of information included in submitted certifications, and requests clarification that the rule requires only that issuers verify that information contained in the eligibility certification establishes employer

eligibility for the program.

Agency Response: The Department understands the concern of the commenter and makes a clarifying change in response. Subsection (c) provides that the issuer collect and examine the eligibility certifications required by the Insurance Code §1508.151. As noted in the previous responsive paragraph, the Insurance Code §1508.151(c) provides that a participating health benefit plan issuer may require a small employer to submit appropriate documentation in support of either an initial certification or a recertification at time of plan renewal. Correspondingly, §26.512(c) is changed to make it clear that the basis of verification is review of the certification and, as appropriate, any supporting documentation requested and received by the issuer. The subsection as changed is reasonably clear that the issuer is not required to exercise independent examination or investigation beyond the certification and any supporting documentation that the issuer, on a case-by-case basis, determines is appropriate or necessary to support the certification it receives. The Department appreciates the value and benefit of a certification that is as uniform, direct and efficient as possible, while at the same time attaining the fundamental objective of the form. For that reason, subsection (d) provides for a standardized application form that would include an employer eligibility certification component. Similarly, the verification of income provisions of §26.522 make it reasonably clear that in instances where payroll data received by the issuer is sufficient to verify that the income requirements of the Healthy Texas Program have been satisfied, nothing is required of the issuer in addition to obtaining, reviewing and verifying that the data indicates satisfaction of Healthy Texas

Program income criteria. The section also provides discretionary authority to the issuer in conjunction with the requirement that if payroll data is unobtainable or insufficient, other documentation sufficient to verify satisfaction of Healthy Texas Program income criteria may be requested and must be provided.

Comments directed to participation by regional and local health care programs. Three comments are directed to participation by regional and local health care programs.

Comment: A commenter raises a question about the extent to which individual employees of small employers presently participating in a regional or local health care program pursuant to Health and Safety Code Chapter 75 are, as a group, eligible to participate in the Healthy Texas Program. The commenter expresses concern that the definition of eligible employee in §26.502(2), when applied in conjunction with remaining provisions of Subchapter E as published, would not allow regional or local health care programs to cover existing enrollees nor enroll part-time and temporary workers who are covered by businesses that elect to include them.

Agency Response: The points of focus for the comment are the extent to which enrollees in existing regional or local health care programs will be able to participate in the program under the subchapter as published, and the extent to which present or future small employers participating in regional or local health care programs will be permitted to have individual part-time or temporary employees, who are covered by such programs, to participate in the Healthy Texas Program and the premium

stabilization fund. The Department will address both. In responding, the Department evaluates the phrase “to cover existing enrollees” to mean “to permit the participation of existing enrollees, with respect to claims paid, in the small employer premium stabilization fund.”

With respect to the first point, though the legislation affording regional and local health care programs the opportunity to participate in the Healthy Texas Program makes no provision for grandfathering existing, already established, health care programs, it does provide the basis upon which the regulatory provisions in this subchapter directed to such regional and local health care programs are founded. Essentially, Division 4 of the published proposal addresses participation by such programs. Section 26.532 provides that either existing or newly formed regional or local health care programs may elect to participate in the Healthy Texas Program. Section 26.533 addresses submission requirements for participation by such regional or local health care programs, including submission of an election on an application form for participation in the Healthy Texas Program. Options for participation include direct purchase or facilitation of purchase of a health benefit plan as provided in the Health and Safety Code §75.102(a)(3) and set out in §26.534, or participation through the implementation of a regional or local health care program containing benefit, operational and administrative provisions that meet or exceed standards established by the Commissioner for benefit and service level categories described in §26.535. Substantive and procedural details of both §26.534 and §26.535 are set out elsewhere in this document.

With respect to the second point of focus for the comment, the extent to which existing and future part-time or temporary employees of small employers enrolled in regional or local health care programs may participate in the Healthy Texas Program, the brief answer is that this subchapter provides for the participation of part-time employees of qualifying small employers, but does not provide for the participation of temporary employees of qualifying small employers. Specifically with respect to regional or local health care programs, §26.535(c)(1) provides that a small employer participation in such health care programs applying to participate in the Healthy Texas Program must comply with applicable small employer participation provisions of §26.521. In addition to mandatory provisions, §26.521(d) contains a discretionary provision permitting coverage for part-time employees and their dependents. The subsection also contains clarification that such employees or their dependents are not eligible employees for purposes of determining the small employer's eligibility to purchase a qualifying group health benefit plan under Chapter 1508 and applicable portions of this subchapter. However, the provision does afford opportunity for participation by part-time employees. Finally, regarding the exclusion of temporary employees from the Healthy Texas Program, the Department notes that the fundamental purposes and overarching objectives of the Healthy Texas Program do not accommodate inclusion of temporary employees or their dependents, and for that reason neither the Insurance Code Chapter 1508 nor this subchapter provide for participation of such employees in the Healthy Texas Program. For regional or local programs which have small employers who want to enroll full-time, part-time and

temporary employees, the exclusion discussed in this response would not necessarily preclude participation in Healthy Texas by such small employers with respect to their full-and-part-time employees, so long as all statutory and regulatory provisions are met. But the exclusion would not permit participation of the temporary employees who otherwise are persons receiving services or benefits through the regional or local health care program.

Comment: A commenter requests, with respect to participation in the Healthy Texas Program by regional and local health care programs under the Health and Safety Code Chapter 75, as provided in Division 4 of the published proposal, that the Department ensure that the same consumer protections and rights offered to health plan enrollees are also available to persons receiving care under such regional or local programs. The commenter also expresses concern about a “level playing field” for participating health plan issuers and regional and local health care programs. The commenter notes that while the Department has indicated a limit on plans that may be offered by participating issuers to promote efficiency and ensure that employers and consumers understand their benefits, it has been suggested that regional or local health care programs would be allowed to offer non-Healthy Texas programs side-by-side.

Agency Response: The Department understands the expressed concern but points out that Subchapter E as published reflects a purposeful effort to achieve a level of consumer protection for persons in participating regional or local health care programs that is as close as possible to substantially the same level of consumer

protection afforded to persons covered in the Healthy Texas Program under qualifying health benefit plans. Provisions of Division 4 of this subchapter and discussion of such provisions, set out elsewhere in this document, highlight such consumer protections.

With respect to the second point of the comment, the Department also notes that the provisions of the subchapter as published reflect purposeful effort to attain as level a "playing field" as possible. In the same way that participating health benefit plan issuers may offer only approved qualifying health benefit plans, a regional or local health care program that is approved for participation in the Healthy Texas Program must first have met and continue to meet the provisions of §26.535 if it chooses that option for participation instead of the option to directly purchase or facilitate purchase of an approved qualifying health benefit plan. Additionally, in the same way that a small employer group health benefit plan issuer – either one that is a participating Healthy Texas plan issuer or one that is not – may continue to offer nonqualifying, non-Healthy Texas Program, plans permitted by Texas law and approved to be offered in Texas to small employer groups, a regional or local health care program may opt not to apply to participate in the Healthy Texas Program and therefore not be required to meet the provisions of §26.535, but also not be eligible to have the claims of enrolled employees of small employers participate in the premium stabilization fund.

Comment: A commenter raises a point about §26.534(1)(B), which requires that employers of employees for whom regional or local health care programs purchase or facilitate purchase of a qualifying Healthy Texas plan contribute an amount of premium

cost for employees which, when combined with any amount obtained from any other eligible source as provided in the Health and Safety Code §75.055, amounts to at least 50 percent of the premium for each employee covered under the Healthy Texas benefit plan. The commenter states its belief that the Department should require that all plans offering coverage meet the same requirements. The commenter notes that the Insurance Code §1508.054 requires a small employer to pay 50 percent or more of the premium for each employee covered under the qualifying health benefit plan, and does not appear to permit employer contribution to be provided by another party.

Agency Response: The Department agrees that uniformity of requirement among plans is an important objective to be attained. However, the provision in §26.534(1)(B) represents the purposeful effort by the Department to reconcile the provisions of both §§1508.054(a)(1) and 1508.101(d) of the Insurance Code with the provisions of the Health and Safety Code §75.102(a)(3). Section 1508.054(a)(1) provides that a small employer which purchases a qualifying health benefit plan must pay 50 percent or more of the premium for each employee covered under the qualifying health benefit plan. Section 1508.101(d) requires the Commissioner by rule to establish participation requirements applicable to regional and local health care programs that consider the unique plan designs, benefit levels, and participation criteria of each program. The Health and Safety Code §75.102(a) provides that a regional or local health care program may provide health care benefits to the employees of a small employer by purchasing or facilitating purchase of health benefit plan coverage for those employees from a health benefit plan issuer under any of a variety of health

benefit plans, including, pursuant to paragraph (3), a qualifying Healthy Texas health benefit plan. The provision in §26.534(1)(B), though a departure from strict uniformity, results from consideration of the specific provisions in each of the three referenced Insurance Code and Health and Safety Code sections, and reconciliation of their application for Healthy Texas Program purposes.

§26.511. Health Benefit Plan Issuer Participation. Two comments are directed to §26.511.

Comment: A commenter requests clarification that participation in the Healthy Texas Program precludes qualified health benefit plan issuers from offering competing small group health insurance products outside the Healthy Texas Program that could pose a conflict of interest.

Agency Response: The Department offers the following clarification in response to the comment. A participating health benefit plan issuer may offer only approved qualifying Healthy Texas plans in connection with the Healthy Texas Program. However, any issuer is authorized to continue to offer any other employer health benefit plan permitted by Texas law, that it is authorized to issue, and that has been approved to be offered in Texas. Participation in the Healthy Texas Program is not intended to restrict an issuer from continuing to offer other plans in the Texas employer market, since the statement of purpose for the Healthy Texas Program in the Insurance Code §1508.001 highlights its objectives of both encouraging small employers to offer health benefit plan coverage to employees and their dependents, while at the same time

avoiding interference with the availability of traditional small employer health benefit plan coverage under Chapter 1501 of the Insurance Code.

Comment: A commenter asks how the Department proposes to ensure a competitive balance between statewide and regional insurers, what the basis will be for determining how many issuers will compete in a market, and how a market will be defined.

Agency Response: The Department appreciates the questions and offers the following in response. First, the questions are directed to the competitive procurement process for selection of participating health benefit plan issuers to provide qualifying health benefit plan coverage, as set forth in the Insurance Code §1508.101(c) and §26.511(c) of this subchapter. A basic factor influencing competitive balance, as well as the number of issuers that will compete in a given area, will be the response to the Healthy Texas Health Benefit Plan Request for Proposals (RFP), both in terms of number of respondents and the geographic areas they serve, and also in terms of overall qualifications of such respondents. That RFP has not yet been issued, resulting in uncertainty about both the number and type of issuers that will compete in a particular area. The general target market is the uninsured small employer market in Texas. Minimum qualifications for consideration include the essential and clear indication that a respondent has the necessary qualified personnel, skills, organization and facilities to fulfill all of the services required under the RFP and any resulting contract. Additional familiarity and experience qualifications also will be evaluated, again to assure that any issuer selected to participate in the program has the ongoing overall capability to fulfill

all services required under the RFP. Moreover, the Department, as part of the ongoing process of program administration, will have to consider and respond to changing small employer market dynamics and relevant factors affecting or associated with those dynamics.

In connection with the commenter's questions, comments during stakeholders meetings on program implementation emphasize the importance of a "level playing field" among participating health benefit plan issuers as a component essential to the successful launch and ongoing operation of the Healthy Texas Program. The Department recognizes the importance of vigorous and fair competition to attainment of the fundamental objectives of the program. Those objectives are marked by (1) lower cost health insurance to presently uninsured persons, and (2) reduced premium costs for all enrolled persons, in support of the overarching goal of increased health care coverage for employees of small employers and their dependents throughout the entire state. Because the Healthy Texas Program is designed to operate within the context of, and to help further develop, the existing small employer insurance model, consideration of program objectives must necessarily include all aspects of the commercial market and various factors affecting the Healthy Texas program, including access throughout all geographic areas, in the overall evaluation of probable program success. Pursuing achievement of Healthy Texas' fundamental goal through the process of building on the existing employer-based insurance model necessitates consideration of means resulting in incentive for qualified health benefit plan issuers to participate in the program. The presence of statewide coverage and vibrant competition through the RFP process is

essential to the pursuit and attainment of Healthy Texas' core objectives and primary goal. The Department also recognizes the market variation across the state and will consider both regional and statewide health benefit plan issuers submitting RFPs to assure the greatest possibility for program participation by both issuers and enrollees. Based on the commenter's questions and those of other commenters during the implementation process, and discussion points of this response, the Department makes a clarifying change to §26.551(a) to permit, pursuant to the Insurance Code §1508.202(d), a health benefit plan issuer to use the geographic location of the employer's primary place of business as an additional criterion in setting premium rates for a qualifying health benefit plan.

§26.512. Application, Initial Certification of Eligibility, and Enrollment.

Comment: A commenter proposes that the §26.512(a) requirement that a participating issuer record the date and time of receipt of employer applications for Healthy Texas plans should apply only to applications for which verification of eligibility requirements has been completed.

Agency Response: The Department does not make the proposed change, but makes a clarifying change to subsection (a) to note that the date and time record requirement is to document and acknowledge submission and receipt of an application, but not necessarily one that is in all respects a complete application that includes necessary verifications.

Comment: A commenter recommends that in §26.512(f) the 20th day of the month be changed to the 15th day of the month for purposes of establishing a cut-off date by which an employer applicant meeting eligibility criteria must be accepted and issued coverage by the first of the following month.

Agency Response: The Department makes no change as a result of the comment because the establishment of the 20th day of the month for purposes of establishing a cut-off date by which an employer applicant meeting eligibility criteria must be accepted and issued coverage by the first of the following month was the result of input from participants in one or more of the three stakeholders meetings that focused on the proposed Healthy Texas Program rules and possible content of the rules. The Department's understanding from stakeholder meeting comments is that the provisions of the subsection as published reflect current practice among small employer health benefit plan issuers with respect to issuance and effective dates of coverage. Moreover, the provision helps assure timely issuance of coverage to applicants who successfully complete application and enrollment requirements.

§26.513. Annual Recertification of Eligibility.

Comment: A commenter expresses support for a standardized form and process for recertification of eligibility similar to the process set out in §26.512(d) for initial certification. The commenter also requests clarification about whether a covered employer failing to meet either the eligibility requirements for continued participation in Healthy Texas or the reporting requirements sufficient to recertify eligibility at renewal

becomes subject to treatment as a new applicant subject to a 12-month period of non-participation as an employer applicant that has provided group health insurance coverage to its employees in the previous 12 months.

Agency Response: In response to the first comment, a clarifying provision has been added to §26.513(b), stating that the Commissioner may prescribe a standardized health benefit plan renewal certification form to be utilized for employer renewal certification purposes. In response to the request for clarification about consequences of an employer's failing to continue to meet participation eligibility or failing to provide recertification of eligibility documentation, the Department notes that provisions of the Insurance Code §1508.051(a)(1) do not permit a small employer to participate in the program if it has offered employees group health benefits on an expense-reimbursed or prepaid basis during the 12-month period immediately preceding the date of application for a qualifying health benefit plan. Chapter 1508 does not provide discretionary authority to provide for a period of less than 12 months immediately preceding the date of application for a qualifying health benefit plan. For these reasons, the failure to continue to meet participation eligibility requirements or the failure to provide recertification of eligibility as set forth in §26.513 would result in an employer being subject to nonrenewal. If nonrenewed, the employer would have opportunity to establish itself as an eligible employer by submitting an application for coverage 12 months after the effective date of nonrenewal.

§26.514(b)(3). Small employer failure to comply with premium contribution,

group size, or participation requirements.

Comment: A commenter requests that the word “material” be removed from §26.514(b)(3). The commenter explains its belief that if a small employer has failed to comply with a provision of the health benefit plan relating to premium contribution, group size or participation requirements, the issuer should be permitted to nonrenew the small employer’s health benefit plan.

Agency Response: The Department agrees that §26.514(b)(3) as published can be made more clear, and has changed paragraph (3) to remove the word “material” and further to clarify that nonrenewal is permitted in the situation where the small employer has not complied with a provision of the health benefit plan relating to premium contribution, group size, or participation requirements as set forth in the Insurance Code Chapter 1508 and this subchapter.

§26.514(d). Required 45-day prior written nonrenewal notice.

Comment: A commenter states that the proposed provision requiring a 45-day prior written nonrenewal notice should not apply to situations involving nonpayment of premium, fraud or any other misrepresentation of eligibility information provided by the employer or employees of the employer.

Agency Response: The Department makes no change as a result of the comment because advance notice of nonrenewal or termination under any circumstance serves an important information and notification function for all persons or parties of interest who may be affected by the nonrenewal or termination. Although the

time frame for providing the notice differs somewhat, the provision is consistent with notice and disclosure requirements which apply to small employer health benefit plan coverage in the conventional small employer health coverage market. For these reasons, no change is made to the subsection.

§26.514(e): Continuation of coverage provisions.

Comment: Commenters express concern that the Healthy Texas rules as published except qualifying Healthy Texas health benefit plans from continuation of coverage provisions. Commenters note their understanding that the cyclical nature and character of the program preclude a guarantee of its continuation, but nonetheless urge reconsideration and inclusion of provisions for continuation of coverage for applicable program enrollees, consistent with the primary purpose of the program to increase coverage for employees of small employers.

Agency Response: The Department agrees that provision of continuation of coverage is consistent with the primary purpose of the Healthy Texas Program and for that reason makes a change to §26.514(e) to provide that a qualifying group health benefit plan is subject to the continuation of coverage provisions of the Insurance Code, Chapter 1251, Subchapters F and G, except that a plan issued by a participating health benefit plan issuer that elects to discontinue Healthy Texas coverage by withdrawing from participation in the Healthy Texas Program pursuant to §26.515 of the subchapter is not subject to such continuation of coverage provisions. In instances where a health benefit plan issuer withdraws from the Healthy Texas Program, eligible employers and

enrollees may be provided the opportunity to obtain coverage in another approved Healthy Texas plan.

§26.516. Grace Period.

Comment: One commenter requests clarification about how payment of claims eligible for reimbursement from the premium stabilization fund would be handled in situations where the claim occurs during the 30-day grace period required by §26.516, but non-payment of premium is not addressed by the employer.

Agency Response: The Department appreciates the comment, but because the comment is general and comprehensive in terms of the variety of factual situations to which it might apply, the Department must provide a general response designed to address the comment and request as submitted. Generally, the payment of a claim by a participating issuer during a calendar year in which the plan termination effective date occurs -- but before such effective date, and which claim otherwise satisfies the statutory and regulatory criteria for eligibility for reimbursement from the fund -- would place the claim among those that are eligible for reimbursement from the premium stabilization fund, subject to availability of funds for reimbursement from the fund.

§26.521(e)(3). Participation by eligible employee earning annual wages equal to or less than 300 percent of poverty guidelines.

Comment: One commenter proposes that the participation requirement should be greater than the published requirement in paragraph (3) for employees at or below

the standard set out in Insurance Code §1508.051(a)(2) and §26.521(b) and (e) of this subchapter regarding annual income criteria. The commenter states that a higher participation requirement would assure the Healthy Texas Program is providing affordable coverage for lower income families, not simply subsidizing coverage for higher income families.

Agency Response: The Department appreciates the comment, but makes no change to paragraph (3) for the following reasons. First, a primary purpose of the Healthy Texas Program is to increase the number of insured small business owners and their employees. Certainly one important component of this primary purpose is to target low-income employees, as indicated in the portions of the Insurance Code Chapter 1508 as enacted by the Legislature that address the proportion of eligible employees of a qualifying small employer who must meet certain income criteria in order for the employer to qualify for participation in the program. Second, in conjunction with its purpose of encouraging small employers to offer health benefit plan coverage to employees and the dependents of employees, the Healthy Texas Program is designed to help provide access to quality small employer health benefit plans at an affordable price for the entire small employer group, which, depending on the particular group, may include a broad range of income levels among employees of the employer. Third, the Legislature could have required a specified level of participation from employees at a given income level, but did not do so in the enacted provisions that are codified in Chapter 1508. Paragraph (3) as published represents consistency in the overall purposeful effort to implement provisions of Chapter 1508 as enacted by pursuing the

fundamental goal of providing lower-cost health insurance to targeted uninsured persons in the small employer market; building on the existing employer-based insurance model; and making best use of limited public funds to increase health care coverage among workers not previously able to purchase employer sponsored coverage, by helping reduce health benefit plan issuers' exposure to high cost claims and by helping reduce the premium costs for all of the enrolled employees.

§26.521(i): Mid-year fluctuations in group size, wage levels and employee participation.

Comment: A commenter proposes amending the subsection to give participating issuers the discretion to terminate coverage prior to the annual recertification period if the small employer does not have at least one enrolled employee who meets the provisions of the Insurance Code §1508.051(a)(2) and §26.521(b) and (e) of this subchapter regarding annual income criteria.

Agency Response: The Department makes no change to the proposed subsection as a result of the comment because to permit discretion to terminate coverage under the circumstances described in the comment would be generally inconsistent with the overarching purposes of the Healthy Texas Program as stated in the Insurance Code §1508.001 and restated in §26.501 of this subchapter. Moreover, it would be particularly inconsistent with the provisions of §26.521(i), since that subsection clarifies that fluctuations in group size, wage levels and employee participation during the term of coverage is not a basis for termination of a qualifying group health benefit

plan prior to the anniversary date of the plan.

§26.522(a): Verification of income.

Comment: A commenter recommends change to the language of the subsection to shift the primary focus of the statement from employees to the small employer, since it is the small employer that must provide certification for eligibility and participation in the Healthy Texas Program.

Agency Response: The Department agrees with the comment and changes the language of §26.522(a) to provide that in order for a small employer to qualify for coverage under the Healthy Texas Program, eligible employees of the employer must, as a group, satisfy income criteria set forth in the Insurance Code §1508.051(a)(2).

§26.551. Rating of Plans Eligible for Claims Reimbursements.

Three comments are directed to §26.551.

Comment: A commenter states a preference for including in the rule a restriction on the extent to which rates may vary based on age. The commenter believes a maximum variation of 3.7 to 1, which was utilized in the Healthy Texas actuarial analysis, is too wide, but an improvement over what presently exists in the small group market. The commenter recommends inclusion of the actuarial study maximum variation standard in §26.551.

Agency Response: The Department appreciates the comment but makes no change to the subsection as a result of the comment for the following reasons. Rating

criteria will be clearly established as part of the RFP in the competitive selection process for participating health benefit plan issuers. The Healthy Texas Program considers it essential for program success to retain sufficient flexibility in the area of premium rating and rate variation so that it may appropriately respond to the dynamics of the small employer coverage market. The inclusion of the referenced standard in the rule would interfere with its ability to appropriately respond to changing dynamics of the small employer coverage market.

Comment: Two commenters recommend a clear statement in §26.551(a) that health status related factors are not permitted to be used in setting premium rates for a qualifying health benefit plan. The commenters emphasize that the Department has been clear throughout the stakeholder meeting process that such factors would not be permitted to be used as part of the premium rate development process. The commenters also state their belief that prohibiting use of such factors will help attain the objectives of the program, including attracting new employers to the market, making the program easier and less costly to administer, spreading the risk more effectively and reducing the significance of variation in premium rates.

Agency Response: The Department agrees with the comments and that a statement of the prohibition in the rule is helpful. For these reasons the Department has changed §26.551(a) by adding a paragraph (3) to provide that a health benefit plan issuer may not use a “health status related factor” as defined in the Insurance Code §1501.002(7) in setting premium rates for a qualifying health benefit plan.

Comment: A commenter recommends a clarifying addition to §26.551(b) to indicate the Commissioner as the information source regarding availability of reimbursement from the fund for purposes of establishing premium rates that consider availability of reimbursement from the fund.

Agency Response: The Department agrees that clarification regarding reimbursement fund availability information to be considered by participating issuers in establishing rates is helpful. For that reason, §26.551(b) is changed to provide that a participating group health benefit plan issuer may rely on available annual reported and published data concerning Healthy Texas enrollment and operations, and other available data communicated by the Commissioner on an ongoing basis in establishing premium rates that consider availability of reimbursement from the fund.

§§26.561 – 26.562. Small Employer Premium Stabilization Fund.

Comment: Two commenters make observations, recommendations and suggestions with respect to eligibility of claims paid for reimbursement from the premium stabilization fund. Because the comments are closely related to one another, they will be addressed in a single response.

A commenter notes the proposed rule limits reimbursement to claims paid in a calendar year. The commenter suggests that settlement of so-called “run off” claims (i.e., claims that are treated as a liability of an insurance company for which it expects to pay future claim amounts and for which a reserve has been established) could be addressed through different mechanisms, and requests the Department consider the

establishment of an “incurred but not paid” fund to address run off claims, or alternatively to build an assumption of some level of run off claims into premiums.

Another commenter suggests that reimbursement from the premium stabilization fund should be made more often than annually, recommends it be done quarterly, and that it be based on monthly claim data reports provided by issuers or other entities. The commenter also recommends reimbursement be based on claims-incurred and policy-effective dates rather than claims-paid dates, stating that use of claims-incurred and policy-effective dates represent more appropriate methodology for accurately matching reimbursements to claim risks.

Agency Response: The Department appreciates the comments, but makes no change to the text of either section and responds as follows. It is helpful to highlight the Insurance Code Chapter 1508 provisions which address eligibility of and corresponding constraints on claims submitted for reimbursement from the premium stabilization fund addressed in Subchapter F of Chapter 1508. Section 1508.251(a) provides for establishment of the fund from which participating health benefit plan issuers may receive reimbursement for claims paid by such issuers for individuals covered under qualifying group health plans. Section 1508.252(a) specifies that the eligible reimbursement amount is 80 percent of the dollar value of claims paid between $5,000 and $75,000 in a calendar year for an enrollee in a qualifying health benefit plan. Section 1508.252(b) is clear that such reimbursement eligibility is only for the calendar year in which claims are paid. Section 1508.254, with a focus on fund availability, provides in subsection (a) that the Commissioner is to compute a total claims

reimbursement amount for all participating issuers, for the calendar year for which paid claims are reported and reimbursement is requested.

These summaries emphasize that the Chapter 1508 provisions enacted to address establishment and operation of the premium stabilization fund and its claim reimbursement function are both clear and constraining. Chapter 1508 provisions addressing specific details concerning the claim reimbursement process and the premium stabilization fund recognize, for example, uncertainty with respect to ongoing availability of funds for reimbursement. The Department, in developing provisions regarding eligibility of claims paid for reimbursement from the fund, is subject to and must be consistent with constraints imposed by legislative enactment. The provisions of §26.562 are consistent with the Insurance Code Chapter 1508, Subchapter F. The Department understands and appreciates that from a health benefit plan issuer perspective and standpoint, focused on actuarial standards of practice, accounting principles, and financial statement reporting requirements, the utilization of incurred claims methodology provides for attainment of the matching principle in the relationship between reimbursement and claim risk. However, §26.562 as published supports the criteria set forth in Chapter 1508 Subchapter F for claim reimbursement eligibility and purposefully pursues attainment of the objectives at work in Chapter 1508 Subchapter F. The provisions set forth in Chapter 1508 Subchapter F result in an incentive for participating issuers to promptly identify, evaluate, and pay claims arising from coverage under qualifying health benefit plans. The Department acknowledges that depending on the date of incurral of a particular claim in a calendar year, all or part of the payment of

the claim might have to be delayed until the subsequent year, resulting in a potential lag for possible reimbursement pursuant to premium stabilization fund provisions in Subchapter F.

Regarding reimbursement on a frequency other than annually, the provisions of §§1508.252 - 1508.254 relating to claim eligibility, reimbursement request submission, and fund availability, respectively, are reasonably clear with respect to the annual nature of the process.

Regarding the establishment of an “incurred but not paid” fund to address run off claims or alternatively to build an assumption of some level of run off claims into premiums, the Department again appreciates the comment, and takes the comment under advisement, but has no further immediate response to it.

§26.564(a)(2): Data filing requirements.

Comment: A commenter requests a definition for the term “geographic regions” referenced in paragraph (2) and asks if the term is intended to reference the regional designations comprising the 11 Health Service Regions established by the Department of State Health Services, and presently under discussion for possible inclusion by the Department in its draft proposed Health Care Reimbursement Rate Information rules.

Agency Response: The Department agrees that the term “geographic regions” is undefined in §26.564, and that greater clarity about what the term means is helpful to potential Healthy Texas Program participating health benefit plan issuers. The term used in §26.564(a)(2) is not intended to reference the 11 zip code associated

geographic regions designated by the Department of State Health Services as Health Service Regions. What will comprise a “geographic region” under this subchapter has not yet been determined, and will depend on indicators which have presently undetermined values. For example, these indicators will include the number of participating health benefit plan issuers, and the extent of their geographic area for service, among others. For this reason, the Department is not presently able to provide a textual definition of the term. However, factors essential to the establishment of what comprises a geographic region for purposes of data submission include utility, administrative efficiency and uniformity. The Department intends to work with participating health benefit plan issuers to develop reporting requirements that are consistent with such issuers’ current market practices, while at the same time sufficient to meet the reporting needs of the Healthy Texas program.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: None.

Against: None.

Neither for nor against, with changes: American Association of Retired Persons; Celtic Insurance Company; Office of Public Insurance Counsel; Texas Association of Health Plans; and TexHealth Coalition.

6. STATUTORY AUTHORITY. The new sections are adopted under the Insurance Code Chapter 1508 and §36.001. Section 1508.003 authorizes the Commissioner to

adopt rules to implement Chapter 1508, which establishes the Healthy Texas Program. Section 1508.101(d) requires the Commissioner by rule to establish participation requirements applicable to regional and local health care programs considering the unique plan designs, benefit levels and participation criteria of each program. Section 1508.202(d) provides that the Commissioner by rule may establish additional rating criteria and requirements for qualifying health benefit plans if the Commissioner determines that the criteria and requirements are necessary to achieve the purposes of Chapter 1508, Subchapter E. Section 1508.251 requires the Commissioner to adopt rules necessary to implement and administer the Healthy Texas Premium Stabilization Fund, including rules setting out procedures for operation of the fund and distribution of money from the fund. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

DIVISION 1. GENERAL PROVISIONS

§26.501. Purpose. The purpose of this subchapter is to implement the provisions of the Healthy Texas Program as set out in the Insurance Code Chapter 1508 and to facilitate the attainment of its objectives to:

(1) provide access to quality small employer health benefit plans at an affordable price;

(2) encourage small employers to offer health benefit plan coverage to

employees and the dependents of employees; and

(3) maximize reliance on proven managed care strategies and procedures.

§26.502. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Dependent--Has the meaning assigned by the Insurance Code §1501.002(2).

(2) Eligible employee--Has the meaning assigned by the Insurance Code §1501.002(3).

(3) Fund--The Healthy Texas small employer premium stabilization fund established under the Insurance Code Chapter 1508, Subchapter F.

(4) Health benefit plan--Has the meaning assigned by the Insurance Code §1501.002(5).

(5) Health benefit plan issuer--Has the meaning assigned by the Insurance Code §1501.002(6).

(6) Participating health benefit plan issuer--A health benefit plan issuer which has elected to participate in the Healthy Texas Program in accordance with the Insurance Code Chapter 1508 and this subchapter.

(7) Qualifying group health benefit plan--A health benefit plan that provides benefits for health care services in the manner described by the Insurance Code Chapter 1508, and as approved by the commissioner.

(8) Small employer--Has the meaning assigned by the Insurance Code §1501.002(14).

DIVISION 2. PARTICIPATION BY HEALTH BENEFIT PLAN ISSUERS

§26.511. Health Benefit Plan Issuer Participation.

(a) A health benefit plan issuer electing to participate in the Healthy Texas Program by offering qualifying group health benefit plans shall file an application with the department to be a participating health benefit plan issuer in a form and manner prescribed by the commissioner.

(b) A health benefit plan issuer electing to participate in the program must do so under the terms and conditions of the Insurance Code Chapter 1508 and this subchapter.

(c) A participating health benefit plan issuer must offer only qualifying group health benefit plans to small employers participating in the Healthy Texas Program.

(d) The commissioner has determined that limitation concerning which health benefit plan issuers may participate in the Healthy Texas Program is necessary to achieve the purposes of the program, and will, in accordance with the Insurance Code §1508.101(c), contract on a competitive procurement basis with one or more health benefit plan issuers to provide qualifying health benefit plan coverage.

§26.512. Application, Initial Certification of Eligibility, and Enrollment.

(a) Applications from employers applying for qualifying group health benefit

plans must be made directly to a participating health benefit plan issuer. For purposes of submission acknowledgment, a participating health benefit plan issuer shall maintain a record of the date and time it receives an employer application for coverage under a qualifying group health benefit plan.

(b) A participating health benefit plan issuer shall provide all necessary information, including application and enrollment forms to applicants on request.

(c) A participating health benefit plan issuer:

(1) Shall collect the initial employer eligibility certifications required by the Insurance Code §1508.151;

(2) May collect appropriate documentation in support of a certification as provided in the Insurance Code §1508.151(c);

(3) Shall be responsible for examination of such employer eligibility certifications and any supporting documentation to verify that applicants meet applicable eligibility requirements; and

(4) Shall base verification upon review of the employer certification and any supporting documentation requested and received.

(d) The commissioner may prescribe a standardized health benefit plan application form that includes an employer eligibility certification section.

(1) The commissioner may, as part of such standardized application form process, prescribe a standardized notification form to be utilized by a participating health benefit plan issuer to inform a small employer applicant about submission of an incomplete application, and actions necessary to complete the application.

(2) A participating health benefit plan issuer must use any standardized application form that may be prescribed by the commissioner.

(e) A qualified group health benefit plan must provide employees with an initial enrollment period that is at least 31 days in length, and at least one open enrollment period annually that is at least 31 days in length.

(f) Unless the commissioner suspends enrollment in the Healthy Texas Program pursuant to the Insurance Code §1508.258, or limits the dates on which a health benefit plan issuer must accept employer applications pursuant to the Insurance Code §1508.152, all applicants meeting eligibility criteria shall be accepted and coverage must be issued on the first day of the month following the month in which a complete application has been submitted if such completed application has been submitted on or prior to the 20th day of the month of application. For complete applications submitted after the 20th day of a month, coverage shall be issued no later than the first day of the second month following the date of complete submission.

(g) A participating health benefit plan issuer shall provide to applicants who have failed to demonstrate eligibility a written notice of denial which clearly states the basis for the denial within two weeks of receipt of the completed initial employer eligibility certification or renewal certification and supporting documentation.

(h) A participating health benefit plan issuer must submit, monthly or at other intervals as determined reasonable and necessary by the commissioner, enrollment reports in the format specified by the commissioner. Pursuant to the Insurance Code §1508.154, such reports shall be submitted to the commissioner within a reasonable

time frame as set by the commissioner.

(i) In the event that the enrollment in the small employer Healthy Texas Program is suspended by the commissioner pursuant to the Insurance Code §1508.258, a participating health benefit plan issuer shall:

(1) notify applicants that enrollment has been suspended; and

(2) maintain a waiting list to be filled in the order of receipt of application in the event that enrollment is reactivated.

(j) An enrollment suspension pursuant to the Insurance Code §1508.258 shall not preclude the addition of dependents or new employees to existing qualifying group health benefit plans.

§26.513. Annual Recertification of Eligibility.

(a) A participating health benefit plan issuer shall, at least 90 days prior to the annual renewal date of the group health benefit plan, provide any forms necessary for small employers to submit recertification of eligibility.

(b) A participating health benefit plan issuer shall annually collect certifications of continued eligibility for the Healthy Texas Program and shall be responsible for examination of such certifications to verify that small employers and enrollees participating in the program continue to meet eligibility requirements and continue to comply with the terms of the program. The commissioner may prescribe a standardized health benefit plan renewal certification form to be utilized for employer renewal certification purposes. A participating health benefit plan issuer shall determine whether

the small employer and enrollees continue to meet the requirements for participation in the Healthy Texas Program and shall provide written notice of such eligibility determination to the small employer within two weeks of receipt of the annual recertification.

(c) The failure of an employer to provide written certification demonstrating continued eligibility and continued compliance with the terms of the Healthy Texas Program shall be a basis for nonrenewal of a qualifying health benefit plan.

§26.514. Health Plan Renewal Provisions.

(a) A qualifying group health benefit plan is renewable at the option of a participating small employer so long as:

(1) the Healthy Texas Program is active and operational;

(2) the small employer continues to meet eligibility requirements that are set forth in the Insurance Code Chapter 1508 and §26.521 of this subchapter (relating to Small Employer Participation); and

(3) the small employer timely provides a participating health benefit plan issuer the initial or renewal certification information as addressed in §26.512(c) of this division (relating to Application, Initial Certification of Eligibility, and Enrollment), §26.513(b) and (c) of this division (relating to Annual Recertification of Eligibility), and §26.521(j) of this subchapter.

(b) In accordance with subsection (a) of this section, a participating health benefit plan issuer shall renew any small employer health benefit plan for any covered

small employer at the option of the small employer, unless:

(1) the premium has not been paid as required by the terms of the plan;

(2) the small employer has committed fraud or intentional misrepresentation of a material fact not related to health status;

(3) the small employer has not complied with a provision of the health benefit plan relating to premium contribution, group size, or participation requirements as set forth in the Insurance Code Chapter 1508 and this subchapter; or

(4) membership of an employer in an association terminates, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual.

(c) A participating health benefit plan issuer may not cancel a qualifying group health benefit plan except for the reasons specified for refusal to renew under subsection (b) of this section. A participating health benefit plan issuer may not cancel the coverage of an eligible employee or dependent except for the reasons specified for refusal to renew under subsection (b) of this section.

(d) A participating health benefit plan issuer shall provide written notice to the contract holder and any covered employees of a nonrenewal or termination at least 45 days prior to its effective date. Notice of the nonrenewal or termination shall state the basis for the nonrenewal or termination and include a description of any available conversion opportunities. Notice of the nonrenewal or termination also shall include a description of other coverage options available for purchase from the participating health benefit plan issuer.

(e) A qualifying group health benefit plan is subject to the continuation of coverage provisions of the Insurance Code, Chapter 1251, Subchapters F and G, except that a plan issued by a participating health benefit plan issuer that elects to discontinue Healthy Texas coverage by withdrawing from participation in the Healthy Texas Program pursuant to §26.515 of this subchapter (relating to Notice of Discontinuance of Health Plan; Issuer Withdrawal from Participation) is not subject to such continuation of coverage provisions.

§26.515. Notice of Discontinuance of Health Plan; Issuer Withdrawal from Participation.

(a) A participating health benefit plan issuer may elect to discontinue Healthy Texas coverage only if the participating health benefit plan issuer has filed written notice of withdrawal from participation in the Healthy Texas Program with the commissioner on a form and in the manner prescribed by the commissioner and the participating health benefit plan issuer:

(1) before the 90th day preceding the date of the discontinuation of the coverage:

(A) provides notice of the discontinuation to each employer and the department; and

(B) offers to each employer the option to purchase other small employer coverage offered by the participating health benefit plan issuer at the time of the discontinuation; and

(2) acts uniformly without regard to the claims experience of the employer or any health status related factors of employees or dependents or new employees or dependents who may become eligible for the coverage.

(b) This section does not exempt a participating health benefit plan issuer from any other legal requirements, such as those in Insurance Code Chapter 827, §26.511(c) of this division (relating to Health Benefit Plan Issuer Participation), and §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures), or requirements for discontinuation of certain plans under this chapter.

§26.516. Grace Period. A qualifying group health benefit plan shall provide a 30-day grace period for payment of premiums.

§26.517. Health Plan Contact Information. A participating health benefit plan issuer shall submit to the department:

(1) the name, mailing address, email address, and telephone number of a health plan issuer contact person assigned to the Healthy Texas Program;

(2) the mailing address, email address, and toll-free telephone number to which consumer inquiries regarding the Healthy Texas Program are to be directed;

(3) the service area in which the Healthy Texas Program will be available; and

(4) any revisions or updates to the information specified in paragraphs (1) – (3) of this section, or subsequently required contact information, in the timeframe and

manner prescribed by the commissioner.

DIVISION 3. PARTICIPATION BY SMALL EMPLOYERS

§26.521. Small Employer Participation.

(a) In accordance with the Insurance Code §1508.002(7), qualifying small employers must have at least two but no more than 50 eligible employees.

(b) Qualifying small employers must offer coverage to all persons who are considered to be eligible employees as defined in §26.502(2) of this subchapter (relating to Definitions) for the purpose of determining the employer's eligibility to purchase a qualifying group health benefit plan, at least 30 percent of which must be eligible employees who are earning annual wages from the employer equal to or less than 300 percent of the poverty guidelines for an individual as defined and updated annually by the United States Department of Health and Human Services, or as adjusted by the commissioner in accordance with the Insurance Code §1508.052(b).

(c) Qualifying small employers must offer coverage to each dependent of an eligible employee. An eligible employee’s spouse and dependent children younger than age 25 shall be considered eligible dependents under qualifying group health benefit plans.

(d) Qualifying small employers may offer coverage to part-time employees working at least 20 hours per week, and their dependents. Part-time employees or their dependents to whom coverage may be offered are not eligible employees for purposes of determining the small employer’s eligibility to purchase a qualifying group health

benefit plan pursuant to the Insurance Code §1508.051(a)(2) and §1508.053 and subsections (e) and (f) of this section .

(e) Qualifying small employers must, in accordance with the Insurance Code §1508.051 and §1508.053, have eligible employees as defined in §26.502(2) of this subchapter who meet the criteria specified in paragraphs (1) – (3) of this subsection.

(1) At least 30 percent of eligible employees must earn annual wages from the employer equal to or less than 300 percent of the poverty guidelines for an individual as defined and updated annually by the United States Department of Health and Human Services, or as adjusted by the commissioner in accordance with the Insurance Code §1508.052(b).

(2) At least 60 percent of eligible employees must participate in group health insurance coverage through the Healthy Texas Program.

(3) At least one eligible employee earning annual wages from the employer equal to or less than 300 percent of the poverty guidelines for an individual as defined and updated annually by the United States Department of Health and Human Services, or as adjusted by the commissioner in accordance with the Insurance Code §1508.052(b) must participate in group health insurance coverage through the Healthy Texas Program.

(f) On behalf of participating employees, qualifying small employers must contribute at least 50 percent of the premium charge for each employee for the qualifying group health benefit plan, except as provided in this division and Division 4 of this subchapter (relating to Participation by Regional and Local health Care Programs).

Qualifying small employers may choose the level of any premium contribution to be made on behalf of dependents of employees and/or part-time employees or their dependents, but such employers are not required to make an employer contribution to the premium paid to a group health benefit plan issuer for dependent or part-time employee coverage.

(g) A qualifying small employer's place of business must be located within the State of Texas in order for the small employer to be eligible to purchase a qualifying group health benefit plan.

(h) In accordance with the Insurance Code §1508.051(a)(1), qualifying small employers shall in no case include any small employers who have provided group health insurance covering any of their employees at any time during the 12-month period preceding the date of application. Small employer applicants shall be considered to have provided group health insurance if they have arranged for group health insurance coverage (insured or self-insured) on behalf of their employees and have either contributed more than a *de minimus* amount towards the cost of coverage on behalf of their employees or provided coverage that exceeds the threshold specified in paragraph (2) of this subsection.

(1) *De minimus* contributions are those that are less than an average of $50 per employee per month, based on the number of employees at the time the coverage was provided. Small employers who have paid more than this amount are not qualified to purchase health insurance coverage through the Healthy Texas Program.

(2) A health benefit plan providing coverage with an annual maximum

benefit level equal to or greater than $50,000 exceeds the threshold for arranging for employee group health insurance.

(i) Mid-year fluctuations in group size, wage levels and employee participation shall not serve as a basis for termination of a qualifying group health benefit plan.

(j) Upon initial application by a small employer, a participating health benefit plan issuer shall collect and examine employer certifications of eligibility and any supporting documentation to determine eligibility for a qualifying group health benefit plan and compliance with the terms of the Healthy Texas Program. A small employer must provide the participating health benefit plan issuer with information requested to enable the participating health benefit plan issuer to process the employer eligibility certification.

(k) A qualifying small employer may impose waiting periods which newly hired workers must satisfy in advance of obtaining coverage under the small employer's qualifying group health benefit plan.

(1) The waiting period shall not exceed 90 days from the date of hire.

(2) The waiting period must be the same for all newly hired workers.

§26.522. Verification of Income.

(a) In order for a small employer to qualify for coverage under the Healthy Texas Program, eligible employees must, as a group, satisfy the income criteria set forth in the Insurance Code §1508.051(a)(2).

(b) A participating health benefit plan issuer shall collect from the employer such

documentation in the form of payroll data or other documentation as is necessary and sufficient to verify that the income requirements of the Healthy Texas Program have been satisfied.

DIVISION 4. PARTICIPATION BY REGIONAL AND LOCAL HEALTH CARE PROGRAMS

§26.531. Purpose. The purpose of this division is to establish participation requirements applicable to regional and local health care programs described by the Health and Safety Code Chapter 75 that elect to participate in the Healthy Texas Program. Regional and local health care programs are programs that provide health care services or benefits to employees of participating small employers who are located within the boundaries of a participating county or counties as applicable. Section 75.052 provides that a regional or local health care program may be operated by a joint council, tax-exempt nonprofit entity, or other entity that operates the program under a contract with a county commissioners court or courts, as applicable, or is an entity in which the county or counties participate or that is established or designated by the commissioners court or courts, as applicable, to operate the program.

§26.532. Applicability and Scope. This division applies to any existing or newly formed regional or local health care program described by the Health and Safety Code Chapter 75 that desires to participate in the Healthy Texas Program.

§26.533. Submission of Election to Participate in Healthy Texas.

(a) As provided in this division, a regional or local health care program described by the Health and Safety Code Chapter 75 may file an election with the commissioner, on an application form and in the manner prescribed by the commissioner, to participate in the Healthy Texas Program and its small employer premium stabilization fund, utilizing the options set forth in subsections (b) and (c) of this section.

(b) A regional or local health care program may apply to participate through purchase of an available Healthy Texas health benefit plan pursuant to the Health and Safety Code §75.102(a)(3) in accordance with Divisions 3 and 6 of this subchapter (relating to Participation by Small Employers and Healthy Texas Small Employer Premium Stabilization Fund, respectively) applicable to the facilitation of purchase or direct purchase of a Healthy Texas qualifying health benefit plan, and as further provided in §26.534 of this division (relating to Participation Through Direct Purchase of Health Benefit Plan).

(c) A regional or local health care program also may apply to participate through the completion of a process that results in a regional or local health care program with benefit, operational and administrative provisions that meet or exceed the standards set forth in §26.535 of this division (relating to Participation Through Eligible Regional or Local Health Care Program Implementation).

(d) Any newly formed regional or local health care program electing to participate must meet all requirements for participation as provided in this division, and must file its election not later than the 90th day before the date coverage for health care

is to become effective for such regional or local health care program.

(e) Any existing regional or local health care program electing to participate must meet all requirements for participation as provided in this division, and must file its election not later than the 90th day before the anniversary date on which post-anniversary date coverage for health care is to become effective for such regional or local health care program.

§26.534. Participation Through Direct Purchase of Health Benefit Plan. A regional or local health care program may apply to participate through purchase of an available Healthy Texas health benefit plan pursuant to the Health and Safety Code §75.102(a)(3), so long as the eligibility criteria in paragraphs (1) and (2) of this section are met.

(1) Employers of employees for whom the regional or local health care program is purchasing or facilitating the purchase of health benefit plan coverage through Healthy Texas must:

(A) comply with the provisions of §26.521(a) – (e) and (g) – (k) of this subchapter (relating to Small Employer Participation); and

(B) contribute an amount of premium costs for employees which, when combined with any amount obtained from any other eligible source as provided in the Health and Safety Code §75.055, amounts to at least 50 percent of the premium for each employee covered under the Healthy Texas benefit plan.

(2) Employees of small employers associated with the regional or local

health care program must:

(A) meet the definition of "eligible employee" as defined in the Insurance Code §1508.002(2);

(B) meet the annual wage criteria of the Insurance Code §1508.051(a)(2) or §1508.052(b);

(C) elect to participate in the Healthy Texas Program at a rate equal to or greater than 60 percent of eligible employees; and

(D) comply with §26.521(e)(3) of this subchapter.

§26.535. Participation Through Eligible Regional or Local Health Care Program Implementation.

(a) A regional or local health care program may apply to participate through the development and implementation of a regional or local health care program with benefit, operational and administrative provisions that meet or exceed the standards specified in this section.

(b) A regional or local health care program participating in the Healthy Texas Program under this section must provide benefits and service levels for participating enrollees that meet or exceed those that are established by the commissioner for the benefit categories set forth in paragraphs (1) – (9) of this subsection. Such compliance must be certified by an authorized representative of the governing body of the regional or local health care program on a form and in the manner prescribed by the commissioner for the following categories of benefits and service levels:

(1) an annual maximum benefit requirement per enrollee;

(2) an annual maximum financial requirement prerequisite to payment of eligible claims of participating enrollees;

(3) cost-sharing maximum requirements for benefits or services covered by or through a regional or local health care program;

(4) an annual out-of-pocket maximum requirement;

(5) hospital inpatient and outpatient benefits;

(6) radiology and diagnostic tests;

(7) emergency care;

(8) maternity coverage with a limited copay for the initial prenatal visit; and

(9) immunization coverage at 100 percent of cost.

(c) A small employer participating in a regional or local health care program applying to participate in the Healthy Texas Program under this section must:

(1) meet the small employer participation provisions of §26.521(a), (b), (d), (e)(1) and (g) – (k) of this subchapter (relating to Small Employer Participation);

(2) have eligible employees that elect to participate in the Healthy Texas Program at a rate equal to or greater than 60 percent; and

(3) contribute an amount of premium or program health care costs for employees which, when combined with any amount obtained from any other eligible source as provided in the Health and Safety Code §75.055, amounts to at least 50 percent of the premium or program health care costs for each employee covered under

the health care program.

(d) A regional or local health care program participating in the Healthy Texas Program under this section must meet the claims eligibility provisions of §26.562 of this subchapter (relating to Eligibility of Claims Paid for Reimbursement from the Fund), the response provisions to information requests under §26.563(b) of this subchapter (relating to Fund Administration), and the data filing requirements of §26.564 of this subchapter (relating to Data Filing Requirements) that apply to a health benefit plan issuer participating in the Healthy Texas Program.

(e) A regional or local health care program participating in the Healthy Texas Program under this section shall, within 90 days of the end of its fiscal year, file the documents described in paragraphs (1) – (3) of this subsection with the commissioner in a form and manner prescribed by the commissioner:

(1) financial statements audited by a certified public accountant;

(2) an actuarial opinion prepared and signed by a qualified actuary who is a member of the American Academy of Actuaries. The actuarial opinion must opine on the adequacy of reserves in support of the program benefits and must include the amount of any additional reserves needed in order to render an unqualified opinion. A determination of adequacy must include a determination that a good and sufficient provision is made for all unpaid claims and other actuarial liabilities in support of the program benefits. In no event can the total reserves held be less than 20 percent of the total contributions in the preceding program operating year or less than 20 percent of the total estimated contributions for the current program operating year. Reserves must

be maintained in cash or federally guaranteed obligations of less than five-year maturity that have fixed principal amounts; and

(3) a report prepared and certified by the governing board or program operator. The certified report shall include a summary and description of the financial soundness of the regional or local health care program, including any actions the program is recommended to take or intends to implement to improve or to enhance the financial soundness of the program.

§26.536. Withdrawal from Participation.

(a) Any existing participating regional or local health care program may withdraw from participation in the Healthy Texas Program at any time by written notice filed with the commissioner on a form and in the manner prescribed by the commissioner.

(b) Any existing participating regional or local health care program also must provide enrollees under the program written notice of its intention to withdraw from participation in the Healthy Texas Program not later than the 90th day prior to the anniversary date on which the withdrawal is to become effective.

§26.537. Program Certification.

(a) At the time of initial application, a regional or local health care program electing to participate in Healthy Texas shall obtain from small employers participating in its program written certification or information to ensure that the regional or local health care program can provide written certification to the health benefit plan issuer or

to the commissioner, as applicable, that each employer meets the eligibility requirements of the Insurance Code §1508.051 and the minimum employer participation requirements of the Insurance Code §1508.053.

(b) A regional or local health care program participating in the Healthy Texas Program under §26.534 of this division (relating to Participation Through Direct Purchase of Health Benefit Plan) shall, not later than the 90th day before the renewal date of the health benefit plan, provide the health benefit plan issuer a written certification that each employer continues to meet the eligibility requirements of the Insurance Code §1508.051 and the minimum employer participation requirements of the Insurance Code §1508.053.

(c) A regional or local health care program participating in the Healthy Texas Program under §26.535 of this division (relating to Participation Through Eligible Regional or Local Health Care Program Implementation) shall, not later than the 90th day before the renewal date of the health services contract, provide the commissioner a written certification that each employer continues to meet the eligibility requirements of the Insurance Code §1508.051 and the minimum employer participation requirements of the Insurance Code §1508.053.

(d) The health benefit plan issuer may require the submission of appropriate documentation to support a certification described by subsection (a) or (b) of this section.

§26.538. Applicability of Other Subchapter Provisions. Except as expressly

provided in this division, the provisions of Division 3 of this subchapter (relating to Participation by Small Employers) apply to small employers and employees of small employers that participate in a regional or local health care program that elects to participate in the Healthy Texas Program.

DIVISION 5. RATING OF QUALIFIED HEALTH BENEFIT PLANS

§26.551. Rating of Plans Eligible for Claims Reimbursements.

(a) Premium rates to be charged for qualifying group health benefit plans must be filed with the department for review and approval by the commissioner in a form and within the timeframe set by the commissioner.

(1) In accordance with the Insurance Code §1508.202(c), a health benefit plan issuer may use only age and gender as case characteristics, as defined in the Insurance Code §1501.201(2), in setting premium rates for a qualifying health benefit plan.

(2) Pursuant to the Insurance Code §1508.202(d), a health benefit plan issuer may use the geographic location of the employer's place of business as an additional criterion in setting premium rates for a qualifying health benefit plan.

(3) A health benefit plan issuer may not use a "health status related factor" as defined in the Insurance Code §1501.002(7) in setting premium rates for a qualifying health benefit plan.

(b) Premium rates established for qualifying group health benefit plans must recognize and consider the availability of reimbursement from the fund. In considering

fund reimbursement availability, a participating group health benefit plan issuer may rely on:

(1) Available annual reported and published data concerning Healthy Texas Program enrollment and operations; and

(2) Available data communicated by the commissioner on an ongoing basis.

(c) Rating factors shall be applied consistently with respect to all small employers in a class of business.

(d) Reimbursement from the fund shall reduce claims expenses for the purposes of calculating loss ratios, premium rates and premium rate adjustments.

(e) Initial rate submissions and rate adjustment applications submitted for qualifying group health benefit plans shall contain such information as may be needed and prescribed by the commissioner in order to assist the commissioner in determining the anticipated premium rate impact on the availability of reimbursement from the fund.

(f) Estimates of anticipated receipts from the fund may be calculated based upon available enrollment data and such other data as may be deemed appropriate by the commissioner.

§26.552. Reinsurance Permitted. Participating health benefit plan issuers may reinsure their Healthy Texas business in whole or in part if they determine it would favorably impact premium rates. The impact of any such reinsurance shall be factored into the premium rates for affected qualifying group health benefit plan premiums.

§26.553. Required Policy Form and Rate Filings. Not later than 30 days from the effective date of any amendment to this subchapter, participating health benefit plan issuers shall submit the policy form amendments and premium rate adjustments necessitated by the amendments.

DIVISION 6. HEALTHY TEXAS SMALL EMPLOYER PREMIUM STABILIZATION FUND

§26.561. Definitions. The following words and terms, when used in this Division, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Claims corridor--Claims paid on behalf of a covered person in excess of $5,000 and less than $75,000 per calendar year.

(2) Claims paid--Claims paid by a participating health benefit plan issuer pursuant to a qualifying health benefit plan issued under the Healthy Texas Program as determined by the date of payment rather than the date of service or date the claim was incurred.

(3) Claims threshold--The aggregate amount that a participating health benefit plan issuer must pay out as claims paid before reaching the claims corridor and becoming eligible for reimbursement on behalf of an enrollee in a given calendar year.

§26.562. Eligibility of Claims Paid for Reimbursement from the Fund.

(a) For each health benefit plan eligible for reimbursement from the fund, a participating health benefit plan issuer shall record and aggregate claims paid on a per-

covered-person basis. Reimbursement from the fund shall be calculated based on such per-covered-person aggregates.

(b) A participating health benefit plan issuer shall be eligible for reimbursement of 80 percent of eligible claims paid within the claims corridor on behalf of each person covered under a qualifying group health benefit plan.

(c) A participating health benefit plan issuer shall not be entitled to any reimbursement on behalf of an enrollee if the claims paid on behalf of that person in a given calendar year do not, in the aggregate, reach the claims threshold. Additionally, claims paid on behalf of an enrollee which exceed the claims corridor in a given calendar year shall not be eligible for reimbursement from the fund.

(d) Claims paid within a calendar year shall be determined by the date of payment rather than the date of service or date the claim was incurred. A participating health benefit plan issuer may not delay or defer payment of a claim solely for the purpose of causing the date of payment to fall into a subsequent calendar year.

(e) Claims paid shall not include interest paid by a participating health benefit plan issuer in connection with any claim.

(f) Claims paid that are not submitted for reimbursement prior to April 1 of the calendar year following the calendar year in which they are paid shall not be eligible for reimbursement from the fund and shall not be credited as paid claims in any year for the purpose of determining whether the claims threshold has been reached.

(1) If the commissioner determines that the claims data submitted in conjunction with a reimbursement request is insufficient to make a reimbursement

determination, the commissioner or the fund administrator shall make a request for clarification of the data or for the submission of additional data.

(2) Participating health benefit plan issuers shall comply with all such requests within 15 business days of the date of the request.

(3) If a participating health benefit plan issuer fails to comply with such a request from the commissioner or the fund administrator within 15 business days, the commissioner has discretion to deem any affected claims ineligible for reimbursement.

(g) Claims paid shall not include claims paid prior to January 1, 2010.

§26.563. Fund Administration.

(a) The commissioner shall establish the fund and oversee its administration. The functions of the commissioner may include the following:

(1) choosing a firm or firms, to administer the fund, based on an evaluation of competitive bids received in a public procurement process;

(2) granting approval of the general systems and procedures used by the firm or firms to administer the fund, including procedures utilized to verify the appropriateness of payments from the fund to any participating health benefit plan issuer;

(3) making payment of reasonable fees from the fund to the firm or firms for administration of the fund;

(4) changing the administrating firm or firms, or the administrative systems and procedures, if necessary;

(5) collecting necessary data from participating health benefit plan issuers;

(6) arranging for periodic audits of participating health benefit plan issuers and for the payment of reasonable fees for such audits from the fund; and

(7) reviewing and approving the format and content of the annual report of the administrating firm or firms regarding the affairs and operation of the fund, and requiring such other reports as are deemed necessary by the commissioner.

(b) A participating health benefit plan issuer must respond to requests for information from the commissioner and/or the fund administrator(s) within 15 business days of the date on which the request for information is made.

§26.564. Data Filing Requirements.

(a) Each participating health benefit plan issuer or regional or local health care program shall submit to the commissioner necessary claims data in connection with its annual submission of requests for reimbursement from the fund. Each participating health benefit plan issuer or regional or local health care program also shall provide the commissioner with such additional data, as deemed necessary by the commissioner, to oversee the operation of the fund and the Healthy Texas Program. Reports pertaining to reimbursement or loss ratio shall be certified, by an officer of the submitting entity, as to their accuracy and completeness. Data to be submitted may include the following:

(1) the total number of plans issued or groups enrolled in a regional or local health care program within the reporting period and the total number of plans in

force or groups enrolled in a regional or local health care program that are covered by the fund;

(2) the total number of primary insured persons or primary covered persons, the total number of dependents covered, and the total number of child dependents covered; the commissioner may require that such totals be specified by geographic region;

(3) total premium earned, and per-enrollee per-month premium earned, for all plans covered by the fund for the reporting period;

(4) claims payment data, reported individually for each enrollee and/or for each enrollee for whom the participating health benefit plan issuer has paid claims eligible for reimbursement;

(5) total claims eligible for reimbursement year-to-date; and

(6) other data and information as necessary to determine continuing program compliance.

(b) Data reporting periods may be other than a calendar year and reporting frequency for some data may be as often as monthly, as determined by the commissioner to be reasonably necessary to determine or monitor ongoing effective and efficient operation of the fund and the Healthy Texas Program and continuing attainment of program objectives. Claims payment data shall state clearly both the date the claim was incurred and the date the claim was paid. Claims payment data also may be requested on a cumulative basis or in the form of aggregates, specific categories,

and averages.

(c) A participating health benefit plan issuer shall use a coding system to ensure the privacy of insured individuals.

CERTIFICATION. This agency hereby certifies that Subchapter E, §§26.501 - 26.502, 26.511 - 26.517, 26.521, 26.522, 26.531 - 26.538, 26.551 - 26.553, and 26.561 - 26.564, as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on February 17, 2010.

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that new Subchapter E, §§26.501 - 26.502, 26.511 - 26.517, 26.521, 26.522, 26.531 - 26.538, 26.551 - 26.553, and 26.561 - 26.564 specified herein, concerning provisions essential to the operation of the Healthy Texas Program and changes in law made by the Insurance Code Chapter 1508, is adopted.

AND IT IS SO ORDERED.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO. 10-0136
FEB 23 2010