CHAPTER 26
SUBCHAPTER A. DEFINITIONS, SEVERABILITY, AND SMALL EMPLOYER HEALTH REGULATIONS
28 TAC §§26.3 - 26.16, 26.18 - 26.20, 26.25, and 26.28

REPEAL OF 28 TAC §§26.1, 26.17, 26.21 - 26.24, 26.26, and 26.27

SUBCHAPTER C. LARGE EMPLOYER HEALTH INSURANCE REGULATIONS
28 TAC §§26.301 - 26.310, 26.312 - 26.314

REPEAL OF 28 TAC §26.311

SUBCHAPTER D. COOPERATIVES
§§26.400 - 26.403, 26.405 - 26.411, 26.421 - 26.426, 26.431, 26.441, and 26.442

REPEAL OF 28 TAC §26.404 AND §26.413

INTRODUCTION. The Texas Department of Insurance adopts the repeal of sections and amended and new sections in 28 TAC Chapter 26, concerning large and small employer health insurance regulations and health group cooperatives.

TDI adopts a revised title for 28 TAC Chapter 26, "Employer-Related Health Benefit Plan Regulations."

TDI adopts the repeal of §§26.1, 26.17, 26.21 - 26.24, 26.26, and 26.27 in Subchapter A; §26.311 in Subchapter C; and §26.404 and §26.413 in Subchapter D.

TDI adopts amendments to the titles of Subchapters A, C, and D. TDI also adopts amendments to §§26.3 - 26.16, 26.18 - 26.20, and 26.25 in Subchapter A; §§26.301 - 26.310 and 26.312 in Subchapter C; and §§26.401 - 26.403 and 26.405 - 26.411 in Subchapter D.

TDI adopts new §26.28 in Subchapter A and new §26.313 and §26.314 in Subchapter C. TDI also adopts amendments separating Subchapter D into four divisions, and TDI adopts new §26.400 in Division 1 of Subchapter D; new §§26.421 - 26.426 in Division 2 of Subchapter D; new §26.431 in Division 3 of Subchapter D; and new §26.441 and §26.442 in Division 4 of Subchapter D.

TDI adopts the repeals, amendments, and new sections with changes to the proposed text published in the October 28, 2016, issue of the *Texas Register* (41 TexReg 8459). Sections 26.3, 26.7, 26.8, 26.10, 26.12, 26.14, 26.15, 26.25, 26.28, 26.303 - 26.305, 26.307 - 26.310, 26.313, 26.314, 26.400 - 26.403, 26.405 - 26.408, 26.410, 26.421, 26.422, 26.424, 26.425, 26.431, 26.441, and 26.442 are

adopted without changes to the text as proposed. Sections 26.4 - 26.6, 26.9, 26.11, 26.13, 26.16, 26.18 - 26.20, 26.301, 26.302, 26.306, 26.312, 26.409, 26.411, 26.423, and 26.426 are adopted with nonsubstantive changes as described in this adoption order.

TDI adopts §26.5 with a change from the proposed text to add subsection (i) addressing the applicability date of the changes. TDI adopts §§26.6(c), 26.18(d), 26.20(b), and 26.302(c) with minor changes from the proposed text to correct the web address for form access and §26.19 with a change from the proposed text to remove the requirement for filing of a form that TDI no longer needs. TDI also adopts §26.13(a) with a change to eliminate a provision adopted in the original Chapter 26 rules that is no longer needed because the issue was addressed in later-adopted rules relating specifically to consumer choice health benefit plans. TDI adopts §26.13(c) with a change to restore the original rule language due to a mistake in the proposal. TDI adopts §26.20 with a change to update the revision date of a form. TDI adopts §26.4(5) and §26.18(a)(2)(A) with nonsubstantive changes to make the lists parallel. TDI adopts §26.4(28) with a nonsubstantive change to eliminate a redundant word. TDI adopts §§26.6(a), 26.9(a)(9), and 26.16(c)(1) with nonsubstantive changes to make the language more plain and readable. TDI adopts §§26.11(c)(3), 26.301(e)(4), 26.312(e), and 26.411(c)(2) with nonsubstantive changes to correct grammar. TDI adopts §§26.301(g), 26.306(a), 26.423(a), and 26.426(d) with nonsubstantive changes to correct punctuation. Finally, TDI adopts §26.409 with changes to correct citations.

The amendments and new sections are applicable to any insurance policy, evidence of coverage, contract, or other document that is delivered or issued for delivery to or renewed for a small or large employer and the small or large employer's employees on or after September 1, 2017.

REASONED JUSTIFICATION. The repeals, amendments, and new sections are necessary to make the rules consistent with Texas statutes and clarify issues arising from the enactment of federal laws. They are also necessary to conform Chapter 26 to statutory changes made by SB 859, 82nd Legislature, Regular Session (2011) and SB 784, 84th Legislature, Regular Session (2015).

TDI modifies the existing regulations by changing the title of the chapter to "Employer-Related Health Benefit Plan Regulations" because the chapter addresses more than small employer plans. TDI amends the titles of subchapters and sections to more accurately reflect their contents. Amendments include updates to language and format, changes to citations in statutes and other rules that have been

recodified or redesignated, and nonsubstantive changes to conform to current agency writing style guidelines.

The changes are also necessary to eliminate redundant language, improve readability, and clarify wording. Adopted deletions remove language that is clear in statute. The amendments move some content to group relevant provisions together.

In addition, TDI reviewed all sections of Chapter 26 to assess whether the reasons for initially adopting the sections continue to exist, in accordance with Texas Government Code §2001.039. TDI determined that in most, but not all, cases, the reasons for initially adopting the sections continue to exist. In those cases, TDI adopts those sections with any amendments necessary for the purposes addressed in this adoption. In some cases, TDI determined that the reasons for initially adopting the sections no longer exist and now adopts the repeal of those sections. These repealed sections are §26.27 and §26.413.

TDI amends the title of Subchapter A to more accurately specify the contents of the subchapter, which relates to definitions and severability for Subchapters A, C, and D, and small employer health regulations for the remainder of the subchapter.

TDI repeals §26.1, relating to Statement of Purpose, because the chapter implements more than just Insurance Code Chapter 1501, the Health Insurance Portability and Availability Act. TDI has moved the information about the various purposes of the chapter to the applicable subchapters.

Amendments to §26.3, relating to Severability, update language.

Amendments to §26.4, relating to Definitions, clarify that the terms defined in the section apply to Subchapters A, C, and D. The amendments also redesignate some definitions to preserve alphabetical order, change some definitions to reference statutory definitions to minimize unnecessary duplication of statutory language, delete definitions of unused terms, and update citations and language. Definitions are moved from §26.312, relating to Point-of-Service Coverage, to Subchapter A. Definitions for the terms "eligible dependent," "gross premiums," and "TDI" are added to the section. TDI changes the term "actuary" to "qualified actuary" and modifies the definition for greater accuracy.

TDI changes definitions of the following words and phrases to conform them to statutory definitions for the terms: "affiliation period," "base premium rate," "case characteristics," "class of business," "creditable coverage," "dependent," "eligible employee," "employee," "genetic information," "genetic test," "health benefit plan," "index rate," "large employer," "large employer health benefit

plan," "new business premium rate," "participation criteria," "person," "point-of-service plan," "preexisting condition provision," "premium," "rating period," "risk-assuming carrier," "small employer," "small employer health benefit plan," and "waiting period." The amendments also eliminate some definitions by combining terminology. TDI also amends the definition of "child" to include any other child considered a dependent under an employer's health benefit plan. The adoption deletes references to the Texas Health Insurance Risk Pool because it no longer exists.

Amendments to §26.5, relating to Applicability and Scope, clarify that the remainder of Subchapter A governs small employers. The amendments delete outdated references to documents that were delivered, issued for delivery, renewed, or not renewed on or after July 1, 1997, and any required notice associated with those documents. New §26.5(g) provides that a Texas-licensed carrier that issues a certificate of insurance covering a Texas resident is responsible for ensuring that the certificate complies with applicable Texas insurance laws and rules, including mandated benefits, regardless of whether the group policy underlying the certificate was issued outside the state. The provision clarifies the application of Insurance Code Article 21.42 to small groups. Insurance Code Article 21.42 says that any contract of insurance payable to any citizen or inhabitant of Texas by a company doing business within Texas will be held to be a contract made and entered into under and governed by Texas law despite whether execution of the contract or payment of the premiums are made outside of the state. The substance of §26.5(k) is updated and moved to subsection (h).

Amendments to §26.6, relating to Status of Health Carriers as Small Employer Carriers, change the section title by removing "and Geographic Service Area." SB 784 removed the requirement for geographic service information to be filed with TDI because that information is collected by TDI in another manner. Section 26.6(a) removes the annual March filing deadline regarding status of health carriers and instead requires only an original filing and a filing of change in status. The amendments prescribe the elements of the filing, and provide a web address for a form that fulfills the requirements. The amendments remove the requirement for small employer carrier status information regarding health benefit plans issued before July 1, 1997, because it is unnecessary. Section 26.6(c) eliminates the requirement for the health carrier to file Form Number 1212 CERT GEOG (also known as Figure 44) regarding the establishment of geographic service areas, to comply with SB 784. Section 26.6(e) is deleted to remove a provision addressing ineligibility for participation in the Texas Health Reinsurance System, and what was previously §26.6(f) is redesignated §26.6(e).

Section 26.7(f) is deleted because it is a duplicate of Insurance Code §1501.155(d). Redesignated §26.7(i) clarifies when waiting periods apply. Subsections (m) and (n) are also deleted as unnecessary because small employer carriers can no longer exclude or deny coverage under separate guaranteed enrollment requirements.

Amendments to §26.8(b) specify that an "eligible employee" does not include an employee within the waiting period or affiliation period for percentage of participation requirement purposes because the employee does not have the opportunity to participate in the insurance. Section 26.8(c) is deleted because the substance of the contribution information is clear in Insurance Code §1501.153, and the termination information is clear in §§1501.108 - 1501.110. Section 26.8(d) is amended and §26.8(e) and (f) are deleted because the minimum percentage participation requirements are sufficiently addressed by statute in Insurance Code §1501.154 and §1501.155.

Amendments to §26.9, relating to Exclusions, Limitations, Waiting Periods, Affiliation Periods and Preexisting Conditions and Restrictive Riders, clarify that a small employer may not exclude any eligible employee or dependent who would otherwise be covered under a small employer's health benefit plan, except to the extent permitted by statute. The amendments clarify when waiting periods or affiliation periods apply and update the examples.

To clarify wording, and update citations and formatting, TDI makes nonsubstantive changes to §26.10, relating to Establishment of Classes of Business; §26.11, relating to Restrictions Relating to Premium Rates; and §26.12, relating to Disclosure.

Amendments to §26.13, relating to Fair Marketing, clarify that an agent authorized by a small employer carrier to market consumer choice health benefit plans must also be authorized to market fully-mandated health benefit plans, to ensure that the consumer is offered both consumer choice health benefit plans and state-mandated plans. The carrier or agent must offer all plans to the small employer for which it qualifies. One sentence in §26.13(a) related to the marketing of consumer choice health benefit plans is deleted as no longer necessary. After the provision was originally adopted in this rule, the issue was also addressed in rules relating specifically to consumer choice health benefit plans. Removing the provision in §26.13(a) will eliminate possible confusion arising from the issue being addressed with similar but not identical language in two separate rules. Section 26.13(d) is deleted because Insurance Code Chapter 1501 does not require a written affirmation that the small employer carrier offered the small employer a consumer choice health benefit plan.

TDI amends §26.14, relating to Coverage, by deleting subsections (a), (b), and (f) because it is not necessary to state that a small employer carrier should comply with the statutes. TDI adds catchlines to these subsections for clarity. TDI adds new §26.14(d), relating to point-of-service (POS) coverage, allowing an HMO issuing small employer HMO coverage to also offer POS coverage as long as it meets the requirements set forth in Insurance Code Chapter 843, concerning Health Maintenance Organizations; 28 TAC Chapter 11, Subchapter Z, relating to Point-of-Service Riders; and 28 TAC Chapter 21, Subchapter U, relating to Arrangements Between Indemnity Carriers and HMOs for Point-of-Service Coverage, which allow the enrollee to access out-of-plan coverage at the option of the enrollee. Texas Insurance Code Chapter 1273 also allows an HMO issuing small employer HMO coverage to offer POS coverage. The new section is not a change in law or practice for HMOs.

Amendments to §26.15, relating to Renewability of Coverage and Cancellation, remove dates in subsections (a)(2) and (b) regarding "intentional misrepresentation of a material fact on or after September 1, 1995," because that date has passed. Section 26.15(a)(3) clarifies that the participation requirement is the minimum percentage. TDI deletes the specific reference to "HMOs" in §26.15(a)(4) so that it reads, "the small employer has no enrollee, in connection with the plan, who resides or works in the service area of the small employer carrier or in the area where the small employer carrier is authorized to do business." This amendment is made in accordance with Insurance Code §1501.108(4), which does not restrict this provision to HMOs.

Amendments to §26.16, relating to Refusal to Renew and Application to Reenter Small Employer Market, update citations and wording. Part of §26.16(a) and all of subsections (b) and (c) are deleted to remove references to geographic service areas in accordance with changes to the Insurance Code made by SB 784. Section 26.16(f) is deleted because there is no need to remind anyone that all laws must be followed.

TDI repeals §26.17, relating to Notice to Covered Persons, because the notice requirements are clear in Insurance Code §§1501.108 - 1501.110.

Amendments to §26.18, relating to Election and Application to be a Risk-Assuming or Reinsured Carrier, list the existing requirements that must be submitted in a risk-assuming carrier application and provide a web address carriers can use to access a form that meets the requirements. Amendments to §26.18(a)(1) require a risk-assuming carrier's initial application to include a history of rating and underwriting; description of the carrier's commitment to fairly market to small employers, including

sample marketing materials and marketing plan; description of experience in managing risk; description of plans to manage the risk; list of affiliated carriers; and signature of the chief executive officer, attorney for the named health carrier, or actuary. Amendments to §26.18(a)(2) require that a reinsured carrier's notification must include a statement of the carrier's election to operate as a reinsured carrier, and signature of the chief executive officer, attorney for the named health carrier, or actuary.

TDI amends §26.18(b)(1) to provide that if a carrier is requesting a change to be a risk-assuming carrier, its filing must include the same information supplied in §26.18(a) and information demonstrating good cause for the request to change status and a signature of the chief executive officer, attorney for the named health carrier, or actuary.

Amendments to §26.19, relating to Filing Requirements, delete Form Number 1212 CERT ANN LIST-OTHER/SEHBP in §26.19(a) because TDI no longer needs to collect the information on the form, and Form Number 1212 CERT GEOG (also known as Figure 44) in §26.19(b) because of the elimination of that requirement by SB 784 and because similar information is collected by TDI in another manner.

Amendments to §26.20, relating to Reporting Requirements, add new subsection (b) to provide a web address for carriers to access Form Number 1212 CERT ACTUARIAL. The amendments to renumbered subsection (c) provide a web address for carriers to access Form Number 1212 CERT DATA, clarify that the information provided in the form relates to the previous calendar year, and they delete the requirement in §26.20(c)(3) to provide a physical copy of the certificate of coverage for each of the carrier's three most frequently issued consumer choice health benefit plans because TDI no longer uses this information. The definition of "gross premiums" in §26.20(b)(8) has been moved to §26.4, relating to Definitions.

TDI repeals §26.21, relating to Cost Containment, because the requirements of the section are clearly addressed in Insurance Code §1501.257.

TDI repeals §26.22, relating to Private Purchasing Cooperatives, and §26.23, relating to Powers and Duties of Texas Health Benefits Purchasing Cooperative and Private Purchasing Cooperatives, and moves their substance to Subchapter D.

TDI repeals §26.24, relating to Procedure for Obtaining the Approval of Commissioner and Filing with the Commissioner, because the delegation is considered a routine matter under 28 TAC Chapter 1, Subchapter F.

TDI amends and updates citations in §26.25, relating to Unfair Competition and Unfair Practices.

TDI repeals §26.26, relating to Administrative Violations and Penalties, because the requirements are clearly addressed in Insurance Code §1501.357. TDI also repeals §26.27, relating to Forms, because amendments in other sections point to where particular forms can be found on TDI's website, making the section unnecessary.

TDI adds new §26.28, relating to Territorial Exclusions, which imposes limitations on a small employer health benefit plan's ability to exclude health care services, supplies, or drugs provided for medical emergencies outside the plan service area, including outside the United States.

TDI amends the title of Subchapter C to include a reference to health insurance regulations for large employers, because the subchapter encompasses more than the Health Insurance Portability and Availability Act regulations.

TDI amends §26.301, relating to Applicability, Definitions, and Scope, adding a new subsection (a) to incorporate the terms defined in §26.4. A new §26.301(b) is added to clarify that Insurance Code Chapter 1501 and 28 TAC Chapter 26, Subchapter C, regulate all health benefit plans sold to large employers. Section 26.301(c) and (d) are deleted to eliminate references to documents that were delivered, issued for delivery, renewed, or not renewed to large employers and their employees on or after July 1, 1997, because that time period is no longer relevant. The amendments replace and simplify language in §26.301(d) and (g). New §26.301(h) provides that if a large employer has employees in more than one state, the provisions of Insurance Code Chapter 1501 and 28 TAC Chapter 26, Subchapter C, apply to its health benefit plan if the majority of employees are employed in this state on the issue date or renewal date, or if the primary business location is in this state on the issue date or renewal date and no state contains a majority of the employees. The language in §26.301(h) tracks similar language provided for small employers in §26.5(f). New §26.301(i) requires a carrier licensed in this state that issues a certificate of insurance covering a Texas resident to ensure that the certificate complies with applicable Texas insurance laws and rules, including mandated benefits. The provision clarifies the application to large groups of Insurance Code Article 21.42, which allows for any contract of insurance payable to any citizen or inhabitant of this state by a company doing business within Texas to be held to be a contract made and entered into under and governed by Texas law despite execution of the contract or payment of the premiums made outside of the state.

The title of §26.302, relating to Status of Health Carriers as Large Employer Carriers, is amended to delete a reference to geographic service areas. Section 26.302(a) removes the annual March filing

deadline regarding status of health carriers and instead requires only an original filing and a filing of change in status. TDI deletes the unnecessary requirement for large employer carrier status information regarding health benefit plans issued before July 1, 1997. New §26.302(c) points to a link on TDI's website for the form carriers can use to fulfill the requirements of §26.302(a) and (b). References to Form Number 1212 LEHC GEOG (also known as Figure 51) and geographic services areas are deleted in §26.302(c) and (d), because SB 784 eliminated that requirement and TDI collects similar information in another manner.

TDI deletes §26.303(a), (d), (f), and (h) because they are repetitive of Insurance Code Chapter 1501, Subchapter M, and the remaining subsections are redesignated as appropriate. A sentence is added to §26.303(e) to clarify that an "eligible employee" does not include an employee within the waiting period or affiliation period for percentage of participation requirement purposes because the employee does not have the opportunity to participate in the insurance.

Amendments to subsection (b) of §26.304, relating to Requirement to Insure Entire Groups, clarify wording. Subsections (g) and (h) are deleted because they are no longer necessary.

Amendments to §26.305, relating to Enrollment, delete subsection (l) as repetitive of Insurance Code §1503.003; subsection (m) as repetitive of the annual prostate exam required by Insurance Code §1362.003; and subsection (n) as repetitive of obstetrical or gynecological care required by Insurance Code Chapter 1451, Subchapter F and 28 TAC Chapter 11.

Amendments to §26.306, relating to Exclusions, Limitations, Waiting Periods, Affiliation Periods and Preexisting Conditions, and Restrictive Riders, clarify language relating to waiting periods and affiliation periods, update citations, and update the example dates.

TDI adds new §26.307(h), relating to Fair Marketing, which clarifies the requirement that if a large employer carrier issues coverage under a consumer choice benefit plan, it must also comply with requirements for consumer choice health benefit plans under 28 TAC Chapter 21, Subchapter AA.

TDI updates language and citations in §26.308, relating to Renewability of Coverage and Cancellation.

TDI deletes the obligation of a large employer carrier to notify the commissioner of geographic information in §26.309(a), relating to Refusal to Renew and Application to Reenter Large Employer Market, due to the deletion of language referring to Form Number 1212 LEHC GEOG in §26.302. The

amendments to this section also update citations and delete unnecessary language and redesignate subsections as a appropriate to reflect the revisions.

TDI amends the title of §26.310, relating to Unfair Competition and Unfair Practices and updates insurance code citations in the section.

TDI repeals §26.311, relating to Administrative Violations and Penalties, as unnecessary in light of similar Insurance Code provisions.

The definitions in §26.312, relating to Point-of-Service Coverage, are moved from this section to §26.4 because they apply to small and large group health benefit plans.

New §26.313, relating to Filing Requirements, does not impose any additional duties on large employer carriers. Section 26.313 is modeled after §26.19, relating to Filing Requirements, as that section now relates to small employer carriers. The requirements of the new section are existing requirements under Insurance Code Chapters 1271, 1273, and 1501, and in other chapters of 28 TAC. The new section requires each large employer carrier, other than an HMO, to use a policy shell format for any group or individual health benefit plan form. The new section requires filings to be submitted, as applicable, in the following order: a policy face page; the group certificate page or individual data page; the toll-free number and complaint notice page; the table of contents; insert pages for the general provisions; insert pages for the required provisions and optional provisions; an insert page for the benefits section of the health benefit plan; insert pages for any amendments, applications, enrollment forms, or other form filings that comprise part of the contract; insert pages for any required outline of coverage for individual products; any additional form filings and documentation; the information required under this section; and the rate schedule. Each HMO must submit health benefit plan forms for use in the large employer market that include the agreement; alternate pages to the agreement or the schedule of benefits and any alternate schedules of benefit; and additional riders, amendments, applications, enrollment forms, or other forms and required documentation. The filing must include any applicable requirements of 28 TAC Chapter 11, Subchapters D and F, except for continuation and conversion of coverage, which must meet the requirements of Insurance Code Chapter 1271, and 28 TAC Chapter 26, Subchapter G. The filing must also include any rider forms.

New §26.314, related to Territorial Exclusions, imposes limitations on the ability of a large employer health benefit plan to exclude health care services, supplies, or drugs provided for medical emergencies outside the plan service area, including outside the United States.

TDI amends the title of Subchapter D to include all cooperatives as provided by Insurance Code Chapter 1501. TDI creates four divisions within the subchapter. Division 1 relates to Nonprofit Health Group Cooperatives. SB 859, 82nd Legislature, Regular Session (2011), which amended provisions for small and large employer health group cooperatives, requires that a health group cooperative making an election must file evidence of the election as prescribed by rule. In addition, SB 859 requires the commissioner to adopt rules under which a health group cooperative, for good cause, may rescind an election and rules governing the eligibility of a single-employee business to participate in a health group cooperative.

New §26.400, relating to Definitions and Filing, incorporates the terms defined in §26.4, updates the address for filing information under Subchapter D, and clarifies that all references to health group cooperatives in the subchapter refer only to nonprofit health group cooperatives.

Amendments to §26.401, relating to Establishment of Health Group Cooperatives, clarify wording, and §26.401(d) is amended to delete a reference to the Filings Intake Division because it is outdated, and the address for filing information required by Subchapter D is relocated to new §26.400(d). The amendment to §26.401(e) prohibits a health group cooperative from admitting an eligible single-employee business if it restricts its membership to 50 eligible employees under Insurance Code §1501.0581. TDI also amends §26.401(f) to reference single-employee businesses and to delete the reference to Form Number HGC-1.

Amendments to §26.402(a), relating to Membership of Health Group Cooperatives, add that the membership of a health group cooperative may also consist of small employers and eligible single-employee businesses; large employers and eligible single-employee businesses; and small employers, large employers, and eligible single-employee businesses as provided by Insurance Code §1501.0581. In order to give reasonable notice of nonrenewal, §26.402(b) requires a health group cooperative that does not have at least 10 participating employers to notify those employers of the potential for nonrenewal.

TDI makes nonsubstantive grammatical changes to §26.403, relating to Marketing Activities of Health Group Cooperatives.

TDI repeals §26.404, relating to Health Group Cooperative's Status as Employer, because the content is duplicative of Insurance Code §1501.063.

The amendment to §26.405, relating to Premium Tax Exemption for Previously Uninsured, updates wording.

TDI amends §26.406, relating to Standard Prevention Form, to provide the relevant Insurance Code and Texas Administrative Code citations for brevity.

The amendments update wording in §26.407, relating to Health Carrier Filing Prior to Issuance of Coverage to a Health Group Cooperative, and in §26.408, relating to Issuance of Coverage to Health Group Cooperatives. The reference to the Filings Intake Division in §26.407(a) is deleted because it is outdated and the address for filing information required by the subchapter is included in new §26.400(d).

Amendments to the state mandate exceptions in subsection (a) of §26.409, relating to Health Benefit Plans Offered Through Health Group Cooperatives, more accurately reflect current statutory mandates. Amendments to §26.409(a) delete references to continuation of coverage for certain drugs under a drug formulary, as required by Insurance Code §1369.055; coverage of off-label drugs, as required by Insurance Code §§1369.001 - 1369.005; and the limitations or restrictions on copayments and deductibles imposed by 28 TAC §11.506 (2)(A) and (B), because the exemption from state law requirements found in Insurance Code §1501.0581(i) does not apply to them. The amendments also add the following state coverage mandates to the current list of exemptions in §26.409(a): transplant donor coverage, as established by 28 TAC §3.3040(h); coverage for certain tests for detection of human papillomavirus, ovarian cancer, and cervical cancer as required by Insurance Code Chapter 1370; certain tests for detection of cardiovascular disease as required by Insurance Code Chapter 1376; certain amino acid-based elemental formulas as required by Insurance Code Chapter 1377; prosthetic devices, orthotic devices, and related services as required by Insurance Code Chapter 1371; and orally administered anticancer medications as required by Insurance Code Chapter 1369. Paragraphs in the subsection are renumbered as appropriate to reflect the amendments.

The amendments update citations and wording in §26.410, relating to Expedited Approval for Plans Offered Through a Health Group Cooperative. Subsection 26.411(b) and (c), related to Service Areas for Health Carriers Offering Coverage Through a Health Group Cooperative, are amended to delete the references to the Filings Intake Division because the address for filing information required by Subchapter D is included in new §26.400(d).

The repeal of §26.413, relating to Health Carrier Reporting Requirements, eliminates the requirement for cooperatives and coalitions to file an annual statement of amounts collected and expenses incurred, in accordance with amendments to the Insurance Code made by SB 784.

TDI establishes Division 2 as Single-Employee Business Participation in Health Group Cooperatives.

New §26.421, relating to Election to Permit Single-Employee Businesses to Participate in a Health Group Cooperative, requires a health group cooperative that elects to admit eligible single-employee businesses to file an election with TDI at least 90 days before the date coverage becomes effective for single-employee business members. The election filing must contain the election date, the election results, affirmation that the cooperative has a written agreement with a small or large employer health benefit plan issuer, and a signature by an authorized officer of the cooperative.

New §26.422, relating to Condition Precedent to Filing Election to Admit Single-Employee Businesses as Members, permits a health group cooperative to admit eligible single-employee businesses if a small or large employer health benefit plan issuer has agreed in writing to offer to issue coverage to the cooperative based on its membership.

New §26.423, relating to Initial and Annual Enrollment Periods, requires a health group cooperative that elects to admit eligible single-employee businesses to permit participation and enrollment in the cooperative's health benefit plan coverage during the initial and annual open enrollment periods. It also requires such a health group cooperative to apply the provisions of Insurance Code §1501.0581(a-1) to eligible single-employee businesses.

New §26.424, relating to Membership Eligibility Requirements for Single-Employee Businesses, establishes that a single-employee business is eligible to join a health group cooperative if it is owned and operated by a sole proprietor, is engaged in commercial activity for livelihood or profit, is not operated solely to obtain health benefit plan coverage, and employs fewer than two employees on business days during the preceding calendar year.

New §26.425, relating to Plan Issuance, Rating Requirements, and Mandated Benefits, applies the provisions of Insurance Code Chapter 1501 relating to guaranteed issuance of plans, rating requirements, and mandated benefits to eligible single-employee businesses that are members of the health group cooperative.

New §26.426, relating to Rescission of Election, allows a health group cooperative to rescind its

election to admit eligible single-employee business members if the election has been effective for at least two years, the cooperative files notice of the rescission, and the cooperative provides written notice of termination of coverage. The section also provides that a cooperative may rescind its election to admit eligible single-employee business members before the second anniversary by showing good cause in writing to TDI. A cooperative that rescinds its election may choose to permit existing single-employee business members to maintain their membership and coverage. A cooperative that has rescinded an election may not reelect to accept eligible single-employee businesses for five years.

TDI establishes Division 3 as Health Group Cooperative Election to Treat Members as Separate Employers for Rating Purposes.

New §26.431, relating to Election to Treat Members as Separate Employers for Rating Purposes, allows a health group cooperative to treat each member as a separate employer for purposes of rating health benefit plans. It requires an existing health group cooperative to file its election with TDI no later than the 90th day before the election becomes effective, and to provide all members written notice at least 90 days before the election becomes effective. When a prospective member applies to join a health group cooperative, the cooperative must provide written notice to the applicant that the cooperative has elected to treat each member as a separate employer for the purpose of rating health benefit plans. An election is effective on the earliest date after the election when the plan is next issued or renewed. The election remains in effect for no less than 12 months.

TDI creates Division 4, relating to Private Purchasing Cooperatives, which derives substantially from repealed §26.22 and §26.23.

New §26.441, relating to Private Purchasing Cooperatives, allows two or more employers to form a cooperative for the purchase of health benefit plans. It requires that a Texas cooperative be organized in accordance with Business Organizations Code Chapter 22, concerning Nonprofit Corporations, and file with the commissioner notification of the receipt of its certificate and a copy of its organizational documents. It requires that a private purchasing cooperative health benefit plan that is issued to a small employer must be a small employer health benefit plan, and one that is issued to a large employer must be a large employer health benefit plan. It also requires that a private purchasing health benefit plan issued to a school district electing to be treated as a small employer must be a small employer health benefit plan.

New §26.442, relating to Powers and Duties of Texas Health Benefits Purchasing Cooperative and Private Purchasing Cooperatives, requires a cooperative to arrange for health benefit plan coverage for employer groups that participate in the cooperative by contracting with small or large employer carriers to: collect premiums, contract to market coverage, establish administrative and accounting procedures, establish grievance procedures, contract with a carrier or third-party administrator to provide administrative services, contract with carriers for the provision of services to small or large employers covered through the cooperative, develop and implement a plan to maintain public awareness of the cooperative, negotiate premiums, and offer other ancillary products and services to its members that are customarily offered in conjunction with health benefit plans. Section 26.442(b) would allow a cooperative to contract only with small or large employer carriers who demonstrate that they are licensed and in good standing with TDI; have the capacity to administer the health benefit plans; have the ability to monitor and evaluate the quality and cost effectiveness; have the ability to conduct utilization management; have the ability to ensure enrollees adequate access to health care providers; have a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints; and have financial capacity. A cooperative may not self-insure or self-fund.

The amendments and new sections are applicable to any insurance policy, evidence of coverage, contract, or other document that is delivered or issued for delivery to or renewed for a small or large employer and the small or large employer's employees on or after September 1, 2017. An insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed prior to September 1, 2017, is subject to the rules in effect at the time the insurance policy, evidence of coverage, contract, or other document was delivered, issued for delivery, or renewed.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received two written comments and one oral comment. Commenters in support of the proposal with changes were: Office of Public Insurance Counsel and Texas Association of Health Plans.

Comment on effective date of the rule. One commenter requested that the rules be effective on or after January 1, 2018, due to filing requirements.

Agency Response. TDI agrees that the adopted rules should allow sufficient time for health carriers to bring forms into compliance and file them. Accordingly, TDI has revised the text of §26.5 as proposed to include an applicability date of September 1, 2017, which is approximately four months from the date of adoption of the rules and provides ample to time to make and file the minimal changes to forms that may become necessary by the amendments and new sections. In addition, the change clarifies that an insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed prior to September 1, 2017, is subject to the rules in effect at the time the insurance policy, evidence of coverage, contract, or other document was delivered, issued for delivery, or renewed.

Comment on §§26.4, 26.7, 26.9, 26.12, 26.304, 26.305, and 26.306. A commenter requested the removal of references to preexisting condition limitations in these sections to conform the rule to federal law and regulations in order to more accurately reflect a carrier's overall responsibilities and reduce confusion in the rules.

Agency Response. While removing these references would more accurately reflect a group health carrier's current overall responsibilities, they are necessary to implement provisions of the Insurance Code relating to preexisting condition limitations that still exist. Keeping them in the rule does not prevent health carriers from having provisions that are more favorable to consumers or complying with current federal law. TDI declines to make the change.

Comment on §26.5(g) and §26.301(i). A commenter questioned the applicability of Insurance Code Article 21.42 to employee and dependent coverage under employer-based health insurance. The commenter further questioned the need for a new rule based on a statute that has been in existence for many years, particularly in light of the current uncertainty regarding federal law governing health

benefit plans. Accordingly, the commenter requested that TDI not adopt new language in §26.5(g) and §26.301(i) based on Article 21.42.

Agency Response. Recent questions received by TDI have brought to light the need to clarify existing requirements. The new language is not a change and reflects how TDI has consistently applied the statutory and regulatory requirements. In the event changes are made at the federal level, TDI will revisit the rules to determine whether additional changes are necessary. TDI declines to remove the new language.

Comment on §26.28 and §26.314. A commenter withdrew the verbal comment the commenter made at the public hearing on new §26.28 and §26.314 in favor of a written comment requesting clarification that the new sections apply only to emergency services and do not require coverage for medical tourism services or claims.

Agency Response. The sections provide that small and large employer health benefit plans may not exclude health care services, supplies, or drugs provided for medical emergencies outside the plan service area, including outside the United States. They require coverage for emergency services only and are not intended to require coverage for medical tourism services or claims.

SUBCHAPTER A

REPEAL OF 28 TAC §§26.1, 26.17, 26.21 - 26.24, 26.26, and 26.27

STATUTORY AUTHORITY. The repeal of §§26.1, 26.17, 26.21 - 26.24, 26.26, and 26.27, is adopted under Insurance Code §§1251.008, 1501.010, 1501.256, and 36.001.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251, concerning Group and Blanket Health Insurance.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501, concerning the Health Insurance Portability and Availability Act, and to meet the minimum requirements of federal law.

Section 1501.256 authorizes the commissioner to adopt rules modifying a small employer health benefit plan or adopting a substitute for the plan using the Texas Health Benefits Purchasing Cooperative, to the extent required to comply with applicable federal law.

Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

TEXT.

SUBCHAPTER A. DEFINITIONS, SEVERABILITY, AND SMALL EMPLOYER HEALTH REGULATIONS

§26.1. Statement of Purpose.

§26.17. Notice to Covered Persons.

§26.21. Cost Containment.

§26.22. Private Purchasing Cooperatives.

§26.23. Powers and Duties of Texas Health Benefits Purchasing Cooperative and Private Purchasing Cooperative.

§26.24. Procedure for Obtaining the Approval of Commissioner and Filing with the Commissioner.

§26.26. Administrative Violation and Penalties.

§26.27. Forms.

SUBCHAPTER A

28 TAC §§26.3 - 26.16, 26.18 - 26.20, 26.25, and 26.28

STATUTORY AUTHORITY. The amendments to §§26.3 - 26.16, 26.18 - 26.20, and 26.25, and new §26.28 are adopted under Insurance Code Article 21.42 and Insurance Code §§1251.008, 1501.010, 1501.256, 1251.154, 1201.062, 1503.003, and 36.001.

Article 21.42 provides that any insurance payable to any citizen or inhabitant of this state by a company doing business within this state to be held to be a contract made and entered into and governed by Texas insurance law despite execution of the contract or payment of the premiums made outside of this state.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251, concerning Group and Blanket Health Insurance.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501, concerning the Health Insurance Portability and Availability Act, and to meet the minimum requirements of federal law.

Section 1501.256 authorizes the commissioner to adopt rules modifying a small employer health benefit plan or adopting a substitute for the plan using the Texas Health Benefits Purchasing Cooperative, to the extent required to comply with applicable federal law.

Section 1251.154 and §1201.062 mandate coverage for certain children, including adopted children.

Section 1503.003 mandates coverage of certain students.

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

TEXT.

SUBCHAPTER A. DEFINITIONS, SEVERABILITY, AND SMALL EMPLOYER HEALTH REGULATIONS

§26.3. Severability.

If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid, the invalidity does not affect the remainder of the chapter and the application of its provisions to any persons under other circumstances.

§26.4. Definitions.

The following terms, when used in Subchapters A, C, and D of this chapter, have the following meanings unless the context clearly indicates otherwise.

(1) Affiliation period--As defined in Insurance Code §1501.104 (concerning Affiliation Period).

(2) Agent--A person who may act as an agent for the sale of a health benefit plan under a license issued by TDI.

(3) Base premium rate--As defined in Insurance Code §1501.201 (concerning Definitions).

(4) Case characteristics--As defined in Insurance Code §1501.201.

(5) Child--

(A) An unmarried natural child of the employee, including a newborn child;

(B) An unmarried adopted child, including a child about whom the insured employee is a party in a suit seeking the adoption of the child;

(C) An unmarried natural child or adopted child of the employee's spouse including a child about whom the spouse is a party in a suit seeking the adoption of the child; and

(D) Any other child included as an eligible dependent under an employer's benefit plan.

(6) Class of business--As defined in Insurance Code §1501.201.

(7) Commissioner--The commissioner of insurance.

(8) Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Chapter 1507 (concerning Consumer Choice of Benefits Plans).

(9) Creditable coverage--As defined in Insurance Code §1205.004 (concerning Creditable Coverage).

(10) Dependent--As defined in Insurance Code §1501.002 (concerning Definitions).

(11) Effective date--The first day of coverage under a health benefit plan or, if there is a waiting period, the first day of the waiting period.

(12) Eligible dependent--A dependent who meets the requirements for coverage under a small or large employer health benefit plan.

(13) Eligible employee--As defined in Insurance Code §1501.002.

(14) Employee--As defined in Insurance Code §1501.002.

(15) Franchise insurance policy--An individual health benefit plan under which a number of individual policies are offered to a selected group of a small or large employer. The rates for the policy may differ from the rate applicable to individually solicited policies of the same type and may differ from the rate applicable to individuals of essentially the same class.

(16) Genetic information--As defined in Insurance Code §546.001 (concerning Definitions).

(17) Genetic test--As defined in Insurance Code §546.001.

(18) Gross premiums--The total amount of money collected by the health carrier for health benefit plans during the applicable calendar year or the applicable calendar quarter, including premiums collected:

(A) for individual and group health benefit plans issued to employers or their employees; and

(B) under certificates issued or delivered to Texas employees of employers, regardless of where the policy is issued or delivered.

(19) HMO--Any person governed by the Texas Health Maintenance Organization Act, Insurance Code Chapter 843 (concerning Health Maintenance Organizations), including:

(A) a person defined as a health maintenance organization under the Texas Health Maintenance Organization Act;

(B) an approved nonprofit health corporation that is certified under Occupations Code §162.001 (concerning Certification by Board), and that holds a certificate of authority issued by the commissioner under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations);

(C) a statewide rural health care system under Insurance Code Chapter 845 (concerning Statewide Rural Health Care System) that holds a certificate of authority issued by the commissioner; or

(D) a nonprofit corporation created and operated by a community center under Health and Safety Code Chapter 534, Subchapter C (concerning Health Maintenance Organizations).

(20) Health benefit plan--As defined in Insurance Code §1501.002.

(21) Health carrier--Any entity authorized under the Insurance Code or another insurance law of this state that provides health insurance or health benefits in this state including an insurance company, a group hospital service corporation under Insurance Code Chapter 842 (concerning Group Hospital Service Corporations), an HMO under Insurance Code Chapter 843, or a stipulated premium company under Insurance Code Chapter 884 (concerning Stipulated Premium Insurance Companies).

(22) Health insurance coverage--Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract.

(23) Health-status-related factor--Health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; disability; and evidence of insurability, including conditions arising out of acts of domestic violence and tobacco use.

(24) Index rate--As defined in Insurance Code §1501.201.

(25) Large employer--As defined in Insurance Code §1501.002.

(26) Large employer carrier--A health carrier, to the extent that carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act).

(27) Large employer health benefit plan--As defined in Insurance Code §1501.002.

(28) Late enrollee--

(A) Any employee or dependent eligible for enrollment who:

(i) requests enrollment in a small or large employer's health benefit plan after the expiration of the initial enrollment period established under the terms of the first plan for which that employee or dependent was eligible through the small or large employer, or after the expiration of an open enrollment period under Insurance Code §1501.156(a) (concerning Employee Enrollment; Waiting Period) and §1501.606(a) (concerning Employee Enrollment; Waiting Period);

(ii) does not fall within the exceptions listed in subparagraph (B) of this paragraph; and

(iii) is accepted for enrollment and not excluded until the next open enrollment period.

(B) An employee or dependent eligible for and requesting enrollment cannot be excluded until the next open enrollment period and, when enrolled, is not a late enrollee, in the following special circumstances:

(i) the individual:

(I) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;

(II) declines in writing, at the time of initial eligibility, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(III) has lost coverage under another health benefit plan or self-funded employer health benefit plan as a result of termination of employment, reduction in the number of hours of employment, termination of the other plan's coverage, termination of contributions toward the premium made by the employer, death of a spouse, or divorce; and

(IV) requests enrollment not later than the 31st day after the date on which coverage under the other health benefit plan or self-funded employer health benefit plan terminates;

(ii) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;

(iii) a court has ordered coverage to be provided for a spouse under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued;

(iv) a court has ordered coverage to be provided for a child under an insured's plan and the request for enrollment is made not later than the 31st day after the date on which the employer receives the court order or notification of the court order;

(v) the individual is a child of an insured and has lost coverage under Health and Safety Code Chapter 62 (concerning Child Health Plan for Certain Low-Income Children) or Title XIX of the Social Security Act (42 U.S.C. §§1396, et seq., concerning Medicaid and CHIP Payment and Access Commission), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. §1396s, concerning Program for Distribution of Pediatric Vaccines);

(vi) the individual has a change in family composition due to marriage, birth of a child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child;

(vii) an individual becomes a dependent due to marriage, birth of a child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child; and

(viii) the individual described in clauses (v) - (vii) of this subparagraph requests enrollment no later than the 31st day after the date of the marriage, birth, adoption of the child, loss of the child's coverage, or within 31 days of the date an insured becomes a party in a suit for the adoption of a child.

(29) Limited scope dental or vision benefits--Dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital, medical, or surgical benefits contracts.

(30) Medical care--Amounts paid for:

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) transportation primarily for and essential to the medical care described in subparagraph (A) of this paragraph; or

(C) insurance covering medical care described in either subparagraph (A) or (B) of this paragraph.

(31) Medical condition--Any physical or mental condition including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. Genetic information does not constitute a medical condition in the absence of a diagnosis of a condition related to the information.

(32) New business premium rate--As defined in Insurance Code §1501.201.

(33) New entrant--An eligible employee, or the dependent of an eligible employee, who becomes eligible for coverage in an employer group after the initial period for enrollment in a health benefit plan. After the initial enrollment period, this includes any employee or dependent who becomes eligible for coverage and who is not a late enrollee.

(34) Participation criteria--As defined in Insurance Code §1501.601 (concerning Participation Criteria).

(35) Person--As defined in Insurance Code §1501.002.

(36) Plan year--For purposes of Insurance Code Chapter 1501 and this chapter, a 365-day period that begins on the plan or policy's effective date or a period of one full calendar year, under a health benefit plan providing coverage to small or large employers and their employees, as defined in the plan or policy. Health carriers must use the same definition of plan year in all small or large employer health benefit plans.

(37) Point-of-service coverage--Coverage provided under a point-of-service plan as described in §21.2901 of this title (relating to Definitions) and as permitted by Insurance Code §1501.255 (concerning Health Maintenance Organization Plans).

(38) Point-of-service option--Coverage that complies with the out-of-plan coverage set forth in either Chapter 11, Subchapter Z of this title (relating to Point-of-Service Riders), or Chapter 21, Subchapter U of this title (relating to Arrangements Between Indemnity Carriers and HMOs for Point-of-Service Coverage), and that allows the enrollee to access out-of-plan coverage at the option of the enrollee.

(39) Point-of-service plan--As defined in Insurance Code §1273.051 (concerning Definitions).

(40) Postmark--A date stamp by the U.S. Postal Service or other delivery entity, including any electronic delivery available.

(41) Preexisting condition provision--As defined in Insurance Code §1501.002.

(42) Premium--As defined in Insurance Code §1501.002.

(43) Premium rate quote--A statement of the premium a health carrier offers and will accept to make coverage effective for a small or large employer.

(44) Public health plan--Any plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals.

(45) Qualified actuary--An actuary who is a member:

(A) of the Society of Actuaries; and

(B) in good standing of the American Academy of Actuaries.

(46) Rating period--As defined in Insurance Code §1501.201.

(47) Reinsured carrier--A small employer carrier participating in the Texas Health Reinsurance System.

(48) Renewal date--For each small or large employer's health benefit plan, the earlier of the date, if any, specified in the plan for renewal; the policy anniversary date; or the date the small or large employer's plan is changed. To determine the renewal date for employer association or multiple employer trust group health benefit plans, health carriers may use the date specified for renewal, or the policy anniversary date, of either the master contract or the contract or certificate of coverage of each small or large employer in the association or trust. Health carriers must use the same method of determining renewal dates for all small or large employer health benefit plans. A change in the premium rate is not considered a renewal if the change is due solely:

(A) to the addition or deletion of an employee or dependent if the deletion is due to a request by the employee, death or retirement of the employee or dependent, termination of employment of the employee, or because a dependent is no longer eligible; or

(B) to fraud or intentional misrepresentation of a material fact by a small or large employer or an eligible employee or dependent.

(49) Risk-assuming carrier--A risk-assuming health benefit plan issuer as defined in Insurance Code §1501.301 (concerning Definitions).

(50) Risk characteristic--The health-status-related factors, duration of coverage, or any similar characteristic, except genetic information, related to the health status or experience of a small employer group or of any member of that group.

(51) Risk load--The percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of that group. A small employer carrier may not use genetic information to alter or otherwise affect risk load.

(52) Short-term limited duration insurance--Health insurance coverage provided under a contract with an issuer that:

(A) has an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder without the issuer's consent; and

(B) is within 12 months of the date the contract becomes effective.

(53) Significant break in coverage--A period of 63 consecutive days during which the individual does not have creditable coverage. Neither a waiting period nor an affiliation period is counted in determining a significant break in coverage.

(54) Small employer--As defined in Insurance Code §1501.002. A small employer includes an independent school district that elects to participate in the small employer market under Insurance Code §1501.009 (concerning School District Election).

(55) Small employer carrier--A health carrier, to the extent that health carrier is offering, delivering, issuing for delivery, or renewing, under Insurance Code §1501.003 (concerning Applicability: Small Employer Health Benefit Plans), health benefit plans subject to Insurance Code Chapter 1501.

(56) Small employer health benefit plan--As defined in Insurance Code §1501.002.

(57) State-mandated health benefits--As defined in §21.3502 of this title (relating to Definitions).

(58) TDI--The Texas Department of Insurance.

(59) Waiting period--As defined in Insurance Code §1501.002. If an employee or dependent enrolls as a late enrollee, under special circumstances that except the employee or dependent from the definition of late enrollee, or during an open enrollment period, any period of eligibility before the effective date of enrollment is not a waiting period.

§26.5. Applicability and Scope.

(a) Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) and this subchapter regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers.

(b) Except as otherwise provided, this subchapter applies to any health benefit plan providing health care benefits covering two or more employees of a small employer, whether provided on a group or individual franchise insurance policy basis, regardless of whether the policy was issued in this state, if the plan meets one of the following conditions:

(1) a portion of the premium or benefits is paid by a small employer;

(2) the health benefit plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of the United States Internal Revenue Code of 1986, 26 U.S.C.

§106 (concerning Contributions by Employer to Accident and Health Plans) or §162 (concerning Trade or Business Expenses);

(3) the health benefit plan is a group policy issued to a small employer; or

(4) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. §2510.3-1(j) (concerning Employee Welfare Benefit Plan).

(c) For an employer that was not in existence the previous calendar year, the determination of whether the employer is a small employer is based on the average number of employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

(d) The provisions of Insurance Code Chapter 1501 and this subchapter apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

(e) If a small employer or the employees of a small employer are issued a health benefit plan under the provisions of Insurance Code Chapter 1501 and this subchapter, and the small employer, due to an increase or decrease in the number of employees, ceases to meet the definition of a small employer, the provisions of Insurance Code Chapter 1501 and this subchapter continue to apply to that particular health plan, subject to the provisions of §26.15 of this title (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to an employer must, within 60 days of becoming aware that the employer no longer meets the definition of small employer, but not later than the first renewal date occurring after the small employer has ceased to be a small employer, notify the employer of its change in status. The carrier must also notify the employer that the protections provided to small employers under Insurance Code Chapter 1501, and this subchapter will cease to apply to the employer if the employer fails to renew its current health benefit plan; fails to comply with the contribution, minimum group size, or minimum participation requirements of this subchapter; or elects to enroll in a different health benefit plan. The notice requirement of this subsection does not apply to a health carrier electing to issue coverage to a group consisting of one employee.

(f) If a small employer has employees in more than one state, the provisions of Insurance Code Chapter 1501 and this subchapter applicable to small employer plans, including provisions regarding marketing and rates, apply to a health benefit plan issued to the small employer if:

(1) the majority of employees are employed in this state on the issue date or renewal date; or

(2) the primary business location is in this state on the issue date or renewal date and no state contains a majority of the employees.

(g) A carrier licensed in this state that issues a certificate of insurance covering a Texas resident is responsible for ensuring that the certificate complies with applicable Texas insurance laws and rules, including mandated benefits, regardless of whether the group policy underlying the certificate was issued outside the state.

(h) A small employer nonfederal governmental employee health benefit plan that is not self-funded is subject to the Insurance Code and this title, as applicable, including Chapter 1501 and this chapter.

(i) This chapter is applicable to an insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed on or after September 1, 2017. An insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed prior to September 1, 2017, is subject to the rules in effect at the time the insurance policy, evidence of coverage, contract, or other document was delivered, issued for delivery, or renewed.

§26.6. Status of Health Carriers as Small Employer Carriers.

(a) With the original filing to enter the small employer market or when notifying TDI of a change in status, each health carrier providing health benefit plans in this state must file with the commissioner a statement indicating whether the health carrier will or will not offer, renew, issue, or issue for delivery health benefit plans to small employers in this state. The filing must include a certification, signed by an officer of the company, that the carrier intends to operate in accordance with the status certification unless or until it is changed in accordance with this section, and provide a statement to the effect of one of the following statements:

(1) the health carrier intends to offer, renew, issue, and issue for delivery health benefit plans to small employers in Texas and will operate in accordance with Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) and this subchapter;

(2) the health carrier does not intend to offer, issue, or issue for delivery health benefit plans to small employers in Texas, but the health carrier intends to renew existing health benefit plans;

(3) the health carrier does not intend to offer, issue, or issue for delivery health benefit plans to small employers in Texas; intends to nonrenew all health benefit plans issued to small employers in Texas; and will provide notice to the commissioner and employers in accordance with §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market) and Insurance Code §1501.110 (concerning Notice to Covered Persons); or

(4) the health carrier has no health benefit plans issued to small employers or to employees of a small employer and does not intend to offer, issue, or issue for delivery health benefit plans to small employers.

(b) If a health carrier chooses to change its election or the date of implementing its election under subsection (a)(1), (2), or (4) of this section, the health carrier must notify the commissioner of its new election at least 30 days before the date the health carrier intends to begin operations under the new election as required in subsection (a) of this section.

(c) A form fulfilling the requirements of subsections (a) and (b) of this section is available online at www.tdi.texas.gov/forms/form10smgroup.html through the link for Small Employer Carrier Status Certification.

(d) Health carriers providing coverage under any health benefit plans issued to small employers and their employees, whether on a group or franchise insurance policy basis, will be considered small employer carriers for purposes of those plans, and must comply with all provisions of Insurance Code Chapter 1501 and this subchapter, as applicable.

(e) The small employer carrier must also comply with any other applicable legal requirements, including those for withdrawal from the market under Chapter 7, Subchapter R of this title (relating to Withdrawal Plan Requirements and Procedures).

§26.7. Requirement to Insure Entire Groups.

(a) A small employer carrier that offers coverage to a small employer and its employees must offer coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in subsection (b) of this section, the small employer carrier must provide the same health benefit plan to each employee or dependent eligible for coverage.

(b) If elected by the small employer, a small employer carrier may offer one or more health benefit plans, provided that each eligible employee may choose any of the plans offered. Except as

provided in Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) with respect to an affiliation period or exclusions for preexisting conditions, the choice among benefit plans may not be limited, restricted, or conditioned based on the risk characteristics of each employee or dependent eligible for coverage.

(c) A small employer carrier may require each small employer that applies for coverage, as part of the application process, to provide a complete list of employees, eligible employees, and dependents of eligible employees. The small employer carrier may also require the small employer to provide reasonable and appropriate supporting documentation to verify the information required under this subsection, and to confirm the applicant's status as a small employer. The small employer carrier must make a determination of eligibility within five business days of receipt of any requested documentation. A small employer carrier may not condition the issuance of coverage on an employer's production of a particular document, where the employer can otherwise provide the information required by this section. Similarly, if a particular document an employer produces does not reasonably evidence the employer's compliance with this subsection, the employer must produce other documentation to satisfy the requirements. Examples of the types of reasonable and appropriate supporting documentation that a small employer carrier may request from an employer as needed to fulfill the purposes of this subsection are:

(1) a W-2 Summary Wage and Tax Form or other federal or state tax records;

(2) a loan agreement;

(3) an invoice;

(4) a business check;

(5) a sales tax license;

(6) articles of incorporation or other business entity filings with the secretary of state;

(7) assumed name filings;

(8) professional licenses; and

(9) reports required by the Texas Workforce Commission.

(d) A small employer carrier may not deny two individuals who are married the status of eligible employee solely on the basis that the two individuals are married. The small employer carrier must provide a reasonable opportunity for the individuals to submit evidence as provided in subsection (c) of this section to establish each individual's status as an eligible employee.

(1) A small employer carrier must provide married eligible employees of the same employer the option to have one spouse be treated under a small employer health benefit plan as an employee, and the other spouse treated as an employee or alternatively as the dependent of the other employee.

(2) A child of either of the two individuals may only be covered under the same small employer health benefit plan as a dependent by one of the two individuals.

(3) An election by a spouse to be treated as a dependent under this subsection does not impact the individual's status as an eligible employee for any other purpose under Insurance Code Chapter 1501, except that the individual may be treated as a dependent for purposes of employer premium contributions.

(e) A small employer carrier must secure a waiver with respect to each eligible employee and each dependent of the eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. If a small employer elects to offer coverage through more than one small employer carrier, waivers are only required to be signed if the individual is declining all offered plans. The small employer carriers may enter into an agreement designating which small employer carrier will receive and retain the waiver. Waivers must be maintained by the small employer carrier for a period of six years. The waiver must be signed by the employee (on behalf of the employee or dependent) and must certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. Receipt by the small employer carrier of a facsimile transmission of the waiver is permissible, provided that the transmission includes a representation from the small employer that the employer will maintain the original waiver on file for a period of six years from the date of the facsimile transmission. The waiver form must:

(1) require that the reason for declining coverage be stated on the form;

(2) include a written warning of the penalties imposed on late enrollees; and

(3) include a statement that the employee and dependents were not induced or pressured by the small employer, agent, or health carrier into declining coverage, but elected of their own accord to decline the coverage.

(f) An agent must notify a small employer carrier, before submitting an application for coverage with the health carrier on behalf of a small employer or employee of a small employer, of any

circumstances that would indicate that the small employer has induced or pressured the employee or dependent to decline coverage due to the individual's risk characteristics.

(g) New entrants in a health benefit plan issued to a small employer group must be offered an opportunity to enroll in the health benefit plan currently held by the employer group or be offered an opportunity to enroll in the health benefit plan if the plan is provided through an individual franchise insurance policy, or if more than one plan is available. If a small employer carrier has offered more than one health benefit plan to eligible employees of a small employer group under subsection (b) of this section, the new entrant must be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant who does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the health carrier, provided that the period provided to enroll in the health benefit plan complies with subsection (h) of this section.

(h) Periods provided for enrollment in and application for any health benefit plan provided to a small employer group must comply with the following:

(1) the initial enrollment period must extend at least 31 consecutive days after the date the new entrant begins employment or, if the waiting period exceeds 31 days, at least 31 consecutive days after the date the new entrant completes the waiting period for coverage;

(2) the new entrant must be notified of his or her opportunity to enroll at least 31 days in advance of the last date enrollment is permitted;

(3) the new entrant's application for coverage will be considered timely if the application is submitted within the initial enrollment period:

(A) in person;

(B) by mail, postmarked by the end of the specified period; or

(C) in an alternative method normally accepted by the small employer carrier, including facsimile transmission (fax), email, or web-based application; and

(4) the small employer carrier must provide an open enrollment period of at least 31 consecutive days on an annual basis.

(i) A small employer may establish a waiting period in accordance with Insurance Code §1501.156 (concerning Employee Enrollment; Waiting Period) that must not exceed 90 days. A small employer carrier may not apply a waiting period, elimination period, or other similar limitation of

coverage, other than an exclusion for preexisting medical conditions or affiliation period consistent with Insurance Code §1501.102 (concerning Preexisting Condition Provision) and §1501.104 (concerning Affiliation Period), with respect to a new entrant, that is longer than the waiting period established by the small employer.

(j) New entrants in a health plan issued to a small employer group must be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a health carrier may exclude coverage for preexisting medical conditions or impose an affiliation period, to the extent allowed under Insurance Code Chapter 1501.

(k) A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Insurance Code Chapter 1501, Subchapter E (concerning Underwriting and Rating of Small Employer Health Benefit Plans) and this chapter. The risk load must be the same risk load charged to the small employer group immediately before acceptance of the new entrant into the group.

§26.8. Guaranteed Issue, Contribution, and Participation Requirements.

(a) A small employer carrier must issue a health benefit plan to any small employer that elects to be covered under the plan and agrees to satisfy other requirements of the plan factors.

(b) Health carriers may require small employers to answer questions designed to determine the level of contribution by the small employer, the number of employees and eligible employees of the small employer, and the percentage of participation of eligible employees of the small employer. In this section, an "eligible employee" does not include employees within their waiting or affiliation period for percentage of participation requirement purposes.

(c) Availability of coverage under a small employer health benefit plan is subject to the minimum participation requirements of Insurance Code §1501.154 (concerning Minimum Participation Requirement) and §1501.155 (concerning Exception to Minimum Participation Requirement). A small employer that has only two eligible employees will be subject to a 100 percent participation requirement.

(d) A health carrier must treat all similarly situated small employer groups in a consistent and uniform manner when terminating health benefit plans due to a participation level of less than the qualifying participation level or group size.

(e) If a small employer fails to meet the qualifying minimum participation requirement for a small employer health benefit plan for six consecutive months, the health carrier may terminate coverage under the plan on the first renewal date following that period. The termination must conform to the terms and conditions of the plan concerning termination for failure to meet the qualifying minimum participation requirement and in accordance with Insurance Code §§1501.108 - 1501.111 (concerning Renewability of Coverage; Cancellation; Refusal to Renew; Discontinuation of Coverage; Notice to Covered Persons; and Written Statement of Denial, Cancellation, or Refusal to Renew Required) and §26.15 of this title (relating to Renewability of Coverage and Cancellation).

(f) In determining whether an employer has the required percentage of participation of eligible employees, if the percentage of eligible employees is not a whole number, the result of applying the percentage to the number of eligible employees must be rounded down to the nearest whole number. For example, 75 percent of five employees is 3.75, so 3.75 would be rounded down to three, and 75 percent participation by a five employee group will be achieved if three of the eligible employees participate.

(g) If a small employer fails to meet, for six consecutive months, the qualifying minimum group size requirement set forth in Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) for a small employer health benefit plan, the health carrier may terminate coverage under the plan no earlier than the first day of the next month following the end of that period. The termination must conform to the terms and conditions of the plan concerning termination for failure to meet the qualifying minimum group size requirement and in accordance with Insurance Code §§1501.108 - 1501.111 and §26.15 of this title.

§26.9. Exclusions, Limitations, Waiting Periods, Affiliation Periods, Preexisting Conditions, and Restrictive Riders.

(a) All health benefit plans that provide coverage for small employers and their employees must comply with the following requirements.

(1) A small employer carrier may not exclude any eligible employee or dependent (including a late enrollee who would otherwise be covered under a small employer health benefit plan), except to the extent permitted under Insurance Code §1501.156 (concerning Employee Enrollment; Waiting Period).

(2) A small employer carrier may not limit or exclude (by use of rider, amendment, or other provision of the plan, applicable to a specific individual) coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases or an affiliation period, as permitted under Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act).

(3) A preexisting condition provision in a small employer health benefit plan may not apply to expenses incurred on or after the expiration of the 12 months following the effective date of coverage of the enrollee or late enrollee, except as authorized by paragraph (9)(B) of this subsection.

(4) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an employee under this subsection terminates on the 32nd day after the date of the birth of the child unless notification of the birth and any required additional premium are received by the small employer carrier not later than the 31st day after the date of birth. A small employer carrier must not terminate coverage of a newborn child if the carrier's billing cycle does not coincide with this 31-day premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium, within 30 days of the due date of the premium.

(5) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. An adopted child of an insured may be enrolled, at the option of the insured, within either:

(A) 31 days after the insured is a party in a suit for adoption; or

(B) 31 days of the date the adoption is final.

(6) Coverage of an adopted child of an insured under paragraph (5) of this subsection terminates unless notification of the adoption and any required additional premium are received by the small employer carrier not later than either:

(A) the 31st day after the insured becomes a party in a suit in which the adoption of the child by the insured is sought; or

(B) the 31st day after the date of the adoption. A small employer carrier may not terminate coverage of an adopted child if the carrier's billing cycle does not coincide with this 31-day premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium, within 30 days of the due date of the premium.

(7) For purposes of paragraphs (4) and (6) of this subsection, "received by the small employer within a specified period" means that the item(s) must be either received or postmarked by the specified period.

(8) If a newborn or adopted child is enrolled in a health benefit plan or other creditable coverage within the periods specified in paragraph (4) or (5) of this subsection, and subsequently enrolls in another health benefit plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion or affiliation period with regard to the child. If a newborn or adopted child is not enrolled within the periods specified in paragraph (4) or (5) of this subsection, then in accordance with paragraph (9) of this subsection, the newborn or adopted child may be considered a late enrollee or excluded from coverage until the next open enrollment period.

(9) A small employer carrier must choose one of the methods set forth in subparagraph (A) or (B) of this paragraph for handling requests for enrollment as a late enrollee in any health benefit plan subject to this subchapter. The small employer carrier must use the same method for all small employer health benefit plans.

(A) The eligible employee or dependent may be excluded from coverage and any application for coverage rejected until the next annual open enrollment period and, once enrolled, may be subject to a 12-month preexisting condition provision or, in the case of an HMO, may be subject to a 60-day affiliation provision, as described by Insurance Code §§1501.102 - 1501.104 (concerning Preexisting Condition Provision; Treatment of Certain Conditions as Preexisting Prohibited; and Affiliation Period).

(B) The eligible employee or dependent's application may be accepted immediately and the employee or dependent enrolled as a late enrollee during the plan year. If so enrolled, the preexisting condition provision imposed for a late enrollee may not exceed 18 months or, in the case of an HMO, the affiliation period may not exceed 90 days from the date of the late enrollee's application for coverage.

(C) The provisions of subparagraphs (A) and (B) of this paragraph do not apply to eligible employees or dependents under the special circumstances listed as exceptions under the definition of late enrollee in §26.4 of this title (relating to Definitions).

(D) Examples for applying subparagraphs (A) and (B) of this paragraph, in the case of both insurers and HMOs: Individual A requests coverage on October 1, 2014, after the enrollment period of July 1, 2014, through July 31, 2014, has ended. The next annual open enrollment period is July 1, 2015, through July 31, 2015. The effective date of coverage for persons enrolling during an open enrollment period is the beginning of the plan year, which is September 1 of each year.

(i) If the carrier is an insurer and has elected to exclude all applicants requesting late enrollment until the next open enrollment period, Individual A must reapply for coverage in July 2015 and the carrier may apply up to a 12-month preexisting condition period from the effective date of coverage, and as with any other enrollee, the preexisting condition period would begin on September 1, 2015, and expire on September 1, 2016.

(ii) If the carrier is an insurer and has elected to accept applications for late enrollment immediately and enroll the applicant during the plan year, the carrier may apply up to an 18-month preexisting condition period from the date of application. If Individual A applied for coverage on October 1, 2014, the preexisting condition period would begin on that date and expire on April 1, 2016.

(iii) If the carrier is an HMO and has elected to exclude all applicants requesting late enrollment until the next open enrollment period, Individual A must reapply for coverage in July 2015, and the carrier may apply up to a 60-day affiliation period, as with any other enrollee.

(iv) If the carrier is an HMO and has elected to accept applications for late enrollment immediately and enroll the applicant during the plan year, the carrier may apply up to a 90-day affiliation period from the day Individual A applied for coverage.

(10) A preexisting condition provision in a small employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received from an individual licensed to provide the services under state law and operating within the scope of practice authorized by state law during the six months before the effective date of coverage.

(11) A small employer carrier may not treat genetic information as a preexisting condition described by Insurance Code §1501.002 (concerning Definitions) in the absence of a diagnosis of the condition related to the information.

(12) A small employer carrier may not treat a pregnancy as a preexisting condition described in Insurance Code §1501.002.

(13) A preexisting condition provision in a small employer health benefit plan does not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the small employer health benefit plan, excluding any waiting period under the previous coverage. For example, Individual A has coverage under an individual policy for six months beginning on May 1, 2014, through October 31, 2014, followed by a gap in coverage of 61 days until December 31, 2014. Individual A is covered under an individual health plan beginning on January 1, 2015, for six months through June 30, 2015, followed by a gap in coverage of 62 days until August 31, 2015. Individual A's effective date of coverage under a small employer health benefit plan is September 1, 2015. Individual A has 12 months of creditable coverage and would not be subject to a preexisting condition exclusion under the small employer health benefit plan.

(14) In determining whether a preexisting condition provision applies to an individual covered by a small employer health benefit plan, the small employer carrier must credit the time the individual was covered under creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under a small employer health benefit plan. Any waiting period that applied before that coverage became effective also must be credited against the preexisting condition provision period. For instance, Individual B is covered under an individual health insurance policy for 18 months beginning May 1, 2014, through November 30, 2015, followed by a four-month gap in coverage from December 1, 2015, to March 31, 2016. On April 1, 2016, Individual B is covered under a group health plan for three months through June 30, 2016, followed by a two-month gap in coverage until August 31, 2016. Individual B's coverage became effective on September 1, 2016. Under this example, since there was a significant break in coverage, to determine the length of creditable coverage, the small employer carrier counts the creditable coverage the individual had for the 12-month period preceding the effective date of the individual's coverage under the small employer health benefit plan. Individual B has creditable coverage of six months and the issuer

of the small employer health benefit plan may impose a preexisting condition limitation for six months on Individual B.

(15) A small employer may establish a waiting period in accordance with Insurance Code §1501.156. On completion of the waiting period and enrollment within the time frame allowed by §26.7(h) of this title (relating to Requirement to Insure Entire Groups), coverage must be effective no later than the next premium due date. Coverage may be effective at an earlier date as agreed between the small employer and the small employer carrier.

(16) An HMO may impose an affiliation period in accordance with Insurance Code §1501.104, if the period is applied uniformly without regard to any health-status-related factor. The affiliation period may not exceed two months for an enrollee, other than a late enrollee, and may not exceed 90 days for a late enrollee. An affiliation period under a plan must run concurrently with any applicable waiting period under the plan. An HMO may not impose any preexisting condition limitation, except for an affiliation period.

(17) The imposition of an affiliation period by an HMO does not preclude application of any applicable waiting period as determined by the employer for all new entrants under a health benefit plan.

(18) An affiliation period provision in a small employer health benefit plan does not apply to an individual who would not be subject to a preexisting condition limitation in accordance with paragraphs (12) and (13) of this subsection.

(b) To determine if preexisting conditions exist, a small employer carrier must ascertain the source of previous or existing coverage of each eligible employee or dependent at the time the employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier has the responsibility to contact the source of the previous or existing coverage to resolve any questions about the benefits or limitations related to that coverage in the absence of a creditable coverage certification form.

§26.10. Establishment of Classes of Business.

(a) A small employer carrier that establishes more than one class of business in accordance with the provisions of Insurance Code §1501.202 (concerning Establishment of Classes of Business) and §1501.203 (concerning Establishment of Classes of Business on Certain Bases Prohibited) must maintain

on file for inspection by the commissioner the following information with respect to each class of business so established:

(1) a description of each criterion employed by the health carrier (or any of its agents) for determining membership in the class of business;

(2) a statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act); and

(3) a statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of the plans.

(b) A health carrier may not directly or indirectly use the number of employees and dependents of a small employer, the trade or occupation of the employees of a small employer, or the industry or type of business of the small employer as criteria for establishing eligibility for a health benefit plan or for a class of business, except as provided in Insurance Code §1501.202 and §1501.203.

(c) A health carrier may not establish a separate class of business based on minimum participation requirements or whether the coverage provided to a small employer group is provided on a guaranteed issue basis or is subject to underwriting or proof of insurability.

§26.11. Restrictions Relating to Premium Rates.

(a) A small employer carrier must develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier must be computed solely from the applicable rate manual developed under this subsection. To the extent that a portion of the premium rates charged by a small employer carrier are based on objective criteria established by the small employer carrier consistent with the criteria set out in Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act), the manual must specify the criteria and factors considered by the health carrier in exercising this discretion.

(b) A small employer carrier must file with TDI, at least 60 days before the proposed date of the change, any proposed change to the rating method used in the rate manual for a class of business. The small employer carrier must ensure that the rating method used is actuarially sound and appropriate to ensure compliance with Insurance Code Chapter 1501 and this chapter, and that differences in rates

charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design. The commissioner may disapprove a change to the rating method that does not meet the requirements of this chapter. At the expiration of 60 days from the filing of the form with TDI, the proposed change will be deemed compliant unless the commissioner has disapproved it by written order.

(1) The filing must contain at least the following information:

(A) the reasons the change in rating method is being requested;

(B) a complete description of each of the proposed modifications to the rating method;

(C) a description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals and a description of the types of groups or individuals whose premium rates may change by more than 10 percent due to the proposed change in rating method (not including general increases in premium rates applicable to all small employers in a health benefit plan);

(D) a certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(E) a certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Insurance Code Chapter 1501.

(2) For the purpose of this section, a change in rating method means:

(A) a change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(B) a change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(C) a change in the method of allocating expenses among health benefit plans in a class of business; or

(D) a change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10 percent. For the

purpose of this paragraph, a change in a rating factor means the cumulative change with respect to the factor considered over a 12-month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12-month period, the health carrier must consider the cumulative effect of all the changes in applying the 10 percent test under this paragraph.

(c) Each rate manual developed under subsection (a) of this section must specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(1) A small employer may not use case characteristics other than those specified in Insurance Code §1501.210 (concerning Premium Rates: Nondiscrimination), without the prior approval of the commissioner. A small employer carrier seeking approval must file for a change in rating method under subsection (b) of this section with the commissioner.

(2) A small employer carrier must use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and must apply them in the same manner in establishing premium rates for each health benefit plan. Case characteristics may include the employer's industry classification consistent with Insurance Code §1501.208 (concerning Premium Rates: Industry Classification). Case characteristics must be applied without regard to the risk characteristics of a small employer.

(3) The rate manual developed under subsection (a) of this section must clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different from the base premium rate for a health benefit plan, the rate manual must illustrate the difference.

(4) Differences among base premium rates for health benefit plans must be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and may not be based in any way on the actual or expected health-status-related factors of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier must apply case characteristics and rate factors within a class of business in a manner that ensures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health-status-related factors of the small employer groups that choose or are expected to choose a particular health benefit plan.

(5) Each rate manual developed under subsection (a) of this section must provide for premium rates to be developed in a two-step process. In the first step, the small employer carrier must develop a base premium rate for the small employer group without regard to any risk characteristics of the group. In the second step, the small employer carrier may adjust the resulting base premium rate by the risk load of the group, subject to the provisions of Insurance Code Chapter 1501, to reflect the risk characteristics of the group.

(6) Except as provided in this subsection, a premium charged to a small employer for a health benefit plan may not include a separate application fee, underwriting fee, or any other separate fee or charge. A small employer carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to each plan) provided the fee is no more than $5 per month per covered employee and that the fee is applied in a uniform manner to each health benefit plan in a class of business.

(7) A small employer carrier must allocate administrative expenses to the small employer health benefit plans on no less favorable a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed under subsection (a) of this section must describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(8) The health carrier must retain each rate manual developed under subsection (a) of this section for a period of six years, including all updates and changes.

(9) Each rate manual and the rating practices of a small employer carrier must comply with any applicable rules.

(d) If a small employer carrier uses the number of employees and dependents of a small employer as a case characteristic, the highest rate factor associated with a classification based on the number of employees and dependents of a small employer may not exceed the lowest rate factor associated with the classification by more than 20 percent.

(e) The restrictions related to changes in premium rates in Insurance Code Chapter 1501 must be applied as follows.

(1) A small employer carrier must revise its rate manuals each rating period to reflect changes in base premium rates and changes in new business premium rates.

(2) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate will be deemed to be the change in the base premium rate for the purposes of Insurance Code Chapter 1501.

(3) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan will be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Insurance Code Chapter 1501.

(4) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20 percent, the health carrier must make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing must be made at least 60 days before the beginning of the rating period during which the change is applicable. The filing allows the commissioner to determine whether the methodology is actuarially sound and appropriate to ensure compliance with Insurance Code Chapter 1501.

(5) A small employer carrier must keep the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period for six years.

(f) Changes in premium rates and revised premium rates must comply with the following.

(1) Except as provided in subsection (e) of this section, a change in premium rate for a small employer must produce a revised premium rate that is no more than the base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by one plus the sum of:

(A) the risk load applicable to the small employer during the previous rating period; and

(B) 15 percent (prorated for periods of less than one year).

(2) In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer must produce a revised premium rate that is no more than the base premium rate for the small employer (given its present

composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by one plus the lesser of:

(A) the change in the base rate; or

(B) the percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by one plus the sum of:

(i) the risk load applicable to the small employer during the previous rating period; and

(ii) 15 percent (prorated for periods of less than one year).

(3) In the case of a health benefit plan described in Insurance Code §1501.208, if the current premium rate for the health benefit plan exceeds the ranges set forth in Insurance Code §1501.204 (concerning Index Rates), the formulae set forth in paragraphs (1) and (2) of this subsection will be applied as if the 15 percent adjustment provided in paragraphs (1)(B) and (2)(B)(ii) of this subsection were a 0 percent adjustment.

(4) Notwithstanding the provisions of paragraphs (1) and (2) of this subsection, a change in premium rate for a small employer may not produce a revised premium rate that would exceed the limitations on rates provided in Insurance Code §1501.204.

(g) An HMO offering any state-approved, federally qualified plan described in Insurance Code §1501.255 (concerning Health Maintenance Organization Plans) and §26.14 of this title (relating to Coverage) must establish premium rates for those plans in accordance with formulae or schedules of charges filed with TDI under the procedures set forth in Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges) and Chapter 11, Subchapter H of this title (relating to Schedule of Charges). An HMO must follow the rating requirements set out in this section for any plan it offers that is not federally qualified.

(h) An HMO participating in a purchasing cooperative that provides employees of small employers a choice of benefit plans, which has established a separate class of business as provided by Insurance Code §1501.202 (concerning Establishment of Classes of Business) and §1501.203 (concerning Establishment of Classes of Business on Certain Bases Prohibited), and a separate line of business as provided under Insurance Code §1501.255 and 42 U.S.C. §§300e et seq. (concerning Health Maintenance Organizations), may use rating methods in accordance with this subchapter that are used

by other small employer carriers participating in the same purchasing cooperative, including rating by age and gender.

(i) When seeking to obtain information relating to a small employer group, including the risk characteristics of the small employer group, a small employer carrier must comply with §26.13(l) of this title (relating to Fair Marketing).

§26.12. Disclosure.

In connection with the offering for sale of any small employer health benefit plan, each small employer carrier and each agent must make a reasonable disclosure, as part of its solicitation and sales material, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in claim costs or the actual or expected variation in health status of the employees of the small employer and their dependents;

(2) provisions concerning the small employer carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(3) provisions relating to renewability of policies and contracts; and

(4) any preexisting condition provision or affiliation period.

§26.13. Fair Marketing.

(a) A small employer carrier must market each of its small employer health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of the small employer benefit plans unless the health carrier has good cause and has received prior approval from the commissioner or the commissioner's designee. Any agent authorized by a small employer carrier to market consumer choice health benefit plans to small employers in this state must also be authorized to market small employer health benefit plans that contain state-mandated health benefits.

(b) Before issuing coverage to a small employer, a small employer carrier must offer the employer a choice of all health benefit plans that the small employer carrier offers and for which the small employer qualifies. The small employer carrier may provide the offer directly to the small employer or deliver it through an agent, but in either case must offer each required plan

contemporaneously with the offer of any other small employer health benefit plan. The offer must be in writing and include at least the following:

(1) information describing how the small employer may enroll in the plan or plans;

(2) information set out in Insurance Code §1501.354 (concerning Required Disclosures) and §26.12 of this title (relating to Disclosure); and

(3) a written disclosure, as required by Chapter 21, Subchapter AA of this title (relating to Consumer Choice Health Benefit Plans).

(c) On request, a small employer carrier must explain to a small employer each of the small employer health benefit plans it offers.

(d) A small employer carrier must comply with this subsection when providing a premium rate quote to a small employer.

(1) A small employer carrier must provide a premium rate quote to a small employer, directly or through an authorized agent, within 15 business days of receiving the small employer's completed application for coverage and individual enrollment forms.

(2) A small employer carrier may request, directly or through an authorized agent, any additional information, using the applicable rate manual and associated underwriting guidelines developed under §26.11 of this title (relating to Restrictions Relating to Premium Rates), necessary to provide the premium rate quote. If the carrier requests this additional information before the end of the 15-day period described in paragraph (1) of this subsection, the request for additional information tolls the running of the 15-day period until the small employer carrier receives the requested additional information.

(3) A small employer carrier may give a small employer an estimated cost of coverage before the end of the 15-day period described in paragraph (1) of this subsection, so long as the carrier makes clear that the estimate is not a premium rate quote.

(4) A small employer carrier may not impose any additional conditions to its provision of a premium rate quote.

(e) A small employer carrier may not apply more stringent or detailed requirements related to the application process for, or otherwise discriminate in the offer of, any small employer health benefit plan than are applied for other health benefit plans offered by the health carrier to small employers.

(f) If a small employer carrier denies coverage under a health benefit plan to a small employer on any basis, the denial must be in writing and specifically state the reasons for the denial (subject to any restrictions related to confidentiality of medical information).

(g) A small employer carrier must establish and maintain a means to provide information to small employers who request information on the availability of small employer health benefit plans in this state. The information provided to small employers must include information about how to apply for coverage from the health carrier and may include the names and phone numbers of agents located geographically proximate to the caller or other information that is reasonably designed to assist the caller in locating an authorized agent or applying for coverage.

(h) The small employer carrier may not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply that requirement, subject to the requirements of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act).

(i) A small employer carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

(j) Health carriers offering individual and group health benefit plans in this state must determine whether the plans are subject to the requirements of Insurance Code Chapter 1501 and this subchapter. Health carriers must obtain the following information from applicants for those plans at the time of application:

(1) whether any portion of the premium will be paid by a small employer;

(2) whether the prospective policyholder, certificate holder, or any prospective covered individual intends to treat the health benefit plan as part of a plan or program under the United States Internal Revenue Code of 1986, 26 U.S.C. §106 (concerning Contributions by Employer to Accident and Health Plans), or §162 (concerning Trade or Business Expenses);

(3) whether the health benefit plan is an employee welfare benefit plan under 29 C.F.R. §2510.3-1 (concerning Employee Welfare Benefit Plan); or

(4) whether the applicant is a small employer.

(k) If a health carrier fails to comply with subsection (j) of this section, the health carrier will be deemed to be on notice of any information that could reasonably have been attained if the health carrier had complied with subsection (j) of this section.

(l) A small employer carrier may not discriminate between small employer groups when obtaining information relating to a small employer, including information related to the risk characteristics of the small employer group or other aspects of the application or application process.

(m) A small employer carrier may not terminate, fail to renew, limit its contract or agreement of representation with, or take any other negative action against an agent for the agent's request that the carrier issue or renew a health benefit plan to a small employer.

§26.14. Coverage.

(a) Continuation and conversion. All small employer health benefit plans must provide for continuation and may provide an option for conversion that complies with Insurance Code Chapters 1251 (concerning Group and Blanket Health Insurance) and 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges) and rules adopted under those statutes. A state-approved health benefit plan that complies with the requirements of Title XIII, Public Health Service Act (42 U.S.C. §§300e, et seq., concerning Health Maintenance Organizations) must provide coverage for continuation that complies with the requirements of Insurance Code Chapter 1271 and must offer conversion in compliance with 42 C.F.R. §417.124(e) (concerning Administration and Management) and applicable federal law.

(b) Plain language. Each health benefit plan, certificate, policy, rider, or application used by health carriers to provide coverage to small employers and their employees must comply with Insurance Code §1501.258 (concerning Forms) and §1501.260 (concerning Plain Language Required), be written in plain language, and meet the requirements of Chapter 3, Subchapter G of this title (relating to Plain Language Requirements for Health Benefit Policies). Requirements for use of plain language are not applicable to a health benefit plan group master policy or a policy application or enrollment form for a health benefit plan group master policy.

(c) Dependent coverage. Every small employer carrier providing health benefit plans to small employers is required to offer dependent coverage to each eligible employee. Dependent coverage may be paid for by the employer, the employee, or both.

(d) Point-of-service coverage. An HMO issuing small employer HMO coverage may also offer point-of-service coverage that complies, as applicable, with the requirements set forth in Insurance Code Chapter 843 (concerning Health Maintenance Organizations); Chapter 11, Subchapter Z of this title (relating to Point-of-Service Riders); and Chapter 21, Subchapter U of this title (relating to Arrangements Between Indemnity Carriers and HMOs for Point-of-Service Coverage) that allow the enrollee to access out-of-plan coverage at the option of the enrollee.

§26.15. Renewability of Coverage and Cancellation.

(a) Except as provided by Insurance Code §1501.109 (concerning Refusal to Renew; Discontinuation of Coverage), a small employer carrier must renew any small employer health benefit plan 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. An intentional misrepresentation of a material fact does not include any misrepresentation related to health status;

(3) the small employer has not complied with a material provision of the health benefit plan relating to premium contribution, group size, or minimum participation requirements;

(4) the small employer has no enrollee, in connection with the plan, who resides or works in the service area of the small employer carrier or in the area where the small employer carrier is authorized to do business; or

(5) 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.

(b) A small employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or intentional misrepresentation of a material fact by that individual and with respect to an eligible employee or dependent who is a subscriber or enrollee in an HMO, for the reasons specified in §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate). The coverage is also subject to any policy or contractual provisions relating to incontestability or time limits on certain defenses. An intentional misrepresentation of a material fact does not include any misrepresentation related to health status.

(c) A small employer carrier may not cancel a small employer health benefit plan except for the reasons specified for refusal to renew under Insurance Code §1501.108 (concerning Renewability of Coverage; Cancellation), and subsections (a) and (b) of this section. A small employer carrier may not cancel the coverage of an eligible employee or dependent except for the reasons specified for refusal to renew under Insurance Code §1501.108 and subsections (a) and (b) of this section.

(d) A carrier is not prevented from seeking any legal remedies against a person who fraudulently misrepresents health status during the initial application for coverage. Legal remedies available to a carrier do not include cancellation or nonrenewal.

(e) Other small employer health benefit plans, provided through individual policies, must be guaranteed renewable for life or until maximum benefits have been paid, or may be guaranteed renewable with the only reasons for termination being those set out in Insurance Code §1501.108 and §1501.109 and this subchapter. All other health benefit plans issued to small employers must be renewed at the option of the small employer, but may provide for termination in accordance with Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act), and this subchapter.

§26.16. Refusal to Renew and Application to Reenter Small Employer Market.

(a) A small employer carrier may elect to refuse to renew all small employer health benefit plans delivered or issued for delivery by the small employer carrier in this state or in a geographic service area. The small employer carrier must notify the commissioner and each affected covered small employer of the election as provided in Insurance Code §1501.109 (concerning Refusal to Renew; Discontinuation of Coverage).

(b) The small employer carrier may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, for five years after notice to the commissioner of the election to refuse to renew. A small employer carrier that elects not to renew may not resume offering health benefit plans to small employers in this state or in the geographic area for which the election was made until it has filed a petition with the commissioner to be reinstated as a small employer carrier and the petition has been approved. In reviewing the petition, the commissioner may ask for information and assurances as the commissioner finds reasonable and appropriate.

(c) A small employer carrier may elect to discontinue a particular type of small employer coverage only if the small employer carrier:

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

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

(B) offers to each employer the option to purchase other small employer coverage offered by the small employer carrier 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.

§26.18. Election and Application to be Risk-Assuming or Reinsured Carrier.

(a) Each small employer carrier must file with the commissioner, no later than with the first filing of a small employer health benefit plan, notification of whether the carrier elects to operate as a risk-assuming or reinsured carrier.

(1) A small employer carrier's operation as a risk-assuming carrier is subject to approval by the commissioner, and each small employer carrier electing to operate as a risk-assuming carrier must file an application with the commissioner contemporaneously with its election to operate as a risk-assuming carrier. A risk-assuming carrier's application, in addition to the financial information already on file with TDI, must include a:

(A) history of rating and underwriting small employer groups, including a description of underwriting experience to identify high risks and the percentage of aggregate rate increases for the past three years for small employer groups for Texas and nationwide;

(B) description of the carrier's commitment to fairly market to all small employers in Texas or in the small employer carrier's established geographic service areas, including sample material used, or planned to be used, to market to small employers;

(C) description of experience in managing the risk of small groups, including;

(i) the number of years, volume of business, results, etc.;

(ii) a list of other states with guaranteed issue requirements where the carrier provides small employer group coverage;

(iii) the total number of lives currently covered under those guaranteed issue plans; and

(iv) a list of other states where the carrier voluntarily participates in reinsurance programs;

(D) description of plans to manage the risk of guaranteed issue as a risk-assuming carrier;

(E) list of affiliated small employer carriers and whether they have been approved as either a risk-assuming or reinsured carrier;

(F) list of any other affiliated small employer carrier applicants, indicating their requested designation as either a risk-assuming or reinsured carrier; and

(G) the name, title, and signature of the chief executive officer, attorney, or actuary for the named health carrier.

(2) A reinsured carrier's notification must include:

(A) a statement of the carrier's election to operate as a reinsured carrier; and

(B) the name, title, and signature of the chief executive officer, attorney, or actuary of the named health carrier.

(b) A small employer carrier seeking to change its status as a risk-assuming or reinsured carrier must file an application with the commissioner. If the carrier is requesting a change to be a:

(1) risk-assuming carrier, the filing must include:

(A) the information requested in subsection (a) of this section;

(B) information demonstrating good cause for the request to change status; and

(C) the name, title, and signature of the chief executive officer, attorney, or actuary for the named health carrier; or

(2) reinsured carrier, the filing must include:

(A) information demonstrating good cause for the request to change status; and

(B) the name, title, and signature of the chief executive officer, attorney, or actuary for the named health carrier.

(c) A small employer carrier's election is effective until the fifth anniversary of the election. A small employer carrier seeking to maintain its status after that date must file with the commissioner, at

least 90 days before the fifth anniversary of its election, the same information required by subsection (a)(1) and (2) of this section.

(d) A form fulfilling the requirements of this section is available at www.tdi.texas.gov/forms/form10smgroup.html through the link for Election and Application to be a Risk-Assuming or Reinsured Carrier.

§26.19. Filing Requirements.

(a) Each small employer carrier must file each form, including, but not limited to, each policy, contract, certificate, agreement, evidence of coverage, endorsement, amendment, enrollment form, and application that will be used to provide a health benefit plan in the small employer market, in accordance with Insurance Code Chapter 1701 (concerning Policy Forms), and Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings), or Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), and §11.301 of this title (relating to Filing Requirements) or §11.302 of this title (relating to Service Area Expansion or Reduction Applications), as applicable.

(b) Each small employer carrier, other than an HMO, must use a policy shell format for any group or individual health benefit plan form used to provide a health benefit plan in the small employer market. To expedite the review and approval process, all group and individual health benefit plan form filings (excluding HMO filings that are covered in subsection (c) of this section) must be submitted in the following order:

(1) a group policy face page or individual policy face page, as applicable;

(2) the group certificate page or individual data page, as applicable;

(3) as applicable under Chapter 3, Subchapter A of this title, the toll-free number and complaint notice page, as required by Chapter 1, Subchapter E of this title (relating to Notice of Toll-Free Telephone Numbers and Procedures for Obtaining Information and Filing Complaints);

(4) the table of contents;

(5) insert pages for the general provisions;

(6) insert pages for the required provisions and any optional provisions, if elected and as applicable;

(7) for small employer health benefit plans, an insert page for the benefits section of the health benefit plan, including but not limited to schedule of benefits; definitions; benefits provided; exclusions and limitations; continuation provisions; and, if applicable, alternative cost containment, preferred provider, conversion and coordination of benefits provisions, and riders;

(8) insert pages for any amendments, applications, enrollment forms, or other form filings that comprise part of the contract;

(9) insert pages for any required outline of coverage for individual products;

(10) any additional form filings and documentation as outlined in Chapter 3, Subchapter A of this title and Chapter 3, Subchapter G of this title (relating to Plain Language Requirements for Health Benefit Policies);

(11) the certifications required under this section and any other rating information required under §26.10 of this title (relating to Establishment of Classes of Business) and §26.11 of this title (relating to Restrictions Relating to Premium Rates); and

(12) the rate schedule applicable to any individual health benefit plan, as required by Chapter 3, Subchapter A of this title.

(c) In addition to subsection (a) of this section, the following provisions apply to each HMO. The HMO must submit health benefit plan forms for use in the small employer market that include the following.

(1) Any HMO group or individual agreement must address and include all required provisions of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act). The agreement must be in compliance with any other applicable provisions of the Insurance Code. In addition, the agreement must comply with the provisions of Chapter 11, Subchapter F of this title (relating to Evidence of Coverage) where those provisions are not in conflict with Insurance Code Chapter 1501.

(2) The filing must include any alternative pages to the agreement or the schedule of benefits and any alternative schedules of benefit.

(3) The filing must include any additional riders, amendments, applications, enrollment forms, or other forms and any other required documentation outlined in Chapter 11, Subchapter F of this title.

(4) The filing must include any applicable requirements of Chapter 11, Subchapter D, of this title (relating to Regulatory Requirements for an HMO Subsequent to Issuance of a Certificate of Authority), and Chapter 11, Subchapter F of this title, except for:

(A) continuation and conversion of coverage, in accordance with Insurance Code Chapter 1271 and this title; and

(B) cancellation, in accordance with §26.15 of this title (relating to Renewability of Coverage and Cancellation).

(5) The filing must include any rider forms that will be used with health benefit plans offered to small employers. The rider forms, if developed subsequent to approval of the agreement, must be submitted with an explanation of the market in which the forms will be used. All rider forms must comply with Insurance Code Chapter 1271, and applicable provisions of Chapter 11, Subchapters D and F of this title.

§26.20. Reporting Requirements.

(a) Small employer health carriers offering a small employer health benefit plan must file annually, not later than March 1 of each year, an actuarial certification Form Number 1212 CERT ACTUARIAL, Annual Small Employer Health Benefit Plan Actuarial Certification, Rev. 09/16, signed by a qualified actuary stating that the underwriting and rating methods of the small employer carrier:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with the provisions of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) and this chapter.

(b) Form Number 1212 CERT ACTUARIAL is available at www.tdi.texas.gov/forms/forms10smgroup.html through the link for Form Number 1212 CERT ACTUARIAL Annual Small Employer Health Benefit Plan Actuarial Certification.

(c) Not later than March 1 of each calendar year, a small employer carrier must complete and file with the commissioner Form Number 1212 CERT DATA Annual Small Employer Health Benefit Plan Report, Rev. 09/16, available at www.tdi.texas.gov/forms/forms10smgroup.html. This annual filing must

include the following information related to the previous calendar year for health benefit plans issued by the small employer carrier to small employers in this state:

(1) the number of small employers that were issued and the number of lives that were covered under health benefit plans in the previous calendar year (separated, if applicable, as to newly issued plans and renewals);

(2) the number of small employers that were issued and the number of lives that were covered under consumer choice health benefit plans; plans offering all state-mandated health benefits; HMO consumer choice health benefit plans and HMO plans, including all state-mandated health benefits in the previous calendar year (as applicable, separated as to newly issued plans and renewals and by groups based on the following covered-employee size ranges: 2 - 9, 10 - 20, 21 - 35, 36 - 50, and more than 50);

(3) the number of small employer health benefit plans in force and the number of lives covered under those plans, broken down by the ZIP code of the small employers' principal place of business in Texas;

(4) the number of small employer health benefit plans voluntarily not renewed by small employers in the previous calendar year;

(5) the number of small employer health benefit plans terminated or nonrenewed (for reasons other than nonpayment of premium) by the health carrier in the previous calendar year;

(6) the number of small employer health benefit plans issued to small employers that were uninsured for at least the two months before issue;

(7) the health carrier's gross premiums derived from health benefit plans delivered, issued for delivery, or renewed to small employers in the previous calendar year;

(8) the name and license information regarding any other small employer carrier whose health benefit plans the health carrier assumed; and

(9) the number of small employers and the number of lives that were covered under plans issued to small employer health coalitions and cooperatives in the previous calendar year (as applicable, separated as to newly issued plans and renewals).

§26.25. Unfair Competition and Unfair Practices.

A misrepresentation about the effects of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) or this subchapter in marketing small employer health plans or in the marketing, renewing, or canceling of other health insurance products will be considered a violation of Insurance Code Chapter 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices) and §543.001 (concerning Misrepresentation Prohibited).

§26.28. Territorial Exclusions.

Subject to the provisions of Chapter 3 of this title (relating to Life, Accident, and Health Insurance and Annuities) and Chapter 11 of this title (relating to Health Maintenance Organizations), a small employer health benefit plan may not exclude health care services, supplies, or drugs provided for medical emergencies outside the plan service area, including outside the United States.

SUBCHAPTER C

REPEAL OF 28 TAC §26.311

STATUTORY AUTHORITY. The repeal of §26.311 is adopted under Insurance Code §§1251.008, 1501.010, and 36.001.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

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

TEXT.

SUBCHAPTER C. LARGE EMPLOYER HEALTH INSURANCE REGULATIONS

§26.311. Administrative Violations and Penalties.

SUBCHAPTER C

28 TAC §§26.301 - 26.310, 26.312, 26.313, and 26.314

STATUTORY AUTHORITY. The amendments to 28 TAC §§26.301 - 26.310, 26.312, and new §26.313 and §26.314 are adopted under Insurance Code Article 21.42 and §§1251.008, 1501.010, and 36.001.

Article 21.42 provides that any insurance payable to any citizen or inhabitant of this state by a company doing business within this state to be held to be a contract made and entered into and governed by Texas insurance law despite execution of the contract or payment of the premiums made outside of this state.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

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

TEXT.

SUBCHAPTER C. LARGE EMPLOYER HEALTH INSURANCE REGULATIONS

§26.301. Applicability, Definitions, and Scope.

(a) The applicable terms defined in §26.4 of this title (relating to Definitions) are incorporated into this subchapter.

(b) Insurance Code Chapter 1501 (concerning the Health Insurance Portability and Availability Act) and this subchapter regulate all health benefit plans sold to large employers, whether the plans are sold directly or through associations or other groupings of large employers.

(c) Except as otherwise provided, this subchapter applies to any health benefit plan providing health care benefits covering 51 or more employees of a large employer, whether provided on a group or individual franchise insurance policy basis, regardless of whether the policy was issued in this state, if it provides coverage to any citizen or inhabitant of this state and if the plan meets one of the following conditions:

(1) a portion of the premium or benefits is paid by a large employer;

(2) the health benefit plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of the United States Internal Revenue Code of 1986 (26 U.S.C.

§106, concerning Contributions by Employer to Accident and Health Plans, or §162, concerning Trade or Business Expenses);

(3) the health benefit plan is a group policy issued to a large employer; or

(4) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. 2510.3-1 (concerning Employee Welfare Benefit Plan).

(d) For an employer that was not in existence the previous calendar year, the determination is based on the average number of employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

(e) If a large employer or the employees of a large employer are issued a health benefit plan under the provisions of Insurance Code Chapter 1501 and this subchapter, and the large employer subsequently employs fewer than 51 employees, the provisions of Insurance Code Chapter 1501 and this subchapter continue to apply to that particular health plan if the employer elects to renew the large employer health benefit plan subject to the provisions of §26.308 of this title (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to an employer must, within 60 days of becoming aware that the employer has fewer than 51 employees, but not later than the first renewal date occurring after the employer ceases to be a large employer, notify the employer of the following:

(1) The employer may renew the large employer policy.

(2) If the employer does not renew the large employer health benefit plan, the employer will be subject to the requirements of Insurance Code Chapter 1501 that apply to small employers, and Chapter 26, Subchapter A of this title (relating to Definitions, Severability, and Small Employer Health Regulations), including:

(A) guaranteed issue;

(B) rating protections; and

(C) minimum participation, contribution, and minimum group size requirements.

(3) The employer has the option to purchase a small employer health benefit plan from the employer's current health carrier, if the carrier is offering small employer coverage, or from any small employer carrier currently offering small employer coverage in this state.

(4) If the employer fails to comply with the qualifying minimum participation, contribution, or group size requirements of §26.303 of this title (relating to Coverage Requirements) and Insurance Code §1501.605 (concerning Minimum Contribution or Participation Requirements), the

health carrier may terminate coverage under the plan, provided that the termination complies with the terms and conditions of the plan concerning termination for failure to meet the qualifying minimum participation, contribution, or minimum group size requirement and in accordance with Insurance Code §§1501.108 - 1501.111 (concerning Renewability of Coverage: Cancellation; Refusal to Renew; Discontinuation of Coverage; Notice to Covered Persons; and Written Statement of Denial, Cancellation, or Refusal to Renew Required, respectively) and §26.308 of this title.

(f) If a health benefit plan is issued to an employer that is not a large employer, but subsequently the employer becomes a large employer, the provisions of Insurance Code Chapter 1501 and this subchapter apply to the health benefit plan on the first renewal date, unless the employer was a small employer and renews its current health benefit plan as provided under §26.5(e) of this title (relating to Applicability and Scope).

(g) A large employer nonfederal governmental employee health benefit plan that is not self-funded is subject to the Insurance Code and this title, as applicable, including Chapter 1501 and this chapter.

(h) If a large employer has employees in more than one state, the provisions of Insurance Code Chapter 1501 and this subchapter apply to a health benefit plan issued to the large employer if the:

(1) majority of employees are employed in this state on the issue date or renewal date; or

(2) primary business location is in this state on the issue date or renewal date and no state contains a majority of the employees.

(i) A carrier licensed in this state that issues a certificate of insurance covering a Texas resident is responsible for ensuring that the certificate complies with applicable Texas insurance laws and rules, including mandated benefits, regardless of whether the group policy underlying the certificate was issued outside the state.

26.302. Status of Health Carriers as Large Employer Carriers.

(a) With the original filing to enter the large employer market or when notifying TDI of a change in status, each health carrier providing health benefit plans in this state must file with the commissioner a statement indicating whether the health carrier will or will not offer, renew, issue, or issue for delivery health benefit plans to large employers in this state. The filing must include a certification, signed by an

officer of the company, that the carrier intends to operate in accordance with the status certification unless or until changed in accordance with this section, and provide a statement that:

(1) the health carrier intends to offer, renew, issue, and issue for delivery health benefit plans to large employers in Texas, and will operate in accordance with Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) and this subchapter;

(2) the health carrier does not intend to offer, issue, or issue for delivery health benefit plans to large employers in Texas, but the health carrier intends to renew existing health benefit plans;

(3) the health carrier does not intend to offer, issue, or issue for delivery health benefit plans to large employers in Texas; intends to nonrenew all health benefit plans issued to large employers in Texas; and will provide notice to the commissioner and employers in accordance with §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) and Insurance Code §1501.110 (concerning Notice to Covered Persons); or

(4) the health carrier has no health benefit plans issued to large employers or to employees of a large employer and does not intend to offer, issue, or issue for delivery health benefit plans to large employers.

(b) If a health carrier chooses to change its election or the date of implementing its election under subsection (a)(1), (2), or (4) of this section, the health carrier must notify the commissioner of its new election at least 30 days before the date the health carrier intends to begin operations under the new election.

(c) A form fulfilling the requirements of subsections (a) and (b) of this section is available online at www.tdi.texas.gov/forms/form10smgroup.html through the link for Large Employer Carrier Status Certification.

(d) The large employer carrier must also comply with any other applicable legal requirements, including those for withdrawal from the market under Chapter 7, Subchapter R of this title (relating to Withdrawal Plan Requirements and Procedures).

§26.303. Coverage Requirements.

(a) The large employer carrier must accept or reject the entire group of individuals who meet the participation criteria established by the employer and who choose coverage, and may exclude only those eligible employees or dependents who have declined coverage. The carrier may charge premiums

in accordance with Insurance Code §1501.107 (concerning Discounts, Rebates, and Reductions) and §1501.610 (concerning Premium Rates; Adjustments) to the group of employees or dependents who meet the participation criteria established by the employer and who do not decline coverage.

(b) A large employer carrier must secure a written waiver for each eligible employee who meets the participation criteria and each dependent, if dependent coverage is offered to enrollees under a large employer health benefit plan, who declines an offer of coverage under a health benefit plan provided to a large employer. If a large employer elects to offer coverage through more than one large employer carrier, waivers are only required to be signed if the individual is declining all offered plans. The large employer carriers may enter into an agreement designating which large employer carrier will receive and retain the waiver. Waivers must be maintained by the large employer carrier for a period of six years. The waiver must ensure that the employee was not induced or pressured into declining coverage because of the employee's health-status-related factors. The waiver must be signed by the employee (on behalf of the employee or the dependent, if applicable) and must certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. Receipt by the large employer carrier of a facsimile transmission of the waiver is permissible, provided the transmission includes a representation from the large employer that the employer will maintain the original waiver on file for a period of six years from the date of the facsimile transmission. The waiver form must:

(1) require that the reason for declining coverage be stated on the form;

(2) include a written warning of the penalties imposed on late enrollees; and

(3) include a statement that the following individuals were not induced or pressured by the large employer, agent, or health carrier into declining coverage, but elected to decline coverage:

(A) an eligible employee who meets the large employer's participation criteria; and

(B) the employee's dependents, if dependent coverage is offered to enrollees under a large employer health benefit plan.

(c) An agent must notify a large employer carrier, before submitting an application for coverage with the health carrier on behalf of a large employer or its employees, of any circumstances that would indicate that the large employer has induced or pressured an eligible employee who meets the large

employer's participation criteria or a dependent to decline coverage due to the individual's health-status-related factors.

(d) Health carriers may require large employers to answer questions designed to determine the level of premium contribution by the large employer and the percentage of participation of eligible employees.

(e) In this section, an "eligible employee" does not include employees who are within their waiting or affiliation period for percentage of participation requirement purposes. In determining whether an employer has the required percentage of participation of eligible employees who meet the large employer's participation criteria, if the percentage of eligible employees is not a whole number, the result of applying the percentage to the number of eligible employees must be rounded down to the nearest whole number. For example, if a large employer health carrier uses a minimum participation requirement of 75 percent of the eligible employees meeting the large employer's participation criteria, 75 percent of 55 employees is 41.25. Round 41.25 down to 41; so, 75 percent participation by a 55-employee group would be achieved if 41 of the eligible employees who meet the large employer's participation criteria participate.

(f) If a large employer fails to meet the qualifying minimum participation requirement for six consecutive months, the large employer health carrier may terminate coverage under the plan on the first renewal date following that period. The termination must comply with the terms and conditions of the plan concerning termination for failure to meet the qualifying minimum participation percentage and in accordance with Insurance Code §§1501.108 - 1501.111 (concerning Renewability of Coverage; Cancellation; Refusal to Renew; Discontinuation of Coverage; Notice to Covered Persons; and Written Statement of Denial, Cancellation, or Refusal to Renew Required, respectively) and §26.308 of this title (relating to Renewability of Coverage and Cancellation). A large employer health carrier must treat all similarly situated large employer groups in a consistent and uniform manner when terminating health benefit plans due to a participation level of less than the qualifying participation level.

(g) A large employer must continue to meet the qualifying minimum group size requirement of §26.301(c) of this title (relating to Applicability, Definitions, and Scope) to be entitled to elect to renew coverage under §26.301(e) of this title. If a large employer fails to meet, for six consecutive months, the minimum group size requirement of §26.301(c) of this title, the health carrier may terminate coverage under the plan on the first renewal date following that period. The termination must comply with the

terms and conditions of the plan concerning termination for failure to meet the minimum group size requirements in §26.301(c) of this title, and in accordance with Insurance Code §§1501.108 - 1501.111 and §26.308 of this title.

§26.304. Requirement to Insure Entire Groups.

(a) A large employer carrier that offers coverage to a large employer and its employees must offer coverage to each eligible employee who meets the large employer's participation criteria. If dependent coverage is offered to enrollees under a large employer health benefit plan, a large employer carrier must offer coverage to each eligible dependent. Except as provided in subsection (b) of this section, the large employer carrier must provide the same health benefit plan to each employee and dependent.

(b) If elected by the large employer, a large employer carrier may offer one or more health benefit plans, provided that each eligible employee who meets the participation criteria may choose any of the plans offered. Except as provided in Insurance Code §1501.104 (concerning Affiliation Period) and §1501.106 (concerning Certain Limitations or Exclusions of Coverage Prohibited), with respect to an affiliation period or exclusions for preexisting conditions, the choice among benefit plans may not be limited, restricted, or conditioned based on the health-status-related factors of the employees or dependents, if applicable.

(c) A large employer carrier may require each large employer that applies for coverage, as part of the application process, to provide a complete list of employees, eligible employees, and if dependent coverage is offered to enrollees under a large employer health benefit plan, a complete list of dependents of eligible employees. The large employer carrier may also require the large employer to provide reasonable and appropriate supporting documentation to verify the information required under this subsection, and to confirm the applicant's status as a large employer. The large employer carrier must make a determination of eligibility within five business days of receipt of any requested documentation. A large employer carrier may not condition the issuance of coverage on an employer's production of a particular document, where the employer can otherwise provide the information required by this section. Similarly, if a particular document an employer produces does not reasonably evidence the employer's compliance with this subsection, the employer must produce other documentation to satisfy the requirements. Examples of the types of reasonable and appropriate

supporting documentation that a large employer carrier may request from an employer as needed to fulfill the purposes of this subsection are:

(1) a W-2 Summary Wage and Tax Form or other federal or state tax records;

(2) a loan agreement;

(3) an invoice;

(4) a business check;

(5) a sales tax license;

(6) articles of incorporation or other business entity filings with the secretary of state;

(7) assumed name filings;

(8) professional licenses; and

(9) reports required by the Texas Workforce Commission.

(d) A large employer carrier may not deny two individuals who are married the status of eligible employee solely on the basis that the two individuals are married. The large employer carrier must provide a reasonable opportunity for the individuals to submit evidence as provided in subsection (c) of this section to establish each individual's status as an eligible employee.

(1) A large employer carrier must provide married eligible employees of the same employer the option to have one spouse be treated under a large employer health benefit plan as an employee, and the other spouse treated as an employee or alternatively as the dependent of the other employee.

(2) A child of either of the two individuals may only be covered under the large employer health benefit plan as a dependent by one of the two individuals.

(3) An election by a spouse to be treated as a dependent under this subsection does not impact the individual's status as an eligible employee for any other purpose under Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act), except that the individual may be treated as a dependent for purposes of employer premium contributions.

(e) New entrants who meet the large employer's participation criteria in a health benefit plan issued to a large employer group must be offered an opportunity to enroll in the health benefit plan currently held by the employer group or be offered an opportunity to enroll in the health benefit plan if the plan is provided through an individual franchise insurance policy or more than one plan is available. If a large employer carrier has offered more than one health benefit plan to eligible employees of a large

employer group under subsection (b) of this section, the new entrant must be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant who does not exercise the opportunity to enroll in the health benefit plan within the period provided by the large employer carrier may be treated as a late enrollee by the health carrier, provided that the period provided to enroll in the health benefit plan complies with §26.305(a) of this title (relating to Enrollment).

(f) New entrants meeting the participation criteria in a health benefit plan issued to a large employer group must be accepted for coverage by the large employer carrier without any restrictions or limitations on coverage related to the health-status-related factors of the employee or dependent, except that a health carrier may exclude coverage for preexisting medical conditions or impose an affiliation period, to the extent allowed under Insurance Code Chapter 1501.

§26.305. Enrollment.

(a) Periods provided for enrollment in and application for any health benefit plan provided to a large employer group must comply with the following:

(1) the initial enrollment period for the employees meeting the large employer's participation criteria must extend at least 31 consecutive days after the employee's initial date of employment, or if the waiting period exceeds 31 days, at least 31 consecutive days after the date the new entrant completes the waiting period for coverage;

(2) the new entrant who meets the large employer's participation criteria must be notified of his or her opportunity to enroll at least 31 days in advance of the last date enrollment is permitted;

(3) a new entrant's application for coverage is timely if he or she submits the application within 31 consecutive days following the initial date of employment, or following the date the new entrant is eligible for coverage:

(A) in person;

(B) by mail, postmarked by the end of the specified period; or

(C) in an alternative method normally accepted by the large employer carrier, including facsimile transmission (fax), email, or web-based application; and

(4) the large employer carrier must provide an annual open enrollment period of at least 31 consecutive days.

(b) If dependent coverage is offered to enrollees under a large employer health benefit plan, the initial enrollment period for the dependents must be at least 31 consecutive days, with a 31-consecutive-day annual open enrollment period.

(c) A new employee who meets the participation criteria of a covered large employer may not be denied coverage if the application for coverage is received by the large employer carrier not later than the 31st day after the later of:

(1) the date on which the employment begins; or

(2) the date on which the waiting period established under Insurance Code §1501.606 (concerning Employee Enrollment; Waiting Period) expires.

(d) If dependent coverage is offered to the enrollees under a large employer health benefit plan, a dependent of a new employee who meets the participation criteria established by the large employer may not be denied coverage if the application for coverage is received by the large employer carrier not later than the 31st day after the later of:

(1) the date on which the employment begins;

(2) the date on which the waiting period established under Insurance Code §1501.606 expires; or

(3) the date on which the dependent becomes eligible for enrollment.

(e) A large employer carrier may not exclude any eligible employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group.

(f) A large employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an insured under this subsection terminates on the 32nd day after the date of the birth of the child unless:

(1) dependent children are eligible for coverage under the large employer health benefit plan; and

(2) notification of the birth and any required additional premium are received by the large employer not later than the 31st day after the date of birth. A large employer carrier may not terminate coverage of a newborn child if the carrier's billing cycle does not coincide with this 31-day

premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium, within 30 days of the due date of the premium.

(g) If dependent children are eligible for coverage under the large employer health benefit plan, a large employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured.

(h) If dependent children are eligible for coverage under the large employer health benefit plan, an adopted child of an insured may be enrolled, at the option of the insured, within either:

(1) 31 days after the an insured is a party in a suit for adoption; or

(2) 31 days of the date the adoption is final.

(i) Coverage of an adopted child of an employee terminates unless notification of the adoption and any required additional premiums are received by the large employer not later than either:

(1) the 31st day after the insured becomes a party in a suit in which the adoption of the child by the insured is sought; or

(2) the 31st day after the date of the adoption. A large employer carrier may not terminate coverage of an adopted child if the carrier's billing cycle does not coincide with this 31-day premium payment requirement, until the next billing cycle has occurred and there has been nonpayment of the additional required premium within 30 days of the date of the premium.

(j) For purposes of this section, "received by the large employer" within a specified period means that the item(s) must be postmarked by the specified period.

(k) If a newborn or adopted child is enrolled in a health benefit plan or other creditable coverage within the periods specified in this section, and subsequently enrolls in another health benefit plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child. If a newborn or adopted child is not enrolled within the periods specified in this section, then in accordance with §26.306(h) of this title (relating to Exclusions, Limitations, Waiting Periods, Affiliation Periods, Preexisting Conditions, and Restrictive Riders), the newborn or adopted child may be considered a late enrollee or excluded from coverage until the next open enrollment period.

§26.306. Exclusions, Limitations, Waiting Periods, Affiliation Periods, Preexisting Conditions, and Restrictive Riders.

(a) A large employer carrier may not exclude any eligible employee who meets the participation criteria or an eligible dependent, if dependent coverage is offered to enrollees under a large employer health benefit plan (including a late enrollee, who would otherwise be covered under a large employer's health benefit plan), except to the extent permitted under Insurance Code §§1501.102 - 1501.106 (concerning Preexisting Condition Provision; Treatment of Certain Conditions as Preexisting Prohibited; Affiliation Period; Waiting Period Permitted; and Certain Limitations or Exclusions of Coverage Prohibited) and 1501.601 - 1501.609 (concerning Participation Criteria; Coverage Requirements; Exclusion of Eligible Employee or Dependent Prohibited; Declining Coverage; Minimum Contribution or Participation Requirements; Employee Enrollment; Waiting Period; Coverage for Newborn Children; Coverage for Adopted Children; and Coverage for Unmarried Children).

(b) A preexisting condition provision in a large employer health benefit plan may not apply to expenses incurred on or after the expiration of the 12 months following the effective date of coverage of the enrollee or late enrollee, except as authorized by subsection (h)(2) of this section.

(c) A preexisting condition provision in a large employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received from an individual licensed to provide those services under state law and operating within the scope of practice authorized by state law during the six months before the effective date of coverage.

(d) A large employer carrier may not treat genetic information as a preexisting condition described by Insurance Code §1501.102 in the absence of a diagnosis of the condition related to the information.

(e) A large employer carrier may not treat a pregnancy as a preexisting condition described by Insurance Code §1501.102.

(f) A preexisting condition provision in a large employer health benefit plan may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the large employer health benefit plan, excluding any waiting or affiliation period. For example, Individual A has coverage under an individual policy for six months beginning on May 1, 2014, through October 31, 2014, followed by a gap in coverage of 61 days until December 31, 2014. Individual A is covered under an individual health plan beginning on January 1, 2015, for six months through June 30,

2015, followed by a gap in coverage of 62 days until August 31, 2015. The effective date of Individual A's coverage under a large employer health benefit plan is September 1, 2015. Individual A has 12 months of creditable coverage and would not be subject to a preexisting condition exclusion under the large employer health benefit plan.

(g) In determining whether a preexisting condition provision applies to an individual covered by a large employer benefit plan, the large employer carrier must credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under a large employer health benefit plan. If the previous coverage was issued under a health benefit plan, any waiting or affiliation period that applied before that coverage became effective also must be credited against the preexisting condition provision period. For instance, Individual B is covered under an individual health insurance policy for 18 months beginning May 1, 2014, through November 30, 2015, followed by a four-month gap in coverage from December 1, 2015, to March 31, 2016. On April 1, 2016, Individual B is covered under a group health plan for three months through June 30, 2016, followed by a two-month gap in coverage until August 31, 2016. The effective date of Individual B's coverage under a large employer health insurance policy is September 1, 2016. Under this example, since there was a significant break in coverage, to determine the length of creditable coverage, the large employer carrier counts the creditable coverage the individual had for the 12-month period preceding the effective date of the individual's coverage under the large employer plan. Individual B has creditable coverage of six months and the issuer of the large employer health benefit plan may impose a preexisting condition limitation for six months on Individual B.

(h) A large employer carrier must choose one of the methods set forth in paragraph (1) or (2) of this subsection for handling requests for enrollment from a late applicant in any health benefit plan subject to this subchapter. The large employer carrier must use the same method in regard to all health benefit plans.

(1) The employee or dependent may be excluded from coverage and any application for coverage rejected until the next annual open enrollment period and, on enrollment, may be subject to a 12-month preexisting condition provision or, in the case of an HMO, may be subject to a 60-day affiliation provision, as described by Insurance Code §§1501.102 - 1501.104.

(2) The employee or dependent's application may be accepted immediately and the employee or dependent enrolled as a late enrollee during the plan year, in which case the preexisting condition provision imposed for a late enrollee may not exceed 18 months or, in the case of an HMO, the affiliation period may not exceed 90 days, from the date of the late enrollee's application for coverage.

(3) The provisions of paragraphs (1) and (2) of this subsection do not apply to employees or dependents under the special circumstances listed as exceptions under the definition of late enrollee in §26.4 of this title (relating to Definitions).

(4) Examples for applying subparagraphs (A) and (B) of this paragraph, in the case of both insurers and HMOs: Individual A requests coverage on October 1, 2014, after the enrollment period of July 1, 2014, through July 31, 2014, has ended. The next annual open enrollment period is July 1, 2015, through July 31, 2015. The effective date of coverage for persons enrolling during an open enrollment period is the beginning of the plan year, which is September 1 of each year.

(A) If the carrier is an insurer and has elected to exclude all applicants requesting late enrollment under health benefit plans subject to this subchapter until the next open enrollment period, Individual A must reapply for coverage in July 2015, and the carrier may apply up to a 12-month preexisting condition period from the effective date of coverage and, as with any other enrollee, the preexisting condition period would begin on September 1, 2015, and expire on September 1, 2016.

(B) If the carrier is an insurer and has elected to immediately accept applications for late enrollment under health benefit plans subject to this subchapter and enroll the applicant during the plan year, the carrier may apply up to an 18-month preexisting condition period from the date of application. If Individual A applied for coverage on October 1, 2014, the preexisting condition period would begin on that date and would expire on April 1, 2016.

(C) If the carrier is an HMO and has elected to exclude all applicants requesting late enrollment under health benefit plans subject to this subchapter until the next open enrollment period, Individual A must reapply for coverage in July 2015, and the carrier may apply up to a 60-day affiliation period, as with any other enrollee.

(D) If the carrier is an HMO and has elected to immediately accept applications for late enrollment under health benefit plans subject to this subchapter and enroll the applicant during

the plan year, the carrier may apply up to a 90-day affiliation period from the day Individual A applied for coverage.

(i) An HMO may impose an affiliation period if the period is applied uniformly to each enrollee without regard to any health-status-related factor. The affiliation period may not exceed two months for an enrollee, other than a late enrollee, and may not exceed 90 days for a late enrollee. An affiliation period under a plan must run concurrently with any applicable waiting period under the plan. An HMO may not impose any preexisting condition limitation, except for an affiliation period.

(j) A large employer may establish a waiting period under Insurance Code §1501.606(b) applicable to all new entrants under the health benefit plan during which a new employee is not eligible for coverage. The large employer must determine the duration of the waiting period. A large employer carrier may not apply a waiting period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions or an affiliation period consistent with Insurance Code §§1501.102 - 1501.106 and 1501.601 - 1501.609, with respect to a new entrant, that is longer than the waiting period established by the large employer for all other employees. On completion of the waiting period and enrollment within the time frame allowed by §26.305(a) of this title (relating to Enrollment), coverage must be effective no later than the next premium due date. Coverage may be effective at an earlier date, as agreed on by the large employer and the large employer carrier.

(k) A large employer health benefit plan may not, by use of a rider or amendment applicable to a specific individual, limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for a preexisting condition or affiliation period permitted under Insurance Code §§1501.102 - 1501.106 and 1501.601 - 1501.609.

(l) To determine if preexisting conditions exist, a carrier must determine the source of previous or existing coverage of each eligible employee meeting the participation criteria at the time the employee or dependent initially enrolls into the health benefit plan provided by the large employer carrier. The large employer carrier has the responsibility to contact the source of previous or existing coverage to resolve any questions about the benefits or limitations related to any previous or existing coverage in the absence of a creditable coverage certification form.

§26.307. Fair Marketing.

(a) On request, a large employer carrier must provide to the large employer a summary of all health benefit plans offered by the large employer carrier for which the large employer qualifies.

(b) Denial by a large employer carrier of an application for coverage or cancellation, or refusal to renew, must be in writing and must state with specificity the reasons for the denial, cancellation, or refusal to renew (subject to any restrictions related to confidentiality of medical information). The large employer carrier must notify the large employer in accordance with Insurance Code §1501.109 (concerning Refusal to Renew; Discontinuation of Coverage) and §1501.110 (concerning Notice to Covered Persons).

(c) A large employer carrier may not require, as a condition to the offer or sale of a health benefit plan to a large employer, that the large employer purchase or qualify for any other insurance product or service.

(d) The large employer carrier may not require a large employer to join or contribute to any association or group as a condition of being accepted for coverage by the large employer carrier, except that, if membership in an association or other group is a requirement for accepting a large employer into a particular health benefit plan, a large employer carrier may apply that requirement, subject to the requirements of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act).

(e) Health carriers offering individual and group health benefit plans in this state are responsible for determining whether the plans are subject to the requirements of Insurance Code Chapter 1501 and this subchapter. At the time of application, health carriers must obtain the following information from applicants for those plans:

(1) whether any portion of the premium will be paid by a large employer;

(2) whether the prospective policyholder, certificate holder, or any prospective insured intends to treat the health benefit plan as part of a plan or program under the United States Internal Revenue Code of 1986 (26 U.S.C. §106, concerning Contributions by Employer to Accident and Health Plans, or §162, concerning Trade or Business Expenses);

(3) whether the health plan is an employee welfare benefit plan under 29 C.F.R. §2510.3-1 (concerning Employee Welfare Benefit Plan); or

(4) whether the applicant is a large employer.

(f) If a health carrier fails to comply with subsection (e) of this section, the health carrier is deemed to be on notice of any information that could reasonably have been attained if the health carrier had complied with subsection (e) of this section.

(g) A large employer carrier may not terminate, fail to renew, limit its contract or agreement of representation with, or take any other negative action against an agent for any reason related to the agent's request that the carrier issue or renew a health benefit plan to a large employer.

(h) If a large employer carrier issues coverage under Insurance Code Chapter 1507 (concerning Consumer Choice of Benefits Plans) to a large employer, it must comply with Chapter 21, Subchapter AA of this title (relating to Consumer Choice Health Benefit Plans).

§26.308. Renewability of Coverage and Cancellation.

(a) Except as provided by Insurance Code §1501.109 (concerning Refusal to Renew; Discontinuation of Coverage), a large employer carrier must renew any large employer health benefit plan at the option of the large employer, unless:

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

(2) the large employer has committed fraud or intentional misrepresentation of a material fact;

(3) the large employer has not complied with a material provision of the health benefit plan relating to premium contribution, group size, or minimum participation requirements;

(4) the large employer has no enrollee, in connection with the plan, who resides or works in the service area of the large employer carrier or in the area where the large employer carrier is authorized to do business; or

(5) 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.

(b) A large employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or intentional misrepresentation of a material fact by that individual and, with respect to an eligible employee or dependent who is a subscriber or enrollee in an HMO, for the reasons specified in §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate). The coverage is also subject to any policy or contractual provisions relating to incontestability or time limits on certain defenses.

§26.309. Refusal to Renew and Application to Reenter Large Employer Market.

(a) A large employer carrier may elect to refuse to renew all large employer health benefit plans delivered or issued for delivery by the large employer carrier in this state or in a geographic service area. The large employer carrier must notify the commissioner and each affected covered large employer of the election as provided in Insurance Code §1501.109 (concerning Refusal to Renew; Discontinuation of Coverage).

(b) The large employer carrier may not write a new large employer health benefit plan in this state or in the geographic service area, as applicable, for five years after notice to the commissioner of the election to refuse to renew. A large employer carrier that elects not to renew all large employer health benefit plans under Insurance Code §1501.109 and this section may not resume offering health benefit plans to large employers in this state or in the geographic area for which the election was made until it has filed a petition with the commissioner to be reinstated as a large employer carrier and the petition has been approved. In reviewing the petition, the commissioner may ask for information and assurances as the commissioner finds reasonable and appropriate.

(c) A large employer carrier may elect to discontinue a particular type of large employer coverage, only if the large employer carrier:

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

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

(B) offers to each employer the option to purchase other large employer coverage offered by the large employer carrier 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 who are or may become eligible for the coverage.

§26.310. Unfair Competition and Unfair Practices.

A misrepresentation about the effects of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) or this subchapter in marketing large employer health plans or in the marketing, renewing, or canceling of other health insurance products will be considered a

violation of Insurance Code Chapter 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices) and §543.001 (concerning Misrepresentation Prohibited).

§26.312. Point-of-Service Coverage.

(a) A large employer carrier that offers point-of-service coverage must comply, as applicable, with the requirements set forth in either Chapter 11, Subchapter Z of this title (relating to Point-of-Service Riders) or Chapter 21, Subchapter U of this title (relating to Arrangements Between Indemnity Carriers and HMOs for Point-of-Service Coverage).

(b) If an HMO issues coverage to a large employer and eligible employees have access only to in-plan coverage through one or more HMOs, each of the HMOs issuing coverage must offer the eligible employees the option of obtaining coverage that complies with the out-of-plan coverage set forth in either Chapter 11, Subchapter Z of this title or Chapter 21, Subchapter U of this title, and that allows the enrollee to access out-of-plan coverage at the option of the enrollee in compliance with Insurance Code §1273.052 (concerning Offer of Coverage Through Non-Network Plan Required).

(c) All HMOs offering coverage to eligible employees of a large employer may enter into a written agreement designating one or more of the HMOs to offer the point-of-service option required under this section.

(1) A copy of the agreement must be retained on file by each of the HMOs participating in the agreement and be made available to TDI on request.

(2) If an HMO participating in the agreement ceases to offer coverage to the large employer, a new agreement that complies with all of the requirements of this section must be entered into by all remaining HMOs offering coverage to employees of the large employer.

(3) If for any reason, an agreement is not in existence that ensures that all eligible employees have the option of selecting out-of-plan coverage under this section from at least one of the HMOs offering coverage to the eligible employees, each HMO must offer the eligible employees the option of selecting out-of-plan coverage as required by this section.

(d) Except as otherwise agreed to by the employer, an eligible employee who selects a point-of-service option is responsible for paying all costs, including premiums, coinsurance, copayments, deductibles, and any other cost-sharing provisions imposed by the point-of-service option, including any

administrative costs imposed by a large employer as permitted by Insurance Code §1273.055 (concerning Cost-Sharing Provisions).

(e) The premium for coverage required to be offered under this section must be based on the actuarial value of that coverage and may be different from the premium for the in-plan coverage provided by the HMO through the enrollee's evidence of coverage.

§26.313. Filing Requirements.

(a) Each large employer carrier, other than an HMO, must use a policy shell format for any group or individual health-benefit-plan form used to provide a health benefit plan in the large employer market. To expedite the review and approval process, all group and individual health-benefit-plan form filings (excluding HMO filings covered in subsection (b) of this section) must be submitted in the following order:

(1) a group policy face page or individual policy face page, as applicable;

(2) the group certificate page or individual data page, as applicable;

(3) as applicable under Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings), the toll-free number and complaint notice page, as required by Chapter 1, Subchapter E of this title (relating to Notice of Toll-Free Telephone Numbers and Procedures for Obtaining Information and Filing Complaints);

(4) the table of contents;

(5) insert pages for the general provisions;

(6) insert pages for the required provisions and any optional provisions, if elected and as applicable;

(7) for large employer health benefit plans, an insert page for the benefits section of the health benefit plan including, but not limited to, schedule of benefits, definitions, benefits provided, exclusions and limitations, continuation provisions, and if applicable, alternative cost containment, preferred provider, conversion and coordination-of-benefits provisions, and riders;

(8) insert pages for any amendments, applications, enrollment forms, or other form filings that comprise part of the contract;

(9) insert pages for any required outline of coverage for individual products;

(10) any additional form filings and documentation as outlined in Chapter 3, Subchapter A of this title and Subchapter G of this title (relating to Plain Language Requirements for Health Benefit Policies);

(11) the information required under this section; and

(12) the rate schedule applicable to any individual health benefit plan, as required by Chapter 3, Subchapter A of this title.

(b) In addition to subsection (a) of this section, the following provisions apply to each HMO. The HMO must submit health-benefit-plan forms for use in the large employer market that include the following:

(1) Any HMO group or individual agreement must address and include all required provisions of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act). The agreement must comply with any other applicable provisions of the Insurance Code. In addition, the agreement must comply with the provisions of Chapter 11, Subchapter F of this title (relating to Evidence of Coverage) where those provisions are not in conflict with Insurance Code Chapter 1501.

(2) The filing must include any alternative pages to the agreement or the schedule of benefits and any alternative schedules of benefit.

(3) The filing must include any additional riders, amendments, applications, enrollment forms, or other forms and any other required documentation outlined in Chapter 11, Subchapter F of this title.

(4) The filing must include any applicable requirements of Chapter 11, Subchapter D (relating to Regulatory Requirements for an HMO Subsequent to Issuance of Certificate of Authority) and Chapter 11, Subchapter F of this title, except for:

(A) continuation and conversion of coverage, in accordance with Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), and this title; and

(B) cancellation, in accordance with §26.308 of this title (relating to Renewability of Coverage and Cancellation).

(5) The filing must include any rider forms that will be used with health benefit plans offered to large employers. The rider forms, if developed subsequent to approval of the agreement,

must be submitted with an explanation of the market in which the forms will be used. All rider forms must comply with Insurance Code Chapter 1271, and applicable provisions of Chapter 11, Subchapter D of this title.

§26.314. Territorial Exclusions.

Subject to the provisions of Chapter 3 of this title (relating to Life, Accident and Health Insurance and Annuities) and Chapter 11 of this title (relating to Health Maintenance Organizations), a large employer health benefit plan may not exclude health care services, supplies, or drugs provided for medical emergencies outside the plan service area, including outside the United States.

SUBCHAPTER D, DIVISION 1

REPEAL OF 28 TAC §26.404

STATUTORY AUTHORITY. The repeal of 28 TAC §26.404 is adopted under Insurance Code §§1501.063, 1501.010, and 36.001.

Section 1501.063 addresses a health group cooperative's status as an employer.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

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

TEXT.

SUBCHAPTER D. COOPERATIVES

§26.404. Health Group Cooperative's Status as Employer.

SUBCHAPTER D, DIVISION 2

REPEAL OF 28 TAC §26.413

STATUTORY AUTHORITY. The repeal of 28 TAC §26.413 is adopted under SB 784 and Insurance Code §1501.010 and §36.001.

SB 784 repealed Insurance Code §1501.056(c).

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

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

TEXT.

SUBCHAPTER D. COOPERATIVES

§26.413. Health Carrier Reporting Requirements.

SUBCHAPTER D, DIVISION 1
28 TAC §§26.400 - 26.403 and 26.405 - 26.411

STATUTORY AUTHORITY. The amendments to 28 TAC §§26.401 - 26.403 and 26.405 - 26.411 and new §26.400 are adopted under Insurance Code §§1251.008, 1501.010, 1501.058(c)(1), 1501.0581, 1501.067, 1501.256, and 36.001.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

Section 1501.058(c)(1) authorizes the commissioner to adopt rules relating to a cooperative's compliance with federal laws applicable to cooperatives and health benefit plans issued through cooperatives.

Section 1501.0581 provides that the commissioner must adopt rules to implement the exemption of certain required coverage from health benefit plans offered through cooperatives, and that give a cooperative the option to rescind its election to permit eligible single-employee businesses for good cause.

Section 1501.067 directs the commissioner to adopt rules governing the eligibility of a single-employee business to participate in a health group cooperative under Chapter 1501, Subchapter B, including provisions to ensure that each eligible single-employee business has a business purpose and was not formed solely to obtain health benefit plan coverage under the subchapter.

Section 1501.256 authorizes the commissioner to adopt rules modifying a small employer health benefit plan or adopting a substitute for the plan using the Texas Health Benefits Purchasing Cooperative, to the extent required to comply with applicable federal law.

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

TEXT.

SUBCHAPTER D. COOPERATIVES.

DIVISION 1 - NONPROFIT HEALTH GROUP COOPERATIVES.

§26.400. Definitions and Filing.

(a) The terms defined in §26.4 of this title (relating to Definitions) are incorporated into this subchapter.

(b) The following terms have the meanings assigned in Insurance Code §1501.051:

(1) board of directors;

(2) board of trustees;

(3) cooperative;

(4) eligible single-employee business; and

(5) expanded service area.

(c) All references to health group cooperatives in this subchapter refer only to nonprofit health group cooperatives.

(d) Information required by this subchapter must be filed with the Life and Health Lines Office Filings Intake, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

§26.401. Establishment of Health Group Cooperatives.

(a) Under the Insurance Code and this subchapter, a person may form a health group cooperative for the purchase of employer health benefit plans.

(b) A health carrier may not form, or be a member of, a health group cooperative. A health carrier may associate with a sponsoring entity of a health group cooperative, such as a business association, chamber of commerce, or other organization representing employers or serving an analogous function, to assist the sponsoring entity in forming a health group cooperative.

(c) A health group cooperative must be incorporated as a nonprofit organization and be authorized to transact business in Texas, as required by the Business Organizations Code.

(d) A health group cooperative must file with TDI its organizational documents and, if applicable, authorization to transact business in Texas. The organizational documents must demonstrate the health group cooperative's compliance with Insurance Code §§1501.058 (concerning Powers and Duties of Cooperatives), 1501.059 (concerning Self-Insured or Self-funded Plan Prohibited), and 1501.061 (concerning Requirements Applicable to Heath Benefit Plan Issuers with Which Cooperative May Contract).

(e) A health group cooperative consisting only of small employers that elects to restrict its membership to 50 eligible employees in accordance with Insurance Code §1501.0581(o) (concerning Special Provisions Relating to Health Group Cooperatives) must include that election in the organizational documents filed under subsection (d) of this section. A health group cooperative making this election may not admit an eligible single-employee business, as defined in Insurance Code §1501.051 (concerning Definitions).

(f) A health group cooperative may elect to admit eligible single-employee businesses as members of the cooperative and allow single-employee business members to enroll in health benefit plan coverage as specified in Chapter 26, Subchapter D, Division 2 of this title (relating to Single-employee Business Participation in Health Group Cooperatives).

(g) The provisions of this subchapter do not limit or restrict an employer's access to health benefit plans under this chapter or Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act).

§26.402. Membership of Health Group Cooperatives.

(a) The membership of a health group cooperative may consist of:

(1) only small employers;

(2) only large employers;

(3) small and large employers;

(4) small employers and eligible single-employee businesses;

(5) large employers and eligible single-employee businesses; or

(6) small employers, large employers, and eligible single-employee businesses.

(b) To be eligible to arrange for coverage in accordance with Insurance Code §1501.058 (concerning Powers and Duties of Cooperatives), a health group cooperative must, at the end of its initial open enrollment period, have at least 10 participating employers. A health group cooperative must maintain at least 10 participating employers to continue eligibility for coverage. If the health group cooperative drops below 10 participating employers, it must add additional participating employers by the end of the next open enrollment period. If the health group cooperative does not have at least 10 participating employers by the beginning of the next open enrollment period, the health group cooperative must immediately notify the participating employers of the potential for nonrenewal under this section. If the health group cooperative does not have at least 10 participating employers by the end of the next open enrollment period, the health carrier may elect to immediately cease providing coverage to the health group cooperative.

(c) Subject to the requirements of Insurance Code §1501.101 (concerning Geographic Service Areas), and the limitations identified under subsections (d) and (e) of this section, a health group cooperative:

(1) must allow any small employer to join the cooperative and enroll in health benefit plan coverage during the initial and annual open enrollment periods unless the cooperative consists of only large employers;

(2) may allow eligible single-employee businesses to join the cooperative and enroll in health benefit plan coverage during the initial and annual open enrollment periods, if it has made the election in compliance with Chapter 26, Subchapter D, Division 2 of this title (relating to Single-employee Business Participation in Health Group Cooperatives); and

(3) may allow a large employer to join the cooperative and enroll in health benefit plan coverage during the initial enrollment and annual open enrollment periods.

(d) A health group cooperative that has elected to limit membership to 50 eligible employees and has filed the election with TDI as required by §26.401(e) of this title (relating to Establishment of Health Group Cooperatives) may decline to allow a small employer to join the cooperative if, after the small employer has joined the cooperative, the total number of eligible employees employed on business days during the preceding calendar year by all small employers participating in the cooperative would exceed 50.

(e) A health group cooperative may restrict its membership to small and large employers within a single industry grouping as defined by the most recent edition of the United States Census Bureau's North American Industry Classification System.

(f) A health group cooperative may not use risk characteristics of an employer or employee to restrict or qualify membership in the health group cooperative.

(g) An employer's participation in a health group cooperative is voluntary, but an employer electing to participate in a health group cooperative must, through a contract with the health group cooperative, commit to purchasing coverage through the health group cooperative for two years, except as provided for in subsection (h) of this section.

(h) A contract between an employer and a health group cooperative must allow an employer to terminate without penalty its health benefit plan coverage with a health group cooperative before the end of the two-year minimum contractual period required by subsection (g) of this section if it can demonstrate to the health group cooperative that continuing to purchase coverage through the cooperative would be a financial hardship in accordance with subsection (i) of this section.

(i) The contract between an employer and a health group cooperative may define what constitutes a financial hardship for the purposes of subsection (h) of this section. If the contract does not define the term, an employer may demonstrate financial hardship if it can show that at the end of the immediately preceding fiscal quarter, or on receipt of notice of a rate increase, the premium cost to the employer, as a percentage of the employer's gross receipts, increased by a factor of at least .50.

§26.403. Marketing Activities of Health Group Cooperatives.

(a) A health group cooperative may engage in marketing activities related and restricted to membership in the cooperative, including general availability of health coverage, and is not required to

maintain an agent's license for soliciting membership in the cooperative. All health coverage issued through the cooperative must be issued through a licensed agent that is employed by or contracted with the cooperative.

(b) A sponsoring entity of a health group cooperative may inform its members regarding the health group cooperative and the general availability of coverage through the health group cooperative. All coverage issued through the cooperative must be issued through a licensed agent.

(c) A licensed agent that is used and compensated by a health group cooperative is not required to be appointed by a health carrier offering coverage through the health group cooperative. This exemption does not allow an agent to market other products and services not offered through the health group cooperative without an appointment from the health carrier.

(d) A health group cooperative or a member of the board of directors, the executive director, an employee, or an agent of a health group cooperative is not liable for failure to arrange for coverage of any particular illness, disease, or health condition in arranging for coverage through the cooperative.

(e) A health group cooperative may offer other ancillary products and services to its members that are customarily offered in conjunction with health benefit plans.

§26.405. Premium Tax Exemption for Previously Uninsured.

(a) In accordance with Insurance Code §1501.0581(g)(4) (concerning Special Provisions Relating to Health Group Cooperatives), a health carrier providing coverage through a health group cooperative is exempt from premium tax and retaliatory tax for two years for premiums received for a previously uninsured employee or dependent. The two-year period for the exemption begins on the first date of coverage for the previously uninsured employee or dependent.

(b) For the purposes of this section and Insurance Code §1501.0581(g)(4), a previously uninsured employee or dependent is an employee or the dependent of an employee of an employer member of a health group cooperative who did not have creditable coverage for the 63 days preceding the effective date of coverage purchased through the health group cooperative.

(c) A health carrier must maintain documentation for four years for each insured that demonstrates that coverage of the insured or enrollee qualifies the health carrier for a tax exemption under subsection (b) of this section. The documentation must comply with any applicable rules or procedures adopted by the Comptroller of Public Accounts related to the tax exemption.

§26.406. Standard Presentation Form.

(a) A health carrier offering coverage through a health group cooperative must use a standard presentation form for employer members of the health group cooperative that includes the information listed in subsection (b) of this section. A standard presentation form may include additional information.

(b) A standard presentation form must include, at a minimum:

(1) an explanation that the coverage is being offered through a health group cooperative;

(2) the name of the health group cooperative;

(3) an explanation of small employers' eligibility to join the health group cooperative and purchase coverage without regard for membership in any other organization or the health status or claims experience of the employer and employees;

(4) an explanation of any fees or charges associated with membership in the health group cooperative;

(5) a statement that coverage is available to a small employer on a guaranteed-issue basis from any health carrier offering coverage in the small employer market with no requirement of joining a health group cooperative;

(6) for multiple plans that are offered through the health group cooperative, an explanation that the employer may select any of the plans without limitation due to health status or claims experience;

(7) a description of the plans offered through the health group cooperative by the health carrier; and

(8) if coverage is offered under Insurance Code Chapter 1507 (concerning Consumer Choice of Benefits Plans), a written disclosure in compliance with Chapter 21, Subchapter AA (relating to Consumer Choice Health Benefit Plans).

§26.407. Health Carrier Filing Before Issuance of Coverage to a Health Group Cooperative.

(a) A health carrier that intends to issue coverage to a health group cooperative must file with TDI information concerning the health carrier's offer of coverage no later than 30 days before the cooperative's initial enrollment period.

(b) A filing required by subsection (a) of this section must include:

(1) the name of the health carrier;

(2) the name, address, and telephone number or other contact information of the health group cooperative to which the health carrier intends to offer coverage;

(3) the county or expanded service area in which the health carrier intends to offer coverage to the health group cooperative;

(4) any limitations concerning the number of participating employers or employees in a health group cooperative that the health carrier is capable of administering; and

(5) the health benefit plan filed for use by the health carrier as a product available to health group cooperatives, or when appropriate under subsection (c) of this section, reference to a previously approved form, including the form number and date of approval.

(c) The form filing required by subsection (b)(5) of this section must comply, as appropriate, with all applicable filing requirements under Chapter 3 of this title (relating to Life, Accident and Health Insurance and Annuities) or Chapter 11 of this title (relating to Health Maintenance Organizations).

§26.408. Issuance of Coverage to Health Group Cooperatives.

(a) Subject to the limitations identified in §26.411 of this title (relating to Service Areas for Health Carriers Offering Coverage Through a Health Group Cooperative), a health carrier may elect to not offer or issue coverage to health group cooperatives or may elect to offer or issue coverage to one or more health group cooperatives of its choosing.

(b) Notwithstanding subsection (a) of this section, a health carrier must comply with the guaranteed issuance requirements of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) and this chapter with respect to offering and issuing coverage to a health group cooperative that:

(1) consists of only small employers;

(2) has elected to restrict membership in the cooperative to 50 employees; and

(3) has notified TDI consistent with §26.401(e) of this title (relating to Establishment of Health Group Cooperatives).

§26.409. Health Benefit Plans Offered Through Health Group Cooperatives.

(a) A health benefit plan issued by a health carrier through a health group cooperative is not subject to the following provisions of the Insurance Code or this title:

(1) the offer of in vitro fertilization coverage as required by Insurance Code Chapter 1366, Subchapter A (Coverage for In Vitro Fertilization Procedures);

(2) coverage of HIV, AIDS, or HIV-related illnesses as required by Insurance Code Chapter 1364, Subchapter A (concerning Exclusion from or Denial of Coverage Prohibited);

(3) coverage of chemical dependency and stays in a chemical dependency treatment facility as required by Insurance Code Chapter 1368 (concerning Availability of Chemical Dependency Coverage);

(4) coverage or offer of coverage of serious mental illness as required by Insurance Code §§1355.001 - 1355.007 (concerning Definitions, Applicability of Subchapter, Exception, Required Coverage for Serious Mental Illness, Managed Care Plan Authorized, Coverage for Certain Conditions Related to Controlled Substance or Marihuana Not Required, Small Employer Coverage);

(5) the offer of mental or emotional illness coverage as required by Insurance Code §1355.106 (concerning Offer of Coverage Required; Alternative Benefits);

(6) coverage of inpatient mental health and stays in a psychiatric day treatment facility as required by Insurance Code Chapter 1355, Subchapter C (concerning Psychiatric Day Treatment Facilities);

(7) the offer of speech and hearing coverage as required by Insurance Code Chapter 1365 (concerning Loss or Impairment of Speech or Hearing);

(8) coverage of mammography screening for the presence of occult breast cancer as required by Insurance Code §1356.005 (concerning Coverage Required);

(9) standards for proof of Alzheimer's disease as required by Insurance Code §1354.002 (concerning Proof of Organic Disease);

(10) coverage of stays in a crisis stabilization unit or residential treatment center for children and adolescents as required by Insurance Code §1355.055 (concerning Determinations for

Treatment in a Residential Treatment Center for Children and Adolescents) and §1355.056 (concerning Determinations for Treatment by a Crisis Stabilization Unit);

(11) coverage for formulas necessary for the treatment of phenylketonuria as required by Insurance Code Chapter 1359 (concerning Formulas for Individuals with Phenylketonuria or Other Heritable Diseases);

(12) coverage of contraceptive drugs and devices as required by Insurance Code Chapter 1369, Subchapter C (concerning Coverage of Prescription Contraceptive Drugs and Devices and Related Services) and §21.404(3) of this title (relating to Underwriting);

(13) coverage of diagnosis and treatment affecting temporomandibular joint and treatment for a person unable to undergo dental treatment in an office setting or under local anesthesia as required by Insurance Code Chapter 1360 (concerning Diagnosis and Treatment Affecting Temporomandibular Joint);

(14) coverage of bone mass measurement for osteoporosis as required by Insurance Code Chapter 1361 (concerning Detection and Prevention of Osteoporosis);

(15) coverage of diabetes care as required by Insurance Code Chapter 1358 (concerning Diabetes);

(16) coverage of childhood immunizations as required by Insurance Code Chapter 1367, Subchapter B (concerning Childhood Immunizations);

(17) coverage for screening tests for hearing loss in children and related diagnostic follow-up care as required by Insurance Code Chapter 1367 Subchapter C (concerning Hearing Test);

(18) offer of coverage for therapies for children with developmental delays as required by Insurance Code Chapter 1367, Subchapter E (concerning Developmental Delays);

(19) coverage of certain tests for detection of prostate cancer as required by Insurance Code Chapter 1362 (concerning Certain Tests for Detection of Prostate Cancer);

(20) coverage of acquired brain injury treatment and services as required by Insurance Code Chapter 1352 (concerning Brain Injury);

(21) coverage of certain tests for detection of colorectal cancer as required by Insurance Code Chapter 1363 (concerning Certain Tests for Detection of Colorectal Cancer);

(22) coverage for reconstructive surgery for craniofacial abnormalities in a child as required by Insurance Code Chapter 1367, Subchapter D (concerning Childhood Craniofacial Abnormalities);

(23) coverage of rehabilitation therapies as required by Insurance Code §1271.156 (concerning Benefits for Rehabilitation Services and Therapies);

(24) limitations on the treatment of complications in pregnancy established by §21.405 of this title (relating to Policy Terms and Conditions);

(25) coverage for services related to immunizations and vaccinations under managed care plans as required by Insurance Code Chapter 1353 (concerning Immunization or Vaccination Protocols under Managed Care Plans);

(26) coverage of a minimum stay for maternity as required by Insurance Code Chapter 1366, Subchapter B (concerning Minimum Inpatient Stay Following Birth of Child and Postdelivery Care);

(27) coverage of reconstructive surgery incident to mastectomy as required by Insurance Code Chapter 1357, Subchapter A (concerning Reconstructive Surgery Following Mastectomy);

(28) coverage of a minimum stay for mastectomy treatment and services as required by Insurance Code Chapter 1357, Subchapter B (concerning Hospital Stay Following Mastectomy and Certain Related Procedures);

(29) coverage of autism spectrum disorder as required by the Insurance Code §1355.015 (concerning Required Coverage for Certain Enrollees);

(30) transplant donor coverage, as established by 28 TAC §3.3040(h) of this title (relating to Prohibited Policy Provisions);

(31) coverage for certain tests for detection of human papillomavirus, ovarian cancer, and cervical cancer as required by Insurance Code Chapter 1370 (concerning Certain Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer);

(32) coverage of certain tests for detection of cardiovascular disease as required by Insurance Code Chapter 1376 (concerning Certain Tests for Early Detection of Cardiovascular Disease);

(33) coverage of certain amino acid-based elemental formulas as required by Insurance Code Chapter 1377 (concerning Coverage for Certain Amino Acid-Based Elemental Formulas);

(34) coverage of prosthetic devices, orthotic devices, and related services as required by Insurance Code Chapter 1371 (concerning Coverage for Certain Prosthetic Devices, Orthotic Devices, and Related Services); and

(35) coverage of orally-administered anticancer medications as required by Insurance Code Chapter 1369 (concerning Benefits Related to Prescription Drugs and Devices and Related Services).

(b) A health benefit plan issued by an HMO through a health group cooperative must provide for the basic health care services as provided in §11.508 or §11.509 of this title (relating to Mandatory Benefit Standards: Group, Individual and Conversion Agreements; and Additional Mandatory Benefit Standards: Group Agreement Only).

(c) A health benefit plan offered by an insurer through a health group cooperative is not subject to §3.3704(a)(6) of this title (relating to Freedom of Choice; Availability of Preferred Providers).

§26.410. Expedited Approval for Plans Offered Through a Health Group Cooperative.

(a) Unless a health carrier has identified a previously approved health benefit plan in the filing required by §26.407 of this title (relating to Health Carrier Filing Before Issuance of Coverage to a Health Group Cooperative), the health carrier must file each health benefit plan that will be offered to a health group cooperative for approval and must clearly indicate in the filing that the health benefit plan is to be offered to a health group cooperative and is subject to review under this section.

(b) A health benefit plan subject to review under this section may be filed as a file-and-use form consistent with Insurance Code Chapter 1701, Subchapter B (concerning Filing Requirement) and Subchapter C (concerning Sanctions; Applicability of Other Laws), and §3.5(a)(2) of this title (relating to Filing Authorities and Categories).

(c) An insurer that does not elect to file for approval under subsection (b) of this section must file for approval consistent with Insurance Code §1701.051 (concerning Filing Required), and §1701.054 (concerning Approval of Form), and §3.5(a)(1) of this title. TDI will approve or disapprove the filing within 40 calendar days of receipt of the complete filing.

(d) An HMO must file for approval an HMO evidence of coverage that is to be offered solely to a health group cooperative and must indicate that review of the evidence of coverage is subject to the expedited process available under this section. The HMO must file the evidence of coverage as required

by Chapter 11 of this title (relating to Health Maintenance Organizations), and TDI will approve or disapprove the evidence of coverage within 20 calendar days of receipt of a complete filing.

§26.411. Service Areas for Health Carriers Offering Coverage Through a Health Group Cooperative.

(a) A health carrier may provide coverage to only one health group cooperative in any county, except that a health carrier may provide coverage to additional health group cooperatives if it is providing coverage in an expanded service area.

(b) A health carrier may provide health group cooperative coverage to an expanded service area that includes the entire state on providing certification to TDI, signed by an officer of the health carrier, that the health carrier intends to provide health group cooperative coverage to an expanded service area that includes the entire state.

(c) A health carrier may apply for an expanded service area that includes less than the entire state by submitting an application for approval to TDI. The health carrier may begin using the expanded service area on approval or 60 days after the day the application is received by TDI, unless the application is disapproved by TDI within that time. The application must include, in a nondiscriminatory manner and in compliance with Insurance Code Chapter 544 (concerning Prohibited Discrimination):

(1) the geographic service areas, defined in terms of counties or ZIP codes, to the extent possible; and

(2) if the service area cannot be defined by counties or ZIP codes, a map that clearly shows the geographic service areas.

(d) A filing under this section does not affect any service areas that have been established in accordance with Insurance Code Chapter 843 (concerning Health Maintenance Organizations) or Chapter 1301 (concerning Preferred Provider Benefit Plans). A health carrier may not issue coverage to a health group cooperative in a service area that is not also contained entirely within the health carrier's service area established under Insurance Code Chapter 843 or 1301.

SUBCHAPTER D, DIVISION 2

28 TAC §§26.421 - 26.426

STATUTORY AUTHORITY. New §§26.421 - 26.426 are adopted under Insurance Code §§1251.008, 1501.010, 1501.058(c)(1), 1501.0581, 1501.067, 1501.256, and 36.001.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

Section 1501.058(c)(1) authorizes the commissioner to adopt rules relating to a cooperative's compliance with federal laws applicable to cooperatives and health benefit plans issued through cooperatives.

Section 1501.0581 provides that the commissioner must adopt rules to implement the exemption of certain required coverage from health benefit plans offered through cooperatives, and that give a cooperative the option to rescind its election to permit eligible single-employee businesses for good cause.

Section 1501.067 directs the commissioner to adopt rules governing the eligibility of a single-employee business to participate in a health group cooperative under Chapter 1501, Subchapter B, including provisions to ensure that each eligible single-employee business has a business purpose and was not formed solely to obtain health benefit plan coverage under the subchapter.

Section 1501.256 authorizes the commissioner to adopt rules modifying a small employer health benefit plan or adopting a substitute for the plan using the Texas Health Benefits Purchasing Cooperative, to the extent required to comply with applicable federal law.

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

TEXT.

SUBCHAPTER D. COOPERATIVES.

DIVISION 2. SINGLE-EMPLOYEE BUSINESS PARTICIPATION IN HEALTH GROUP COOPERATIVES

§26.421. Election to Permit Single-Employee Businesses to Participate in a Health Group Cooperative.

A health group cooperative that elects to admit eligible single-employee businesses must file an election with TDI at least 90 days before the date coverage becomes effective for single-employee business members. The election filing must contain:

(1) the election date;

(2) the results of the election;

(3) that the cooperative has a written agreement with a small or large employer health benefit plan issuer; and

(4) a signature by an authorized officer of the cooperative.

§26.422. Condition Precedent to Filing Election to Admit Single-Employee Businesses as Members.

A health group cooperative may elect to admit eligible single-employee businesses only if a small or large employer health-benefit-plan issuer has agreed in writing to offer to issue coverage to the cooperative based on its membership once the election becomes effective.

§26.423. Initial and Annual Enrollment Periods.

(a) A health group cooperative that elects to admit eligible single-employee businesses must permit participation and enrollment in the cooperative's health benefit plan coverage during the initial and annual open enrollment periods.

(b) For purposes of this section, the provisions of Insurance Code §1501.0581(a-1) (concerning Special Provisions Relating to Health Group Cooperatives) apply to eligible single-employee businesses.

§26.424. Membership Eligibility Requirements for Single-Employee Businesses.

A single-employee business is eligible to join a health care cooperative if it:

(1) is owned and operated by a sole proprietor;

(2) is engaged in commercial activity for the purpose of the sole proprietor's livelihood or profit;

(3) is not operated solely to obtain health benefit plan coverage under Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act); and

(4) employed fewer than two employees on business days during the preceding calendar year.

§26.425. Plan Issuance, Rating Requirements, and Mandated Benefits.

On the date an election under this division becomes effective and until the election is rescinded, the provisions of Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) relating to guaranteed issuance of plans, rating requirements, and mandated benefits that are applicable to small employers apply to eligible single-employee businesses that are members of the health group cooperative.

§26.426. Rescission of Election.

(a) A health group cooperative may rescind its election to admit eligible single-employee business members only if the:

(1) election has been effective for at least two years, except as provided by subsection (b) of this section;

(2) health group cooperative files notice of the rescission with the commissioner not later than the 180th day before the effective date of the rescission; and

(3) health group cooperative provides written notice of termination of coverage to all eligible single-employee business members of the cooperative not later than the 180th day before the effective date of the termination.

(b) A health group cooperative may rescind its election to admit eligible single-employee business members before the second anniversary of the effective date of the election by showing good cause in a written request to TDI that includes the:

(1) description of the specific circumstance requiring early rescission of the election, supported by any evidence of the cooperative's undue financial or operational hardship;

(2) geographical area in which the cooperative operates;

(3) total number of lives covered through the cooperative and the number of lives covered by enrollment of single-employer business members that will be affected by the rescission; and

(4) a signature by an authorized officer of the cooperative.

(c) A health group cooperative that rescinds its election under this division may choose to permit existing single-employee business members to maintain their membership and coverage but only if all single-employee business members are provided the same opportunity.

(d) A health group cooperative that has rescinded an election under this division may not reelect to accept eligible single-employee businesses to join the cooperative before the fifth anniversary of the effective date of the rescission.

SUBCHAPTER D, DIVISION 3

28 TAC §26.431

STATUTORY AUTHORITY. New §26.431 is adopted under Insurance Code §§1251.008, 1501.010, 1501.058(c)(1), 1501.0581, 1501.067, 1501.256, and 36.001.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

Section 1501.058(c)(1) authorizes the commissioner to adopt rules relating to a cooperative's compliance with federal laws applicable to cooperatives and health benefit plans issued through cooperatives.

Section 1501.0581 provides that the commissioner must adopt rules to implement the exemption of certain required coverage from health benefit plans offered through cooperatives, and that give a cooperative the option to rescind its election to permit eligible single-employee businesses for good cause.

Section 1501.067 directs the commissioner to adopt rules governing the eligibility of a single-employee business to participate in a health group cooperative under Chapter 1501, Subchapter B, including provisions to ensure that each eligible single-employee business has a business purpose and was not formed solely to obtain health benefit plan coverage under the subchapter.

Section 1501.256 authorizes the commissioner to adopt rules modifying a small employer health benefit plan or adopting a substitute for the plan using the Texas Health Benefits Purchasing Cooperative, to the extent required to comply with applicable federal law.

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

TEXT.

SUBCHAPTER D. COOPERATIVES.

DIVISION 3. HEALTH GROUP COOPERATIVE ELECTION TO TREAT MEMBERS AS SEPARATE EMPLOYERS FOR RATING PURPOSES.

§26.431. Election to Treat Members as Separate Employers for Rating Purposes.

(a) A health group cooperative may elect to treat each member as a separate employer for purposes of rating small and large employer health benefit plans subject to the rating requirements Insurance Code Chapter 843 (concerning Health Maintenance Organizations), as applicable.

(b) An existing health group cooperative must file its election with TDI not later than the 90th day before the date on which the election is to become effective. The election filing must include:

(1) the election date;

(2) the effective date of the election; and

(3) a signature by an authorized officer of the cooperative.

(c) When applicable, a health group cooperative must provide all members written notice at least 90 days before the effective date of the election. The notice must include statements:

(1) that the cooperative is electing to treat each member as a separate employer for the purpose of rating small and large employer health benefit plans; and

(2) specifying each employer's applicable premium rate as of the date the plan is renewed.

(d) When a prospective member applies to join a health group cooperative, the cooperative must provide written notice to the applicant that the cooperative has elected to treat each member as a separate employer for the purpose of rating small and large employer health benefit plans.

(e) Subject to the notice requirements in subsection (c) of this section, an election under this section is effective on the earliest date after the election when the plan is next issued or renewed. The election may not become effective before full compliance with this section's requirements. Once effective, the election remains in effect for not less than 12 months after the effective date.

SUBCHAPTER D, DIVISION 4

28 TAC §26.441 and §26.442

STATUTORY AUTHORITY. New §§26.441 - 26.442 are adopted under Insurance Code §§1251.008, 1501.010, 1501.058(c)(1), 1501.0581, 1501.067, 1501.256, and 36.001.

Section 1251.008 authorizes the commissioner to adopt rules as necessary to administer Chapter 1251.

Section 1501.010 authorizes the commissioner to adopt rules necessary to implement Chapter 1501 and to meet the minimum requirements of federal law.

Section 1501.058(c)(1) authorizes the commissioner to adopt rules relating to a cooperative's compliance with federal laws applicable to cooperatives and health benefit plans issued through cooperatives.

Section 1501.0581 provides that the commissioner must adopt rules to implement the exemption of certain required coverage from health benefit plans offered through cooperatives, and that give a cooperative the option to rescind its election to permit eligible single-employee businesses for good cause.

Section 1501.067 directs the commissioner to adopt rules governing the eligibility of a single-employee business to participate in a health group cooperative under Chapter 1501, Subchapter B, including provisions to ensure that each eligible single-employee business has a business purpose and was not formed solely to obtain health benefit plan coverage under the subchapter.

Section 1501.256 authorizes the commissioner to adopt rules modifying a small employer health benefit plan or adopting a substitute for the plan using the Texas Health Benefits Purchasing Cooperative, to the extent required to comply with applicable federal law.

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

TEXT.

SUBCHAPTER D. COOPERATIVES.

DIVISION 4 – PRIVATE PURCHASING COOPERATIVES.

§26.441. Private Purchasing Cooperatives.

(a) Two or more small or large employers may form a private purchasing cooperative for the purchase of small or large employer health benefit plans. A private purchasing cooperative must be organized as a nonprofit corporation and has the rights and duties provided by the Texas Nonprofit Corporation Act, Business Organizations Code Chapter 22.

(b) On receipt of a certificate of incorporation or certificate of authority from the secretary of state, the private purchasing cooperative must file notification of the receipt of the certificate and a copy of the cooperative's organizational documents with the commissioner.

(c) When a private purchasing cooperative or the Texas Health Benefits Purchasing Cooperative arranges for coverage under a health benefit plan for a small or large employer, the health benefit plan issued to a:

(1) small employer must be a small employer health benefit plan;

(2) large employer must be a large employer health benefit plan; and

(3) school district electing to be treated as a small employer under Insurance Code §1501.009 (concerning School District Election), must be a small employer health benefit plan.

§26.442. Powers and Duties of Texas Health Benefits Purchasing Cooperative and Private Purchasing Cooperatives.

(a) A private purchasing cooperative described in this section and the Texas Health Benefits Purchasing Cooperative described in Insurance Code Chapter 1501:

(1) must arrange for small or large employer health benefit plan coverage for small or large employer groups that participate in the cooperative by contracting with small or large employer carriers that meet the criteria established in Insurance Code §1501.061 (concerning Requirements Applicable to Health Benefit Plan Issuers with Which Cooperative May Contract) and subsection (b) of this section;

(2) must collect premiums to cover the cost of:

(A) small or large employer health benefit plan coverage purchased through the cooperative; and

(B) the cooperative's administrative expenses;

(3) may contract with agents to market coverage issued through the cooperative;

(4) must establish administrative and accounting procedures for the operation of the cooperative;

(5) must establish procedures under which an applicant for or participant in coverage issued through the cooperative may have a grievance reviewed by an impartial person;

(6) may contract with a small or large employer carrier or third-party administrator to provide administrative services to the cooperative;

(7) must contract with small or large employer carriers for the provision of services to small or large employers covered through the cooperative;

(8) must develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in coverage through the cooperative;

(9) may negotiate the premiums paid by its members; and

(10) may offer other ancillary products and services to its members that are customarily offered in conjunction with health benefit plans.

(b) A cooperative may contract only with small or large employer carriers that desire to offer coverage through the cooperative and that demonstrate:

(1) the carrier is a health carrier or HMO licensed and in good standing with TDI;

(2) the capacity to administer the health benefit plans;

(3) the ability to monitor and evaluate the quality and cost effectiveness of care and applicable procedures;

(4) the ability to conduct utilization management and applicable procedures and policies;

(5) the ability to ensure enrollees adequate access to health care providers, including adequate numbers and types of providers;

(6) a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints; and

(7) financial capacity, either through financial solvency standards as applied by the commissioner or through appropriate reinsurance or other risk-sharing mechanisms.

(c) A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan.

(d) A cooperative must comply with federal laws applicable to cooperatives and health benefit plans issued through cooperatives.

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

Issued at Austin, Texas, on April 25, 2017.

Norma Garcia
General Counsel
Texas Department of Insurance

The Texas Department of Insurance adopts the repeals, amendments to, and new sections in Chapter 26, Subchapters A, C, and D.

Kevin Brady
Deputy Commissioner For Agency Affairs
Texas Department of Insurance
Delegation Order 4506

COMMISSIONER'S ORDER NO. **2017-5046**