**CHAPTER 26**
**SUBCHAPTER A. SMALL EMPLOYER HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT 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 PORTABILITY AND AVAILABILITY ACT REGULATION**
**28 TAC §§26.301 - 26.310, 26.312 and 26.314**

**REPEAL OF 28 TAC §26.311**

**SUBCHAPTER D. HEALTH GROUP 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 proposes the repeal of sections and amendment and adoption of new sections in 28 TAC Chapter 26, concerning large- and small-employer health insurance regulations and health group cooperatives.

TDI proposes to revise the name of 28 TAC Chapter 26.

TDI proposes the repeal of §§26.1, 26.17, 26.21 - 26.24, 26.26, and 26.27 in 28 TAC Chapter 26, Subchapter A; §26.311 in 28 TAC Chapter 26, Subchapter C; and §26.404 and §26.413 in 28 TAC Chapter 26, Subchapter D.

TDI proposes amendments to §§26.3 - 26.16, 26.18 - 26.20, and 26.25 in 28 TAC Chapter 26, Subchapter A; §§26.301 - 26.310, 26.312, and 26.314 in 28 TAC, Chapter 26, Subchapter C; and §§26.401 - 26.403, and 26.405 - 26.411 in 28 TAC Chapter 26, Subchapter D.

TDI proposes new, §26.28 in 28 TAC Chapter 26, Subchapter A and §26.313 in 28 TAC Chapter 26, Subchapter C.

TDI proposes dividing 28 TAC Chapter 26, Subchapter D into 4 divisions.

TDI proposes new §26.400 in 28 TAC Chapter 26, Subchapter D, Division 1; new §§26.421 - 26.426 in 28 TAC Chapter 26, Subchapter D, Division 2; new §26.431 in 28 TAC Chapter 26, Subchapter D, Division 3; and new §26.441 and §26.442 in 28 TAC Subchapter D, Division 4.

The repeals, amendments, and new divisions and sections make the rules consistent with Texas statutes and clarify issues arising from of the enactment of federal laws. The proposal would also

conform Chapter 26 to statutory changes made by SB 859, 82nd Legislature, Regular Session (2011) and SB 784, 84th Legislature, Regular Session (2015).

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 the Texas Government Code §2001.039. The department determined that in most, but not all, cases, the reasons for initially adopting the sections continue to exist. In those cases the department is proposing to maintain those sections with any amendments necessary for the purposes addressed in this proposal. In some cases the department determined that the reasons for initially adopting the sections no longer exist, and is proposing to repeal those sections. These sections include §26.27 and §26.413.

**EXPLANATION.** The proposed amendments, new sections, and repeals modify 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. The proposal amends the titles of subchapters and sections to more accurately reflect their contents. Proposed 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 TDI's style and usage guidelines.

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

The proposal 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.

The proposal repeals §26.1, relating to Statement of Purpose, because the chapter has grown to include the implementation of 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.

The proposed amendments to §26.3, relating to Severability, update language.

The proposed 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 in order 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. The proposal changes the term "actuary" to "qualified actuary" and modifies the definition for greater accuracy.

The proposal 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. The proposal amends the definition of "child" to include any other child considered a dependent under an employer's health benefit plan. The proposal deletes references to the Texas Health Insurance Risk Pool because it no longer exists.

The proposed amendments to §26.5, relating to Applicability and Scope, clarify that the remainder of Subchapter A governs small employers. The proposal deletes 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. Insurance Code Article 21.42, concerning Texas Laws Govern Policies, 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).

The proposed amendments to §26.6, relating to Status of Health Carriers as Small Employer Carriers, amend 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

proposed amendments prescribe the elements of the filing, and provide a web address for a form that fulfills the requirements. The proposal removes 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 the elimination of that requirement by SB 784. Section 26.6(e) is deleted to remove the ineligibility for participation in the Texas Health Reinsurance System, since the ineligibility no longer exists.

The proposal deletes §26.7(f) because it is a duplicate of Insurance Code §1501.155(d). Redesignated §26.7(i) clarifies when waiting periods apply. The proposal also deletes §26.7(m) and (n) because they no longer apply due to guaranteed enrollment.

The proposed 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. The proposal amends Section 26.8(d) and deletes §26.8(e) and (f) because the minimum percentage participation requirements are in Insurance Code §1501.154 and §1501.155.

The proposed 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 proposes nonsubstantive amendments 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.

The proposed 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. Section 26.13(d) is deleted because Insurance Code

Chapter 1501 does not required a written affirmation that the small employer carrier offered the small employer a consumer choice health benefit plan.

The proposal 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. The proposal adds catchlines to these subsections for clarity. The proposal adds new §26.14(d), regarding point-of-service (POS) coverage, which allows 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.

The proposed 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. The specific reference to HMOs is deleted from §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," in accordance with Insurance Code §1501.108(4), which does not restrict this provision to HMOs.

The proposed amendments to §26.16, relating to Refusal to Renew and Application to Reenter Small Employer Market, update citations and wording. Part of subsection §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.

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

The proposed 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 provides a web address carriers can use to access a form that meets the requirements.

The proposed 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. Proposed 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.

The proposal amends §26.18(b)(1) to provide that if a carrier is a risk-assuming carrier seeking to change its status, 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.

The proposed amendments to §26.19(a) provide a web address for carriers to use to access a form that fulfills the requirements of the subsection. The proposed amendments delete Form Number 1212 CERT GEOG (also known as Figure 44) in §26.19(b) due to the elimination of that requirement by SB 784 and because similar information is collected by TDI in another manner.

Proposed amendments to §26.20, relating to Reporting Requirements, add new subsection (b) to provide a web address for carriers to access Form Number 1212 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 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 subsection §26.20(b)(8) has been moved to §26.4, relating to Definitions.

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

The proposal 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.

The proposal 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.

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

The proposal repeals §26.26, relating to Administrative Violations and Penalties, and §26.27, relating to Forms, because the requirements of §26.26 are clearly addressed in Insurance Code §1501.357, and because §26.27 is no longer needed due to amendments in other sections pointing to where particular forms can be found on TDI's website.

The proposal adds new §26.28, relating to Territorial Exclusions, which imposes limitations on the ability of a small 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.

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

The proposal amends §26.301, relating to Applicability, Definitions, and Scope, to incorporate the terms defined in §26.4. Section 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. Existing §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 proposal replaces and simplifies language in §26.301(d) and (g). Proposed 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 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. Insurance Code Article 21.42 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. The proposal 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) due to the elimination of that requirement by SB 784, and because similar information is collected by TDI in another manner.

The proposal deletes §26.303(a), (d), (f), and (h) because they are repetitive of Insurance Code Chapter 1501, Subchapter M. A sentence is added to subsection §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.

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

The proposed 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.

The proposed 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.

The proposal 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.

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

The proposal 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.

The proposal amends the section title and citations in §26.310, relating to Unfair Competition and Unfair Practices.

The proposal 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.

Proposed 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 Title 28 of the Texas Administrative Code. 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 include any rider forms.

Proposed 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.

The proposal amends the title of Subchapter D to include all cooperatives as provided by Insurance Code Chapter 1501. The proposal creates four divisions within the subchapter. Division 1 relates to Nonprofit Health Group Cooperatives. SB 859, 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.

Proposed 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.

Proposed amendments to §26.401, relating to Establishment of Health Group Cooperatives, clarify wording, and subsection §26.401(d) is amended to delete the reference to the Filings Intake Division because the address for filing information required by Subchapter D is relocated to new §26.400(d). The proposed amendment to §26.401(e) would prohibit 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. The proposal also amends §26.401(f) to reference single-employee businesses and to delete the reference to Form Number HGC-1.

The proposed amendments to §26.402(a), relating to Membership of Health Group Cooperatives, adds 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.

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

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

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

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

Proposed 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 proposed to be deleted because the address for filing information required by this 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. 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) are deleted from §26.409(a) because the exemption from state law requirements found in Insurance Code §1501.0581(i) does not apply to them. The following state coverage mandates are proposed to be added 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.

Proposed amendments update citations and wording in §26.410, related to Expedited Approval for Plans Offered Through a Health Group Cooperative. Section 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 proposed 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.

The rule proposal establishes Division 2 as Single-Employee Business Participation in Health Group Cooperatives.

Proposed 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.

Proposed 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.

Proposed 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.

Proposed 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.

Proposed 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.

Proposed 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 proposed 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 re-elect to accept eligible single-employee businesses for five years.

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

Proposed 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 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.

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

Proposed 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 under the 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 issued to a small employer must be a small employer health benefit plan, one issued to a large employer must be a large employer health benefit plan, and one issued to a school district electing to be treated as a small employer must be a small employer health benefit plan.

Proposed 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.

**FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT**. Doug Danzeiser, director, Life and Health Lines Office, Regulatory Policy Division, has determined that for each year of the first five years the proposed repeal, amendments, and new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

**PUBLIC BENEFIT AND COST NOTE.** Mr. Danzeiser has determined that for each year of the first five years the repeals, amendments, and new sections are in effect, the public benefits anticipated as a result of the repeals, amendments, and new sections will be a clearer understanding of requirements and health benefits for consumers, small and large employers, small and large employer health benefit plan carriers, and cooperatives. TDI has drafted this proposal to maximize public benefits, consistent with the authorizing statutes, while mitigating costs.

In the informal draft of the rule text posted on TDI's website in October 2015, TDI invited stakeholders and the public to comment regarding any new anticipated costs that could result from the draft rules. TDI received no comments regarding costs.

TDI has determined that the proposed amendments, repeals, and new sections may have an adverse economic effect; however, some carriers and employers may experience savings due to some of the changes.

Proposed new subsection §26.301(h), which requires that a plan issued to an employer having employees in more than one state comply with the provisions of Insurance Code Chapter 1501 and 28 TAC Chapter 26, Subchapter C, if the majority of employees are employed in this state on the issue date or renewal date, or the primary business location is in this state on the issue date or renewal date, and no state contains a majority of the employees, does not impose new costs on carriers because it is a clarification of existing requirements including Insurance Code Article 21.42. The new subsection clarifies that the existing requirement in §26.5(f) for small employer plans is also required of large employer plans. Any associated costs are attributable to existing requirements rather than the new subsection. Further, TDI cannot quantify the cost resulting from the requirements. Carriers are in the best position to estimate these costs, and TDI received no comments on costs in response to the informal posting.

Similarly, proposed new §26.5(g) and §26.301(i), which require a carrier licensed in this state that issues a certificate of insurance covering a Texas resident to be responsible for ensuring that the certificate complies with applicable Texas insurance laws and rules, impose no new costs on carriers because these are a clarification of existing requirements, including requirements in Insurance Code Article 21.42. TDI already requires that certificates issued to Texas residents by Texas-licensed carriers comply with applicable Texas laws and rules. Any costs are attributable to existing requirements rather than these new subsections. Similar to new §26.301(h), TDI cannot quantify the cost resulting from the requirements. Carriers are in the best position to estimate these costs, and TDI received no comments on costs in response to the informal posting.

The deletion of the annual March filing of the Small Employer Carrier Status Certification (Figure 40) form, and the Large Employer Carrier Status Certification (Figure 50) form in §26.6 and §26.302, respectively, would save carriers the time and costs involved in filling out the form. Under the proposed text, carriers would only file the forms as an initial filing, and again when there are changes in status. There is no filing fee for this form. Further, SB 784's repeal of the carrier requirement to file geographic information, proposed to be implemented in §26.6 and §26.19(a) and (b) for small employer carriers and in §26.302(c) and (d), and §26.309(a) for large employer carriers, saves small employer carriers the

time and costs associated with filling out Form 1212 CERT GEOG (Figure 44) and saves large employer carriers time and costs associated with filling out Form 1212 LEHC GEOG (Figure 51).

The clarification that "eligible employees" who are within their waiting period or affiliation period are not included in the count for percentage participation purposes will cost carriers only if they choose to add this clarification to their forms. Adding this type of clarification language is a business choice. Filing an amended form with TDI costs $100. However, if the carrier is already otherwise submitting an amended form to TDI, then only one $100 filing fee is charged.

Amendments to §26.20(b)(3) delete the requirement that physical certificates be attached to Form Number 1212 CERT DATA (Figure 48). Removing this requirement would save carriers time and money.

Carriers may incur some costs regarding the emergency extraterritorial requirements in proposed new §26.28 and §26.314. These sections prohibit small and large employer health plans from excluding health services, supplies, or drugs provided for medical emergencies outside the plan service area, including outside the United States. To TDI's knowledge, all issuers currently comply with this practice, and, presumably, the cost of emergency care is already built into the premiums--except that some carriers limit their coverage to Canada, Mexico, and the United States. There is no way for TDI to know what percentage of plans limit coverage to these three countries or the number of enrollees in those particular plans who travel outside of these three countries. Again, TDI received no estimate of anticipated costs in response to the posting of the informal draft of the rule text.

Subchapter D, Division 2, Single-Employee Business Participation in Health Group Cooperatives, is a new division created to implement SB 859. Costs associated with the new division would be the cost to a health group cooperative to elect to admit eligible single-employee businesses and, if applicable, to rescind the election. The commissioner is required to adopt rules for these functions under Insurance Code §1501.081(q) and (v). TDI estimates that the time to create an election or rescind an election would be approximately two hours each. The cost of the two hours per procedure would depend on the employee who performs the work within the cooperative. These procedures may include computer programming.

Carriers may calculate the total cost of labor for each category by multiplying the number of estimated hours for each cost component by the median hourly wage for each category of labor. The Texas statewide median hourly wage for each category is published online by the Texas Workforce Commission at www.texaswages.com as follows:

(a) a computer programmer: $75,539 per year, divided by 2080 hours per year equals $36.32;

(b) an administrative assistant: $30,477 per year, divided by 2080 hours per year equals $14.65;

(c) an administrative services manager: $97,900 per year, divided by 2080 hours per year equals $47.07; and

(d) a chief executive: $190,000 per year, divided by 2080 hours per year equals $91.35.

The probable cost components for compliance include the cost of printing, copying, and mailing selection or rescission information. TDI estimates the average price of a standard business-size envelope is between $.07 and $.17, and a business catalog-size envelope is between $.31 and $.40. TDI further estimates that the cost of printing or copying is between $.08 and $.12 per page.

According to the United States Postal Service, the current price to mail a domestic first class letter (one ounce) is $.47. The price of each additional ounce is $.21. It is not feasible for TDI to estimate the total increased printing, copying, and mailing costs attributable to compliance with the proposed new division because it is unknown at this time how many members each cooperative has and would be required to notice.

SB 784 eliminates the requirements for cooperatives and coalitions to file an annual statement of amounts collected and expenses incurred, so this requirement is deleted with the deletion of §26.413. There should be a minimal savings to cooperatives and coalitions.

**ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.** As required by Government Code §2006.002(c), TDI has determined that the repeals, amendments, and new sections may have an adverse economic effect on small or micro business carriers. TDI estimates that approximately one to nine insurers and HMOs collect less than $6 million in group premium per year. TDI does not collect information on the number of individuals employed by licensed carriers, but TDI believes that one or more of these entities may be a small or micro business under Government Code §2006.002(c). However, there will not be a disproportionate economic impact on small or micro businesses because the cost of compliance with these proposed rules will not vary between large businesses and small or micro businesses. TDI's cost analysis and resulting estimated costs in the Public Benefit and Cost Note portion of this proposal are equally applicable to large businesses and small or micro businesses.

Government Code §2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small or micro businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Government Code §2006.002(c)(1) requires that the analysis consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses.

Many of the changes will save employers and carriers time and expenses. The costs related to jurisdictional requirements of proposed new §26.301(h) and (i) and §26.5(g) are attributable to existing requirements rather than the proposed amendments. Amending a form to clarify minimum participation requirements so that employees within waiting periods or affiliation periods are not counted as eligible employees, adding emergency extraterritorial requirements, and requiring cooperatives to make elections or rescind elections could create costs.

In compliance with Government Code §2006.002, TDI considered the following three regulatory alternatives: (i) not proposing the new requirements; (ii) proposing different requirements for small and micro businesses; and (iii) exempting small and micro businesses. For the following reasons, TDI rejected each of these alternatives.

*Not proposing the new requirements.*

First, TDI considered the option of not proposing the new requirements.

Not proposing the jurisdictional requirements of new §26.301(h) and (i), and §26.5(g), would not lessen any adverse effect on small or micro businesses because the costs are attributable to existing requirements rather than the rule.

Not proposing that "eligible employees" within waiting periods or affiliation periods are not required to be counted toward the percentage participation would eliminate changes to forms. However, these form changes are optional and will only require a filing fee if not filed with other changes. In addition, the advantage of not counting ineligible employees in the percentage count outweighs the disadvantage of counting employees who do not qualify, because the resulting reduction in percentage does not help the employer or the employees.

Requiring emergency extraterritorial requirements protects consumers, so not proposing these requirements would mean that this protection might not be available. In addition, most carriers already

include this coverage, and there has been no indication that expanding beyond the countries of the United States, Mexico, and Canada would significantly increase costs to the carrier or in the premium.

SB 859 requires cooperatives to have the ability to make elections or rescind elections. The commissioner is required to adopt rules concerning the elections. If these provisions were not proposed, potential cooperatives would not have a procedure to follow.

For these reasons, TDI has rejected this option.

*Proposing different requirements for small and micro businesses.*

TDI also considered the option of proposing different requirements for small and micro businesses.

A purpose of the proposal is to provide consistency and clarity. To propose different requirements for small and micro businesses would hinder their competitive standing in the marketplace because they would not offer the same coverage as large businesses.

Amending forms to clarify the percentage participation calculation is optional, and there is no indication that offering the emergency extraterritorial requirements adds significant costs. As the proposal relates to jurisdiction, existing requirements do not exempt small and micro businesses. Further, consumers are entitled to the same benefits regardless of the size of the business from which they purchase coverage.

To have no rules regarding cooperative elections or rescinding elections hurts small and micro businesses because they could not join the single-employee business participation in health group cooperatives.

For these reasons, TDI has rejected this option.

*Exempting small and micro businesses.*

Finally, TDI considered the option of not requiring small and micro businesses to comply with the rules.

A purpose of the proposal is to provide consistency and clarity. To exempt small and micro businesses would hinder their competitive standing in the marketplace because they would not offer the same coverage as large businesses. Amending forms to clarify the percentage participation calculation is optional, and there is no indication that offering the emergency extraterritorial requirements adds significant costs. As the proposal relates to jurisdiction, existing requirements do not

exempt small and micro businesses. Further, consumers are entitled to the same benefits regardless of the size of the business from which they purchase coverage. Joining a cooperative is optional, so exemption of small or micro businesses from the cooperative rules is not relevant.

For these reasons, TDI has rejected this option.

**TAKINGS IMPACT ASSESSMENT.** TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

**REQUEST FOR PUBLIC COMMENT.** Submit any written comments on the proposal no later than 5 p.m., Central time, on November 28, 2016. TDI requires two copies of your comments. Send one copy either by mail to the Texas Department of Insurance, Office of the Chief Clerk, Mail Code 113-2A, P.O. Box 149104, Austin, Texas 78714-9104; or by email to chiefclerk@tdi.texas.gov. Send the other copy either by mail to Doug Danzeiser, Director, Life and Health Lines Office, Mail Code 106-1D, P.O. Box 149104, Austin, Texas 78714-9104; or by email to LHLComments@tdi.texas.gov.

The commissioner will consider written comments and testimony presented in a public hearing under Docket Number 2793, scheduled for 1:30 p.m., Central time, on November 18, 2016, in Room 100 of the William P. Hobby, Jr. state office building, 333 Guadalupe Street, Austin, Texas.

**SUBCHAPTER A**

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

**STATUTORY AUTHORITY.** The repeal of §§26.1, 26.17, 26.21 - 26.24, and 26.26 - 26.27, is proposed 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.

**CROSS-REFERENCE TO STATUTE.** The repeal of §§26.1, 26.17, 26.21 - 26.24, and 26.26 - 26.27 implements Insurance Code §36.001, §1251.008, and Chapter 1501.

**TEXT.**

**SUBCHAPTER A. SMALL EMPLOYER HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT 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 proposed 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.

**CROSS-REFERENCE TO STATUTE.** The amendments to §§26.3 - 26.16, 26.18 - 26.20, and 26.25, and new §26.28 implement Insurance Code Article 21.42, §36.001, §1201.062, §1251.008, §1251.154, and §1503.003, and Chapter 1501.

**TEXT.**

## SUBCHAPTER A. DEFINITIONS, SEVERABILITY, AND SMALL EMPLOYER HEALTH [~~INSURANCE PORTABILITY AND AVAILABILITY ACT~~] REGULATIONS

### §26.3. Severability.

If any provision of this chapter or its [~~the~~] application [~~thereof~~] to any person or circumstance [~~circumstances~~] 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 [~~shall not be affected thereby~~].

### §26.4. Definitions.

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

(1) [~~Actuary--A qualified actuary who is a member in good standing of the American Academy of Actuaries.~~]

[~~(2)~~] Affiliation period--As defined in Insurance Code §1501.104 (concerning Affiliation Period). [~~A period of time that under the terms of the coverage offered by an HMO, must expire before the coverage becomes effective. During an affiliation period an HMO is not required to provide health care services or benefits to the participant or beneficiary and a premium may not be charged to the participant or beneficiary.~~]

(2) [~~(3)~~] Agent--A person who may act as an agent for the sale of a health benefit plan under a license issued by TDI. [~~under Insurance Code, Chapter 21.~~]

(3) [~~(4)~~] Base premium rate--As defined in Insurance Code §1501.201 (concerning Definitions). [~~For each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for small employer health benefit plans with the same or similar coverage.~~]

(4) [~~(5)~~] Case characteristics--As defined in Insurance Code §1501.201. [~~With respect to a small employer, the geographic area in which that employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification as determined by~~

~~the small employer carrier, the number of employees and dependents, and other objective criteria as established by the small employer carrier that are considered by the small employer carrier in setting premium rates for that small employer. The term does not include health status related factors, duration of coverage since the date of issuance of a health benefit plan, or whether a covered person is or may become pregnant.~~]

(5) [~~(6)~~] Child--An:

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

(B) unmarried adopted child, including a child about whom the insured employee [~~as to whom an insured~~] is a party in a suit seeking the adoption of the child;

(C) 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) [~~(7)~~] Class of business--As defined in Insurance Code §1501.201. [~~All small employers or a separate grouping of small employers established under the Insurance Code, Chapter 26, Subchapters A-G.~~]

(7) [~~(8)~~] Commissioner--The commissioner of insurance.

(8) [~~(9)~~] Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Chapter 1507 (concerning Consumer Choice of Benefits Plans). [~~Article 3.80 or Article 20A.09N.~~]

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

[~~(A) An individual's coverage is creditable for purposes of this chapter if the coverage is provided under:~~]

[~~(i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);~~]

[~~(ii) a group health benefit plan provided by a health insurance carrier or an HMO;~~]

[~~(iii) an individual health insurance policy or evidence of coverage;~~]

[~~(iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);~~]

[~~(v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq., Grants to States for Medical Assistance Programs), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s, Program for Distribution of Pediatric Vaccines);~~]

[~~(vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.);~~]

[~~(vii) a medical care program of the Indian Health Service or of a tribal organization;~~]

[~~(viii) a state or political subdivision health benefits risk pool;~~]

[~~(ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.);~~]

[~~(x) a public health plan as defined in this section;~~]

[~~(xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); and~~]

[~~(xii) short-term limited duration insurance as defined in this section.~~]

[~~(B) Creditable coverage does not include:~~]

[~~(i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance;~~]

[~~(ii) coverage issued as a supplement to liability insurance;~~]

[~~(iii) liability insurance, including general liability insurance and automobile liability insurance;~~]

[~~(iv) workers' compensation or similar insurance;~~]

[~~(v) automobile medical payment insurance;~~]

[~~(vi) credit only insurance;~~]

[~~(vii) coverage for onsite medical clinics;~~]

[~~(viii) other coverage that is similar to the coverage described in this subsection under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;~~]

[~~(ix) if offered separately, coverage that provides limited scope dental or vision benefits;~~]

[~~(x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits;~~]

[~~(xi) if offered separately, coverage for limited benefits specified by federal regulation;~~]

[~~(xii) if offered as independent, noncoordinated benefits, coverage for specified disease or illness;~~]

[~~(xiii) if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or~~]

[~~(xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.~~]

[~~(11) Department--The Texas Department of Insurance.~~]

(10) [~~(12)~~] Dependent--As defined in Insurance Code §1501.002 (concerning Definitions). [~~A spouse; newborn child; child under the age of 25 years; child of any age who is medically certified as disabled and dependent on the parent; any person who must be covered under Insurance Code Article 3.51-6, §3D or §3E, or the Insurance Code Article 3.70-2(L); and any other child included as an eligible dependent under an employer's benefit plan, including a child who is a full-time student as required by Insurance Code Article 21.24-2 and §11.506(19) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate).~~]

[~~(13) DNA--Deoxyribonucleic acid.~~]

(11) [~~(14)~~] 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) [~~(15)~~] Eligible employee--As defined in Insurance Code §1501.002. [~~An employee who works on a full-time basis and who usually works at least 30 hours a week. The term also includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small or large~~

~~employer, regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a fulltime basis and who usually work at least 30 hours a week. The term does not include:~~]

[~~(A) an employee who works on a part-time, temporary, seasonal or substitute basis; or~~]

[~~(B) an employee who is covered under:~~]

[~~(i) another health benefit plan;~~]

[~~(ii) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 United States Code, §§1001, et seq.);~~]

[~~(iii) the Medicaid program if the employee elects not to be covered;~~]

[~~(iv) another federal program, including the TRICARE program or Medicare program, if the employee elects not to be covered; or~~]

[~~(v) a benefit plan established in another country if the employee elects not to be covered.~~]

(14) [~~(16)~~] Employee--As defined in Insurance Code §1501.002. [~~Any individual employed by an employer.~~]

(15) [~~(17)~~] 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 [~~such a~~] 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) [~~(18)~~] Genetic information--As defined in Insurance Code §546.001 (concerning Definitions). [~~Information derived from the results of a genetic test or from family history.~~]

(17) [~~(19)~~] Genetic test--As defined in Insurance Code §546.001. [~~A laboratory test of an individual's DNA, RNA, proteins, or chromosomes to identify by analysis of the DNA, RNA, proteins, or chromosomes the genetic mutations or alterations in the DNA, RNA, proteins, or chromosomes that are associated with a predisposition for a clinically recognized disease or disorder. The term does not include:~~]

[~~(A) a routine physical examination or a routine test performed as a part of a physical examination;~~]

[~~(B) a chemical, blood or urine analysis;~~]

[~~(C) a test to determine drug use; or~~]

[~~(D) a test for the presence of the human immunodeficiency virus.~~]

(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) [~~(20)~~] HMO--Any person governed by the Texas Health Maintenance Organization Act, Insurance Code Chapter [~~, Chapters 20A and~~] 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 [~~§162.001 Texas~~] 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) [~~Article 21.52F~~];

(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 [~~under Insurance Code, Chapter 843~~]; or

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

(20) [~~(21)~~] Health benefit plan--As defined in Insurance Code §1501.002. [~~A group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include the following plans of coverage:~~]

[~~(A) accident-only or disability income insurance or a combination of accident-only and disability income insurance;~~]

[~~(B) credit-only insurance;~~]

[~~(C) disability insurance coverage;~~]

[~~(D) coverage for a specified disease or illness;~~]

[~~(E) Medicare services under a federal contract;~~]

[~~(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;~~]

[~~(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;~~]

[~~(H) coverage that provides limited-scope dental or vision benefits;~~]

[~~(I) coverage provided by a single-service health maintenance organization;~~]

[~~(J) coverage issued as a supplement to liability insurance;~~]

[~~(K) insurance coverage arising out of a workers' compensation or similar insurance;~~]

[~~(L) automobile medical payment insurance coverage;~~]

[~~(M) jointly managed trusts authorized under 29 United States Code §§141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 United States Code §157;~~]

[~~(N) hospital indemnity or other fixed indemnity insurance;~~]

[~~(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;~~]

[~~(P) short-term limited duration insurance as defined in this section;~~]

[~~(Q) liability insurance, including general liability insurance and automobile liability insurance;~~]

[~~(R) coverage for onsite medical clinics; or~~]

[~~(S) coverage that provides other limited benefits specified by federal regulations; or~~]

[~~(T) other coverage that is:~~]

[~~(i) similar to the coverage described in subparagraphs (A) - (S) of this paragraph under which benefits for medical care are secondary or incidental to other insurance benefits; and~~]

[~~(ii) specified in federal regulations.~~]

(21) [~~(22)~~] 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 [~~and~~] a stipulated premium company under Insurance Code[~~,~~] Chapter 884 [~~844~~] (concerning Stipulated Premium Insurance Companies).

(22) [~~(23)~~] 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) [~~(24)~~] Health-status-related [~~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 [~~; and disability~~].

(24) [~~(25)~~] Index rate--As defined in Insurance Code §1501.201. [~~For each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.~~]

(25) [~~(26)~~] Large employer--As defined in Insurance Code §1501.002. [~~An employer who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the policy year. For purposes of this definition, a partnership is the employer of a partner.~~]

(26) [~~(27)~~] 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) [~~26, Subchapters A and H~~].

(27) [~~(28)~~] Large employer health benefit plan--As defined in Insurance Code §1501.002. [~~A health benefit plan offered to a large employer.~~]

(28) [~~(29)~~] 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) [~~Article 26.21(h) or 26.83(f), who~~] does not fall within the exceptions listed in subparagraph (B) of this paragraph [~~below~~];[~~,~~] and

(iii) [~~who~~] 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) [~~(A)~~] the individual:

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

(IV) [~~(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) [~~(B)~~] 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) [~~(C)~~] 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) [~~(D)~~] a court has ordered coverage to be provided for a child under an insured's [~~a covered employee'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) [~~(E)~~] the individual is a child of an insured [~~a covered employee~~] and has lost coverage under [~~Chapter 62,~~] 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 [~~Grants to States for Medical Assistance Programs~~]), 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) [~~(F)~~] 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) [~~(G)~~] an individual becomes a dependent due to marriage, birth of a newborn child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child; and

(viii) [~~(H)~~] the individual described in clauses (v) - (vii) [~~subparagraphs (E), (F) and (G)~~] of this subparagraph [~~paragraph~~] 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) [~~(30)~~] 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) [~~(31)~~] 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) [~~(32)~~] 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 [~~in the absence of a diagnosis of the condition related to such information~~] does [~~shall~~] not constitute a medical condition in the absence of a diagnosis of a condition related to the information.

(32) [~~(33)~~] New business premium rate--As defined in Insurance Code §1501.201. [~~For each class of business as to a rating period, the lowest premium rate that is charged or offered or that could be charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.~~]

(33) [~~(34)~~] New entrant--An eligible employee, or the dependent of an eligible employee, who becomes [~~part of or~~] eligible for coverage in an [~~a small or large~~] 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) [~~(35)~~] Participation criteria--As defined in Insurance Code §1501.601 (concerning Participation Criteria). [~~Any criteria or rules established by a large employer to determine the employees who are eligible for enrollment, including continued enrollment, under the terms of a health benefit plan. Such criteria or rules may not be based on health status related factors.~~]

(35) [~~(36)~~] Person--As defined in Insurance Code §1501.002. [~~An individual, corporation, partnership, or other legal entity.~~]

[~~(37) Point-of-service coverage (POS coverage)--Coverage provided under a POS plan as described in §21.2901 of this title (relating to Definitions) and as permitted by Article 26.48, Insurance Code.~~]

(36) [~~(38)~~] Plan year--For purposes of [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26,~~] 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 [~~Small or large employer~~] 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) [~~(39)~~] Postmark--A date stamp by the U.S. Postal Service or other delivery entity, including any electronic delivery available.

(41) [~~(40)~~] Preexisting condition provision--As defined in Insurance Code §1501.002. [~~A provision that denies, excludes, or limits coverage as to a disease or condition for a specified period after the effective date of coverage.~~]

(42) [~~(41)~~] Premium--As defined in Insurance Code §1501.002. [~~All amounts payable by a small or large employer and eligible employees as a condition of receiving coverage from a small or large employer carrier, including any fees or other contributions associated with a health benefit plan.~~]

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

(44) [~~(43)~~] Public health plan--Any plan established or maintained by a state [~~State~~], county, or other political subdivision of a state [~~State~~] that provides health insurance coverage to individuals [~~who are enrolled in the plan~~].

(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) [~~(44)~~] Rating period--As defined in Insurance Code §1501.201. [~~A calendar period for which premium rates established by a small employer carrier are assumed to be in effect.~~]

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

(48) [~~(46)~~] Renewal date--For each small or large employer's health benefit plan, the earlier of the date,[~~(~~] if any,[~~)~~] specified in the [~~such~~] plan [~~(contract)~~] for renewal; the policy anniversary date; or the date [~~on which~~] 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 [~~small or large employer~~] 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 [~~Small or large employer~~] 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) [~~(47)~~] Risk-assuming carrier--A risk-assuming health benefit plan issuer as defined in Insurance Code §1501.301 (concerning Definitions) [~~A small employer carrier that elects not to participate in the Texas Health Reinsurance System, as approved by the department~~].

(50) [~~(48)~~] Risk characteristic--The health-status-related [~~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 [~~a small employer~~] group.

(51) [~~(49)~~] 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 [~~the small employer~~] group. A small employer carrier may not use genetic information to alter or otherwise affect risk load.

[~~(50) Risk pool--The Texas Health Insurance Risk Pool established under Insurance Code Article 3.77, or other similar arrangements in other states.~~]

[~~(51) RNA--Ribonucleic acid.~~]

(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) [~~that~~] is within 12 months of the date the contract becomes effective.

(53) Significant break in coverage--A period of 63 consecutive days during [~~all of~~] which the individual does not have [~~any~~] 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. [~~An employer that employed an average of at least two employees but not more than 50 eligible employees on business~~

~~days during the preceding calendar year and who employs at least two employees on the first day of the policy year. For purposes of this definition, a partnership is the employer of a partner.~~] A small employer includes an independent school district that elects to participate in the small employer market [~~as provided~~] under Insurance Code §1501.009 (concerning School District Election) [~~Article 26.036~~].

(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) [~~Article 26.06(a)~~], health benefit plans subject to Insurance Code Chapter 1501 [~~Subchapters A-G of the Insurance Code, Chapter 26~~].

(56) Small employer health benefit plan--As defined in Insurance Code §1501.002. [~~A health benefit plan offered to a small employer under the Insurance Code, Chapter 26, Subchapter E.~~]

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

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

(59) [~~(58)~~] Waiting period--As defined in Insurance Code §1501.002. [~~A period of time established by an employer that must pass before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits.~~] 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 [~~such~~] 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, [~~Subchapter A of~~] this subchapter [~~chapter~~] applies [~~shall apply~~] to any health benefit plan providing health care benefits covering two or more [~~eligible~~] 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. [~~United States Code~~] §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. [~~CFR~~] §2510.3-1(j) (concerning Employee Welfare Benefit Plan).

[~~(b) Except as provided by Insurance Code Article 26.06(a), or subsection (a) of this section, this subchapter does not apply to an individual health insurance policy that is subject to individual underwriting, even if the premium is remitted through a payroll deduction method.~~]

(c) For an employer that [~~who~~] was not in existence the previous calendar year [~~throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made~~], 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) An insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed to small employers and their employees on or after July 1, 1997 shall comply with all provisions of the Insurance Code, Chapter 26, Subchapters A - G and with this subchapter~~].

[~~(e) An insurance policy, evidence of coverage, contract or other document establishing coverage under a health benefit plan for small employers and their employees that is delivered, issued for delivery or renewed before July 1, 1997, is governed by the law and this chapter as it existed before that date until the first renewal date of that policy, evidence of coverage, contract or other document establishing coverage on or after July 1, 1997.~~]

[~~(f) If a health carrier continues to provide coverage to small employers and their employees under health benefit plans delivered or issued for delivery before July 1, 1997, and elects not to continue to offer, deliver, or issue for delivery health benefit plans to small employers and their employees, the health carrier will only be considered a small employer carrier for purposes of renewing such existing plans. In this case, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 30 days prior to the first renewal date occurring on or after July 1, 1997. The notice shall~~:]

[(~~1) state that the health carrier (the current health carrier of the small employer's employee health benefit plans) has elected not to continue to offer new health benefit plans in the small employer market;~~]

[(~~2) offer the small employer the option of continuing the existing health benefit plan or plans, with amendments to comply with Insurance Code, Chapter 26, Subchapters A - G and this subchapter; and~~]

[(~~3) state that other health benefit plans may be available to the small employer through other small employer carriers and that such other plans should be compared against existing plans to determine which plan is more beneficial.~~]

[(~~g) If a health carrier continues to provide coverage to small employers and their employees under health benefit plans delivered or issued for delivery before July 1, 1997, and elects to continue to offer, issue, and issue for delivery health benefit plans to small employers and their employees, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 30 days prior to the first renewal date occurring on or after July 1, 1997. The notice shall:~~]

[(~~1) offer the small employer the option of continuing the existing health benefit plan or plans, with amendments to comply with Chapter 26, or purchasing new small employer benefit plans in accordance with the Insurance Code, Chapter 26, Subchapters A - G, and this subchapter; and~~]

[(~~2) provide notice that such other plans should be compared against existing plans to determine which plan is more beneficial.~~]

(d) [(~~h~~)] The provisions of [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26, Subchapters A-G,~~] and this subchapter [~~shall~~] 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) [(~~i~~)] 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 [~~26, Subchapters A-G,~~] 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 [~~subsequently employs more than 50 eligible employees or less than two eligible employees~~], the provisions of Insurance Code[~~,~~] Chapter 1501 [~~26,~~] and this subchapter [~~shall~~] continue to apply to that particular health plan, subject to the provisions of §26.15 of this title [~~chapter~~] (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to [~~such~~] an employer must [~~shall~~], within 60 days of becoming aware that the employer no longer meets the

definition of small employer [~~has more than 50 eligible employees or less than two eligible employees~~], but not later than the first renewal date occurring after the small employer has ceased to be a small employer [~~qualifying for coverage under Insurance Code Article 26.06(a) and this subchapter~~], 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 [~~26, Subchapters A-G~~], and this subchapter will [~~shall~~] cease to apply to the employer[~~,~~] if the [~~such~~] employer fails to renew its current health benefit plan; fails to comply with the contribution, minimum group size [~~(as set forth in subsection (a) of this section)~~], 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 [~~, pursuant to this subchapter,~~] to issue coverage to a group consisting of one [~~eligible~~] employee.

(f) [~~(j)~~] If a small employer has employees in more than one state, the provisions of [~~the~~] Insurance Code Chapter 1501 and this subchapter applicable to small employer plans, including provisions regarding marketing and rates, [~~Chapter 26, Subchapters A-G, and this subchapter shall~~] apply to a health benefit plan issued to the small employer if:

(1) the majority of [~~eligible~~] employees [~~of such small employer~~] are employed in this state on the issue date or renewal date; or

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

(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.

[~~(k) A governmental entity's health benefit plan (subject to Insurance Code Articles 3.51-1, 3.51-2, 3.51-4, 3.51-5, 3.51-5A, or Chapter 1578) that is provided through health insurance coverage and that otherwise meets the requirements of being a small employer is subject to the provisions of Insurance Code, Chapter 26, Subchapters A - G and this subchapter. The portion of a non-federal governmental~~

~~entity's health benefit plan that is self-insured may elect not to comply with §2721 of the Public Health Services Act as added by the Health Insurance Portability and Accountability Act of 1996.~~]

**§26.6. Status of Health Carriers as Small Employer Carriers [~~and Geographic Service Area~~].**

(a) With the original filing to enter the small employer market or when notifying TDI of a change in status [~~No later than March 1 annually~~], each health carrier providing health benefit plans in this state must file [~~shall make a filing~~] 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 [~~as defined in the Insurance Code, Chapter 26, Subchapters A-G, and this subchapter~~]. The [~~required~~] filing must [~~shall~~] include a [~~the~~] 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, [~~provided in the current Form Number1212 CERT SEHC STATUS, completed according to the carrier's status~~] and [~~shall at least~~] 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 their employees~~] and [~~therefore~~] will operate in accordance with [~~the~~] Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~26, Subchapters A-G~~] and this subchapter; [~~or~~]

(2) the health carrier does not intend to offer, issue, or issue for delivery health benefit plans to small employers in Texas, but [~~and their employees; however,~~] the health carrier intends to renew existing health benefit plans [~~issued prior to July 1, 1997, and comply with the Insurance Code, Chapter 26, Subchapters A-G, and this subchapter~~];

(3) the health carrier does not intend to offer, issue, or issue for delivery health benefit plans to small employers [~~and their employees~~] in [~~the State of~~] Texas~~;~~ [~~and~~] 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 [~~which are in force on or after July 1, 1997,~~] and [~~the health carrier~~] 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 [~~shall~~] notify the commissioner of its new election at least 30 days before [~~prior to~~] the date the health carrier intends to begin operations under the new election as required in subsection (a) of this section. [~~This notification shall be made on Form Number 1212 CERT SEHC STATUS.~~]

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

[~~(c) Upon election to become a small employer carrier, the health carrier shall establish geographic service areas within which the health carrier reasonably anticipates it will have the capacity to deliver services adequately to small employers in each established geographic service area. Small employer carriers shall comply with the following:~~]

[~~(1) The carrier shall define geographic service areas in terms of counties or ZIP codes, to the extent possible.~~]

[~~(2) If the service area cannot be defined by counties or ZIP code, the carrier shall submit a map which clearly shows the geographic service areas.~~]

[~~(3) If the geographic service area of the carrier is the entire state, the carrier shall define the service area as the State of Texas and no other documentation is necessary.~~]

[~~(4) Service areas by zip code shall be defined in a non-discriminatory manner and in compliance with the Insurance Code Articles 21.21-6 and 21.21-8~~].

[~~(5) HMO small employer carriers shall establish networks in accordance with Insurance Code, Chapters 20A and 843 and Chapter 11 of this title (relating to Health Maintenance Organizations)~~].

[~~(6) Small employer carriers shall, no later than the initial filing of a small employer health benefit plan, utilize Form Number 1212 CERT GEOG to submit this information, as required by §26.19(b) of this chapter (relating to Filing Requirements).~~]

[~~(7) If a small employer carrier elects to alter its geographic service area, the small employer carrier shall notify the department of its intent at least 30 days prior to the date the health carrier intends to effect the change. The small employer carrier shall utilize Form Number 1212 CERT GEOG to submit this information.~~]

(d) Health carriers providing coverage under any health benefit plans issued to small employers and [~~and/or~~] their employees, whether on a group or franchise insurance policy basis, will [~~shall~~] be

considered small employer carriers for purposes of those [~~such~~] plans, and must [~~shall~~] comply with all provisions of Insurance Code[~~,~~] Chapter 1501 [~~26, Subchapters A-G,~~] and this subchapter, as applicable.

[~~(e) A health carrier that continues to provide coverage pursuant to subsection (a)(2) of this section shall not be eligible to participate in the reinsurance program established under Insurance Code, Chapter 26, Subchapter F.~~]

(e) [~~(f)~~] The small employer carrier must also comply with [~~This subsection does not exempt a health carrier from~~] any other applicable legal requirements, including [~~such as~~] those for withdrawal from the market under Chapter 7, Subchapter R [~~§§7.1801, et seq.~~] 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 [~~shall~~] offer [~~to provide~~] 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 [~~shall~~] provide the same health benefit plan to each [~~such~~] employee or [~~and~~] dependent eligible for coverage.

(b) If elected by the small employer, a small employer carrier may offer [~~the eligible employees of a small employer the option of choosing among~~] one or more health benefit plans, provided that each eligible employee may choose any of the plans offered. Except as provided in [~~the~~] Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~, Article 26.21 and Article 26.49 (~~] with respect to an affiliation period or exclusions for preexisting conditions [~~pre-existing)~~], the choice among benefit plans may not be limited, restricted, or conditioned based on [~~upon~~] the risk characteristics of each employee or dependent eligible for coverage [~~the eligible employees or their dependents~~].

(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 [~~as defined in Insurance Code Article 26.02~~]. 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 [~~as well as~~] to confirm the applicant's status as a small employer. The small employer carrier must [~~shall~~] 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 [~~which~~] a small employer carrier may request [~~, as reasonable and appropriate,~~] 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 [~~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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] provide married eligible employees of the same employer the option to [~~elect 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 [~~pursuant to~~] this subsection does not impact the individual's status as an eligible employee for any other purpose under [~~the~~] Insurance Code[~~,~~] Chapter 1501, except that the [~~such~~] individual may be treated as a dependent for purposes of employer premium contributions.

(e) A small employer carrier must [~~shall~~] secure a waiver with respect to each eligible employee and each dependent of the [~~such an~~] 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 [~~eligible~~] individual is declining all offered [~~small employer health benefit~~] plans [~~offered~~]. The [~~and the~~] small employer carriers may enter into an agreement designating [~~under~~] which [~~one~~] small employer carrier will receive and retain the waiver. Waivers must [~~shall~~] be maintained by the small employer carrier for a period of six years. The waiver must [~~shall~~] be signed by the [~~eligible~~] employee (on behalf of the [~~such~~] employee or [~~the~~] dependent [~~of such employee~~]) and must [~~shall~~] 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 [~~shall~~]:

(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 [~~eligible~~] 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 [~~such~~] coverage.

(f) [~~A small employer carrier may not provide coverage to a small employer or the employees of such employer if the health carrier, or an agent for such health carrier, has knowledge that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.~~]

[~~(g)~~] An agent must [~~shall~~] notify a small employer carrier, before [~~prior to~~] 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 [~~an eligible employee (or dependent of an eligible employee)~~] to decline coverage due to the individual's risk characteristics.

(g) [~~(h)~~] New entrants in a health benefit plan issued to a small employer group must [~~shall~~] be offered an opportunity to enroll in the health benefit plan currently held by the [~~such~~] employer group or [~~shall~~] 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 [~~pursuant to~~] subsection (b) of this section, the new entrant must [~~shall~~] be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant who [~~that~~] 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) [~~(i)~~] of this section.

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

(1) the initial enrollment period must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be considered timely if [~~he or she submits~~] the application is submitted within the initial enrollment period:

(A) in person;

(B) by mail, [~~. Submits, for purposes of this paragraph, means that the item(s) must be~~] postmarked by the end of the specified [~~time~~] period; or

(C) [~~. At the discretion of the small employer carrier,~~] in an alternative method normally accepted by the small employer carrier [~~methods of submission~~], including [~~such as~~] facsimile transmission (fax), email, or web-based application [~~, may be acceptable~~]; and

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

(i) [~~(j)~~] A [~~Any waiting period shall be established by the~~] small employer may establish a waiting period in accordance with Insurance Code §1501.156 (concerning Employee Enrollment: Waiting Period) that must [~~and shall~~] not exceed 90 days. A small employer carrier may [~~shall~~] not apply a waiting period, elimination period, or other similar limitation of coverage (other than an exclusion for preexisting [~~pre-existing~~] medical conditions or [~~impose an~~] affiliation period consistent with Insurance Code §1501.102 (concerning Preexisting Condition Provision) and §1501.104 (concerning Affiliation

Period) [~~, Article 26.21 and Article 26.49~~]), with respect to a new entrant, that is longer than the waiting period established by the small employer.

(j) [~~(k)~~] New entrants in a health plan issued to a small employer group must [~~shall~~] 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 [~~pre-existing~~] medical conditions or impose an affiliation period, to the extent allowed under [~~the~~] Insurance Code Chapter 1501 [~~, Article 26.21 and Article 26.49~~].

(k) [~~(l)~~] A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of [~~the~~] Insurance Code[~~,~~] Chapter 1501, Subchapter E (concerning Underwriting and Rating of Small Employer Health Benefit Plans) [~~26, Subchapter D,~~] and this chapter. The risk load must [~~shall~~] be the same risk load charged to the small employer group immediately before [~~prior to~~] acceptance of the new entrant into the group.

[~~(m) In the case of an eligible employee (or dependent of an eligible employee) who was excluded from coverage, not eligible for coverage, or denied coverage by a small employer carrier, in the process of providing a health benefit plan to an eligible small employer (as defined in the Insurance Code, Chapter 26, and this chapter), the small employer carrier shall provide an opportunity for the eligible employee (or dependent(s) of such eligible employee) to enroll in the health benefit plan issued to the small employer or the employees of the small employer on the earlier of the first renewal date occurring on or after July 1, 1997, or the first open enrollment period occurring on or after July 1, 1997. The opportunity to enroll shall meet the following requirements.~~]

[~~(1) The opportunity to enroll under this subsection shall comply with subsection (i) of this section.~~]

[~~(2) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with subsection (l) of this section.~~]

[~~(3) The terms of coverage offered to an individual described in this subsection may exclude coverage for preexisting medical conditions or impose an affiliation period only if the health benefit plan currently held by the small employer contains such an exclusion or an affiliation period.~~]

[~~(4) A small employer carrier shall provide written notice at least 45 days prior to the opportunity to enroll provided in this subsection or if less than 45 days are available, within five working days after determination that subsections (h) – (m) of this section apply to each small employer insured~~

~~under a health benefit plan offered by such health carrier. A small employer carrier may provide the notice to the employer if the carrier has entered into an agreement with the employer to provide the notice to the employees. The notice shall clearly describe the rights granted under subsections (h) - (m) of this section to employees and dependents who were previously excluded from, not eligible for, or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.~~]

[~~(n) A small employer carrier may require an individual who requests enrollment under subsection (m) of this section to sign a statement indicating that such individual sought coverage under the group contract or franchise policy (other than as a late enrollee) and that the coverage was not offered or provided to the individual.~~]

**§26.8. Guaranteed Issue,[~~;~~] Contribution, and Participation Requirements.**

(a) A small employer carrier must [~~shall~~] 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 [~~. A small employer carrier shall provide health benefit plans to small employers~~] without regard to health-status-related [~~health status related~~] 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) [~~A health carrier may require an employer premium contribution for the plan selected by the employer for each eligible employee in accordance with the carrier's usual and customary practices for all employer group health insurance plans in the state.~~]

[~~(1) The same premium contribution level shall be applied to each small employer offered or issued coverage by the small employer carrier, except that a small employer carrier may simultaneously offer to each small employer an additional plan that requires the small employer to contribute 100 percent of the premium paid for each eligible participating employee.~~]

[~~(2) If two or more small employer carriers participate in a purchasing cooperative established under Insurance Code §1501.056, the carrier may use the contribution requirement established by the purchasing cooperative for policies marketed by the cooperative.~~]

[~~(3) A health carrier shall treat all similarly situated small employer groups in a consistent and uniform manner when terminating health benefit plans due to failure of the small employer to meet a contribution requirement.~~]

[~~(4) If a small employer fails to meet a contribution requirement for a small employer health benefit plan, the health carrier may terminate coverage as provided under the plan in accordance with the terms and conditions of the plan requiring contribution and in accordance with Insurance Code §§1501.108 , 1501.109, and 1501.110.~~]

[~~(d)~~] Availability of coverage [~~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) [~~available if at least 75 percent of the eligible employees of a small employer elect to be covered, as provided in Insurance Code §1501.154. This 75 percent requirement shall not apply to a small employer that has only two eligible employees~~]. A small employer that has only two eligible employees will [~~shall~~] be subject to a 100 percent participation requirement.

[~~(1) If a small employer makes available multiple health benefit plans to its employees, the collective enrollment of all of those plans must be at least 75 percent of the small employer's eligible employees or, if applicable, the lower participation level offered by the small employer carrier under subsection (e) of this section.~~]

[~~(2) A small employer carrier may elect not to offer health benefit plans to a small employer who offers multiple health benefit plans if such plans are to be provided by more than one carrier and the carrier would have less than 75 percent of the small employer's eligible employees enrolled in the carrier's health benefit plan unless the coverage is provided through a purchasing cooperative.~~]

[~~(e) A small employer carrier may offer small employer health benefit plans to a small employer even if less than 75 percent of the eligible employees of that employer elect to be covered if the small employer carrier permits the same percentage of participation as a qualifying percentage for each small employer benefit plan offered by that carrier in the state.~~]

[~~(f) A small employer carrier may offer small employer health benefit plans to a small employer even if the employer's percentage of participation is less than the small employer carrier's qualifying participation level established under subsection (e) of this section if the small employer carrier:~~]

[~~(1) obtains the written waiver required by §26.7(e) of this subchapter (relating to Requirement to Insure Entire Groups); and~~]

[~~(2) accepts or rejects the entire group of eligible employees that choose to participate and excludes only those employees that have declined coverage. A carrier may not provide coverage under this subsection if the circumstances set out in §26.7(f) of this subchapter apply and may not use this subsection to circumvent the guaranteed issue and other requirements of Insurance Code Chapter 1501 or this subchapter.~~]

(d) [~~(g)~~] A health carrier must [~~shall~~] 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) [~~(h)~~] If a small employer fails to meet the qualifying minimum participation requirement for a small employer health benefit plan[~~,~~] for [~~a period of at least~~] six consecutive months, the health carrier may terminate coverage under the plan on [~~upon~~] the first renewal date following that period. The [~~the end of the six-month consecutive period during which the qualifying participation requirement was not met, provided that the~~] termination must conform to [~~shall be in accordance with~~] 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) [~~, 1501.109, and 1501.110~~] and §26.15 of this title [~~subchapter~~] (relating to Renewability of Coverage and Cancellation).

(f) [~~(i)~~] 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 [~~shall~~] be rounded down to the nearest whole number. For example: 75 percent of five [~~5~~] employees is 3.75, so 3.75 would be rounded down to three [~~3~~], and 75 percent participation by a five employee group will be achieved if three of the eligible employees participate.

(g) [~~(j)~~] If a small employer fails to meet, for [~~a period of at least~~] six consecutive months, the qualifying minimum group size requirement set forth in Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~§26.5(a) of this subchapter (relating to Applicability and Scope)~~] 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 [~~the six-~~

~~month consecutive period during which the small employer did not meet the qualifying minimum group size requirement, provided that the~~] termination must conform to [~~shall be in accordance with~~] 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 [~~, 1501.109, and 1501.110~~] and §26.15 of this title [~~subchapter~~].

**§26.9. Exclusions, Limitations, Waiting Periods, Affiliation Periods, [~~and~~] Preexisting Conditions, and Restrictive Riders.**

(a) All health benefit plans that provide coverage for small employers and their employees [~~as defined in Insurance Code Article 26.02(29) and §26.4 of this chapter (relating to Definitions)~~] must [~~shall~~] comply with the following requirements.

(1) A small employer carrier may [~~shall~~] 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 [~~the~~] Insurance Code §1501.156 (concerning Employee Enrollment: Waiting Period) [~~, Article 26.21(k)~~].

(2) A small employer carrier may [~~shall~~] 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 [~~the~~] Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~, Article 26.49~~].

(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 [~~shall~~] not terminate coverage of a newborn child if the [~~such~~] 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 [~~such~~] premium.

(5) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. [~~A child is considered to be the child of an insured if the insured is a party in a suit seeking the adoption of the child.~~] An [~~The~~] 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) [~~within~~] 31 days of the date the adoption is final.

(6) Coverage of an adopted child of an insured under paragraph (5) [~~(4)~~] 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 [~~shall~~] not terminate coverage of an adopted child if the [~~such~~] 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 [~~such~~] premium.

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

(8) If a newborn or adopted child is enrolled in a health benefit plan or other creditable coverage within the [~~time~~] periods specified in paragraph (4) or (5) of this subsection, [~~respectively,~~] 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 [~~time~~] periods specified in paragraph (4) or (5) of this subsection, [~~respectively,~~] 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 [~~shall~~] 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 in regard [~~regards~~] to all small employer [~~such~~] 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 [~~upon 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 [~~such provisions are~~] described by [~~the~~] Insurance Code §§1501.102 - 1501.104 (concerning Preexisting Condition Provision; Treatment of Certain Conditions as Preexisting Prohibited; and Affiliation Period) [~~, Article 26.49~~].

(B) The eligible [~~the~~] 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, [~~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.

(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) [~~chapter~~].

(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 [~~1997~~], after the enrollment period of July 1, 2014 [~~1997~~], through July 31, 2014, [~~1997~~] has ended. The next annual open enrollment period is July 1, 2015 [~~1998~~], through July 31, 2015 [~~1998~~]. 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 [~~under health benefit plans subject to this subchapter~~] until the next open enrollment period, Individual A must reapply for coverage in July 2015 [~~1998~~] 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 [~~1998~~], and expire [~~expires~~] on September 1, 2016 [~~1999~~].

(ii) If the carrier is an insurer and has elected to accept applications for late enrollment [~~under health benefit plans subject to this subchapter~~] immediately and enroll the applicant during the plan year, [~~then~~] 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 [~~1997~~], the preexisting condition period would begin on that date and [~~would~~] expire on April 1, 2016 [~~1999~~].

(iii) 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, [~~1998~~] 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 [~~under health benefit plans subject to this subchapter~~] immediately and enroll the applicant during the plan year, [~~then~~] 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 [~~such~~] 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 [~~shall~~] not treat genetic information as a preexisting condition described by Insurance Code[~~,~~] §1501.002 (concerning Definitions) [~~, Article 26.49(b)~~] in the absence of a diagnosis of the condition related to the information.

(12) A small employer carrier may [~~shall~~] not treat a pregnancy as a preexisting condition described in Insurance Code §1501.002 [~~Article 26.49(b), Insurance Code~~].

(13) A preexisting condition provision in a small employer health benefit plan does [~~shall~~] 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 [~~1997~~], through October 31, 2014 [~~1997~~], followed by a gap in coverage of 61 days until December 31, 2014 [~~1997~~]. Individual A is covered under an individual health plan beginning on January 1, 2015 [~~1998~~], for six months through June 30, 2015 [~~1998~~], followed by a gap in coverage of 62 days until August 31, 2015 [~~1998~~]. Individual A's effective date of coverage under a small employer health benefit plan is September 1, 2015 [~~1998~~]. 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 [~~shall~~] 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 [~~shall~~] 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 [~~1995~~], through November 30, 2015 [~~1996~~], followed by a four-month [~~four month~~] gap in coverage from December 1, 2015 [~~1996~~], to March 31, 2016 [~~1997~~]. On April 1, 2016[~~1997~~], Individual B is covered under a group health plan for three months through June 30, 2016 [~~1997~~], followed by a two-month [~~two month~~] gap in coverage until August 31, 2016 [~~1997~~]. Individual B's coverage became effective on September 1, 2016 [~~1997~~]. 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 [~~that cannot exceed 90 days from the first day of employment during which a new employee is not eligible for coverage~~]. On [~~Upon~~] completion of the waiting period and enrollment within the time frame allowed by §26.7(h) [~~(i)~~] of this title [~~chapter~~] (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 [~~upon by~~] the small employer and the small employer carrier.

(16) An [~~A~~] HMO [~~health maintenance organization~~] 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 [~~health status related~~] factor. The affiliation period may [~~shall~~] not exceed two months for an enrollee, other than a late enrollee, and may [~~shall~~] not exceed 90 days for a late enrollee. An affiliation period under a plan must [~~shall~~] run concurrently with any applicable waiting period under the plan. An HMO may [~~shall~~] not impose any preexisting condition limitation, except for an affiliation period.

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

(18) An affiliation period provision in a small employer health benefit plan does [~~shall~~] 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 [~~as defined in Insurance Code Article 26.02,~~] exist, a small employer carrier must [~~shall~~] ascertain the source of previous or existing coverage of each eligible employee or [~~and each~~] dependent [~~of an eligible employee~~] at the time the [~~such~~] employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier has [~~shall have~~] the responsibility to contact the source of the [~~such~~] previous or existing coverage to resolve any questions about the benefits or limitations related to that [~~such previous or existing~~] 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 [~~pursuant to~~] the provisions of [~~the~~] Insurance Code §1501.202 (concerning Establishment of Classes of Business) and §1501.203 (concerning Establishment of Classes of Business on Certain Bases Prohibited) [~~, Article 26.31,~~] must [~~shall~~] 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 [~~the~~] Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~26, Subchapter D~~]; 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 [~~such~~] plans.

(b) A health carrier may not directly or indirectly use the number of employees and dependents of a small employer [~~or, except as provided in Insurance Code Article 26.31(a)~~], 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 [~~shall~~] 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 [~~shall~~] be computed solely from the applicable rate manual developed under [~~pursuant to~~] this subsection. To the extent that a portion of the premium rates charged by a small employer carrier are [~~is~~] based on objective criteria established by the small employer carrier consistent with the criteria set out in [~~the~~] Insurance Code Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~, Article 26.02(5) and Article 26.36~~], the manual must [~~shall~~] specify the criteria and factors considered by the health carrier in exercising this [~~such~~] discretion.

(b) A small employer carrier must [~~shall~~] file with TDI [~~the department~~], at least 60 days before [~~prior to~~] 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 [~~shall~~] ensure that the rating method used is actuarially sound and appropriate to ensure [~~assure~~] compliance with Insurance Code[~~,~~] Chapter 1501 [~~26,~~] 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 department~~] the proposed change will [~~shall~~] be deemed compliant unless [~~prior to thereto~~] the commissioner has disapproved it by written order.

(1) The filing must [~~shall~~] 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 [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26, Subchapter D~~].

(2) For the purpose of this section, a change in rating method means [~~shall mean~~]:

(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 [~~shall mean~~] the cumulative change with respect to the [~~such~~] 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 [~~shall~~] consider the cumulative effect of all the [~~such~~] changes in applying the 10 percent [~~%~~] test under this paragraph.

(c) Each rate manual developed under [~~pursuant to~~] subsection (a) of this section must [~~shall~~] 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 [~~the~~] Insurance Code §1501.210 (concerning Premium Rates: Nondiscrimination) [~~, Article 26.36(c)~~], without the prior approval of the commissioner. A small employer carrier seeking [~~such an~~] approval must file [~~shall make a filing with the commissioner~~] for a change in rating method under subsection (b) of this section with the commissioner.

(2) A small employer carrier must [~~shall~~] use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and must [~~shall~~] apply them in the same manner in establishing premium rates for each [~~such~~] health benefit plan. Case characteristics may include the employer's industry classification consistent with [~~the~~] Insurance Code §1501.208 (concerning Premium Rates: Industry Classification) [~~, Article 26.33(c)~~]. Case characteristics must [~~shall~~] be applied without regard to the risk characteristics of a small employer.

(3) The rate manual developed under [~~pursuant to~~] subsection (a) of this section must [~~shall~~] 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 than the base premium rate for a health benefit plan, the rate manual must [~~shall~~] illustrate the difference.

(4) Differences among base premium rates for health benefit plans must [~~shall~~] be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and may [~~shall~~] not be based in any way on the actual or expected health-status-related [~~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 [~~shall~~] apply case characteristics and rate factors within a class of business in a manner that ensures [~~assures~~] 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 [~~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 [~~pursuant to~~] subsection (a) of this section must [~~shall~~] provide for premium rates to be developed in a two-step process. In the first step, the small employer carrier must [~~shall~~] 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 [~~26, Subchapter D~~], 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 [~~shall~~] 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 [~~such~~] plan), provided the fee is no more than $5

[~~$5.00~~] 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 [~~shall~~] allocate administrative expenses to the small employer health benefit plans on no less favorable [~~of~~] a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed under [~~pursuant to~~] subsection (a) of this section must [~~shall~~] 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 [~~shall~~] retain each rate manual developed under [~~pursuant to~~] subsection (a) of this section for a period of six years, including [~~. The health carrier shall maintain~~] all updates and changes [~~with the manual~~].

(9) Each rate manual and the rating practices of a small employer carrier must [~~shall~~] 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 [~~shall~~] not exceed the lowest rate factor associated with the [~~such a~~] classification by more than 20 percent [~~%~~].

(e) The restrictions related to changes in premium rates in [~~the~~] Insurance Code Chapter 1501 must [~~, Article 26.33 and Article 26.34, shall~~] be applied as follows.

(1) A small employer carrier must [~~shall~~] 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 [~~shall~~] be deemed to be the change in the base premium rate for the purposes of [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~, Article 26.33 and Article 26.34~~].

(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 [~~shall~~] be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of [~~the~~] Insurance Code Chapter 1501 [~~, Article 26.33 and Article 26.34~~].

(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 [~~shall~~] 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 [~~shall~~] be made at least 60 days before [~~prior to~~] the beginning of the rating period during which [~~when~~] the change is [~~when the change would be~~] applicable. The filing allows [~~is for the purpose of allowing~~] the commissioner to determine whether the methodology [~~used~~] is actuarially sound and appropriate to ensure [~~insure~~] compliance with [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26~~].

(5) A small employer carrier must [~~shall~~] keep [~~on file for a period of at least six years~~] 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 [~~shall~~] comply with the following.

(1) Except as provided in subsection (e) of this section, a change in premium rate for a small employer must [~~shall~~] 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 [~~shall~~] 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 [the] Insurance Code §1501.208 [, Article 26.33(c)], if the current premium rate for the health benefit plan exceeds the ranges set forth in [the]Insurance Code §1501.204 (concerning Index Rates) [, Article 26.32(b)], 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)[(ii)] and (2)(B) [(C)](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 [shall] not produce a revised premium rate that would exceed the limitations on rates provided in [the] Insurance Code §1501.204 [, Article 26.32(c)].

(g) An HMO offering any state-approved [state approved], federally qualified plan described in Insurance Code §1501.255 (concerning Health Maintenance Organization Plans) [Article 26.48] and §26.14 of this title [chapter] (relating to Coverage) must [shall] establish premium rates for those plans in accordance with formulae or schedules of charges filed with TDI [the department] under the procedures set forth in Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges) [Article 20A.09(b),] and Chapter 11, Subchapter H of this title (relating to Schedule of Charges). An HMO must [shall] 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 [that] has established a separate class of business as provided by [the] Insurance Code §1501.202 (concerning Establishment of Classes of Business) and §1501.203 (concerning Establishment of Classes of Business on Certain Bases Prohibited) [,Article 26.31], and [that has established] a separate line of business as provided under [the] Insurance Code §1501.255 [, Article 26.48(a),] and 42 U.S.C. [United States Code] §§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. [This subsection applies to all employer health benefit plans offered, issued or delivered for issue to small employers and their employees on or after September 1, 1995.]

(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 [shall] comply with §26.13(l) [(m)] of this title [chapter] (relating to [Rules 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 [~~shall~~] 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 [~~pre-existing~~] condition provision or affiliation period.

**§26.13. [~~Rules Related to~~] Fair Marketing.**

(a) A small employer carrier must [~~shall~~] 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 [~~the~~] prior approval from [~~of~~] the commissioner or the commissioner's designee. In marketing consumer choice health benefit plans to small employers, a small employer carrier must [~~shall~~] use at least the same sources and methods of distribution that it uses to market other small employer health benefit plans [~~to small employers~~]. Any agent authorized by a small employer carrier to market consumer choice health benefit plans to small employers in this state must [~~shall~~] also be authorized to market [~~the~~] small employer health benefit plans that contain state-mandated health benefits.

(b) Before issuing coverage to a [~~To each~~] small employer [~~who inquires about purchasing a small employer health benefit plan~~], a small employer carrier must [~~shall~~] offer the employer a choice of all health benefit plans that the small employer carrier offers and for which the small employer qualifies [~~as required by §26.14 of this chapter (relating to Coverage)~~]. The small employer carrier may provide the offer directly to the small employer or deliver it through an agent, but in either case must [~~shall~~] offer each required plan contemporaneously with the offer of any other small employer health benefit plan. The offer must [~~shall~~] be in writing and [~~shall~~] 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) [~~Article 26.40~~] and §26.12 of this title [~~chapter~~] (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) [~~§21.3530 of this title (relating to Health Carrier Disclosure)~~].

(c) On [~~Upon~~] request, a small employer carrier must explain its health benefit plans [~~shall explain~~] to a small employer each of the small employer health benefit plans it offers.

(d) [~~As required by §21.3542(a) of this title (relating to Offer of State-Mandated Plan), a small employer carrier shall obtain from each small employer to which it issues coverage, at or before the time of application, a written affirmation that the small employer carrier offered the small employer a consumer choice health benefit plan and a comparable policy or plan as required by Insurance Code Articles 3.80, §8 and 20A.9N(k)~~].

[~~(e)~~] A small employer carrier must [~~shall~~] comply with this subsection when providing a premium rate quote to a small employer.

(1) A small employer carrier must [~~shall~~] 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 [~~pursuant to~~] §26.11 of this title [~~chapter~~] (relating to Restrictions Relating to Premium Rates), necessary to provide the premium rate quote. If the carrier requests this additional information before [~~prior to~~] 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 [~~prior to~~] 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 [~~shall~~] not impose any additional conditions to its provision of a premium rate quote.

(e) [~~(f)~~] A small employer carrier may [~~shall~~] 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) [~~(g)~~] If a small employer carrier denies coverage under a health benefit plan to a small employer on any basis, the denial must [~~shall~~] be in writing and specifically [~~shall~~] state [~~with specificity~~] the reasons for the denial (subject to any restrictions related to confidentiality of medical information).

(g) [~~(h)~~] A small employer carrier must [~~shall~~] 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 [~~shall~~] 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 [~~such~~] other information that is reasonably designed to assist the caller in locating [~~to locate~~] an authorized agent or applying [~~to otherwise apply~~] for coverage.

(h) [~~(i)~~] The small employer carrier may [~~shall~~] 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 [~~such~~] requirement, subject to the requirements of Insurance Code [~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~26, Subchapters A-G~~].

(i) [~~(j)~~] 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) [~~(k)~~] Health carriers offering individual and group health benefit plans in this state must determine [~~shall be responsible for determining~~] whether the plans are subject to the requirements of Insurance Code[~~,~~] Chapter 1501 [~~26, Subchapters A-G,~~] and this subchapter. Health carriers must obtain [~~shall elicit~~] the following information from applicants for those [~~such~~] 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 [~~§162 or §106 of~~] the United States Internal Revenue Code of 1986, [~~,~~]26 U.S.C. [~~United States Code~~] §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 [~~§2510.3-1(j)~~] (concerning Employee Welfare Benefit Plan); or

(4) whether the applicant is a small employer.

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

(l) [~~(m)~~] 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) [~~(n)~~] 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) [~~Every small employer carrier other than an HMO shall, as a condition of transacting business in this state with small employers, offer plans in compliance with Insurance Code Articles 26.42 and 3.80, and Chapter 21, Subchapter AA of this title (relating to Consumer Choice Health Benefit Plans).~~]

[~~(b) An HMO small employer carrier, shall, as a condition of transacting business in this state with small employers, offer plans in compliance with Insurance Code Articles 26.42, 26.48 and 20A.09N, and Chapter 21, Subchapter AA of this title.~~]

[~~(c)~~] Continuation and conversion. All small employer health benefit plans must [~~shall~~] provide for continuation and may provide an option for conversion that [~~which~~] 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) [~~Articles 3.51-6, Sec. 1(d)(3) and 20A.09(k)~~] and rules adopted under those statutes [~~thereunder~~]. A state-approved [~~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 [~~shall~~] provide coverage for continuation that [~~which~~] complies with the requirements of Insurance Code Chapter 1271 [~~Article 20A.09(k)]~~] 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. [~~(d)~~] Each health benefit plan, certificate, policy, rider, or application used by health carriers to provide coverage to small employers and their employees must [~~shall~~] comply with Insurance Code §1501.258 (concerning Forms) and §1501.260 (concerning Plain Language Required) [~~Article 26.43~~], 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. [~~(c)~~] 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.

[~~(f) Every small employer carrier providing a health benefit plan to a small employer shall comply, as applicable, with Insurance Code Articles 3.51-14, 3.51-5A, and 3.50-3, Section 4C.~~]

(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) [~~Article 26.24~~], a small employer carrier must [~~shall~~] renew any small employer health benefit plan [~~for any covered small employer~~] at the option of the small employer, unless:

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

(2) the small employer has committed fraud or intentional misrepresentation of a material fact. An [~~On or after September 1, 1995, an~~] intentional misrepresentation of a material fact does [~~sha~~ll] 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 [~~HMO~~] small employer carrier or in the area where [~~for which~~] 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 [~~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 [~~On or after September 1, 1995, an~~] intentional misrepresentation of a material fact does [~~sha~~ll] 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 [~~the~~] Insurance Code §1501.108 (concerning Renewability of Coverage: Cancellation) [~~, Article 26.23~~], 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 [~~the~~] Insurance Code[~~,~~] §1501.108 [~~Article 26.23,~~] and subsections (a) and (b) of this section.

(d) A carrier is not prevented [~~precluded~~] 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 [~~shall~~] 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 [~~Article 26.23 and Article 26.24,~~] and this subchapter. All other health benefit plans issued to small employers must [~~shall~~] 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) [~~26~~], 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 [~~approved under the Insurance Code, Article 26.22. The small employer carrier shall notify the commissioner of the election not later than the 180th day before the date coverage under the first small employer health benefit plan terminates under the~~] Insurance Code §1501.109 (concerning Refusal to Renew; Discontinuation of Coverage) [~~, Article 26.24(a)~~].

(b) [~~The small employer carrier must notify each affected covered small employer not later than the 180th day before the date on which coverage terminates for that small employer.~~]

[~~(c) A small employer carrier that elects under the Insurance Code, Article 26.24(a) to refuse to renew all small employer health benefit plans in this state or in an approved geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date of notice to the commissioner under the Insurance Code, Article 26.24(a)~~].

[~~(d)~~] 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 [~~under the Insurance Code, Article 26.24, and this section~~] 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 [~~by the commissioner or the commissioner's designee~~]. In reviewing the petition, the commissioner may ask for [~~such~~] information and assurances as the commissioner finds reasonable and appropriate.

(c)[~~(e)~~] 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 the department; 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 [~~health status related~~] factors of employees or dependents or new employees or dependents who may become eligible for the coverage.

[~~(f) This section does not exempt a health carrier from any other legal requirements, such as those contained in Insurance Code Article 21.49-2C, §26.14(a) of this chapter (relating to Coverage) and §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures), or requirements for discontinuation of certain plans under this chapter.~~]

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

(a) Each small employer carrier must [~~shall~~] 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 [~~shall~~] 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. [~~A small employer carrier shall use Form Number 1212 RISK for these purposes.~~]

(b) A small employer carrier seeking to change its status as a risk-assuming or reinsured carrier must [~~shall~~] 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. [~~The required filing shall include a completed certification Form Number 1212 Risk and shall provide information demonstrating good cause why the carrier should be allowed to change its status.~~]

(c) A small employer carrier's election is effective until the fifth anniversary of the election. A [~~, and 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.[~~:~~]

[~~(1) as a reinsured carrier must file with the commissioner, at least 90 days prior to the fifth anniversary of its election, Form Number 1212 RISK to renew that election;~~]

[~~(2) as a risk-assuming carrier must file with the commissioner, at least 90 days prior to the fifth anniversary of its election, Form Number 122 RISK to reapply for the commissioner's approval of that election.~~]

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

**§26.19. Filing Requirements.**

(a) Each small employer carrier must [~~shall~~] 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, [~~with the department~~] in accordance with Insurance Code Chapter 1701 (concerning Policy Forms) [~~Article 3.42~~], 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) [~~Article 20A.09~~], 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. [~~, except as provided in subsection (b) of this section.~~] A small employer carrier desiring to use existing forms to provide a health benefit plan in the small employer market must [~~shall~~] file a certification stating which previously approved forms the health carrier intends to use in that market, provided that the [~~such~~] forms have been amended to comply with applicable laws. A form fulfilling this requirement is available at www.tdi.texas.gov/forms/form10smgroup at the link for Form Number 1212 CERT ANN LIST-OTHER/SEHBP [~~shall be used for this purpose. The certification shall be forwarded to the department as soon as reasonably possible after January 1, 1994, and for newly elected small employer carriers no later than with the first filing of a small employer health benefit plan~~].

(b) [~~Each small employer carrier shall submit a geographic service area certification form, provided in Form Number 1212 CERT GEOG, prior to offering any small employer health benefit plan and subsequent to such filing only if the small employer carrier changes the elections it made in the~~

~~certification. The certification form shall define the geographic service areas within which the small employer carrier will operate as a small employer carrier.~~]

[~~(1) Each small employer carrier shall submit this certification form no later than with the initial filing of a small employer health benefit plan.~~]

[~~(2) If a small employer carrier elects to alter its geographic service areas, the small employer carrier shall notify the department of its intent at least 30 days prior to the date the small employer carrier intends to effect the change. The small employer carrier shall utilize Form Number 1212 CERT GEOG to submit this information. This subsection does not exempt a health carrier from any other legal requirements, such as those for withdrawal from the market under §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures.~~]

[~~(c)~~] Each small employer carrier, other than an HMO, must [~~shall~~] 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 [~~which~~] are covered in subsection (c) [~~(d)~~)] of this section) must [~~shall~~] be submitted in the following order [~~as follows~~]:

(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 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 [~~alternate~~] 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 [~~which~~] 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 [~~chapter~~] (relating to Establishment of Classes of Business) and §26.11 of this title [~~chapter~~] (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) [~~(d)~~] In addition to subsection [~~subsections~~] (a) [~~and (b)~~] of this section, the following provisions apply to each [~~health carrier that is an~~] HMO. The HMO must [~~shall~~] submit health benefit plan forms for use in the small employer market that include [~~in accordance with~~] the following.

(1) Any HMO group or individual agreement must [~~shall~~] address and include all required provisions of [~~the~~] Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~26~~]. The [~~Such~~] agreement must [~~shall~~] be in compliance with any other applicable provisions of the Insurance Code. In addition, the agreement must [~~shall~~] 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 [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26~~].

(2) The filing must [~~shall~~] include any alternative pages [~~alternate page(s)~~] to the agreement or the schedule of benefits and any alternative schedules [~~alternate schedule(s)~~] of benefit.

(3) The filing must [~~shall~~] 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 [~~(relating to Evidence of Coverage)~~].

(4) The filing must [~~shall~~] 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 [~~(relating to Evidence of Coverage)~~], except for:

(A) continuation and conversion of coverage, [~~Continuation/Conversion of Coverage which shall be~~] in accordance with Insurance Code Chapter 1271 [~~, Article 20A.09(k~~)] and this title;[~~,~~], and

(B) cancellation, [~~Cancellation which shall be~~] in accordance with §26.15 of this title (relating to Renewability of Coverage and Cancellation).

(5) The filing must [~~shall~~] 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 [~~shall~~] be submitted with an explanation of the market in which the forms will be used. All rider forms must [~~shall~~] comply with [~~the~~] Insurance Code Chapter 1271 [~~, Articles 20A.09~~], and applicable provisions of Chapter 11, Subchapters [~~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 [~~(relating to Evidence of Coverage)~~].

**§26.20. Reporting Requirements.**

(a) Small employer health carriers offering a small employer health benefit plan must [~~shall~~] 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. 08/16, 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 [~~the~~] Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~26, Subchapters A-G,~~] and this chapter.

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

(c) [~~(b)~~] Not later than March 1 of each calendar year, a small employer carrier must [~~shall~~] complete and file with the commissioner Form Number 1212 CERT DATA Annual Small Employer Health Benefit Plan Report, Rev. 08/16, available at www.tdi.texas.gov/forms/forms10smgroup. This annual filing must [~~shall~~] 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, [~~and~~] 36 - 50, and more than 50);

(3) [~~a copy of the certificate of coverage for each of the carrier's three (if applicable) most frequently issued consumer choice health benefit plans. Each certificate must illustrate the selected benefits and plan features without variability;~~]

[~~(4)~~] the number of small employer health benefit plans in force and the number of lives covered under those plans, [~~. This information should be~~] broken down by the ZIP [~~zip~~] code of the small employers' principal place of business in [~~the state of~~] Texas;

(4) [~~(5)~~] the number of small employer health benefit plans [~~that were~~] voluntarily not renewed by small employers in the previous calendar year;

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

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

(7) [~~(8)~~] 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 [~~. For purposes of this subsection, gross premiums shall be the total amount of monies collected by the health carrier for health benefit plans during the applicable calendar year or the applicable calendar quarter. Gross premiums shall include premiums collected for individual and group health benefit plans issued to small employers or their employees. Gross premiums shall also include premiums collected under certificates issued or delivered to employees (in this state) of small employers, regardless of where the policy is issued or delivered~~];

(8) [~~(9)~~] the name and license information [~~if applicable, information~~] regarding any other small employer carrier whose health benefit plans the health carrier [~~small employer health benefit plans~~] assumed [~~from another small employer carrier~~]; and

(9) [~~(10)~~] 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 [~~under the Insurance Code, Article 21.21~~].**

A misrepresentation about the effects of [~~the~~]Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) or [~~26, Subchapters A-G, and/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 [~~the~~] Insurance Code Chapter 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices) and §543.001 (concerning Misrepresentation Prohibited) [~~, Articles 21.20 and Articles 21.21~~].

**§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**

**PROPOSED REPEAL OF 28 TAC §26.311**

**STATUTORY AUTHORITY.** The repeal of §26.311 is proposed 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.

**CROSS-REFERENCE TO STATUTE.** The repeal of §26.311 implements Insurance Code §36.001 and §1251.008, and Chapter 1501.

**TEXT.**

**SUBCHAPTER C. LARGE EMPLOYER HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT REGULATION**

**§26.311. Administrative Violations and Penalties.**

**SUBCHAPTER C**

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

**STATUTORY AUTHORITY.** The amendments to 28 TAC §§26.301 - 26.310, 26.312, and new §26.313 and §26.314 are proposed under the following sections of the Insurance Code:

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.

**CROSS-REFERENCE TO STATUTE.**

Insurance Code Article 21.42, §36.001 and §1251.008, and Chapter 1501.

**TEXT.**

## SUBCHAPTER C. LARGE EMPLOYER HEALTH INSURANCE REGULATIONS [~~PORTABILITY AND AVAILABILITY ACT REGULATION~~]

### §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 [~~shall apply~~] to any health benefit plan providing health care benefits covering 51 or more [~~eligible~~] 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. [~~United States Code~~] §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 [~~2510.3-1(i)~~] (concerning Employee Welfare Benefit Plan).

(d) [~~(b)~~] For an employer that [~~who~~] was not in existence the previous calendar year [~~throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made~~], 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.

[~~(c) An insurance policy, evidence of coverage, contract, or other document that is delivered, issued for delivery, or renewed to large employers and their employees on or after July 1, 1997, shall~~

~~comply with all provisions of the Insurance Code, Chapter 26, Subchapters A and H and with this subchapter~~].

[~~(d) An insurance policy, evidence of coverage, contract or other document establishing coverage under a health benefit plan for large employers and their employees that is delivered, issued for delivery or renewed before July 1, 1997 is governed by the law as it existed before that date, until the first renewal date of that policy, evidence of coverage, contract or other document establishing coverage on or after July 1, 1997.~~]

(e) If a large employer or the employees of a large employer are issued a health benefit plan under the provisions of [~~the~~] Insurance Code Chapter 1501 [~~,26, Subchapters A and H,~~] and this subchapter, and the large employer subsequently employs fewer [~~less~~] than 51 [~~eligible~~] employees, the provisions of [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26, Subchapters A and H~~] and this subchapter [~~shall~~] 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 [~~chapter~~] (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to [~~such~~] an employer must [~~shall~~], within 60 days of becoming aware that the employer has fewer [~~less~~] than 51 [~~eligible~~] 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 [~~the~~] Insurance Code[~~,~~] Chapter 1501 that apply to [~~26, Subchapters A-G concerning~~] small employers, and Chapter 26, Subchapter A of this title [~~chapter~~] (relating to Definitions, Severability, and Small Employer Health [~~Insurance Portability and Availability~~] 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 [~~such~~] 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 [~~chapter~~] (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 [~~shall be in accordance 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; Written Statement of Denial, Cancellation, or Refusal to Renew Required, respectively) [~~Articles 26.86, 26.87, 26.88~~] and §26.308 [~~§26.303~~] of this title [~~chapter~~].

(f) If a health benefit plan is issued [~~on or after July 1, 1997,~~] to an employer that is not a large employer [~~as defined in the Insurance Code. Chapter 26~~], but subsequently the employer becomes a large employer, the provisions of [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26, Subchapter H~~] and this subchapter [~~shall~~] 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 [~~plans~~] as provided under §26.5(e) [~~§26.5(i)~~] of this title (relating to Applicability and Scope).

(g) A large employer non-federal 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.

[~~A governmental entities' health benefit plan (subject to Insurance Code, Articles 3.51-1, 3.51-2, 3.51-3, 3.51-4, 3.51-5, or 3.51-5A) that is provided through health insurance coverage and that~~

~~otherwise meets the requirements of being a large employer is subject to the provisions of Chapter 26, Insurance Code, Subchapters A and H and this subchapter. The portion of a non-federal governmental entity's health benefit plan that is self-insured may elect not to comply with §2721 of the Public Health and Services Act as added by the Health Insurance Portability and Availability Act of 1996.~~]

**26.302. Status of Health Carriers as Large Employer Carriers [~~and Geographic Service Area~~].**

(a) With the original filing to enter the large employer market or when notifying TDI of a change in status [~~Not later than March 1 annually~~], each health carrier providing health benefit plans in this state must file [~~shall make a filing~~] 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 [~~as defined in the Insurance Code, Chapter 26, Subchapters A and H, and this subchapter~~]. The [~~required~~] filing must [~~shall~~] include a [~~the~~] 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, [~~form Form Number 1212 CERT LEHC STATUS, completed according to the carrier's status,~~] and [~~shall at least~~] provide a statement that [~~to the effect of one of the following~~]:

(1) the health carrier intends to offer, renew, issue, and issue for delivery health benefit plans to large employers in Texas [~~and their employees~~], and [~~therefore~~] will operate in accordance with Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~26, Subchapters A and H~~] 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 [~~and their employees; however,~~] the health carrier intends to renew existing health benefit plans [~~issued prior to July 1, 1997 and comply with the Insurance Code, Chapter 26, Subchapters A and H, and this subchapter~~];

(3) the health carrier does not intend to offer, issue, or issue for delivery health benefit plans to large employers [~~and their employees~~] in [~~the State of~~] Texas; [~~and~~] 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 [~~which are in force on or after July 1, 1997,~~] and [~~the health carrier~~] 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 [~~shall~~] notify the commissioner of its new election at least 30 days before [~~prior to~~] the date the health carrier intends to begin operations under the new election. [~~This notification shall made on Form Number 1212 CERT LEHC STATUS.~~]

(c) A form fulfilling the requirements of subsections (a) and (b) of this section is available online at www.tdi.texas.gov/forms/form10smgroup at the link for Large Employer Carrier Status Certification. [~~Upon election to become a large employer carrier, the health carrier shall establish geographic service areas within which the health carrier reasonably anticipates it will have the capacity to deliver services to large employers in each established geographic service area. Large employer carriers shall comply with the following~~:]

[~~(1) The health carrier shall define and submit the geographic service areas in terms of counties or ZIP codes, to the extent possible.~~]

[~~(2) If the health carrier cannot define the service area by counties or ZIP code, the health carrier shall submit a map which clearly shows the geographic service areas.~~]

[~~(3) If the geographic service area of the carrier is the entire state, the carrier shall define the service area as the State of Texas and no other documentation is necessary.~~]

[~~(4) Service areas by zip code shall be defined in a non-discriminatory manner and in compliance with the Insurance Code, Articles 21.21-6 and 21.21-8~~].

[~~(5) Networks of HMO large employer carriers shall be established in accordance with Chapter 20A, Insurance Code and Chapter 11 of this title (relating to Health Maintenance Organizations)~~].

[~~(6) Large employer carriers shall, no later than the initial filing of a large employer health benefit plan, utilize Form Number 1212 LEHC GEOG to submit this information.~~]

[~~(d) If a large employer carrier elects to alter its geographic service area, the large employer carrier shall notify the department of its intent at least 30 days prior to the date the health carrier intends to effect the change. The large employer carrier shall utilize Form Number 1212 LEHC GEOG to submit this information.~~]

(d) The [~~(c) This section does not exempt a~~] large employer carrier must also comply with [~~from~~] any other applicable legal requirements, including [~~such as~~] those for withdrawal from the market under Chapter 7, Subchapter R [~~§§7.1801, et seq.~~] of this title (relating to Withdrawal Plan Requirements and Procedures).

**§26.303. Coverage Requirements.**

(a) [~~A large employer carrier may refuse to provide coverage to a large employer in accordance with the carrier's underwriting standards and criteria. However, on issuance to a large employer, each large employer carrier shall provide coverage to the eligible employees meeting the participation criteria established by the large employer without regard to an individual's health status related factors. The participation criteria may not be based on health status related factors. A large employer's participation criteria may not require an employee to maintain an actively at work status, unless the actively at work status is wholly unrelated to health status related factors, such as time off for a sabbatical leave or vacation.~~]

[~~(b)~~] The large employer carrier must [~~shall~~] 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[~~, if applicable,~~] 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) [~~Article 26.89~~] to the group of employees or dependents [~~, if applicable,~~] who meet the participation criteria established by the employer and who do not decline coverage.

(b)[~~(c)~~] A large employer carrier must [~~shall~~] 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 [~~eligible~~] individual is declining all offered plans [~~large employer health benefit plans offered~~]. The large employer carriers may enter into an agreement designating which large employer carrier will receive and retain the waiver. Waivers must [~~shall~~] 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 [~~health status related~~] factors. The waiver must [~~shall~~] be signed by the employee (on

behalf of the [~~such~~] employee or the dependent, if applicable [~~, of such employee~~]) and must [~~shall~~] 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 [~~that~~] 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 [~~shall~~]:

(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 [~~, were not induced or pressured by the large employer, agent, or health carrier into declining coverage, but elected of their own accord to decline such coverage~~].

[~~(d) A large employer carrier may not provide coverage to a large employer or the employees of a large employer if the carrier or an agent for the carrier knows that the large employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status related factors.~~]

(c) [~~(e)~~] An agent must [~~shall~~] notify a large employer carrier, before [~~prior to~~] submitting an application for coverage with the health carrier on behalf of a large employer or its employees [~~employee of a large employer~~], of any circumstances that would indicate that the large employer has induced or pressured an eligible employee [~~eligible employee~~] who meets the large employer's participation criteria or a dependent [~~of the employee~~] to decline coverage due to the individual's health-status-related [~~health status related~~] factors.

[~~(f) A large employer carrier may require a large employer to meet minimum premium contribution requirements as a condition of issuance and renewal in accordance with the carrier's usual and customary practices for all employer health benefit plans in this state. A health carrier shall treat all similarly situated large employer groups in a consistent and uniform manner when terminating health benefit plans due to failure of the large employer to meet a contribution requirement. If a large~~

~~employer fails to meet a contribution requirement for a large employer health benefit plan, the health carrier may terminate coverage as provided under the plan in accordance with the terms and conditions of the plan requiring such contribution and in accordance with Insurance Code Articles 26.86, 26.87, and 26.88 and §26.308 of this chapter (relating to Renewability of Coverage and Cancellation).~~]

(d) [~~(g)~~] 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 [~~of the large employer~~].

[~~(h) A large employer carrier may require a large employer to meet minimum participation requirements as a condition of issuance and renewal in accordance with the carrier's usual and customary practices for all employer health benefit plans in this state. The minimum participation requirements may determine the percentage of individuals that must be enrolled in the plan in accordance with participation criteria established by the employer. These minimum participation requirements must be stated in the contract and must be applied uniformly to each large employer offered or issued coverage by the large employer carrier in this state. A large employer health carrier shall accept or reject the entire group of eligible employees meeting the participation criteria and minimum participation requirements that choose to participate and exclude only those employees and dependents, if applicable, that have declined coverage.~~]

(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. [~~(i)~~] 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 [~~shall~~] 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 [~~, so~~] 41.25 [~~would be rounded~~] down to 41; so, [~~therefore,~~] 75 percent [~~%~~] participation by a 55-employee [~~55 employee~~] group would [~~will~~] be achieved if 41 of the eligible employees who meet [~~meeting~~] the large employer's participation criteria participate.

(f) [~~(j)~~] If a large employer fails to meet the qualifying minimum participation requirement [~~for a large employer health benefit plan,~~] for [~~a period of at least~~] six consecutive months, the large employer health carrier may terminate coverage under the plan on [~~upon~~] the first renewal date following that

period. The [~~the end of the six-month consecutive period during which the qualifying minimum participation requirement was not met, provided that the~~] termination must comply [~~shall be in accordance~~] with the terms and conditions of the plan concerning termination for failure to meet the qualifying minimum participation percentage [~~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) [~~Articles 26.86, 26.87, 26.88~~] and §26.308 of this title (relating to Renewability of Coverage and Cancellation) [~~chapter~~]. A large employer health carrier must [~~shall~~] 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) [~~(k)~~] A large employer must continue to meet the qualifying minimum group size requirement of §26.301(c) [~~§26.5(a)~~] of this title [~~chapter~~] (relating to Applicability, Definitions, and Scope) to be entitled to elect to renew coverage under [~~pursuant to~~] §26.301(e) of this title [~~chapter (relating to Applicability and Scope)~~]. If a large employer fails to meet, for [~~a period of at least~~] six consecutive months, the minimum group size requirement of §26.301(c) [~~§26.5(a)~~] of this title [~~chapter~~], the health carrier may terminate coverage under the plan on [~~upon~~] the first renewal date following that period. The [~~the later of the end of the six-month consecutive period during which the large employer did not meet the qualifying minimum group size requirement, provided that the~~] termination must comply [~~shall be in accordance~~] with the terms and conditions of the plan concerning termination for failure to meet the minimum group size requirements in [~~of~~] §26.301(c) [~~§26.5(a)~~] of this title [~~chapter~~], and in accordance with [~~the~~] Insurance Code §§1501.108 - 1501.111 [~~Articles 26.86, 26.87, 26.88~~] and §26.308 of this title. [~~chapter.~~]

**§26.304. Requirement to Insure Entire Groups.**

(a) A large employer carrier that offers coverage to a large employer and its employees must [~~shall~~] offer [~~to provide~~] 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, [~~then~~] a large employer carrier must [~~shall~~] offer [~~to provide~~] coverage to each eligible dependent. Except as provided in subsection (b) of this section, the large employer carrier must [~~shall~~] provide the same health benefit plan to each [~~such~~] employee and dependent.

(b) If elected by the large employer, a large employer carrier may offer [~~the eligible employees of a large employer, who meet the participation criteria, the option of choosing among~~] one or more health benefit plans, provided that each eligible employee who meets the participation criteria may choose any of the plans offered [~~to the employee~~]. Except as provided in [~~the~~] Insurance Code §1501.104 (concerning Affiliation Period) and §1501.106 (concerning Certain Limitations or Exclusions of Coverage Prohibited), [~~Articles 26.83 and 26.90 (~~] 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 [~~upon~~] the health-status-related [~~health status related~~] factors of the [~~eligible~~] employees or [~~their~~] 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 [~~as defined in Insurance Code Article 26.02~~]. 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 [~~as well as~~] to confirm the applicant's status as a large employer. The large employer carrier must [~~shall~~] 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 [~~Following are examples~~] of the types of reasonable and appropriate supporting documentation that [~~which~~] a large employer carrier may request [~~, as reasonable and appropriate,~~] 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 [~~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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] provide married eligible employees of the same employer the option to [~~elect 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 [~~pursuant to~~] this subsection does not impact the individual's status as an eligible employee for any other purpose under [~~the~~] Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act), except that the [~~such~~] 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 [~~shall~~] be offered an opportunity to enroll in the health benefit plan currently held by the [~~such~~] employer group or [~~shall~~] 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 [~~pursuant to~~] subsection (b) of this section, the new entrant must [~~shall~~] be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant who [~~that~~] 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 [~~shall~~] be accepted for coverage by the large employer carrier without any

restrictions or limitations on coverage related to the health-status-related [~~health status related~~] factors of the employee or dependent [~~employees or their dependents, if applicable~~], except that a health carrier may exclude coverage for preexisting [~~pre-existing~~] medical conditions or impose an affiliation period, to the extent allowed under Insurance Code Chapter 1501 [~~, Articles 26.83 and 26.90~~].

[~~(g) In the case of an eligible employee that meets the participation criteria (or dependent of an eligible employee, if applicable) who was excluded from coverage, not eligible for coverage, denied coverage by a large employer carrier, or in the process of providing a health benefit plan to an eligible large employer, the large employer carrier shall provide an opportunity for the eligible employee that meets the participation criteria (or dependent(s) of such eligible employee) to enroll in the health benefit plan issued to the large employer or the employees of the large employer on the earlier of the first renewal date occurring on or after July 1, 1997, or the first open enrollment period [occurring on or after July 1, 1997. The opportunity to enroll shall meet the following requirements:~~]

[~~(1) The opportunity to enroll under this subsection shall comply with §26.305(a) of this title.~~]

[~~(2) Eligible employees that meet the large employer's participation criteria and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants.~~]

[~~(3) The terms of coverage offered to an individual described in this subsection may exclude coverage for preexisting conditions or impose an affiliation period only if the health benefit plan currently held by the large employer contains such an exclusion or affiliation period.~~]

[~~(4) A large employer carrier shall provide written notice at least 45 days prior to the opportunity to enroll provided in this subsection or if less than 45 days are available, within five working days after determination that subsections (e) - (g) of this section apply to each large employer insured under a health benefit plan offered by such health carrier. A large employer carrier may provide the notice to the employer if the carrier has entered into an agreement with the employer to provide the notice to the employees. The notice shall clearly describe the rights granted under subsections (e) - (g) of this section to employees or dependents who were previously excluded from, not eligible for, or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.~~]

[~~(h) A large employer carrier may require an individual who requests enrollment under subsection (g) of this section to sign a statement indicating that such individual sought coverage under~~

~~the group contract or franchise policy (other than as a late enrollee) and that the coverage was not offered or provided to the individual.~~]

**§26.305. Enrollment.**

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

(1) the initial enrollment period for the employees meeting the large employer's participation criteria must [~~shall~~] 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 [~~shall~~] 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 [~~shall be~~] timely if he or she submits the application within [~~a period of at least~~] 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, [~~. For purposes of this paragraph, "submits" means that the item(s) must be~~] postmarked by the end of the specified [~~time~~] period; or

(C) [~~. At the discretion of the large employer carrier,~~] in an alternative method normally accepted by the large employer carrier [~~methods of submission~~], including [~~such as~~] facsimile transmission (fax), email, or web-based application [~~, may be acceptable~~]; and

(4) the large employer carrier must [~~shall~~] 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 [~~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) [~~Article 26.83(h)~~] 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 [~~,~~ ~~Article 26.83(h)~~] 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 [~~a covered employee~~] 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 [~~shall~~] not terminate coverage of a newborn child if the [~~such~~] 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 [~~such~~] 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. [~~A child is considered to be the child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought.~~]

(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 [~~shall~~] not terminate coverage of an adopted child if the [~~such~~] carrier's billing cycle does not coincide with this [~~his~~] 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 [~~such~~] premium.

(j) For purposes of [~~subsections (c), (d), (g), and (j) of~~] this section, "received by the large employer" within [~~by~~] a specified [~~time~~] period means that the item(s) must be postmarked by the specified [~~time~~] period.

(k) If a newborn or adopted child is enrolled in a health benefit plan or other creditable coverage within the [~~time~~] periods specified in [~~subsections (g) or (j) of~~] this section, [~~respectively,~~] 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 [~~time~~] periods specified in [~~subsections (g) or (j) of~~] this section, [~~respectively,~~] then in accordance with §26.306(h) of this title (relating to Exclusions, Limitations, Waiting Periods, Affiliation Periods, [~~and~~] 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.

[~~(l) If dependent coverage is offered to enrollees under a large employer health benefit plan, and the plan conditions dependent coverage for a child 21 years of age or older on the child's being a full-time student at an educational institution, the plan shall provide coverage for the child in accordance with Insurance Code Article 21.24-2.~~]

[~~(m) If benefits for diagnostic medical procedures are included under a large employer health benefit plan, then the plan shall provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer in accordance with Insurance Code Article 21.53F.~~]

[~~(n) An HMO issuing coverage to a large employer whose health benefit plan requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper, shall permit female enrollees access to obstetrical or gynecological care~~

~~in accordance with Insurance Code Article 21.53D and Chapter 11 of this title (relating to Health Maintenance Organizations).~~]

**§26.306. Exclusions, Limitations, Waiting Periods, Affiliation Periods, [~~and~~] 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). [~~Articles 26.83 and 26.90.~~]

(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 [~~such~~] 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 [~~shall~~] not treat genetic information as a preexisting condition described by Insurance Code §1501.102 [~~, Article 26.90(b)~~] in the absence of a diagnosis of the condition related to the information.

(e) A large employer carrier may [~~shall~~] not treat a pregnancy as a preexisting condition described by Insurance Code §1501.102 [~~, Article 26.90(b)~~].

(f) A preexisting condition provision in a large employer health benefit plan may [~~shall~~] 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 [~~6~~] months beginning on May 1, 2014 [~~1997~~], through October 31, 2014 [~~1997~~], followed by a gap in coverage of 61 days until December 31, 2014 [~~1997~~]. Individual A is covered under an individual health plan beginning on January 1, 2015 [~~1998~~], for six [~~6~~] months through June 30, 2015 [~~1998~~], followed by a gap in coverage of 62 days until August 31, 2015 [~~1998~~]. The effective date of Individual A's coverage under a large employer health benefit plan is September 1, 2015 [~~1998~~]. 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 [~~shall~~] 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 [~~shall~~] 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 [~~1995~~], through November 30, 2015 [~~1996~~], followed by a four-month [~~four month~~] gap in coverage from December 1, 2015 [~~1996~~], to March 31, 2016 [~~1997~~]. On April 1, 2016 [~~1997~~], Individual B is covered under a group health plan for three months through June 30, 2016 [~~1997~~], followed by a two-month [~~two month~~] gap in coverage until August 31, 2016 [~~1997~~]. The effective date of Individual B's coverage under a large employer health insurance policy is September 1, 2016 [~~1997~~]. 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 [~~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 [~~shall~~] 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 [~~regards~~] to all [~~such~~] 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 [~~upon~~] 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 [~~such provisions are~~] described by Insurance Code §§1501.102 - 1501.104 [~~Article 26.90~~].

(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 [~~chapter~~] (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 [~~1997~~], after the enrollment period of July 1, 2014 [~~1997~~], through July 31, 2014 [~~1997~~], has ended. The next annual open enrollment period is July 1, 2015 [~~1998~~], through July 31, 2015 [~~1998~~]. 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, [~~1998~~] 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 [~~1998~~], and expire [~~expires~~] on September 1, 2016 [~~1999~~].

(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 [~~immediately~~] and enroll the applicant during the plan year, [~~then~~] 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 [~~1997~~], the preexisting condition period would begin on that date and would expire on April 1, 2016 [~~1999~~].

(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, [~~1998~~] 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 [~~immediately~~] and enroll the applicant during the plan year, [~~then~~] the carrier may apply up to a 90-day affiliation period from the day Individual A applied for coverage.

(i) An HMO [~~A health maintenance organization~~] may impose an affiliation period if the period is applied uniformly to each enrollee without regard to any health-status-related [~~health status related~~] factor. The affiliation period may [~~shall~~] not exceed two months for an enrollee, other than a late enrollee, and may [~~shall~~] not exceed 90 days for a late enrollee. An affiliation period under a plan must [~~shall~~] run concurrently with any applicable waiting period under the plan. An HMO may [~~shall~~] 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 [~~shall~~] determine the duration of the waiting period. A large employer carrier may [~~shall~~] not apply a waiting period [~~elimination period, or~~] or other similar limitation of coverage (other than an exclusion for preexisting medical conditions or [~~impose~~] an affiliation period consistent with Insurance Code §§1501.102 - 1501.106 and 1501.601 - 1501.609 [~~Articles 26.83 and 26.90~~]), with respect to a new entrant, that is longer than the waiting period established by the large employer for all other employees. On [~~Upon~~] completion of the waiting period and enrollment within the time frame allowed by §26.305(a) of this title [~~chapter~~] (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 [~~upon~~] 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 [~~, Articles 26.83 and 26.90~~].

(l) To determine if preexisting conditions [~~as defined in Insurance Code Article 26.02(23)~~] exist, a carrier must determine [~~shall ascertain~~] the source of previous or existing coverage of each eligible

employee meeting the participation criteria [~~and each dependent of an eligible employee~~] 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 [~~shall have~~] the responsibility to contact the source of [~~such~~] previous or existing coverage to resolve any questions about the benefits or limitations related to any [~~such~~] previous or existing coverage in the absence of a creditable coverage certification form.

**§26.307. Fair Marketing.**

(a) On [~~Upon~~] request, a [~~each~~] large employer carrier must provide to the large employer [~~purchasing health benefit plans shall be given~~] a summary of all health benefit plans offered by the large employer carrier for which the large employer qualifies [~~is eligible~~].

(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 [~~shall~~] 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) [~~, Articles 26.87 and 26.88~~].

(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 [~~shall~~] 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 [~~such~~] requirement, subject to the requirements of [~~the~~] Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) [~~26, Subchapters A and H~~].

(e) Health carriers offering individual and group health benefit plans in this state are [~~shall be~~] responsible for determining whether the plans are subject to the requirements of [~~the~~] Insurance Code[~~,~~] Chapter 1501 [~~26, Subchapters A and H,~~] and this subchapter. At the time of application, health [~~Health~~] carriers must obtain [~~shall elicit~~] the following information from applicants for those [~~such~~] plans [~~at the time of application~~]:

(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 [~~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. [~~United States Code~~] §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 [~~§2510.3-1-i~~] (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 [~~shall be~~] 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) [~~Article 26.87~~], a large employer carrier must [~~shall~~] renew any large employer health benefit plan [~~for any covered large employer~~] 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 [~~HMO~~] large employer carrier or in the area where [~~for which~~] 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 [~~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 [~~, if applicable,~~] 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 [~~§11.506(3)~~] 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). [~~approved under Insurance Code Article 26.85(d). The large employer carrier shall notify the commissioner of the election not later than the 180th day before the date coverage under the first large employer health benefit plan terminates under Insurance Code Article 26.87(a) and shall comply with the notification requirements set forth in §26.302(c) and (d)(2) of this chapter (relating to Status of Health Carriers as Large Employer Carriers and Geographic Service Area). This subsection does not exempt a health carrier from any other legal requirements, including such as those for withdrawal from the market under Chapter 7, Subchapter R §§7.1801, et seq. of this title (relating to Withdrawal Plan Requirements and Procedures).~~]

~~[(b)The large employer carrier shall notify each affected covered large employer not later than the 180th day before the date on which coverage terminates for that large employer.]~~
~~[(c)A large employer carrier that elects under the Insurance Code, Article 26.87(a), to refuse to renew all large employer health benefit plans in this state or in an approved geographic service area may not write a new large employer health benefit plan in this state or in the geographic service area, as~~

~~applicable, before the fifth anniversary of the date on which notice is delivered to the commissioner under the Insurance Code, Article 26.87(a).]~~

(b)[~~(d)~~] 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 [~~the~~] Insurance Code §1501.109[~~, Article 26.87(a),~~] 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 [~~by the commissioner or the commissioner's designee~~]. In reviewing the petition, the commissioner may ask for [~~such~~] information and assurances as the commissioner finds reasonable and appropriate.

(c)[~~(e)~~] 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 [~~the department~~]; 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 [~~health status related~~] factors of employees or dependents [~~or new employees or dependents~~] who are or may become eligible for the coverage.

**§26.310. Unfair Competition and Unfair Practices [~~under the Insurance Code, Article 21.21~~].**

A misrepresentation about the effects of [~~the~~] Insurance Code[~~,~~] Chapter 1501 (concerning Health Insurance Portability and Availability Act) or [~~26, Subchapters A and H, and/ 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 [~~the~~] Insurance Code Chapter 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices) and §543.001 (concerning Misrepresentation Prohibited). [~~, Articles 21.20 and Articles 21.21.~~]

**§26.312. Point-of-Service [~~Point-of-service~~] Coverage.**

~~[(a)Definitions. The following words and terms when used in this section shall have the following meanings, unless the context clearly indicated otherwise.]~~

~~[(1)In-plan covered services--Health care services, benefits, and supplies to which an enrollee is entitled under an evidence of coverage issued by an HMO, including emergency services, approved out-of-network services and other authorized referrals.]~~

~~[(2)Nonparticipating physicians and providers--Physicians and providers that are not part of an HMO delivery network.]~~

~~[(3)Out-of-plan covered benefits--All covered health care services, benefits, and supplies that are not in-plan covered services. Out-of-plan covered benefits include health care for services, benefits and supplies obtained from participating physicians and providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining in-plan covered services.]~~

~~[(4)Participating physicians and providers--Physicians and providers that are part of an enrollee's HMO delivery network.]~~

~~[(5)Point-of-service (POS) 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.]~~

~~[(6)] Point-of-service (POS) plan--As defined in Insurance Code Article 26.09(a)(2).]~~

(a)[~~(b)~~] A large employer carrier that offers point-of-service [~~POS~~] coverage must [~~shall~~] 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)[~~(c)~~] If an HMO issues coverage to a large employer and eligible employees have access only to in-plan coverage [~~covered services~~] through one or more HMOs, each of the HMOs issuing [~~such~~] 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)[~~(d)~~] 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 [~~POS~~] 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 [~~the department upon~~] 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 [~~covered benefits~~] 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)[~~(e)~~] Except as otherwise agreed to by the employer, an [~~An~~] eligible employee who [~~that~~] selects a point-of-service [~~POS~~] option is responsible for paying all costs, including premiums, coinsurance, copayments, deductibles, and any other cost-sharing [~~cost sharing~~] provisions imposed by the point-of-service [~~POS~~] option, including any administrative costs imposed by a large employer as permitted by Insurance Code §1273.055 (concerning Cost-Sharing Provisions) [~~Article 26.09(e) of the Code~~].

(e)[~~(f)~~] The premium for coverage required to be offered under this section must [~~shall~~] be based on the actuarial value of that coverage and may be different than the premium for the in-plan coverage [~~covered services~~] 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 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 (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 proposed 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.

**CROSS-REFERENCE TO STATUTE.** The repeal of 28 TAC §26.404 implements Insurance Code §36.001 and Chapter 1501.

**TEXT.**

**SUBCHAPTER D. HEALTH GROUP 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 proposed 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.

**CROSS-REFERENCE TO STATUTE.** The repeal of 28 TAC §26.413 implements Insurance Code §36.001 and Chapter 1501.

**TEXT.**

**SUBCHAPTER D. HEALTH GROUP 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 proposed 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.

**CROSS-REFERENCE TO STATUTE.** The amendments to 28 TAC §§26.401 - 26.403 and 26.405 - 26.411 and new §26.400 implement Insurance Code §36.001 and §1251.008, and Chapter 1501.

**TEXT.**

**SUBCHAPTER D. [~~HEALTH GROUP~~] 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 [~~Subject to the requirements of~~] 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 [~~organized~~] as a nonprofit organization [~~corporation~~] and be authorized to transact business in Texas, as required by the Business Organizations Code [~~has the rights and duties provided by the Texas Non-profit Corporation Act, Texas Civil Statutes, Articles 1396-1.01, et seq~~].

(d) A [~~On receipt of a certificate of incorporation or certificate of authority from the secretary of state, the~~] health group cooperative must file with TDI its organizational documents and, if applicable, authorization to transact business in Texas [~~shall comply with Insurance Code §1501.056 by filing notification of the receipt of the certificate and a copy of the health group cooperative's organizational documents with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~]. The organizational documents must [~~shall~~] 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 [~~electing~~] to restrict its membership to 50 eligible employees in accordance with [~~pursuant to~~] Insurance Code §1501.0581(o) (concerning Special Provisions Relating to Health Group Cooperatives) must include that election in the organizational documents filed under [~~pursuant to~~] 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). [~~The board of directors shall, by March 1 of each year, file with the department a statement of all amounts collected and expenses incurred for each of the preceding three calendar years. The board shall make the annual filing on Form Number HGC-1, which can be obtained from the Texas Department of Insurance, Filings Intake Division, MC 106-1E, P.O. Box 149104, Austin, Texas 78714-9104, as well as from the department's internet web site at~~

~~www.tdi.state.tx.us. The board shall file Form Number HGC-1 with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.~~]

(g) The provisions of this subchapter do not [~~shall not be construed to~~] 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) [~~, or both~~] 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 [~~pursuant to~~] Insurance Code §1501.058 (concerning Powers and Duties of Cooperatives), [~~§1501.058(a)(1)~~] a health group cooperative must, at the end of its initial open enrollment period, have at least 10 [~~ten~~] participating employers. A [~~Thereafter, if the~~] health group cooperative must maintain [~~does not, at any time have~~] at least 10 [~~ten~~] participating employers [~~,~~] to continue [~~maintain~~] eligibility for coverage. If the health group cooperative drops below 10 participating employers, it must add additional participating employers [~~members~~] by the end of the next open enrollment period [~~to maintain at least ten participating employers~~]. 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 [~~, by the end of the next open enrollment period~~] the health group cooperative does not have at least 10 [~~ten~~] 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 [~~pursuant to~~] subsections (d) and (e) of this section, a health group cooperative:

(1) must [~~shall~~] allow any small employer to join the cooperative [~~a health group cooperative that consists of only small employers or both small and large employers~~] and enroll in health benefit plan coverage[~~,~~] during the initial and annual open enrollment periods unless the cooperative consists of only large employers;[~~, enroll in health benefit plan coverage; and~~]

(2) may allow eligible single-employee businesses [~~a large employer~~] to join the cooperative [~~the health group 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 [~~enroll in health benefit plan coverage~~].

(d) A health group cooperative that has elected to limit membership to 50 eligible employees and has filed the election [~~notification~~] with TDI [~~the department~~] as required by §26.401(e) of this title [~~subchapter~~] (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 [~~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 [~~upon~~] 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, [~~or~~] 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 [~~upon~~] 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 [~~that~~] 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 [~~shall~~] maintain [~~four years~~] 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 [~~pursuant to~~] subsection (b) of this section. The documentation must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~guaranteed issue~~] basis from any health carrier offering coverage in the small employer [~~small employer~~] market with no requirement of joining a health group cooperative;

(6) for [~~if~~] multiple plans that are offered through the health group cooperative, an explanation that the employer [~~and employees~~] 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). [~~the employer or employee is considering or purchasing a health benefit plan that does not contain all state-mandated health benefits, a written disclosure statement that:~~]

[~~(A) explains that the health benefit plan being offered or purchased does not provide some or all state-mandated health benefits;~~]

[~~(B) lists those state-mandated health benefits not included under the health benefit plan;~~]

[~~(C) contains a general description of the benefits offered by the health benefit plan;~~]

[~~(D) provides a notice that purchase of the plan may limit future coverage options in the event the policyholder's or certificate holder's health changes and needed benefits are not covered under the health benefit plan.~~]

**§26.407. Health Carrier Filing Before [~~Prior to~~] Issuance of Coverage to a Health Group Cooperative.**

(a) A health carrier that intends to issue coverage to a health group cooperative must [~~shall~~] file with TDI [~~the commissioner, not later than 30 days prior to the initial open enrollment period for the cooperative,~~] information concerning the health carrier's offer of coverage no later than 30 days before the cooperative's initial enrollment period. [~~to the cooperative. The health carrier shall submit this filing to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.~~]

(b) A filing required by subsection (a) of this section must [~~shall~~] 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 [~~pursuant to~~] subsection (c) of this section, reference to a previously approved form, including the form number and date of approval. [~~; and~~]

[~~(6) any other information requested by the department.~~]

(c) The form filing required by subsection (b)(5) of this section must [~~shall~~] 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 [~~subchapter~~] (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 [~~the department~~] consistent with §26.401(e) of this title [~~subchapter~~] (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 [~~state mandates~~]:

(1) the offer of in vitro fertilization coverage as required by Insurance Code Chapter 1366, Subchapter A (Coverage for In Vitro Fertilization Procedures) [~~§§1366.001 and 1366.003~~];

(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) [~~§§1364.001 and 1364.003~~];

(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) [~~§1355.104~~];

(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 [~~and/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)continuation of coverage of certain drugs under a drug formulary as required by Insurance Code §1369.055;]~~

~~[(12)coverage of off-label drugs as required by Insurance Code §§1369.001 - 1369.005;]~~

(11)[~~(13)~~] 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)[~~(14)~~] 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) [~~§§1369.101 - 1369.109~~] and §21.404(3) of this title (relating to Underwriting);

(13)[~~(15)~~] 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)[~~(16)~~] coverage of bone mass measurement for osteoporosis as required by Insurance Code Chapter 1361 (concerning Detection and Prevention of Osteoporosis) [~~§1361.003~~ ];

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

(16)[~~(18)~~] coverage of childhood immunizations as required by Insurance Code Chapter 1367, Subchapter B (concerning Childhood Immunizations) [~~§§1367.051 - 1367.055 and 1367.053~~];

(17)[~~(19)~~] 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) [~~§§1367.101 - 1367.105~~];

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

(19)[~~(21)~~] 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)[~~(22)~~] coverage of acquired brain injury treatment and services [~~treatment/services~~] as required by Insurance Code Chapter 1352 (concerning Brain Injury);

(21)[~~(23)~~] 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)[~~(24)~~] coverage for reconstructive surgery for craniofacial abnormalities in a child as required by Insurance Code Chapter 1367, Subchapter D (concerning Childhood Craniofacial Abnormalities) [~~§§1367.151 - 1367.154~~];

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

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

(25)[~~(27)~~] 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);

~~[(28)limitations or restrictions on copayments and deductibles imposed by §11.506(2)(A) and (B) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate);]~~

(26)[~~(29)~~] coverage of a minimum stay for maternity as required by Insurance Code Chapter 1355, Subchapter B (concerning Minimum Inpatient Stay Following Birth of Child and Postdelivery Care) [~~§§1366.051 - 1366.059~~];

(27)[~~(30)~~] coverage of reconstructive surgery incident to mastectomy as required by Insurance Code Chapter 1357, Subchapter A (concerning Reconstructive Surgery Following Mastectomy) [~~§§1357.001 - 1357.007~~];

(28)[~~(31)~~] coverage of a minimum stay for mastectomy treatment and services [~~treatment/services~~ ] as required by Insurance Code Chapter 1357, Subchapter B (concerning Hospital Stay Following Mastectomy and Certain Related Procedures) [~~§§1357.051 - 1357.057~~];

(29)[~~(32)~~] coverage of autism spectrum disorder as required by the Insurance Code §1355.015 (concerning Required Coverage for Certain Enrollees) [~~Chapter 1355, Subchapter A~~];

(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 [~~§26.407(b)(7)~~] of this title (relating to Health Carrier Filing Before [~~Prior to~~] 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 [~~a health benefit plan that will be offered to a health group cooperative~~] and must [~~shall~~] 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 [~~and filed with the department by an insurer~~] may be filed as a file-and-use [~~file and use~~] form consistent with Insurance Code Chapter 1701, Subchapter B (concerning Filing Requirement) [~~§§1701.051 - 1701.059~~] and Subchapter C (concerning Sanctions; Applicability of Other Laws) [~~1701.101 - 1701.103~~], 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 [~~shall~~] file [~~the form~~] for approval consistent with Insurance Code §1701.051 (concerning Filing Required), [~~§§1701.051~~] and §1701.054 (concerning Approval of Form) [~~1701.054~~], and §3.5(a)(1) of this

title. TDI will [~~The department shall~~] 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 [~~shall~~] indicate that review of the evidence of coverage is subject to the expedited process available under this section. The HMO must [~~shall~~] file the evidence of coverage as required by Chapter 11 of this title (relating to Health Maintenance Organizations) [~~consistent with the requirements of Subchapter F of Chapter 11 of this title (relating to Evidence of Coverage)~~], and TDI will [~~the department shall~~] 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 [~~upon~~] providing certification to TDI [~~the department~~], 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. [~~The health carrier must send the certification to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.~~]

(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 Filings Intake Team Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas, 78701~~]. The health carrier may begin using the expanded service area on [~~upon~~] approval or 60 days after the day the application is received by TDI [~~the department~~], unless the application is disapproved by TDI [~~the department~~] 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, [~~Codes,~~] to the extent possible; and

(2) if the service area cannot be defined by counties or ZIP codes [~~Code~~], a map which clearly shows the geographic service areas [~~must be submitted in conjunction with the application;~~]

[~~(3) service areas by ZIP Code shall be defined in a non-discriminatory manner and in compliance with the Insurance Code §§544.001 - 544.004 and 544.051 - 544.054; and;~~]

[~~(4) any other information requested by the department~~].

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

**SUBCHAPTER D, DIVISION 2**

**28 TAC §§26.421 - 26.426**

**STATUTORY AUTHORITY.** New §§26.421 - 26.426 are proposed 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.

**CROSS-REFERENCE TO STATUTE.** New §§26.421 - 26.426 implement Insurance Code §36.001 and §1251.008, and Chapter 1501.

**TEXT.**

**SUBCHAPTER D. [~~HEALTH GROUP~~] 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 re-elect 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 proposed 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.

**CROSS-REFERENCE TO STATUTE.** New §26.431 implements Insurance Code §36.001 and §1251.008, and Chapter 1501.

**TEXT.**

**SUBCHAPTER D. [~~HEALTH GROUP~~] 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 proposed 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.

**CROSS-REFERENCE TO STATUTE.** New §§26.441 - 26.442 implement Insurance Code §36.001 and §1251.008, and Chapter 1501.

**TEXT.**

**SUBCHAPTER D. [~~HEALTH GROUP~~] 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 proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on October 11, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance