

Subchapter A. SMALL EMPLOYER HEALTH INSURANCE
PORTABILITY AND AVAILABILITY ACT REGULATIONS
§§26.4 - 26.11, 26.13 - 26.16, 26.18 - 26.20,
26.22, 26.24, 26.26, and 26.27

Subchapter C. LARGE EMPLOYER HEALTH INSURANCE PORTABILITY
AND AVAILABILITY ACT REGULATION
§§26.301 - 26.309, 26.311, and 26.312

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §§26.4 – 26.11, 26.13, 26.15, 26.16, 26.18 - 26.20, 26.22, 26.24, 26.26, 26.301 – 26.309, 26.311, 26.312, and new §§26.14 and 26.27 concerning small and large employer health insurance regulations. Sections 26.4, 26.7, 26.9, 26.11, 26.13, 26.20, 26.304, 26.306, and 26.307 are adopted with changes to the proposed text as published in the November 12, 2004 issue of the Texas Register (29 TexReg 10422). Sections 26.5, 26.6, 26.8, 26.10, 26.14 – 26.16, 26.18, 26.19, 26.22, 26.24, 26.26, 26.27, 26.301 – 26.303, 26.305, 26.308, and 26.309 are adopted without changes.

2. REASONED JUSTIFICATION. This adoption is necessary to implement House Bills 1211, 1217, and 2969 and Senate Bill 881, enacted by the 76th Legislature (1999); House Bills 471, 949, 1440, 1676, and 2382 and Senate Bill 990, enacted by the 77th Legislature (2001); and House Bills 897 and 1446, and Senate Bills 10 and 541, enacted by the 78th Legislature (2003). The referenced bills amended provisions of Insurance Code, Chapter 26, to provide for the availability and affordability of health insurance for small and large employers; to conform Texas law with updates to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA); and to

clarify the scope and meaning of certain provisions in the rules. In conjunction with the proposed new sections, the department is repealing existing §§26.14 and 26.27, which is published elsewhere in this issue of the Texas Register. Along with the drafting of language to effect the statutory changes previously mentioned, some non-substantive style and grammatical changes were included to enhance the clarity and readability of the rules.

The department changed §26.4(12) to clarify requirements relating to dependents 25 years of age or older. The department changed §26.4(15) to state more specifically the circumstances under which a carrier must cover a sole proprietor, partner, or independent contractor who does not otherwise qualify as an eligible employee. The department changed §26.7(c) to specify an employer's responsibility to produce documents evidencing employer/employee status. The department changed §26.9 to clarify a carrier's obligation regarding creditable coverage where a waiting period is involved. The department changed §26.13 to focus the new provision more precisely on objectionable acts as well as to broaden the scope to include renewal, and to make the timeframe for an insurer to provide premium rate quotes to employers more workable for both insurers and employers in their contract negotiations. The department changed §26.20 to outline clearly the reporting requirements for consumer choice health benefit plans issued to employer groups. The department changed §26.304(c) to specify an employer's responsibility to produce documents evidencing employer/employee status. The department changed §26.306 to clarify a carrier's

obligation regarding creditable coverage where a waiting period is involved. The department changed §26.307 to focus the new provision more precisely on objectionable acts as well as to broaden the scope to include renewal.

3. HOW THE SECTIONS WILL FUNCTION. Section 26.4 amends existing and adds new definitions of terms relating to small and large employer health coverage. Section 26.5 expands the scope of the chapter in compliance with HIPAA, and clarifies requirements relating to minimum group size. Section 26.6 revises procedures and deadlines and adds new procedures for filing certain certifications. Section 26.7 clarifies that health carriers may require proof of status as a small employer, provides examples of reasonable and appropriate supporting documentation, and redefines open enrollment periods in compliance with recent state legislation. Section 26.8 contains minor changes in compliance with HIPAA as well as new language explaining a health carrier's option to terminate coverage due to group size violations. Section 26.9 makes clarifying changes to language and the example relating to the application of preexisting conditions. Section 26.10 replaces the term "group size" with "the number of employees and dependents of a small employer." Section 26.11 revises procedures for filing proposed changes to rating methodology, amends the procedure for developing and retaining rate manuals in accordance with recent legislation, replaces the term "group size" with "the number of employees and dependents of a small employer" in reference to limits on disparity in rate factors, and requires use of uniform terms for obtaining

information relating to a small employer group. Adopted §26.13 updates references to changes in forms; revises the requirement regarding offers of standard benefit plans, including a requirement that small employers must affirm an offer of the plans; prohibits carriers from discriminating between small employer groups when obtaining information; changes the term “price quote” to “premium rate quote” and sets out procedures for providing premium rate quotes; revises the requirement for eliciting information regarding whether a plan is subject to Insurance Code Chapter 26, Subchapters A – G; and prohibits retaliation against an agent related to the agent’s request that the carrier issue or renew coverage to a small employer. Section 26.14 sets out requirements for offers of plans; revises continuation and conversion requirements to conform to new legislation; and contains minor technical changes in compliance with HIPAA. Section 26.14 contains some provisions from the §26.14 proposed for repeal. Section 26.15 allows nonrenewal of plans not in compliance with minimum group size requirements, and deletes requirements for conversion provisions. Section 26.16 adds a subsection clarifying that carriers are subject to all applicable withdrawal and discontinuation requirements. Section 26.18 revises requirements relating to the election to be a risk-assuming or reinsured carrier and clarifies requirements for renewal of that election or application at the end of the election period. Section 26.19 revises and clarifies requirements related to filing certifications, and revises format requirements for accident and health policy filings. Section 26.20 clarifies a carrier’s obligation to complete certain forms and revises previous reporting requirements in light of new requirements to offer

consumer choice health benefit plans instead of prototype policies. Section 26.22 clarifies that March 1 of each year is the deadline for Private Purchasing Cooperatives to file their statements of amounts collected and expenses incurred, and changes the reference to a form that must be filed. Section 26.24 reflects organizational changes within the department. Section 26.26 updates statutory references due to recodification. Section 26.27 provides notice as to how required forms may be obtained.

Section 26.301 expands the scope of this chapter in compliance with HIPAA as well as clarifying requirements relating to minimum group size and a carrier's option to terminate coverage due to violation of minimum group size requirements. Section 26.302 revises procedures and deadlines and adds new procedures for filing certain certifications. Section 26.303 makes minor amendments to comply with HIPAA and adds language allowing termination for noncompliance with minimum group size requirements. Section 26.304 clarifies that health carriers may require proof of status as a large employer and provides examples of reasonable and appropriate supporting documentation. Section 26.305 redefines open enrollment periods in compliance with recent state legislation. Section 26.306 clarifies that the 12 month limitation on preexisting condition provisions may not apply with regard to certain late enrollees and clarifies language and the example relating to the application of preexisting conditions. Section 26.307 revises the requirement for eliciting information regarding whether a plan is subject to Insurance Code Chapter 26, Subchapters A, C and H, and prohibits retaliation against an agent related to the agent's request that the carrier issue or renew

coverage to a large employer. Section 26.308 allows nonrenewal of plans not in compliance with minimum group size requirements. Section 26.309 clarifies the notification requirements of health carriers withdrawing from the large employer market. Throughout the sections, including §§26.9, 26.11, 26.306, 26.311 and 26.312, the department made minor changes for clarification; to correct form, grammar, and citations; and to update examples and references to form numbers.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

General: A commenter states that the legal framework governing the small employer market is highly complex, and contends that the more complex the requirements become, the less the true marketplace governs insurance. The commenter also states that the more complexity in regulation, the less likely it will be that new entrants will begin offering coverage. The commenter requests that the department keep the marketplace in mind to help encourage availability of coverage.

Agency Response: The department was created by the Texas Legislature, and its duties derive from statute. Section 31.002 of the Insurance Code, for example, requires the department to regulate the business of insurance in this state, and accordingly the department takes marketplace conditions into account in every discretionary decision. The statute continues, however, by specifically requiring the department to execute the laws of the state regarding insurance and insurance companies. Moreover, §31.021 requires the commissioner to administer and enforce the insurance laws of this state, as

well as other laws granting jurisdiction or applicable to the department or the commissioner. The great majority of the proposed changes fall within this legislative direction -- administering and enforcing the insurance laws of this state. The department, however, is always monitoring access to health benefit plan coverage and is always open to actions which will increase that access, no matter their source or nature.

§26.4(11): A commenter is concerned about the amendment to the definition of “dependent,” which includes a child who is a full-time student age 25 or older as described in Insurance Code Article 21.24-2. The commenter is concerned that the definition may be interpreted to require continued coverage of all full-time students over 25, and asks for clarification that the reference to this statute applies only if full-time students over age 25 are to be covered by the health benefit plan.

Agency Response: Insurance Code Article 21.24-2 does not mandate coverage for full-time students over the age of 25. It sets out certain requirements of a health benefit plan that conditions coverage for a child 25 years of age or older on the child's being a full-time student at an educational institution. The department has substituted “as required by” for “described in” to clarify this point.

§26.4(15): Some commenters request that the department revise the definition of “Eligible Employee” to include an owner or employee who works on a full time basis.

Agency Response: The department declines to make this change. An owner of a business is an employee if he has legal status as an employee. To deem him an employee in all cases, regardless of the relevant facts, would create a class not authorized by Insurance Code Article 26.02. Note that under the definition of eligible employee, certain classes of owners (i.e. sole proprietors and partners) may still be entitled to coverage regardless of their status as an “eligible employee.” See Commissioner’s Bulletin B-0043-04 for more detail.

§26.4(15): Several commenters request language clarifying the requirements for coverage of a sole proprietor, partner, or independent contractor who does not usually work 30 hours per week and thus qualify as an eligible employee. Some commenters request specific language indicating that there must be two other employees covered to qualify such employees for coverage. Another commenter notes that the proposed amendment to the definition makes irrelevant the number of hours an independent contractor, sole proprietor or partner works weekly. The commenter states that this qualification creates an internal inconsistency in the definition and may reduce the meaning of the term, with regard to these three classes of individuals, to someone who works only on a sporadic basis, which could promote fraud.

Some commenters suggest that the department should not amend the definition of “Eligible Employee” and instead should add a new section to specifically address sole proprietors, independent contractors, or partners. One commenter urges that the

proposed revision could be interpreted to conflict with Commissioner's Bulletin B-0043-04 and require coverage of an employer with only one eligible employee and one non-working sole proprietor.

Agency Response: The department agrees with commenters and has added language to clarify that an employer plan must cover at least two other eligible employees before it must cover a sole proprietor, partner, or independent contractor who does not otherwise qualify as an eligible employee. The department believes the amendment addresses this issue sufficiently and declines to add a separate section to address the rights of these individuals.

The number of hours an independent contractor, sole proprietor or partner works weekly is irrelevant to the individual's status as an eligible employee, but the amendment to the definition does not create that result. While an employee must generally be full-time and usually work 30 hours per week to be eligible, the legislature has deemed these three classes of individuals eligible solely because they are included in the health benefit plan of a small or large employer. The statute does not make them subject to the 30 hour per week requirement, nor does it suggest an alternative standard. Regardless of the consequences the commenter suggests, the department does not have discretion to alter this legislative directive.

§26.4(18): A commenter seeks clarification of the meaning of family history and queried why it is related to genetic information. Another commenter asserts that use of family

history information is generally considered subjective in nature and contends that the use of family history appears to contradict Insurance Code Article 21.73, which specifically requires genetic information to be based upon scientific determination or testing; both of which are purely objective findings. Another commenter suggests that including family history in this definition is beyond the statute.

A commenter points out that the terms “risk characteristic” and “risk load,” in Article 26.02(29) and (30) do not include genetic information as does the proposed amendment to 28 TAC §26.4. The proposed exclusion of “genetic information” in these terms is incompatible with the definition of “risk characteristic,” which relies on the definition of “health status related factor,” in Article 26.02(13)(F), which itself specifically includes genetic information. Also, as written, Article 26.32(d) permits a carrier to adjust the second step premium rate by the “risk load” of the particular group. Article 26.02(30), as noted above, defines “risk load” to include genetic information due to the ultimate use of the definition’s reliance upon the meaning of “health status related factor.”

Another commenter urges adoption of the proposed amended definition because the commenter believes that the statute clearly contemplates that genetic information is not limited to results of a genetic test but also includes the “presence or absence in an individual of a genetic characteristic.”

Agency Response: Insurance Code Article 26.04 directs the commissioner to adopt rules as necessary to meet the minimum requirements of federal law and regulations.

HIPAA interim regulations include "family histories" within the definition of genetic information at 45 CFR §144.103; 29 CFR §2590.701-2; and 26 CFR §54.9801-2T. Accordingly, the department declines to make the change the commenters suggest.

Staff proposed the changes to the definitions of "risk characteristic" and "risk load" consistent with the enactment of Article 21.73, which prohibits a group health benefit plan issuer from using genetic information to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under a group health benefit plan. Accordingly, the department declines to change the language that was proposed for these definitions.

§§26.4(42) & 26.13(e): Regarding the proposed definition of "Premium Rate Quote" and the requirements of §26.13(e) regarding issuance of a premium rate quote, a commenter observes that the industry practice is to give an initial premium estimate pending completion of the application and enrollment forms. Another commenter points out that many employers request such an estimate before deciding to complete the required application and employee health questionnaires necessary for a formal quote, but suggests that the proposed new definition implies that the quote given will be the final premium rate for the policy. The commenter requests that TDI clarify whether the new definition and revised provisions would prohibit the practice of providing preliminary quotes and whether such a preliminary quote would be subject to the deadlines for response in the proposed regulation.

Another commenter urges that the deadline of five business days for requesting the documents and information necessary to issue a binding quote is not adequate. The commenter asserts that although a carrier can underwrite the majority of cases based on employee enrollment forms and the employer application, some cases require the review of medical records and other information to underwrite and price the case accurately. The commenter states that the carrier may not be able to identify the additional information needed until it has reviewed the documents it received from the employer, at which point the carrier would request the additional information or documents. Once the carrier obtains the additional information, it may adjust the premium rate adequately to reflect the appropriate risk.

The commenter is concerned that the new language suggests that the carrier would have only one opportunity to request the required information and would, after receipt of the information, have to issue a final premium rate for the policy. This quote necessarily would be based on the partial information the carrier had been able to obtain and would most likely result in a higher rate than might otherwise apply due to the carrier acting to protect against the potential of unknown health conditions. The commenter suggests that rates could be lower if carriers have sufficient time to ascertain the actual health and composition of the group.

The commenter recommends changing the time period in which a carrier must request additional information and documents to at least 15 business days from the date of the carrier's receipt of a request for a formal rate quote and changing the

deadline for the final quote to be given to 10 business days from the date the complete information is received.

Agency Response: The proposed definition of “premium rate quote” uses the language “offers and will accept to make coverage effective.” The department understands the cited industry practice of providing preliminary estimates for the convenience of prospective customers and does not intend to disrupt the good faith use of that practice. At the same time, gathering the information needed for a formal rate quote should be expeditious and predictable, and the carrier must communicate to a prospective customer when it is presenting a quote that the prospective customer can rely on as the price that will effect coverage. To address the concern that carriers might quote unnecessarily high prices because of the timeframes in the proposal, the department has adopted changes to §26.13(e) to clarify that a small employer carrier shall provide a premium rate quote within 15 business days of receiving a small employer’s completed application for coverage and individual enrollment forms; that the carrier may request certain additional information necessary to provide the premium rate quote; that such request tolls the running of the 15-day period until receipt of the requested additional information; and that a small employer carrier may provide an estimated cost of coverage so long as the carrier makes clear that the estimate is not a premium rate quote.

§26.4: A commenter suggests that the department should adopt definitions for “private purchasing cooperative” and “small employer health coalition.” The commenter also notes that the term “Health Group Cooperative” is not defined and suggested adding a definition stating it is a group formed under 28 TAC §26.401 and indicating the necessary elements for the definition.

Agency Response: Although the commenter notes that the rule does not specifically define these terms, Article 26.02(32-a) defines “small employer health coalition.” The statutes which create and govern private purchasing cooperatives and health group cooperatives, primarily Articles 26.14 and 26.14A, also provide meaning for these terms. The department has not seen evidence of confusion as to the meaning of these terms to the extent that adding definitions for them in the rule would be useful. The department therefore declines to define them but will continue to monitor the cooperative market and address these issues in the future as needed.

§§26.6(c)(1) and (2); 26.302: Commenters note the proposal requires a map of geographic service areas and requested that the adopted regulations not require an actual map of the state of Texas, when the service area for a carrier is the entire state. Another commenter requests that the department clarify the requirement that a carrier list zip codes would not apply when the service area is the entire state.

Agency Response: While the proposal alters the language of the section, the department notes that the existing rule already contains the requirement to provide a

map in certain circumstances, as well as an exemption from providing additional documentation if the service area comprises the entire state. "Other documentation" includes both the required map and the required list of ZIP codes, thus the rule – existing or as proposed -- does not require either when the geographic service area is the entire state. The department thus declines to revise the rule in response to this comment.

§§26.7(c) & 26.304(c): One commenter suggests that the examples of information requests that were included in the proposal should include all of the information a carrier may request under the health group cooperatives/coalitions requirements to avoid the appearance of a conflict. Another commenter believes the language of the proposal could be interpreted to mean that production of any single document on the example list will be sufficient to prove status as a small employer. The commenter emphasizes that an invoice alone is not sufficient to verify legitimate employer status, and believes that an incorrect interpretation of the rule could promote fraud by non-employers attempting to obtain employer coverage. The commenter recommends revising the section to state, "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 information requested by the small employer carrier in accordance with this section."

Agency Response: The adopted rule includes language changes that address the commenters' concerns about documents evidencing employer/employee status. With regard to the information a carrier may request to determine whether a cooperative exists, Article 26.14 sets out a specific list of documents that an entity must obtain to qualify as a cooperative. Accordingly, the department does not believe it is necessary to relist those documents in this provision.

§26.9(a)(14): A commenter believes that existing rules are not clear about how to administer partial credits for creditable coverage when the member is subject to a waiting period and requests that the department add another example that addresses waiting periods.

Agency Response: The example the commenter submitted would begin the preexisting condition exclusion period at the end of the waiting period. Federal law states that where a plan imposes a waiting period, the waiting period runs concurrently with any preexisting condition exclusion period. HIPAA interim rules, p. 16897. The department thus declines to include the submitted example.

To illustrate this principle, assume an individual with six months of creditable coverage enrolls in his new employer's plan on January 1, 2005; that the plan imposes a 90-day waiting period; and that the carrier imposes a 12-month preexisting condition exclusion.

The waiting period and preexisting condition exclusion period both begin to run concurrently on January 1, 2005, and the waiting period expires on April 2, 2005. The effective date of coverage is April 3, 2005. The preexisting condition exclusion period must by law expire no later than December 31, 2005, so reducing it by six months for the employee's credit will cause it to end on June 30, 2005.

In reviewing the rule in response to the comment, the department noted some inconsistency in the rule's treatment of these situations, as well as with the use of the term "effective date." Section 26.4(14) defines "effective date" to be the first day of coverage under a health benefit plan, or, if there is a waiting period, the first day of the waiting period. In response to the comment and to comply with federal law, the department has revised the rule in several places. First, the department revised §26.9 to add a new paragraph (3), which is substantively the same provision that governs large employer plans at §26.306(b). These provisions prohibit a preexisting condition provision in an employer health benefit plan generally from applying to expenses incurred on or after the expiration of the 12 months following the initial effective date of coverage. As the rule defines effective date, that 12 month period begins to run on the first day of any waiting period. The department has also deleted the term "initial" from §26.306(b) as it is redundant. There is only one effective date of coverage. If there is no waiting period, it is the actual effective date of coverage. If there is a waiting period, it is the first day of the waiting period.

While the department is not changing these provisions, it is important to clarify the effect of §§26.9(a)(13) and 26.306(g). These two provisions also use the term effective date, and they require a carrier to credit the time an individual was covered under creditable coverage if the previous coverage was in effect at any time during the 12 months preceding that effective date. The department has heard reports that some carriers are dating the 12 month look-back period from the first day after the waiting period expires. Where a plan includes a waiting period, this 12-month look-back period must date from the first day of the waiting period.

The other change the department has made to the rule involves the six-month period prior to the effective date of coverage which a carrier may examine to determine whether an individual has a preexisting condition. Consistent with the other applications discussed previously, this period begins on the effective date of coverage, and the department has revised §§26.9(a)(9) and 26.306(c) to eliminate duplicative language and express this standard consistent with the rule's definition of "effective date." The previous rule defined a six-month period before the earlier of the (A) effective date of coverage; or (B) the first day of the waiting period. Since the rule defines effective date to be the earlier of these two dates, this repetition is unnecessary and the department has revised the rule in these two places to reflect only the term "effective date."

§26.11(d): A commenter notes that Chapter 26 throughout references group size as being the total number of employees and dependents, queries whether a carrier must

count dependents when determining the employer's group size, and if so, seeks explanation as to how this requirement correlates with the statutory definitions of a small and large employer.

Agency Response: The changes to the rule reflect changes in terminology made by statute regarding particular calculations such as case characteristics. The usage of this new phrase in both rule and statute does not affect the determination of whether an employer is a small or large employer.

§26.13(d): Commenters suggest that the proposed requirement that carriers obtain a signature regarding the offer of a consumer choice plan is duplicative, as the consumer choice regulation already requires a carrier to obtain affirmation that it offered the employer a plan with mandates, and creates a new and unnecessary administrative burden on the carrier.

Agency Response: The department disagrees because this provision merely references the existing requirement in the consumer choice plan regulation. It does not add a new requirement, nor does it require a second signature. The department thus declines to make the change the commenter requests.

§26.13(k): A commenter observes that the proposal adds a requirement that the carrier determine if the employer's plan is an ERISA plan, which appears to require resubmission of all small employer application forms for this change. The commenter

requests removal of this language because it creates an administrative burden on the carriers.

Agency Response: The department believes that the addition of Insurance Code Article 26.06(a)(3) created the requirement for a carrier to determine if an employer's plan is an ERISA plan and thus declines to make the change the commenter requests.

§§26.13(n) & 26.307(g): A commenter expresses concern that proposed subsection (n) is overly broad and could be interpreted to prohibit termination of an agent for a valid reason. The commenter requests that the department insert "except for a violation of applicable law" after "any reason."

Another commenter notes that the current statute and regulation clearly specify the wrongful acts of terminating an agent or nonrenewing the agent's contract – which are very specific actions that leave no room for interpretation. The commenter requests that the department provide examples of what it believes constitute "any other negative action," phrased in a manner to include such examples without limiting the actions to the stated examples.

Another commenter believes this proposed language is overly broad and could be interpreted to prohibit termination of an agent for valid reasons including but not limited to violation of applicable insurance laws or misconduct by an agent. The commenter recommends that the department delete the phrase "any reason related to" from the regulation. The commenter believes the regulation so revised would still

prohibit a carrier from terminating an agent for requesting the carrier to issue a health benefit plan, while at the same time providing carriers the ability to terminate an agent for illegal and/or inappropriate conduct.

Agency Response: The department agrees with commenters regarding the scope of the proposal and has deleted the phrase “any reason related to” from the adopted rule. To give the rule greater effect, the department has also added the term “or renew” following “issue” in both provisions. With regard to what constitutes “any other negative action,” the listed examples fairly represent common types of negative action, but others may arise on a case-by-case basis. The department intends the rule to give effect to the spirit of Article 26.72, i.e., a negative action would include an action having an adverse effect on an agent that would tend to reduce access to small employer health benefit plans. While the department declines to provide additional examples of what constitutes “any other negative action,” the department will continue to monitor agent and carrier relationships and address this issue in the future as needed.

§§26.15 and 26.308: A commenter requests that the department revise these sections, which address renewability of coverage for small and large employer plans, to allow insurers to make changes to plan benefits as long as changes are made on a uniform and consistent basis. The commenter states that the department’s interpretation of the HIPAA guaranteed renewability provision is burdensome on the industry because it requires indefinite maintenance of multiple plan designs. The commenter contends

that carriers typically develop new products every several years in order to keep benefit plans affordable and to maintain competitiveness, and that allowing carriers to keep policy designs consistent among existing and new policyholders allows for easier administration and claims adjudication.

Agency Response: Insurance Code Article 26.23 precludes the change requested by the commenter. Moreover, authorizing carriers to unilaterally alter the terms of contracts would significantly dilute the meaning and importance of guaranteed renewability. The department also notes that Article 26.23 does not require a carrier to indefinitely maintain multiple plan designs, nor prevent it from keeping policy designs consistent among existing and new policyholders. The statute merely requires it to obtain policyholder approval to make such changes. Should a carrier be unable to obtain policyholder approval, Article 26.24 also provides the carrier the ability to keep policy designs consistent.

§26.20(b)(3): A commenter objects to the proposal that would require the filing of copies of the three most popular consumer choice plans with the annual small employer filing, based on the sheer number of pages for such copies. The commenter also objects to the requirement to identify the three most popular consumer choice plans and the number of employers and employees covered by each. The commenter believes that revealing that information would put a carrier, particularly one that has devoted considerable time, resources and expense to developing consumer choice plans, at a

competitive disadvantage, asserting that if a company's information is readily available through TDI, a competitor could save the expense and time of development and merely duplicate the first company's most popular plan. The commenter suggests that, in the alternative, the rule require the filing of one of a company's three most popular plans, with a copy of the form, but without the number of employers or employees covered under that plan.

Agency Response: The department has changed the rule to require a copy of the exact certificate of coverage for each of the three most frequently issued consumer choice plans. Carriers that wish the department to treat the filing as confidential should indicate that preference with the filing.

§26.303: A commenter suggests that since this provision applies to large employers, the subsection (k) reference to the small employer group rule §26.5(a) could lead to confusion. The commenter requests that the department clarify in the adoption order that the minimum size requirement in this subsection applies to large employer groups.

Agency Response: While the minimum size requirement in §26.5(a) applies specifically to small employer groups, §26.202 incorporates that requirement by reference and applies it to large employer groups as well. While the odds of a large employer falling below the minimum group size requirement are considerably less than the odds of a two-eligible employee group doing so, the possibility exists nonetheless. Since federal law requires renewal of a large employer's plan even if the group's size

drops below 51 eligible employees, it is important to clarify that there is a minimum threshold which large employers and small employers alike must meet to continue to qualify for coverage.

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

For – Office of Public Insurance Counsel.

For, with changes – American Medical Security; Long, Burner, Parks and DeLargy; Scott & White Health Plan; Texas Association of Health Plans; Texas Association of Life and Health Insurers; Unicare, Inc., Humana, Inc., and several individuals, some of whom are insurance agents.

6. STATUTORY AUTHORITY. The sections are adopted under Insurance Code Article 26.04, HIPAA, and Insurance Code §36.001. Chapter 26 of the Insurance Code implements provisions regarding small and large employers which were necessary to comply with the federal requirements contained in HIPAA. Article 26.04 requires the commissioner to adopt rules as necessary to implement the Insurance Code, Chapter 26, and to meet the minimum requirements of federal law and regulations which, for small and large employer health carriers, are contained in HIPAA. Federal agencies have adopted regulations implementing HIPAA as follows: Department of the Treasury, 26 CFR Part 54; Department of Labor, 29 CFR Part 2590; and Department of Health and Human Services, 45 CFR Parts 144 and 146. As identified in the Introduction,

portions of the Federal Regulations are included in these rules as necessary to meet the minimum requirements of federal law. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§26.4. Definitions. The following words and terms, when used in 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--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.

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

(4) Base premium rate--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.

(5) Case characteristics--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.

(6) Child--An unmarried natural child of the employee, including a newborn child; adopted child, including a child as to whom an insured is a party in a suit seeking the adoption of the child; natural child or adopted child of the employee's spouse.

(7) Class of business--All small employers or a separate grouping of small employers established under the Insurance Code, Chapter 26, Subchapters A-G.

(8) Commissioner--The commissioner of insurance.

(9) Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Article 3.80 or Article 20A.09N.

(10) 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.

(12) Dependent--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.

(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.

(15) Eligible employee--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 full-time 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.

(16) Employee--Any individual employed by an employer.

(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 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.

(18) Genetic information--Information derived from the results of a genetic test or from family history.

(19) Genetic test--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.

(20) HMO--Any person governed by the Texas Health Maintenance Organization Act, Insurance Code, Chapters 20A and 843, 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, and that holds a certificate of authority issued by the commissioner under Insurance Code Article 21.52F;

(C) a statewide rural health care system under Insurance Code, Chapter 845 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.

(21) Health benefit plan--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.

(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, an HMO, and a stipulated premium company under Insurance Code, Chapter 844.

(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.

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

(25) Index rate--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.

(26) Large employer--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.

(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 26, Subchapters A and H.

(28) Large employer health benefit plan--A health benefit plan offered to a large employer.

(29) Late enrollee--Any employee or dependent eligible for enrollment who 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 Article 26.21(h) or 26.83(f), who does not fall within the exceptions listed below, and who is accepted for enrollment and not excluded until the next open enrollment period. 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:

(A) the individual:

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

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

(iii) has lost coverage under another health benefit plan or self-funded employer health benefit plan as a result of 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) 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;

(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;

(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;

(D) a court has ordered coverage to be provided for a child 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 employer receives the court order or notification of the court order;

(E) the individual is a child of a covered employee and has lost coverage under Chapter 62, Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §§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. §1396s, Program for Distribution of Pediatric Vaccines);

(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;

(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

(H) the individual described in subparagraphs (E), (F) and (G) of this 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.

(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.

(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 subparagraphs (A) or (B) of this paragraph.

(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 shall not constitute a medical condition.

(33) New business premium rate--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.

(34) New entrant--An eligible employee, or the dependent of an eligible employee, who becomes part of or eligible for 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.

(35) 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.

(36) Person--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.

(38) Plan year--For purposes of the Insurance Code, Chapter 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. Small or large employer carriers must use the same definition of plan year in all small or large employer health benefit plans.

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

(40) Preexisting condition provision--A provision that denies, excludes, or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(41) Premium--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.

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

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

(44) Rating period--A calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

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

(46) Renewal date--For each small or large employer's health benefit plan, the earlier of the date (if any) specified in 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, 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. 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 employer or an eligible employee or dependent.

(47) Risk-assuming carrier--A small employer carrier that elects not to participate in the Texas Health Reinsurance System, as approved by the department.

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

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

(56) Small employer health benefit plan--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) Waiting period--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) Except as otherwise provided, Subchapter A of this chapter 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 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 26 United States Code §106 or §162;

(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 CFR §2510.3-1(j).

(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 who was not in existence throughout the calendar year preceding the year in which the determination of whether the employer is a small 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.

(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.

(h) The provisions of the Insurance Code, Chapter 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.

(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 26, Subchapters A - G, and this subchapter, and the small employer subsequently employs more than 50 eligible employees or less than two eligible employees, the provisions of Insurance Code, Chapter 26, and this subchapter shall continue to apply to that particular health plan subject to the provisions of §26.15 of this chapter (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to such an employer shall, within 60 days of becoming aware that the 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 that the protections provided under Insurance Code, Chapter 26, Subchapters A - G, and this subchapter shall cease to apply to the employer, if 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 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.

(j) If a small employer has employees in more than one state, the provisions of the Insurance Code, 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.

(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) No later than March 1 annually, each health carrier providing health benefit plans in this state shall make a filing with the commissioner 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 shall include the certification provided in the current Form Number 1212 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:

(1) the health carrier intends to offer, renew, issue, and issue for delivery health benefit plans to small employers and their employees and therefore will operate in accordance with the Insurance Code, Chapter 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 and their employees; however, the health carrier intends to renew 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); 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 shall notify the commissioner of its new election at least 30 days prior to the date the health carrier intends to begin operations under the new election. This notification shall be made on Form Number 1212 CERT SEHC STATUS.

(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/or their employees, whether on a group or franchise basis, shall be considered small employer carriers for purposes of such plans, and shall comply with all provisions of Insurance Code, Chapter 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.

(f) This subsection does not exempt a health carrier from any other applicable 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).

§26.7. Requirement to Insure Entire Groups.

(a) A small employer carrier that offers coverage to a small employer and its employees 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 shall provide the same health benefit plan to each such employee and dependent.

(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, Article 26.21 and Article 26.49 (with respect to an affiliation period or exclusions for pre-existing), the choice among benefit plans may not be limited, restricted, or conditioned based upon the risk characteristics of 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, as well as to confirm the applicant's status as a small employer. The small employer carrier 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. Following are examples of the types of supporting documentation which a small employer carrier may request, as reasonable and appropriate, from an employer as needed to fulfill the purposes of this subsection:

- (1) a W-2 Summary Wage and Tax Form or other federal or state tax records;
- (2) a loan agreement;
- (3) an invoice;
- (4) a business check;

(5) a sales tax license;

(6) articles of incorporation or other business entity filings with the Secretary of State;

(7) assumed name filings;

(8) professional licenses; and

(9) reports required by the Texas Workforce Commission.

(d) A small employer carrier 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 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) The two individuals will not be eligible for coverage as a dependent. Each must be covered as an 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.

(e) A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of 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 small employer health benefit plans offered and the small employer carriers may enter into an agreement

under which one small employer carrier will retain the waiver. Waivers shall be maintained by the small employer carrier for a period of six years. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and 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 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 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 shall notify a small employer carrier, 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 an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

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

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

(1) the initial enrollment period 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 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 shall be considered timely if he or she submits the application within the initial enrollment period. Submits, for purposes of this paragraph, means that the item(s) must be postmarked by the end of the specified time period. At the discretion of the small employer carrier, alternative methods of submission, such as facsimile transmission (fax), may be acceptable; and

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

(j) Any waiting period shall be established by the small employer and shall not exceed 90 days. A small employer carrier shall not apply a waiting period, elimination period, or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions or impose an affiliation period consistent with the Insurance Code, 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.

(k) New entrants in a health plan issued to a small employer group 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 pre-existing medical

conditions or impose an affiliation period, to the extent allowed under the Insurance Code, Article 26.21 and Article 26.49.

(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 26, Subchapter D, and this chapter. The risk load shall be the same risk load charged to the small employer group immediately 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 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 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.

(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.

(2) If two or more small employer carriers participate in a purchasing cooperative established under the Insurance Code, Article 26.14, 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 such contribution and in accordance with the Insurance Code, Articles 26.23, 26.24, and 26.25.

(d) Coverage under a small employer health benefit plan is available if at least 75% of the eligible employees of a small employer elect to be covered, as provided in Insurance Code Article 26.21. This 75% requirement shall not apply to a small employer that has only two eligible employees. A small employer that has only two eligible employees shall be subject to a 100% 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% 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% 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% 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 title (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 title apply and may not use this subsection to circumvent the guaranteed issue and other requirements of Insurance Code, Chapter 26, Subchapters A - G, or this subchapter.

(g) A health carrier 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.

(h) If a small employer fails to meet the qualifying 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 upon the first renewal date following the end of the six-month consecutive period during which the qualifying participation requirement was not met, provided that the termination shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the qualifying participation requirement and in accordance with the Insurance Code, Articles 26.23, 26.24, and 26.25 and §26.15 of this title (relating to Renewability of Coverage and Cancellation).

(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 shall be rounded down to the nearest whole number. For example: 75% of 5 employees is 3.75, so 3.75 would be rounded down to 3; therefore, 75% participation by a five employee group will be achieved if 3 of the eligible employees participate.

(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 §26.5(a) of this chapter (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 the six-month consecutive period during which the small employer did not meet the qualifying minimum group size requirement, provided that the termination 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 Articles 26.23, 26.24, and 26.25 and §26.15 of this chapter (relating to Renewability of Coverage and Cancellation).

§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) shall comply with the following requirements.

(1) A small employer carrier shall not exclude any eligible employee or dependent (including a late enrollee, who would otherwise be covered under a small employer's health benefit plan), except to the extent permitted under the Insurance Code, Article 26.21(k).

(2) A small employer carrier 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, 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 shall not terminate coverage of a newborn child if 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 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. 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 (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 shall not terminate coverage of an adopted child if 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 such premium.

(7) For purposes of paragraphs (4) and (6) of this subsection, received by the small employer 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 paragraphs (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 paragraphs (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 shall choose one of the methods set forth in subparagraphs (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 regards to all such health benefit plans.

(A) The employee or dependent may be excluded from coverage and any application for coverage rejected until the next annual open enrollment period and, 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, Article 26.49.

(B) 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.

(C) The provisions of subparagraphs (A) and (B) of this paragraph 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 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, 1997, after the enrollment period of July 1, 1997, through July 31, 1997 has ended. The next annual open enrollment period is July 1, 1998, through July 31, 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 1998 and the carrier may apply up to a 12-month preexisting condition period from the effective date of coverage, as with any other enrollee, the preexisting condition period would begin on September 1, 1998, and expires on September 1, 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, 1997, the preexisting condition period would begin on that date and would expire on April 1, 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 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 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 shall not treat genetic information as a preexisting condition described by Insurance Code, Article 26.49(b) in the absence of a diagnosis of the condition related to the information.

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

(13) A preexisting condition provision in a small employer health benefit plan 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,

1997, through October 31, 1997, followed by a gap in coverage of 61 days until December 31, 1997. Individual A is covered under an individual health plan beginning on January 1, 1998, for six months through June 30, 1998, followed by a gap in coverage of 62 days until August 31, 1998. Individual A's effective date of coverage under a small employer health benefit plan is September 1, 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 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 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, 1995, through November 30, 1996, followed by a four month gap in coverage from December 1, 1996, to March 31, 1997. On April 1, 1997, Individual B is covered under a group health plan for three months through June 30, 1997, followed by a two month gap in coverage until August 31, 1997. Individual B's coverage became effective on September 1, 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 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 that cannot exceed 90 days from the first day of employment during which a new employee is not eligible for coverage. Upon completion of the waiting period and enrollment within the time frame allowed by §26.7(i) of this chapter (relating to Requirement To Insure Entire Groups), coverage must be effective no later than the next premium due. Coverage may be effective at an earlier date as agreed upon by the small employer and the small employer carrier.

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

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

(18) An affiliation period provision in a small employer health benefit plan 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 shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier 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 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 pursuant to the provisions of the Insurance Code, Article 26.31, 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 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 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.

(c) A health carrier may not establish a separate class of business based on 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 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 shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the

premium rates charged by a small employer carrier is based on objective criteria established by the small employer carrier consistent with the criteria set out in the Insurance Code, Articles 26.02(5) and 26.36, the manual shall specify the criteria and factors considered by the health carrier in exercising such discretion.

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

(1) The filing 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% 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 26, Subchapter D.

(2) For the purpose of this section a change in rating method 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%. For the purpose of this paragraph, a change in a rating factor shall mean the cumulative change with respect to 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 shall consider the cumulative effect of all such changes in applying the 10% test under this paragraph.

(c) Each rate manual developed pursuant to subsection (a) of this section 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 carrier may not use case characteristics other than those specified in the Insurance Code, Article 26.36(c), without the prior approval of the commissioner. A small employer carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under subsection (b) of this section.

(2) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and 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, Article 26.33(c). Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(3) The rate manual developed pursuant to subsection (a) of this section 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 shall illustrate the difference.

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

(5) Each rate manual developed pursuant to subsection (a) of this section shall provide for premium rates to be developed in a two-step process. In the first step, the small employer carrier 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 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 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 such plan) provided the fee is no more than \$5.00 per month per covered employee and is applied in a uniform manner to each health benefit plan in a class of business.

(7) A small employer carrier 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 pursuant to subsection (a) of this section 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 shall retain each rate manual developed pursuant to subsection (a) of this section for a period of six years. 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 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

shall not exceed the lowest rate factor associated with such a classification by more than 20%.

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

(1) A small employer carrier 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 shall be deemed to be the change in the base premium rate for the purposes of the Insurance Code, 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 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, 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%, the health carrier 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 shall be made at least 60 days prior to the beginning of the rating period when the change would be applicable. The filing is for the purpose of allowing the commissioner to determine whether the methodology used is actuarially sound and appropriate to insure compliance with the Insurance Code, Chapter 26.

(5) A small employer carrier 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.

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

(1) Except as provided in subsection (e) of this section, a change in premium rate for a small employer 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% (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 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% (prorated for periods of less than one year).

(3) In the case of a health benefit plan described in the Insurance Code, Article 26.33(c), if the current premium rate for the health benefit plan exceeds the ranges set forth in the Insurance Code, Article 26.32(b), the formulae set forth in paragraphs (1) and (2) of this subsection will be applied as if the 15% adjustment provided in paragraphs (1)(B)(ii) and (2)(C)(ii) of this subsection were a 0% adjustment.

(4) Notwithstanding the provisions of paragraphs (1) and (2) of this subsection, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in the Insurance Code, Article 26.32(c).

(g) An HMO offering any state approved, federally qualified plan described in Insurance Code Article 26.48 and §26.14 of this chapter (relating to Coverage) shall

establish premium rates for those plans in accordance with formulae or schedules of charges filed with the department under the procedures set forth in Insurance Code Article 20A.09(b), and Chapter 11, Subchapter H of this title (relating to Schedule of Charges). An HMO 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, that has established a separate class of business as provided by the Insurance Code, Article 26.31, and that has established a separate line of business as provided under the Insurance Code, Article 26.48(a), and 42 United States Code §§300e et seq. 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 shall comply with §26.13(m) of this chapter (relating to Rules Related to Fair Marketing).

§26.13. Rules Related to Fair Marketing.

(a) A small employer carrier 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 of the commissioner or the commissioner's designee. In marketing consumer choice health benefit plans to small employers, a small employer carrier 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 health benefit plans to small employers in this state shall also be authorized to market the small employer health benefit plans.

(b) To each small employer who inquires about purchasing a small employer health benefit plan, a small employer carrier shall offer the employer a choice of health benefit plans 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 shall offer each required plan contemporaneously with the offer of any other small employer health benefit plan. The offer 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 Article 26.40 and §26.12 of this chapter (relating to Disclosure); and

(3) a written disclosure, as required by §21.3530 of this title (relating to Health Carrier Disclosure).

(c) Upon request, a small employer carrier 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 shall comply with this subsection when providing a premium rate quote to a small employer.

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

(f) A small employer carrier shall not apply more stringent or detailed requirements related to the application process, 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.

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

(h) A small employer carrier 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 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 to locate an authorized agent or to otherwise apply for coverage.

(i) The small employer carrier 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 such requirement, subject to the requirements of Insurance Code, Chapter 26, Subchapters A - G.

(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.

(k) Health carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of Insurance Code, Chapter 26, Subchapters A - G, and this subchapter. Health carriers shall elicit the following information from applicants for 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 insured 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 United States Code §106 or §162);

(3) whether the health benefit plan is an employee welfare benefit plan under 29 CFR § 2510.3-1(j); or

(4) whether the applicant is a small employer.

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

(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.

(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) All small employer health benefit plans shall provide for continuation and may provide an option for conversion which complies with Insurance Code Articles 3.51-6, Sec. 1(d)(3) and 20A.09(k) and rules adopted thereunder. A state approved health benefit plan that complies with the requirements of Title XIII, Public Health Service Act (42 U.S.C. §§300e, et seq. shall provide coverage for continuation which complies with the requirements of Insurance Code Article 20A.09(k) and must offer conversion in compliance with 42 C.F.R. §417.124(e) and applicable federal law.

(d) Each health benefit plan, certificate, policy, rider, or application used by health carriers to provide coverage to small employers and their employees shall comply with Insurance Code 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). 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.

(e) 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.

§26.15. Renewability of Coverage and Cancellation.

(a) Except as provided by Insurance Code Article 26.24, a small employer carrier 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. On or after September 1, 1995, an intentional misrepresentation of a material fact shall 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 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 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 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. On or after September 1, 1995, an intentional misrepresentation of a material fact shall 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, Article 26.23(a), 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, Article 26.23(b), and subsections (a) and (b) of this section.

(d) A carrier is not 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, 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 Articles 26.23 and 26.24, and this subchapter. All other health benefit plans issued to small employers shall be renewed at the option of the small employer, but may provide for termination in accordance with Insurance Code, Chapter 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 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, 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) 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.

(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 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 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. 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 shall file an application with the commissioner contemporaneously with its election to operate as a risk-assuming 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 shall file an application with the commissioner. The required filing shall

include a completed certification form, 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, and a small employer carrier seeking to maintain its status after that date:

(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 1212 RISK to reapply for the commissioner's approval of that election.

§26.19. Filing Requirements.

(a) Each small employer carrier 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 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 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 Application), 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 shall file a certification stating which previously approved forms the health carrier intends to use in that market provided such forms have been amended to comply with applicable laws. 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, 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 which are covered in subsection (d) of this section) shall be submitted 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, 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, 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 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 chapter (relating to Establishment of Classes of Business) and §26.11 of this 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.

(d) In addition to subsections (a) and (b) of this section, the following provisions apply to each health carrier that is an HMO. The HMO shall submit health benefit plan forms for use in the small employer market in accordance with the following.

(1) Any HMO group or individual agreement shall address and include all required provisions of the Insurance Code, Chapter 26. Such agreement shall be in compliance with any other applicable provisions of the Insurance Code. In addition, the

agreement 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 26.

(2) The filing shall include any alternate page(s) to the agreement or the schedule of benefits and any alternate schedule(s) of benefit.

(3) The filing 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 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 Continuation/Conversion of Coverage which shall be in accordance with Insurance Code, Article 20A.09(k) and this title, and Cancellation which shall be in accordance with §26.15 of this title (relating to Renewability of Coverage and Cancellation).

(5) The filing 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, shall be submitted with an explanation of the market in which the forms will be used. All rider forms shall comply with the Insurance Code, Article 20A.09, and applicable provisions 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).

§26.20. Reporting Requirements.

(a) Small employer health carriers offering a small employer health benefit plan shall file annually, not later than March 1 of each year, an actuarial certification Form Number 1212 CERT ACTUARIAL, 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 26, Subchapters A - G, and this chapter.

(b) Not later than March 1 of each calendar year, a small employer carrier shall complete and file with the commissioner Form Number 1212 CERT DATA. This annual filing shall include the following information related to 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);

(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 code of the small employers' principal place of business in the state of Texas;

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

(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;

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

(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;

(9) if applicable, information regarding any small employer health benefit plans assumed from another small employer carrier; and

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

§26.22. Private Purchasing Cooperatives.

(a) Two or more small or large employers may form a cooperative for the purchase of small or large employer health benefit plans. A cooperative must be organized as a nonprofit corporation and has the rights and duties provided by the Texas Non-profit Corporation Act, Texas Civil Statutes, Articles 1396-1.01, et seq.

(b) On receipt of a certificate of incorporation or certificate of authority from the secretary of state, the purchasing cooperative shall file notification of the receipt of the certificate and a copy of the cooperative's organizational documents with the

commissioner by filing the required notification and documents with the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(c) The board of directors shall file annually with the commissioner a statement of all amounts collected and expenses incurred for each of the preceding years. The annual filing shall be made, no later than March 1 of each year, on Form Number 1212 CERT COOP and shall be mailed to the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(d) 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:

(1) issued to a small employer shall be a small employer health benefit plan;

(2) issued to a large employer shall be a large employer health benefit plan; and

(3) issued to a school district electing to be treated as a small employer in accordance with Insurance Code, Article 26.036, shall be a small employer health benefit plan.

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

(a) Whenever the approval of the commissioner is required by this chapter for a small employer carrier other than an HMO, the initial approval shall be granted or denied by the deputy commissioner for the Life/Health Division. The initial decision is expressly delegated by this section to the deputy commissioner for the Life/Health Division. Whenever the approval of the commissioner is required by this chapter for HMO small employer plans, the initial approval shall be granted or denied by the deputy commissioner for the HMO Division. The applicant for the approval may appeal the initial decision to the commissioner.

(b) Whenever a filing of a policy, contract, or form is required by §26.19 of this title (relating to Filing Requirements) for a small employer carrier other than an HMO, any approval, withdrawal, or disapproval of the filing shall initially be made by the deputy commissioner for the Life/Health Division. Whenever a filing of a contract, evidence of coverage, or form is required by §26.19 of this title for HMO small employer plans, any approval, withdrawal, or disapproval of the filing shall initially be made by the deputy commissioner for the HMO Division. Notice of any adverse action shall be given to the applicant not later than the fifth day before the action is proposed to be taken. The applicant may appeal an adverse decision to the commissioner.

(c) Whenever a report is required to be filed by this chapter, that filing shall be made to the Deputy Commissioner, Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

§26.26. Administrative Violations and Penalties. If, after notice and opportunity for hearing, the commissioner determines that a health carrier or a small employer carrier has violated or is violating any provision of Insurance Code, Chapter 26, Subchapters A - G, or this subchapter, the commissioner may impose sanctions under Insurance Code §§82.001, et seq., and §§84.001, et seq., and/or issue a cease and desist order under Insurance Code §§83.001, et seq.

§26.27. Forms. The forms relating to Chapter 26, Insurance Code, for small and large employers referenced in this chapter can be obtained from the Texas Department of Insurance, Life/Health & HMO Intake Section, Life/Health Division, MC 106-1E, P. O. Box 149104, Austin, Texas 78714-9104, or at the department's website, www.tdi.state.tx.us.

Subchapter C. LARGE EMPLOYER HEALTH INSURANCE PORTABILITY AND
AVAILABILITY ACT REGULATION.

§26.301. Applicability and Scope.

(a) Except as otherwise provided, this subchapter 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 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 26 United States Code §106 or §162;
- (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 CFR 2510.3-1(i).

(b) For an employer who was not in existence 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 eligible 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 26, Subchapters A and H, and this subchapter, and the large employer subsequently employs less than 51 eligible employees, the provisions of the Insurance Code, Chapter 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 chapter (relating to Renewability of Coverage and Cancellation). A health carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has 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 26, Subchapters A - G concerning small employers, and Subchapter A of this chapter (relating to Small Employer Health Insurance Portability and Availability Regulations), including guaranteed issue, rating protections, and participation/contribution/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 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 participation, contribution, or group size requirements, of §26.303 of this chapter (relating to Coverage Requirements), the health carrier may terminate coverage under the plan, provided that the termination shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the qualifying participation, contribution, or minimum group size requirement and in accordance with Insurance Code Articles 26.86, 26.87, 26.88 and §26.303 of this 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 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 plans as provided under §26.5(i) of this title (relating to Applicability and Scope).

(g) 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) Not later than March 1 annually, each health carrier providing health benefit plans in this state shall make a filing with the commissioner 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 shall include the certification form, Form Number 1212 CERT LEHC STATUS, completed according to the carrier's status, and shall at least provide a statement 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 and their employees and therefore will operate in accordance with the Insurance Code, Chapter 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 and their employees; however, the health carrier

intends to renew 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);
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 shall notify the commissioner of its new election at least 30 days prior to the date the health carrier intends to begin operations under the new election. This notification shall be made on Form Number 1212 CERT LEHC STATUS.

(c) 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 adequately 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.

(e) This section does not exempt a large employer 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).

§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 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 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.

(c) A large employer carrier 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 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 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 factors. The waiver shall be signed by the employee (on behalf of such employee or the dependent, if applicable, of such employee) and 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 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 who meets the large employer's participation criteria and 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 eligible employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status related factors.

(e) An agent shall notify a large employer carrier, prior to submitting an application for coverage with the health carrier on behalf of a large employer or employee of a large employer, of any circumstances that would indicate that the large employer has induced or pressured an eligible employee who meets the large employer's participation criteria or a dependent of the employee to decline coverage due to the individual's 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).

(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.

(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 shall be rounded down to the nearest whole number. For example: if a large employer health carrier uses a minimum participation requirement of 75% of the eligible employees meeting the large employer's participation criteria, 75% of 55 employees is 41.25, so 41.25 would be rounded down to 41; therefore, 75% participation by a 55 employee group will be achieved if 41 of the eligible employees meeting the large employer's participation criteria participate.

(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 upon the first renewal date following the end of the six-month consecutive period during which the qualifying minimum participation requirement was not met, provided that the termination 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 Articles 26.86, 26.87, 26.88 and §26.308 of this chapter. A large employer health carrier 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.

(k) A large employer must continue to meet the qualifying minimum group size requirement of §26.5(a) of this chapter (relating to Applicability and Scope) to be entitled to elect to renew coverage pursuant to §26.301(e) of this 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 §26.5(a) of this chapter, the health carrier may terminate coverage under the plan upon the first renewal date following 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 shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the minimum group size requirement of §26.5(a) of this chapter, and in accordance with the Insurance Code Articles 26.86, 26.87, 26.88 and §26.308 of this chapter.

§26.304. Requirement to Insure Entire Groups.

(a) A large employer carrier that offers coverage to a large employer and its employees 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 shall offer to provide coverage to each eligible dependent. Except as provided in subsection (b) of

this section, the large employer carrier 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, 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 upon the 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, as well as to confirm the applicant's status as a large employer. The large employer carrier 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. Following are examples of the types of supporting documentation which a large employer carrier may request, as reasonable and appropriate, from an employer as needed to fulfill the purposes of this subsection.

- (1) a W-2 Summary Wage and Tax Form or other federal or state tax records;
- (2) a loan agreement;
- (3) an invoice;
- (4) a business check;
- (5) a sales tax license;
- (6) articles of incorporation or other business entity filings with the Secretary of State;
- (7) assumed name filings;
- (8) professional licenses; and
- (9) reports required by the Texas Workforce Commission.

(d) A large employer carrier shall not deny two individuals that are married the status of eligible employee solely on the basis that the two individuals are married. The large employer carrier 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) The two individuals will not be eligible for coverage as a dependent. Each must be covered as an employee.

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

(e) New entrants who meet the large employer's participation criteria in a health benefit plan issued to a large employer group shall be offered an opportunity to enroll in the health benefit plan currently held by 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 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 pursuant to subsection (b) of this section, the new entrant shall be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant 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 shall be accepted for coverage by the large employer carrier without any restrictions or limitations on coverage related to the health status related

factors of the employees or their dependents, if applicable, except that a health carrier may exclude coverage for pre-existing medical conditions or impose an affiliation period, to the extent allowed under Insurance Code, 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 (relating to Enrollment).

(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 an 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 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.

(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 shall comply with the following:

(1) the initial enrollment period for the employees meeting the large employer's participation criteria 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 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 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. For purposes of this paragraph, "submits" means that the item(s) must be postmarked by the end of the specified time period. At the discretion of the large employer carrier, alternative methods of submission such as facsimile transmission (fax), may be acceptable; and

(4) the large employer carrier 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 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 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, 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 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 shall not terminate coverage of a newborn child if 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 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 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 shall not terminate coverage of an adopted child if such carrier's billing cycle does not coincide with 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 such premium.

(j) For purposes of subsections (c), (d), (g), and (j) of this section, received by the large employer 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 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 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 shall not treat genetic information as a preexisting condition described by Insurance Code, Article 26.90(b) in the absence of a diagnosis of the condition related to the information.

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

(f) A preexisting condition provision in a large employer health benefit plan 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 period. For example, Individual A has coverage under an individual policy for 6 months beginning on May 1, 1997, through October 31, 1997,

followed by a gap in coverage of 61 days until December 31, 1997. Individual A is covered under an individual health plan beginning on January 1, 1998, for 6 months through June 30, 1998, followed by a gap in coverage of 62 days until August 31, 1998. The effective date of Individual A's coverage under a large employer health benefit plan is September 1, 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 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 period that applied before that coverage became effective also 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, 1995, through November 30, 1996, followed by a four month gap in coverage from December 1, 1996, to March 31, 1997. On April 1, 1997, Individual B is covered under a group health plan for three months through June 30, 1997, followed by a two month gap in coverage until August 31, 1997. The effective date of Individual B's coverage under a large employer health insurance policy is September 1, 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 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 shall choose one of the methods set forth in paragraphs (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 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, 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 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 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, 1997, after the enrollment period of July 1, 1997, through July 31, 1997 has ended. The next annual open enrollment period is July 1, 1998, through July 31, 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 1998 and the carrier may apply up to a 12-month preexisting condition period from the effective date of coverage, as with any other enrollee, the preexisting condition period would begin on September 1, 1998, and expires on September 1, 1999.

(B) 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, 1997, the preexisting condition period would begin on that date and would expire on April 1, 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 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 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) 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 factor. The affiliation period shall not exceed two months for an enrollee, other than a late enrollee, and shall not exceed 90 days for a late enrollee. An affiliation period under a plan shall run concurrently with any applicable waiting period under the plan. An HMO shall not impose any preexisting condition limitation, except for an affiliation period.

(j) A large employer may establish a waiting period applicable to all new entrants under the health benefit plan during which a new employee is not eligible for coverage. The large employer shall determine the duration of the waiting period. A large employer carrier shall not apply a waiting period, elimination period, or other similar limitation of coverage (other than an exclusion for preexisting medical conditions or impose an

affiliation period consistent with Insurance Code Articles 26.83 and 26.90), with respect to a new entrant, that is longer than the waiting period established by the large employer. Upon completion of the waiting period and enrollment within the time frame allowed by §26.305(a) of this 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 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, Articles 26.83 and 26.90.

(l) To determine if preexisting conditions as defined in Insurance Code Article 26.02(23) exist, a large employer carrier 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 such employee or dependent initially enrolls into the health benefit plan provided by the large employer carrier. The large employer carrier 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 such previous or existing coverage in the absence of a creditable coverage certification form.

§26.307. Fair Marketing.

(a) Upon request, each large employer purchasing health benefit plans shall be given a summary of all plans for which the employer 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 shall notify the large employer in accordance with Insurance Code, 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 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 such requirement, subject to the requirements of the Insurance Code, Chapter 26, Subchapters A and H.

(e) Health carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Insurance Code, Chapter 26, Subchapters A and H, and this subchapter. Health carriers shall elicit the following information from applicants for 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 §162 or §106 of the United States Internal Revenue Code of 1986 (26 United States Code §106 or §162);

(3) whether the health plan is an employee welfare benefit plan under 29 CFR §2510.3-1(i); 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 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.

§26.308. Renewability of Coverage and Cancellation.

(a) Except as provided by Insurance Code Article 26.87, a large employer carrier 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 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 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(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 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, such as those for withdrawal from the market under §§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).

(d) A large employer carrier that elects not to renew all large employer health benefit plans under the Insurance Code, Article 26.87, 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.

(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 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 factors of employees or dependents or new employees or dependents who may become eligible for the coverage.

§26.311. Administrative Violations and Penalties. If, after notice and opportunity for hearing, the commissioner determines that a health carrier or a large employer carrier has violated or is violating any provision of the Insurance Code, Chapter 26, Subchapters A and H, or this subchapter, the commissioner may impose sanctions under Insurance Code §§82.001, *et seq.*, and §§84.001, *et seq.*, and/or issue a cease and desist order under Insurance Code §§83.001, *et seq.*

§26.312. 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) Non-participating 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).

(b) A large employer carrier that offers POS coverage shall comply, as applicable, with the requirements set forth in either Chapter 11, Subchapter Z of this title or Chapter 21, Subchapter U of this title.

(c) If an HMO issues coverage to a large employer and eligible employees have access only to in-plan 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.

(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 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 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 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.

(e) An eligible employee that selects a POS option is responsible for paying all costs, including premiums, coinsurance, copayments, deductibles and any other cost sharing provisions imposed by the POS option, including any administrative cost imposed by a large employer as permitted by Article 26.09(e) of the Code.

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

TITLE 28. INSURANCE
Part I. Texas Department of Insurance
Chapter 26. Small Employer Health Insurance Regulations

Adopted Sections
Page 141 of 141 Pages

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2005.

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

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§26.4 – 26.11, 26.13, 26.15 - 26.16, 26.18 - 26.20, 26.22, 26.24, 26.26, 26.301 – 26.309, 26.311, 26.312, and new §§26.14 and 26.27 concerning small and large employer health insurance regulations, are adopted.

AND IT IS SO ORDERED.

JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

ATTEST:

Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO. _____