

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE G. HEALTH COVERAGE AVAILABILITY

CHAPTER 1501. HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1501.001. SHORT TITLE. This chapter may be cited as the Health Insurance Portability and Availability Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.002. DEFINITIONS. In this chapter:

(1) "Agent" means a person who may act as an agent for the sale of a health benefit plan under a license issued under Title 13.

(2) "Dependent" means:

(A) a spouse;

(B) a child younger than 25 years of age, including a newborn child;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

(i) Section [1251.154](#); or

(ii) Section [1201.062](#); and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section [1503.003](#).

(3) "Eligible employee" means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small or large employer. The term does not include an employee who:

(A) works on a part-time, temporary, seasonal, or substitute basis;

(B) is covered under:

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

(C) elects not to be covered under the employer's health benefit plan and is covered under:

(i) the Medicaid program;
(ii) another federal program, including the CHAMPUS program or Medicare program; or

(iii) a benefit plan established in another country.

(4) "Employee" means an individual employed by an employer.

(5) "Health benefit plan" means 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:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(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 benefit plans 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) workers' compensation insurance coverage or similar insurance coverage;

(K) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains 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 U.S.C. Section 157;

(L) hospital indemnity or other fixed indemnity insurance coverage;

(M) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(N) short-term major medical contracts;

(O) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;

(P) coverage for on-site medical clinics;

(Q) coverage that provides other limited benefits specified by federal regulations; or

(R) other coverage that:

(i) is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) is specified by federal regulations.

(6) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(7) "Health status related factor" means:

- (A) health status;
- (B) medical condition, including both physical and mental illness;
- (C) claims experience;
- (D) receipt of health care;
- (E) medical history;
- (F) genetic information;
- (G) evidence of insurability, including conditions arising out of acts of family violence; and
- (H) disability.

(8) "Large employer" means a person who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, to Chapter 1578, or to Chapter 177, Local Government Code, that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(9) "Large employer health benefit plan" means a health benefit plan offered to a large employer.

(10) "Large employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C and M.

(11) "Person" means an individual, corporation, partnership, or other legal entity.

(12) "Preexisting condition provision" means a provision that excludes or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(13) "Premium" means all amounts paid by a small or large employer and employees as a condition of receiving coverage from a small or large employer health benefit plan issuer, including any fees or other contributions associated with a health benefit plan.

(14) "Small employer" means a person who employed an average of at least two employees but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, to Chapter 1578, or to Chapter 177, Local Government Code, that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(15) "Small employer health benefit plan" means a health benefit plan developed by the commissioner under Subchapter F or any other health benefit plan offered to a small employer in accordance with Section 1501.252(c) or 1501.255.

(16) "Small employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C-H.

(16-a) "Small employer health coalition" means a private purchasing cooperative composed solely of small employers that is formed under Subchapter B.

(17) "Waiting period" means a period established by an employer that must elapse before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.046(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.013, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 1, eff. September 1, 2013.

Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a small employer health benefit plan subject to Subchapters C-H if it provides health care benefits covering two or more employees of a

small employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. [1332](#)), Sec. 2, eff. September 1, 2013.

Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a large employer health benefit plan subject to Subchapters C and M if the plan provides health care benefits to employees of a large employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. [1332](#)), Sec. 3, eff. September 1, 2013.

Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY UNDERWRITTEN POLICIES. Except as provided by Section [1501.003](#) or [1501.004](#), this chapter does not apply to an individual health insurance policy that is subject to individual underwriting, even if the premium is paid through a payroll deduction method.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.006. CERTIFICATION. (a) In accordance with rules adopted by the commissioner, each health benefit plan issuer shall certify that the issuer is offering, delivering, issuing for delivery, or renewing, or that the issuer intends to offer, deliver, issue for delivery, or renew:

(1) a health benefit plan to or through a small employer in this state that is subject to this chapter; or

(2) a health benefit plan to or through a large employer in this state that is subject to this chapter.

(b) A health benefit plan issuer must submit a revised certification to the commissioner only if the issuer changes its status as a small or large employer health benefit plan issuer or changes its intent to become a small or large employer health benefit plan issuer to the extent that its previous certification ceases to be accurate.

(c) The certification must include a statement that the health benefit plan issuer is complying with this chapter to the extent it applies to the issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.007. AFFILIATES. (a) In this section, "affiliate" has the meaning described by Section [823.003](#).

(b) For purposes of this chapter, health benefit plan issuers that are affiliates or that are eligible to file a consolidated tax return are considered to be one issuer, and a restriction imposed by this chapter applies as if the health benefit plans delivered or issued for delivery to small employers in this state by the affiliates were issued by one issuer.

(c) Notwithstanding Subsection (b), a health maintenance organization that is an affiliate is considered to be a separate health benefit plan issuer for purposes of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.008. LATE ENROLLEES. (a) For purposes of this chapter, an employee or dependent eligible for enrollment in a

small or large employer's health benefit plan is a late enrollee if the individual requests enrollment after the expiration of:

(1) the initial enrollment period established under the terms of the first plan for which the individual was eligible through the small or large employer; or

(2) an open enrollment period under Section [1501.156\(a\)](#) or [1501.606\(a\)](#).

(b) An employee or dependent eligible for enrollment is not a late enrollee if the individual:

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

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

(3) has lost coverage under the other health benefit plan or self-funded employer health benefit plan as a result of:

(A) the termination of employment;

(B) a reduction in the number of hours of employment;

(C) the termination of the other plan's coverage;

(D) the termination of contributions toward the premium made by the employer; or

(E) the death of a spouse or divorce; and

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

(c) An employee or dependent eligible for enrollment is also not a late enrollee if the individual is:

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

(2) a spouse for whom a court has ordered coverage under a covered employee's plan and the request for enrollment of the spouse is made not later than the 31st day after the date the court order is issued;

(3) a child for whom a court has ordered coverage under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date the employer receives the court order; or

(4) a child of a covered employee who has lost coverage under Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s), or under Chapter 62, Health and Safety Code, and the request for enrollment is made not later than the 31st day after the date on which the child loses coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.009. SCHOOL DISTRICT ELECTION. (a) An independent school district may elect to participate as a small employer without regard to the number of employees in the district. An independent school district that makes the election is treated as a small employer under this chapter for all purposes.

(b) An independent school district that is participating in the uniform group coverage program established under Chapter 1579 may not participate in the small employer market under this section for health insurance coverage and may not renew a health insurance contract obtained in accordance with this section after the date on which the program of coverages provided under Chapter 1579 is implemented. This subsection does not affect a contract for the provision of optional coverages not included in a health benefit plan under this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.014, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 4, eff. September 1, 2013.

Sec. 1501.0095. SCHOOL DISTRICT EMPLOYEE ELECTION. (a) Notwithstanding any other provision of this chapter, a school district employee who is eligible for coverage under a large or

small employer health benefit plan providing coverage to the school district's employees and who is the spouse of another school district employee covered under the plan may elect whether to be treated under the plan as:

- (1) an employee; or
- (2) the dependent of the other employee.

(b) The commissioner shall adopt rules under Section 1501.010 governing the manner in which an election under this section must be made.

Added by Acts 2005, 79th Leg., Ch. 998 (H.B. 407), Sec. 1, eff. June 18, 2005.

Sec. 1501.010. GENERAL RULES. The commissioner shall adopt rules necessary to:

- (1) implement this chapter; and
- (2) meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR CERTAIN EMPLOYERS. (a) For an employer that did not exist 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.

(b) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made, the determination is based on the average number of employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 199 (S.B. 1332), Sec. 5, eff. September 1, 2013.

SUBCHAPTER B. COALITIONS AND COOPERATIVES

Sec. 1501.051. DEFINITIONS. In this subchapter:

(1) "Board of directors" means the board of directors elected by a private purchasing cooperative or a health group cooperative.

(2) "Board of trustees" means the board of trustees of the Texas cooperative.

(3) "Cooperative" means a private purchasing cooperative or a health group cooperative established under this subchapter.

(3-a) "Eligible single-employee business" means a business entity that:

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

(B) employed an average of fewer than two employees on business days during the preceding calendar year; and

(C) is eligible to participate in a cooperative under this subchapter in accordance with Section [1501.066](#).

(3-b) "Expanded service area" means any area larger than one county in which a health group cooperative offers coverage.

(4) "Texas cooperative" means the Texas Health Benefits Purchasing Cooperative established under Section [1501.052](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.048(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. [859](#)), Sec. 1, eff. June 17, 2011.

Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE; BOARD OF TRUSTEES. (a) The Texas Health Benefits Purchasing Cooperative is a nonprofit corporation established to make health care coverage available to small and large employers and their eligible employees and the eligible employees' dependents.

(b) The Texas cooperative is administered by a board of trustees of five members appointed by the governor with the advice and consent of the senate. Two members must represent employers, two members must represent employees, and one member must represent the public.

(c) Members of the board of trustees serve staggered six-year terms, with the terms of one or two members expiring February 1 of each odd-numbered year.

(d) A member of the board of trustees may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.049(a), eff. September 1, 2005.

Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE: EXECUTIVE DIRECTOR AND OTHER EMPLOYEES. (a) The board of trustees shall employ an executive director. The executive director may hire other employees of the Texas cooperative as necessary.

(b) Salaries for employees of the Texas cooperative and related costs may be paid from administrative fees collected from employers and participating health benefit plan issuers or other sources of funding arranged by the Texas cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The board of trustees may:

(1) develop regional subdivisions of the Texas cooperative; and

(2) authorize each subdivision to separately exercise the powers and duties of a cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION LAW TO

TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The Texas cooperative is subject to the public information law, Chapter 552, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES AND HEALTH GROUP COOPERATIVES. (a) Two or more small or large employers may form a private purchasing cooperative to purchase small or large employer health benefit plans. Subject to Subsection (d), a person may form a health group cooperative to purchase 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 (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

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

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 42, Sec. 3.01(5), eff. September 1, 2015.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.050(a), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.050(b), eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 3.01(5), eff. September 1, 2015.

Sec. 1501.057. IMMUNITY. (a) The Texas cooperative or a

member of the board of trustees, the executive director, or an employee or agent of the Texas cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the cooperative; or

(2) an independent action of a small employer health benefit plan issuer or a person who provides health care services under a health benefit plan.

(b) A private purchasing cooperative, a health group cooperative, or a member of the board of directors, the executive director, or an employee or agent of the private purchasing or health group cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the private purchasing or health group cooperative; or

(2) an independent action of a small or large employer health benefit plan issuer or a person who provides health care services under a health benefit plan.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.050(c), eff. September 1, 2005.

Sec. 1501.0575. VOLUNTARY PARTICIPATION BY ISSUER IN COOPERATIVE. A health benefit plan issuer may elect not to participate in a health group cooperative. The health benefit plan issuer may elect to participate in one or more health group cooperatives and may select the cooperatives in which the issuer will participate.

Added by Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 1, eff. September 1, 2005.

Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES. (a) A cooperative shall:

(1) arrange for small or large employer health benefit plan coverage for small employer groups, large employer groups, and, subject to Section 1501.0581, eligible single-employee businesses that participate in the cooperative by contracting with small or large employer health benefit plan issuers that meet the requirements established by Section 1501.061;

(2) collect premiums to cover the cost of:

(A) small or large employer health benefit plan coverage purchased through the cooperative; and

(B) the cooperative's administrative expenses;

(3) establish administrative and accounting procedures for the operation of the cooperative;

(4) establish procedures under which an applicant for or participant in coverage issued through the cooperative may have a grievance reviewed by an impartial person;

(5) contract with small or large employer health benefit plan issuers to provide services to small or large employers covered through the cooperative; and

(6) develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, coverage through the cooperative.

(b) A cooperative may:

(1) contract with agents to market coverage issued through the cooperative;

(2) contract with a small or large employer health benefit plan issuer or third-party administrator to provide administrative services to the cooperative;

(3) negotiate the premiums paid by its members; and

(4) offer other ancillary products and services to its members that are customarily offered in conjunction with health benefit plans.

(c) A cooperative shall comply with:

(1) federal laws applicable to cooperatives and health benefit plans issued through cooperatives, to the extent required by state law or rules adopted by the commissioner; and

(2) state laws applicable to cooperatives and health

benefit plans issued through cooperatives.

(d) To be eligible to exercise the authority granted under Subsection (a)(1), a health group cooperative must have at least 10 participating employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.053(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 2, eff. June 17, 2011.

Sec. 1501.0581. SPECIAL PROVISIONS RELATING TO HEALTH GROUP COOPERATIVES. (a) The membership of a health group cooperative may consist of only small employers; only large employers; both small and large employers; small employers and eligible single-employee businesses; large employers and eligible single-employee businesses; or small employers, large employers, and eligible single-employee businesses. To participate as a member of a health group cooperative, an employer must be a small or large employer as described by this chapter or an eligible single-employee business.

(a-1) Notwithstanding Subsections (b) and (c), membership in a health group cooperative may be restricted to small and large employers within a single industry grouping as defined by the most recent edition of the United States Census Bureau's North American Industry Classification System.

(b) Subject to the requirements imposed on small employer health benefit plan issuers under Section 1501.101 and subject to Subsections (a-1) and (o), a health group cooperative:

(1) shall allow a small employer to join a health group cooperative, other than a health group cooperative consisting of only large employers, and enroll in health benefit plan coverage;

(2) subject to Subsection (t), may allow eligible single-employee businesses to join a health group cooperative and enroll in health benefit plan coverage; and

(3) may allow a large employer to join the health group cooperative and enroll in health benefit plan coverage.

(c) Subject to Subsections (a-1) and (o), a health group cooperative consisting of only small employers or both small and large employers shall allow any small employer to join the health group cooperative and enroll in the cooperative's health benefit plan coverage during the initial enrollment and annual open enrollment periods.

(d) A sponsoring entity of a health group cooperative may inform the members of the entity about the cooperative and the health benefit plans offered by the cooperative. Coverage issued through the cooperative must be issued through a licensed agent marketing the coverage in accordance with Section [1501.058\(b\)\(1\)](#).

(e) The commissioner shall adopt rules that govern the manner in which an employer may terminate, because of a financial hardship affecting the employer, participation in a health group cooperative.

(f) An employer's participation in a health group cooperative is voluntary, but an employer electing to participate in a health group cooperative must commit to purchasing coverage through the health group cooperative for two years, except as provided by Subsection (e).

(g) A health benefit plan issuer issuing coverage to a health group cooperative:

(1) shall use a standard presentation form, prescribed by the commissioner by rule, to market health benefit plan coverage through the health group cooperative;

(2) may contract to provide health benefit plan coverage with only one health group cooperative in any county, except that a health benefit plan issuer may contract with additional health group cooperatives if it is providing health benefit plan coverage in an expanded service area in accordance with Subsection (1);

(3) shall allow enrollment in health benefit plan coverage in compliance with Subsection (c) and with the health benefit plan issuer's agreement with the health group cooperative;

(4) is exempt from the premium tax or tax on revenues imposed by Chapter [222](#), and the retaliatory tax under Chapter [281](#) for two years, with respect to the premiums or revenues received for

coverage provided to each uninsured employee or dependent as defined by the commissioner in accordance with Subsection (h); and

(5) shall maintain documentation to be provided by health group cooperatives to ensure compliance with the rules adopted by the commissioner under Subsection (h) with respect to uninsured employees or dependents.

(h) The commissioner by rule shall determine who constitutes an uninsured employee or dependent for purposes of Subsection (g)(4).

(i) Notwithstanding any other law, and except as provided by Subsection (n), a health benefit plan issued by a health benefit plan issuer to provide coverage with a health group cooperative is not subject to a state law, including a rule, that:

(1) relates to a particular illness, disease, or treatment; or

(2) regulates the differences in rates applicable to services provided within a health benefit plan network or outside the network.

(j) The commissioner by rule shall implement the exemption authorized by Subsection (i).

(k) A health group cooperative may offer more than one health benefit plan, but each plan offered must be made available to all employers participating in the cooperative.

(l) A health benefit plan issuer may, with notice to the commissioner, provide health benefit plan coverage to an expanded service area that includes the entire state. A health benefit plan issuer may apply for approval of an expanded service area that comprises less than the entire state by filing with the commissioner an application, in a form and manner prescribed by the commissioner, at least 60 days before the date the health benefit plan issuer issues coverage to the health group cooperative in the expanded service area. At the expiration of 60 days after the date of receipt by the department of a filed application, the application is considered approved by the department unless, before that date, the application was either affirmatively approved or disapproved by written order of the commissioner. The commissioner, after notice and opportunity for hearing, may rescind

an approval granted to a health benefit plan issuer under this subsection if the commissioner finds that the health benefit plan issuer has failed to market fairly to all eligible employers in the state or the expanded service area.

(m) The provisions of this section do not limit or restrict a small or large employer's access to health benefit plans under this chapter.

(n) A health benefit plan provided through a health group cooperative must provide coverage for diabetes equipment, supplies, and services as required by Subchapter B, Chapter 1358.

(o) A health group cooperative consisting only of small employers is not required to allow a small employer to join the health group cooperative under Subsection (c) if:

(1) the cooperative has elected to restrict membership in the cooperative in accordance with this subsection and Subsection (p); and

(2) after the small employer has joined the cooperative, the total number of eligible employees employed on business days during the preceding calendar year by all small employers participating in the cooperative would exceed 50.

(p) A health group cooperative must make the election described by Subsection (o) at the time the cooperative is initially formed. A health group cooperative making this election may not include an eligible single-employee business. Evidence of the election must be filed in writing with the commissioner in the form and at the time prescribed by the commissioner by rule.

(q) Except as provided by Subsection (r), a health group cooperative may file an election with the commissioner, on a form and in the manner prescribed by the commissioner, to permit eligible single-employee businesses to join the cooperative and to enroll in health benefit plan coverage. The election must be filed not later than the 90th day before the date coverage for eligible single-employee businesses is to become effective.

(r) A health group cooperative may file an election under Subsection (q) only if a small or large employer health benefit plan issuer has agreed in writing to offer to issue coverage to the cooperative based on its membership after the election to permit

eligible single-employee businesses to participate in the cooperative has become effective.

(s) On the date an election under Subsection (q) becomes effective and until the election is rescinded, the provisions of this subchapter relating to guaranteed issuance of plans, to rating requirements, and to mandated benefits that are applicable to small employers apply to eligible single-employee businesses that are members of the health group cooperative.

(t) A health group cooperative that files an election with the commissioner to permit an eligible single-employee business to join the health group cooperative and enroll in health benefit plan coverage must permit participation and enrollment in the cooperative's health benefit plan coverage during the initial enrollment and annual open enrollment periods by each eligible single-employee business that elects to participate and agrees to satisfy requirements associated with participation in and coverage through the cooperative. For purposes of this subsection, the provisions of Subsection (a-1) applicable to small employers apply to eligible single-employee businesses.

(u) A health group cooperative may rescind its election to permit eligible single-employee businesses to join the cooperative and enroll in health benefit plan coverage only if:

(1) the election has been effective for at least two years, except as provided by Subsection (v);

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

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

(v) The commissioner shall adopt rules under which a health group cooperative may for good cause rescind an election described by Subsection (u) before the second anniversary of the effective date of the election.

(w) Notwithstanding Subsection (u), a health group cooperative that files notice of rescission may choose to permit

existing eligible single-employee businesses to remain active, covered members of the cooperative, but only if all such members of the cooperative are provided the same opportunity.

(x) A health group cooperative that has rescinded an election under Subsection (u) may not file a subsequent election to permit eligible single-employee businesses to join the cooperative and enroll in health benefit plan coverage before the fifth anniversary of the effective date of the rescission.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.051(a), eff. September 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 2, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 547 (S.B. 1255), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 3, eff. June 17, 2011.

Sec. 1501.0582. HEALTH GROUP COOPERATIVE: EXPEDITED APPROVAL PROCESS. The department shall develop an expedited approval process for health benefit plan coverage arranged by a health group cooperative.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.052(a), eff. September 1, 2005.

Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN PROHIBITED. A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.060. SCOPE OF GROUP COVERAGE. Subchapter B, Chapter 1251, does not limit the type of group that may be covered by a group health benefit plan issued through a cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT PLAN ISSUERS WITH WHICH COOPERATIVE MAY CONTRACT. A cooperative

may contract only with a small or large employer health benefit plan issuer that demonstrates that the issuer:

- (1) is in good standing with the department;
- (2) has the capacity to administer health benefit plans;
- (3) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;
- (4) is able to conduct utilization management and establish applicable procedures and policies;
- (5) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;
- (6) has a satisfactory grievance procedure and is able to respond to enrollees' calls, questions, and complaints; and
- (7) has financial capacity, either through satisfying financial solvency standards, as applied by the commissioner, or through appropriate reinsurance or other risk-sharing mechanisms.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.053(b), eff. September 1, 2005.

Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND ADMINISTRATORS. (a) A cooperative is not an insurer and the employees of the cooperative are not required to be licensed under Title 13. This exemption from licensure includes a health group cooperative that acts to provide information about and to solicit membership in the cooperative, subject to Section [1501.0581\(d\)](#).

(b) An agent or third-party administrator used and compensated by a cooperative must be licensed as required by Title 13.

(c) An agent used and compensated by a cooperative may market the products and services sponsored by the cooperative without being appointed by each small or large employer health benefit plan issuer participating in the cooperative. The agent may not market any other product or service of a participating small or large employer health benefit plan issuer that is not sponsored

by the cooperative unless the agent has been appointed by that issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.052(b), eff. September 1, 2005.

Sec. 1501.063. STATUS AS EMPLOYER. (a) A small employer health coalition that otherwise meets the description of a small employer is considered a single small employer for all purposes under this chapter.

(b) A health group cooperative that is composed of only small employers, only large employers, or both small and large employers is considered a single employer under this code.

(b-1) A health group cooperative that is composed only of small employers and that has made the election described by Section 1501.0581(o)(1) in accordance with Subsection (p) of that section shall be treated in the same manner as a small employer for the purposes of this chapter, including for the purposes of any provision relating to premium rates and issuance and renewal of coverage.

(b-2) A health group cooperative that is composed only of small employers and that has not made the election described by Section 1501.0581(o)(1) in accordance with Subsection (p) of that section, or a health group cooperative that is composed of both small and large employers, may be treated in the same manner as a large employer for the purposes of this chapter, including for the purposes of any provision relating to premium rates and issuance and renewal of coverage.

(b-3) Except as provided by Section 1501.0581(k), a health group cooperative shall have sole authority to make benefit elections and perform other administrative functions under this code for the cooperative's participating employers.

(c) Any other cooperative formed under this subchapter is considered an employer solely for the purposes of benefit elections under this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.052(c), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 3, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 547 (S.B. 1255), Sec. 2, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 4, eff. June 17, 2011.

Sec. 1501.064. CERTAIN USE OF APPROPRIATED MONEY PROHIBITED. The Texas cooperative may not use money appropriated by the state to pay or otherwise subsidize any portion of the premium for a small employer covered through the cooperative.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.065. CERTAIN ACTIONS BASED ON RISK CHARACTERISTICS OR HEALTH STATUS PROHIBITED. A cooperative may not limit, restrict, or condition an employer's or employee's membership in a cooperative or an employee's choice among benefit plans based on:

(1) risk characteristics of a group or of any member of a group; or

(2) health status related factors, duration of coverage, or any similar characteristic related to the health status or experience of a group or of any member of a group.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.053(c), eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 5, eff. June 17, 2011.

Sec. 1501.066. ELECTION TO TREAT PARTICIPATING EMPLOYERS SEPARATELY FOR RATING PURPOSES. (a) Notwithstanding Section 1501.063, a health group cooperative may file with the commissioner, on a form and in the manner prescribed by the commissioner, an election to treat each participating employer

within the cooperative as a separate employer for purposes of rating small and large employer health benefit plans, subject to the rating requirements of this code applicable to such plans. An existing health group cooperative must file the election with the department not later than the 90th day before the date on which the election is to become effective.

(b) A health group cooperative must provide to all participating and prospective employers, in a manner prescribed by the commissioner, a written notice of the cooperative's election to treat participating employers within the cooperative as separate employers for purposes of rating small and large employer health benefit plans. Employers participating in the cooperative when such an election is made must be provided notice of the election not later than the 90th day before the date the election is to become effective. For a participating employer, the notice must contain the quote for the premium rate applicable to the employer as of the date the plan is renewed. Prospective employers must be provided notice of the election when the prospective employer applies to become a participating employer in the health group cooperative.

(c) An election under this section is effective on the earliest date after the election is made on which the plan to which the election applies is initially issued or renewed. The election remains in effect for not less than 12 months after the effective date.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 6, eff. June 17, 2011.

Sec. 1501.067. ELIGIBLE SINGLE-EMPLOYEE BUSINESS. The commissioner shall adopt rules governing the eligibility of a single-employee business to participate in a health group cooperative under this subchapter. The rules must include provisions to ensure that each eligible single-employee business has a business purpose and was not formed solely to obtain health benefit plan coverage under this subchapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1067 (S.B. 859), Sec. 6, eff. June 17, 2011.

SUBCHAPTER C. PROVISION OF COVERAGE

Sec. 1501.101. GEOGRAPHIC SERVICE AREAS. (a) Repealed by Acts 2015, 84th Leg., R.S., Ch. 42 , Sec. 3.01(6), eff. September 1, 2015.

(b) A small employer health benefit plan issuer that refuses to issue a small employer health benefit plan in a geographic service area may not offer a health benefit plan to a small employer in the applicable service area before the fifth anniversary of the date of the refusal.

(c) A small or large employer health benefit plan issuer is not required to offer or issue a small or large employer health benefit plan to:

(1) a small or large employer that is not located within a geographic service area of the issuer;

(2) an employee of a small or large employer who neither resides nor works in the geographic service area of the issuer; or

(3) a small or large employer located within a geographic service area of the issuer with respect to which area the issuer demonstrates to the commissioner's satisfaction that the issuer:

(A) reasonably anticipates that it will not have the capacity to deliver services adequately because of obligations to existing covered individuals; and

(B) is acting uniformly without regard to the claims experience of the employer or any health status related factor of employees, employees' dependents, or new employees or dependents who may become eligible for the coverage.

(d) A small or large employer health benefit plan issuer that is unable to offer coverage in a geographic service area in accordance with a determination made by the commissioner under Subsection (c)(3) may not offer a small or large employer benefit plan, as applicable, in that service area before the 180th day after the later of:

(1) the date the issuer refuses to offer coverage; or

(2) the date the issuer demonstrates to the

satisfaction of the commissioner that it has regained the capacity to deliver services to small or large employers in the geographic service area.

(e) If the commissioner determines that requiring the acceptance of small or large employers under this chapter would place a small or large employer health benefit plan issuer in a financially impaired condition and that the issuer is acting uniformly without regard to the claims experience of the small or large employer or any health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for the coverage, the issuer may not offer coverage to small or large employers until the later of:

(1) the 180th day after the date the commissioner makes the determination; or

(2) the date the commissioner determines that accepting small or large employers would not place the issuer in a financially impaired condition.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 3.01(6), eff. September 1, 2015.

Sec. 1501.102. PREEXISTING CONDITION PROVISION. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004 and includes coverage provided under:

(1) a political subdivision health benefits risk pool; and

(2) a short-term limited duration coverage plan.

(b) A preexisting condition provision in a small or large employer health benefit plan may apply only to coverage for a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(c) A preexisting condition provision in a small or large employer health benefit plan may not apply to expenses incurred on

or after the first anniversary of the initial effective date of coverage of the enrollee, including a late enrollee.

(d) A preexisting condition provision in a small or large employer health benefit plan may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect until a date not more than 63 days before the effective date of coverage under the plan, excluding any waiting period.

(e) In determining whether a preexisting condition provision applies to an individual covered by a small or large employer health benefit plan, the plan issuer 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 the plan. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective must also be credited against the preexisting condition provision period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED. (a) A small or large employer health benefit plan issuer may not treat genetic information as a preexisting condition described by Section [1501.102\(b\)](#) in the absence of a diagnosis of the condition related to the information.

(b) A small or large employer health benefit plan issuer may not treat pregnancy as a preexisting condition described by Section [1501.102\(b\)](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.104. AFFILIATION PERIOD. (a) In this section, "affiliation period" means a period that, under a small or large employer health benefit plan offered by a health maintenance organization, must expire before the coverage becomes effective.

(b) 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

may not exceed:

(1) two months for an enrollee, other than a late enrollee; or

(2) 90 days for a late enrollee.

(c) An affiliation period under a small or large employer health benefit plan must run concurrently with any applicable waiting period under the plan. A health maintenance organization must credit an affiliation period against any preexisting condition provision period.

(d) During an affiliation period, a health maintenance organization:

(1) is not required to provide health care services or benefits to the participant or beneficiary; and

(2) may not charge a premium to the participant or beneficiary.

(e) A health maintenance organization may use an alternative method approved by the commissioner to address adverse selection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.105. WAITING PERIOD PERMITTED. Sections 1501.102-1501.104 do not preclude application of a waiting period that applies to all new enrollees under a small or large employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF COVERAGE PROHIBITED. (a) A small or large employer health benefit plan may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident.

(b) This section does not preclude a small or large employer health benefit plan from limiting or excluding coverage for a preexisting condition in accordance with Section [1501.102](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS. (a) A

small or large employer health benefit plan issuer may establish premium discounts, rebates, or a reduction in otherwise applicable copayments, coinsurance, or deductibles, or any combination of these incentives, in return for participation in programs promoting disease prevention, wellness, and health.

(b) A discount, rebate, or reduction established under this section does not violate Section 541.056(a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 112 (H.B. 2252), Sec. 3, eff. May 17, 2007.

Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION.

(a) Except as provided by this section and Section 1501.109, a small or large employer health benefit plan issuer shall renew the small or large employer health benefit plan for any covered small or large employer, as applicable, at the employer's option, unless:

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

(2) the employer has committed fraud or has intentionally misrepresented a material fact;

(3) the employer has not complied with the terms of the plan;

(4) no enrollee in the plan resides or works in the geographic service area of the small or large employer health benefit plan issuer or in the area for which the issuer is authorized to do business; or

(5) membership of the 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 or large employer health benefit plan issuer may refuse to renew the coverage of a covered employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

(c) A small or large employer health benefit plan issuer may not cancel a small or large employer health benefit plan except for a reason specified for refusal to renew under Subsection (a). A

small or large employer health benefit plan issuer may not cancel the coverage of a covered employee or dependent except for a reason specified for refusal to renew under Subsection (b).

(d) Notwithstanding Subsection (a), a small or large employer health benefit plan issuer may modify a small or large employer health benefit plan in accordance with Section [1369.0541](#) or if:

(1) the modification occurs at the time of coverage renewal;

(2) the modification is effective uniformly among all small or large employers covered by that health benefit plan; and

(3) the issuer notifies the commissioner and each affected covered small or large employer of the modification not later than the 60th day before the date the modification is effective.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 891 (H.B. [2467](#)), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 501 (H.B. [1405](#)), Sec. 8, eff. September 1, 2011.

Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF COVERAGE. (a) A small or large employer health benefit plan issuer may elect to refuse to renew all small or large employer health benefit plans delivered or issued for delivery by the issuer in this state or in a geographic service area. The issuer shall notify:

(1) the commissioner of the election not later than the 180th day before the date coverage under the first plan terminates under this subsection; and

(2) each affected covered small or large employer not later than the 180th day before the date coverage terminates for that employer.

(b) A small employer health benefit plan issuer that elects under this section to refuse to renew all small employer health benefit plans in this state or in a 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 notice is provided to the commissioner under Subsection (a).

(c) A large employer health benefit plan issuer that elects under this section to refuse to renew all large employer health benefit plans in this state or in a 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 notice is provided to the commissioner under Subsection (a).

(d) A small or large employer health benefit plan issuer may elect to discontinue a particular type of small or large employer coverage only if the issuer:

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

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

(B) offers to each employer the option to purchase other small or large employer coverage offered by the issuer at the time of the discontinuation; and

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 42 (S.B. 784), Sec. 2.01, eff. September 1, 2015.

Sec. 1501.110. NOTICE TO COVERED PERSONS. (a) A small or large employer health benefit plan issuer that cancels or refuses to renew coverage under a small or large employer health benefit plan under Section 1501.108 or 1501.109 shall, not later than the 30th day before the date termination of coverage is effective, notify the small or large employer of the cancellation of or refusal to renew coverage. The employer is responsible for notifying

enrollees in the plan of the cancellation of or refusal to renew coverage.

(b) The notice provided to a small or large employer by a small or large employer health benefit plan issuer under this section is in addition to any other notice required by Section [1501.109](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW REQUIRED. Denial by a small or large employer health benefit plan issuer of an application from a small or large employer for coverage from the issuer or cancellation of or refusal to renew coverage by a small or large employer health benefit plan issuer must:

(1) be in writing; and

(2) state the reason or reasons for the denial, cancellation, or refusal to renew.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER HEALTH BENEFIT PLANS; CONTINUATION OF COVERAGE

Sec. 1501.151. GUARANTEED ISSUE. (a) A small employer health benefit plan issuer shall issue the small employer health benefit plan chosen by the small employer to each small employer that elects to be covered under the plan and agrees to satisfy the other requirements of the plan.

(b) A small employer health benefit plan issuer shall provide small employer health benefit plans without regard to health status related factors.

(c) This chapter does not require a small employer to purchase health coverage for the employer's employees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.152. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT PROHIBITED. A small employer health benefit plan issuer may not exclude an eligible employee or dependent, including a late

enrollee, who would otherwise be covered under a small employer group.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.153. EMPLOYER CONTRIBUTION. (a) This chapter does not require a small employer to make an employer contribution to the premium paid to a small employer health benefit plan issuer, but the issuer may require an employer contribution in accordance with the issuer's usual and customary practices applicable to the issuer's employer group health benefit plans in this state. The issuer shall apply the employer contribution level uniformly to each small employer offered or issued coverage by the issuer in this state.

(a-1) Notwithstanding Subsection (a), a small employer health benefit plan issuer may offer a small employer the option of a small employer health benefit plan for which the employer is required to contribute 100 percent of the premium paid. A plan offered under this subsection may be offered in addition to a plan offered by the issuer in accordance with Subsection (a) that requires a lower percentage of the premium paid to be contributed by the employer. A plan issued under this subsection must require the employer to contribute 100 percent of the premium paid for each eligible participating employee.

(b) If two or more small employer health benefit plan issuers participate in a purchasing cooperative established under Section [1501.056](#), each participating issuer may use the employer contribution requirement established by the cooperative for policies marketed by the cooperative.

(c) A small employer that elects to make an employer contribution to the premium paid to a small employer health benefit plan issuer is not required to pay any amount with respect to an employee who elects not to be covered.

(d) A small employer may elect to pay the premium for additional coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 462 (S.B. [80](#)), Sec. 1, eff.

September 1, 2009.

Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT. (a) Except as provided by Section 1501.155, coverage is available under a small employer health benefit plan if at least 75 percent of a small employer's eligible employees elect to participate in the plan.

(b) If a small employer offers multiple health benefit plans, the collective participation in those plans must be at least:

(1) 75 percent of the employer's eligible employees;
or

(2) if applicable, the lower participation level offered by the small employer health benefit plan issuer under Section 1501.155.

(c) A small employer health benefit plan issuer may elect not to offer a health benefit plan to a small employer that offers multiple health benefit plans if:

(1) the plans are provided by more than one issuer; and
(2) the issuer would have less than 75 percent of the employer's eligible employees enrolled in the issuer's plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.054(a), eff. September 1, 2005.

Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION REQUIREMENT. (a) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer with a participation level of less than 75 percent of the employer's eligible employees if the issuer permits the same qualifying participation level for each small employer health benefit plan offered by the issuer in this state.

(b) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer even if the employer's participation level is less than the issuer's qualifying participation level established in accordance with Subsection (a)

if:

(1) the employer obtains a written waiver from each eligible employee who declines coverage under a health benefit plan offered to the employer stating that the employee was not induced or pressured to decline coverage because of the employee's risk characteristics; and

(2) the issuer accepts or rejects the entire group of eligible employees who choose to participate and excludes only those employees who have declined coverage.

(c) A small employer health benefit plan issuer may underwrite the group of eligible employees who do not decline coverage under Subsection (b).

(d) A small employer health benefit plan issuer may not provide coverage to a small employer or the employer's employees under Subsection (b) if the issuer or an agent for the issuer knows that the employer has induced or pressured an eligible employee or a dependent of the employee to decline coverage because of the individual's risk characteristics.

(e) A small employer health benefit plan issuer, a small employer, or an agent may not use the exception provided by Subsection (b) to circumvent the requirements of this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period under a small employer health benefit plan for employees and dependents must be at least 31 days, with a 31-day open enrollment period provided annually.

(b) A small employer may establish a waiting period not to exceed 90 days from the first day of employment.

(c) A small employer health benefit plan issuer may not deny coverage to a new employee of a covered small employer or the employee's dependents if the issuer receives an application for coverage not later than the 31st day after the date employment begins or on completion of a waiting period established under Subsection (b).

(d) A small employer health benefit plan issuer may deny coverage to a late enrollee until the next annual open enrollment

period and may subject the enrollee to a one-year preexisting condition provision as described by Section 1501.102. The period during which the preexisting condition provision applies may not exceed 18 months from the date of the initial application.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN. (a) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless, not later than the 31st day after the date of birth, the small employer health benefit plan issuer receives:

- (1) notice of the birth; and
- (2) any required additional premium.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN. (a) 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 to a suit in which the insured seeks to adopt the child.

(b) An adopted child of an insured may be enrolled, at the insured's option, not later than the 31st day after:

- (1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or
- (2) the date the adoption becomes final.

(c) Coverage of an adopted child of an insured under this section ends unless the small employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

- (1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or
- (2) the date the adoption becomes final.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN

DEPENDENTS. An employee's dependent may choose to continue coverage under a small employer health benefit plan if:

(1) the dependent:

(A) is under one year of age; or

(B) has been covered by the small employer under a plan for at least one year;

(2) the dependent loses eligibility for coverage because of the death, divorce, or retirement of the employee, as provided by Subchapter G, Chapter 1251; and

(3) the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) does not require continuation or conversion coverage for dependents of an employee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. UNDERWRITING AND RATING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.201. DEFINITIONS. In this subchapter:

(1) "Base premium rate" means, 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 a small employer health benefit plan issuer to small employers with similar case characteristics for small employer health benefit plans that provide the same or similar coverage.

(2) "Case characteristics" means, with respect to a small employer, the geographic area in which the employer's employees reside, the age and gender of the individual employees and their dependents, the number of employees and dependents, the appropriate industry classification as determined by the small employer health benefit plan issuer, and other objective criteria established by the issuer that are considered by the issuer in setting premium rates for the employer. The term does not include:

(A) health status related factors;

(B) duration of coverage since the date of issuance of a health benefit plan; or

(C) whether a covered individual is or may become

pregnant.

(3) "Class of business" means all small employers or a separate grouping of small employers established under this subchapter.

(4) "Index rate" means, for each class of business and for a specific rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(5) "New business premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or offered or that could be charged or offered by a small employer health benefit plan issuer to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(6) "Rating period" means a calendar period during which premium rates established by a small employer health benefit plan issuer are assumed to be in effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a) Except as otherwise provided by this subchapter, a small employer health benefit plan issuer may not establish a separate class or classes of business for small employers.

(b) A small employer health benefit plan issuer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) the issuer uses more than one type of system to market and sell small employer health benefit plans to small employers;

(2) the issuer has acquired a class of business from another small employer health benefit plan issuer; or

(3) the issuer provides coverage to one or more employer-based association groups.

(c) Except as provided by Subsection (e), a small employer health benefit plan issuer may not establish more than nine separate classes of business under this section.

(d) The commissioner may adopt rules to provide for a transition period to permit a small employer health benefit plan issuer to comply with Subsection (c) after acquiring an additional class of business from another small employer health benefit plan issuer.

(e) On application to the commissioner, the commissioner may approve the establishment of additional classes of business if the commissioner finds that the establishment of additional classes would enhance the efficiency and fairness of the health coverage market for small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON CERTAIN BASES PROHIBITED. (a) A small employer health benefit plan issuer may not establish a separate class of business based on:

(1) participation requirements; or

(2) 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.

(b) A small employer health benefit plan issuer may not directly or indirectly use as a criterion for establishing a separate class of business:

(1) the number of employees and dependents of a small employer; or

(2) except as provided by Section [1501.202\(b\)\(3\)](#), the trade or occupation of the employees of a small employer or the industry or type of business of the small employer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.204. INDEX RATES. Under a small employer health benefit plan:

(1) the index rate for a class of business may not exceed the index rate for any other class of business by more than 20 percent; and

(2) premium rates charged during a rating period to small employers in a class of business with similar case characteristics for the same or similar coverage, or premium rates

that could be charged to those employers under the rating system for that class of business, may not vary from the index rate by more than 25 percent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this section:

(1) "Risk characteristic" means:

(A) a health status related factor;

(B) the duration of coverage; or

(C) any characteristic similar to a characteristic described by Paragraph (A) or (B) that is related to the health status or experience of a small employer group or of any member of a small employer group.

(2) "Risk load" means the percentage above the applicable base premium rate a small employer health benefit plan issuer charges to a small employer to reflect the risk characteristics associated with that particular small employer group.

(b) Small employer health benefit plan issuers shall develop premium rates for each small employer group in a two-step process. In the first step, the small employer health benefit plan issuer shall develop a base premium rate for each small employer group without regard to any risk characteristic of the group. In the second step, the small employer health benefit plan issuer may adjust the resulting base premium rate by the risk load of the group, subject to this subchapter, to reflect the risk characteristics of the group.

(c) The risk load assessed to a particular group shall reflect the risk characteristics of the particular group.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate, measured from the first day of the preceding rating period to

the first day of the new rating period;

(2) any adjustment, not to exceed 15 percent annually and adjusted pro rata for a rating period of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of employees of the small employer, as determined under the small employer health benefit plan issuer's rate manual for the class of business; and

(3) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined under the issuer's rate manual for the class of business.

(b) An adjustment in the premium rate for claims experience, health status, or duration of coverage:

(1) may not be charged to individual employees or dependents; and

(2) must be applied uniformly to the rates charged for all employees and dependents of employees of the small employer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For a closed health benefit plan under which a small employer health benefit plan issuer is no longer enrolling new small employers, the issuer shall use the percentage change in the base premium rate to adjust premium rates under Section 1501.206(a)(1). The portion of change in premium rates computed under that subdivision may not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan under which the issuer is enrolling new small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A small employer health benefit plan issuer may use the industry classification to which a small employer belongs as a case characteristic in establishing the premium rate, but the highest rate factor associated with any industry classification may not exceed by more than 15 percent the lowest rate factor associated with any industry classification.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small employer health benefit plan issuer may use the number of employees and dependents of a small employer as a case characteristic in establishing premium rates for the group. The highest rate factor associated with a classification based on the number of employees and dependents of a small employer may not exceed by more than 20 percent the lowest rate factor associated with a classification based on the number of employees and dependents of a small employer. Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A small employer health benefit plan issuer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premium rates for identical groups that:

(1) differ only by the amounts attributable to health benefit plan design; and

(2) do not reflect differences because of the nature of the groups assumed to select particular health benefit plans.

(b) A small employer health benefit plan issuer shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) Without the prior approval of the commissioner, a small employer health benefit plan issuer may not use case characteristics other than:

(1) the geographic area in which the small employer's employees reside;

(2) the age and gender of the individual employees and their dependents;

(3) the number of employees and dependents; and

(4) the appropriate industry classification.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessment paid or payable by a small employer health benefit plan issuer.

(e) A small employer health benefit plan issuer may not

transfer a small employer involuntarily into or out of a class of business. The issuer may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all other small employers in the employer's class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the issuance of the health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.211. RULES CONCERNING PREMIUM RATES. Rules adopted under Section [1501.010](#) may ensure that:

(1) rating practices used by small employer health benefit plan issuers are consistent with the purposes of this chapter; and

(2) differences in premium rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.212. RESTRICTED PROVIDER NETWORK. (a) A small employer health benefit plan may use a restricted provider network to provide benefits under the plan.

(b) A small employer health benefit plan that uses a restricted provider network does not provide similar coverage to a plan that does not use a restricted provider network if the use of the network results in reduced premium rates charged to the small employer or substantial differences in claim costs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE ORGANIZATION HEALTH BENEFIT PLAN. (a) The premium rates for a state-approved health benefit plan offered by a health maintenance organization under Section [1501.255](#) must be established in accordance with formulas or schedules of charges filed with the department.

(b) A health maintenance organization that participates in a purchasing cooperative that provides employees of small employers

a choice of health benefit plans may use rating methods in accordance with this subchapter that are used by other small employer health benefit plan issuers participating in the same cooperative, including rating by age and gender, if the health maintenance organization has established:

(1) a separate class of business, as provided by Section 1501.202; and

(2) a separate line of business, as provided under Section 1501.255(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.055(a), eff. September 1, 2005.

Sec. 1501.214. ENFORCEMENT. If the commissioner determines that a small employer health benefit plan issuer subject to this chapter exceeds the applicable premium rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Chapter 82.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.215. REPORTING REQUIREMENTS. (a) Annually, each small employer health benefit plan issuer that offers a small employer health benefit plan shall file with the commissioner an actuarial certification stating that the issuer's underwriting and rating methods:

(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 this subchapter.

(b) Each small employer health benefit plan issuer shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based on commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(c) A small employer health benefit plan issuer shall make the information and documentation described in Subsection (b) available to the commissioner on request. Unless the information or documentation relates to a violation of this chapter, the information or documentation is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to a person outside the department except as agreed to by the issuer or as ordered by a court.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.216. PREMIUM RATES: NOTICE OF INCREASE. (a) Not less than 60 days before the date on which a premium rate increase takes effect on a small employer health benefit plan delivered or issued for delivery in this state by an insurer, the insurer shall:

(1) give written notice to the small employer of the effective date of the increase; and

(2) provide the small employer a table that clearly lists:

(A) the actual dollar amount of the premium on the date of the notice;

(B) the actual dollar amount of the premium after the premium rate increase; and

(C) the percentage change between the amounts described by Paragraphs (A) and (B).

(b) The notice required by this section must be based on coverage in effect on the date of the notice.

(c) This section may not be construed to prevent an insurer, at the request of a small employer, from negotiating a change in benefits or rates after delivery of the notice required by this section.

(d) An insurer may not require a small employer entitled to notice under this section to respond to the insurer to renew the policy or take other action relating to the renewal or extension of the policy before the 45th day after the date the notice described by Subsection (a) is given.

(e) The notice required by this section must include:

(1) contact information for the department, including

information concerning how to file a complaint with the department;

(2) contact information for the Texas Consumer Health Assistance Program, including information concerning how to request from the program consumer protection information or assistance with filing a complaint; and

(3) the addresses of Internet websites that provide consumer information related to rate increase justifications, including the websites of the department and the United States Department of Health and Human Services.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.003, eff. September 1, 2011.

SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT REQUIREMENTS. Except as expressly provided by this chapter, a small employer health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.252. HEALTH BENEFIT PLANS. (a) A small employer health benefit plan issuer shall offer a standard health benefit plan as authorized by Chapter 1507.

(b) A small employer health benefit plan issuer may offer to a small employer additional benefit riders to the standard health benefit plan or may design and offer standard health benefit plans with additional mandatory benefits.

(c) Subject to this chapter, a small employer health benefit plan issuer shall also offer to a small employer at least one other health benefit plan authorized under this code that provides state-mandated health benefits. Section 1501.251 does not apply to a health benefit plan offered to a small employer under this subsection.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.056(a),

eff. September 1, 2005.

Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. (a) This section applies only if the basic coverage health benefit plan developed by the commissioner under Section 1501.253 includes coverage for alcohol and substance abuse benefits.

(b) A small employer health benefit plan issuer may offer and the employees of a small employer group may accept a basic coverage health benefit plan without coverage for alcohol and substance abuse benefits if:

(1) at least 50 percent of the employees in writing:

(A) waive the benefits; and

(B) indicate that they have undergone alcoholism or substance abuse treatment or counseling within the preceding three years; and

(2) the exclusion of those benefits applies only to those employees.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS. (a) In this section, "point-of-service contract" means a health benefit plan offered through a health maintenance organization that:

(1) includes corresponding indemnity benefits in addition to benefits relating to out-of-area or emergency services provided through insurers or group hospital service corporations; and

(2) permits the covered individual to obtain coverage under either the health maintenance organization conventional plan or the indemnity plan as determined in accordance with the terms of the contract.

(b) A health maintenance organization:

(1) shall offer at least one state-approved basic health care plan that complies with this chapter, Chapters 843, 1271, 1272, and 1367, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and rules adopted under those laws and may offer additional such plans;

(2) shall offer a standard health benefit plan under Subchapter B, Chapter 1507, and may offer additional benefit riders to the standard health benefit plan or offer standard health benefit plans with additional mandatory benefits; and

(3) may offer a point-of-service contract in connection with an insurer that includes optional coverage for out-of-area services, emergency care, or out-of-network care.

(c) A point-of-service contract offered under Subsection (b)(3) is subject to this chapter unless specifically exempted. The insurer with which the health maintenance organization offers a point-of-service contract is not required to otherwise make available the health benefit plans adopted under this subchapter if the insurer's small employer products are limited to the point-of-service contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.057(a), eff. September 1, 2005.

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

Sec. 1501.256. COORDINATION WITH FEDERAL LAW. (a) To the extent required to comply with federal law applicable to a small employer health benefit plan described by this subchapter, the commissioner by rule may:

- (1) modify the plan; or
- (2) adopt a substitute for the plan.

(b) The commissioner shall use the Texas Health Benefits Purchasing Cooperative in implementing this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.2561. WAIVER OF CERTAIN FEDERAL REQUIREMENTS. The commissioner may apply to and negotiate with the United States secretary of health and human services to obtain a waiver under 42 U.S.C. Section 18052 for small employer health benefit plans of the actuarial value requirements and related levels of health plan coverage requirements imposed under 42 U.S.C.

Section 18022(d)(3).

Added by Acts 2017, 85th Leg., R.S., Ch. 106 (S.B. [1406](#)), Sec. 1, eff. May 23, 2017.

Sec. 1501.257. COST CONTAINMENT. (a) A small employer health benefit plan issuer may use cost containment and managed care features in a small employer health benefit plan, including:

(1) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) case management, including discharge planning and review of stays in hospitals or other health care facilities;

(3) selective contracting with hospitals, physicians, and other health care providers;

(4) reasonable benefit differentials applicable to health care providers that participate or do not participate in restricted network arrangements;

(5) precertification or preauthorization for certain covered services; and

(6) coordination of benefits.

(b) A provision of a small employer health benefit plan that provides for coordination of benefits must comply with this chapter and guidelines established by the commissioner.

(c) Utilization review performed for any cost containment, case management, or managed care arrangement must comply with Chapter [4201](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2G.015, eff. April 1, 2009.

Sec. 1501.258. FORMS. (a) A small employer health benefit plan issuer shall comply with:

(1) Chapter [1701](#) as it relates to policy form approval; and

(2) Chapter [1271](#) as it relates to evidence of coverage approval.

(b) A small employer health benefit plan issuer may not offer benefit plans through a policy form or evidence of coverage that does not comply with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.058(b), eff. September 1, 2005.

Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER. (a) A small employer health benefit plan issuer shall file with the commissioner, in a form and manner prescribed by the commissioner, each rider to a small employer health benefit plan to be used by the issuer, as authorized by Section 1501.252.

(b) A small employer health benefit plan issuer may use a rider filed under this section after the 30th day after the date the rider is filed unless the commissioner disapproves its use.

(c) The commissioner, after notice and an opportunity for a hearing, may disapprove the continued use of a rider by a small employer health benefit plan issuer if the rider does not meet the requirements of this chapter and other applicable statutes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.260. PLAIN LANGUAGE REQUIRED. (a) A health benefit plan issuer may not issue and the commissioner may not approve a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy unless it is written in plain language.

(b) Each provision of a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy relating to renewal of coverage, conditions of coverage, or per occurrence or aggregate dollar limitations on coverage must be clearly explained in plain language.

(c) A health benefit plan issuer may not use and the commissioner may not approve a health benefit plan application form unless it is written in plain language.

(d) Subsections (a)-(c) do not apply if the specific language to be used is required by federal law or state statute or

by rules implementing federal law.

(e) For purposes of Subsections (a)-(d), a health benefit plan certificate or policy, a rider to or a provision of a health benefit plan certificate or policy, or a health benefit plan application form is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner.

(f) This section does not apply to:

- (1) a health benefit plan group master policy; or
- (2) a policy application or enrollment form for a health benefit plan group master policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.301. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Health Reinsurance System.

(2) "Plan of operation" means the plan of operation of the system established under Section [1501.306](#).

(3) "Reinsured health benefit plan issuer" means a small employer health benefit plan issuer that participates in the system.

(4) "Risk-assuming health benefit plan issuer" means a small employer health benefit plan issuer that does not participate in the system.

(5) "System" means the Texas Health Reinsurance System established under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM. (a) The Texas Health Reinsurance System is a nonprofit entity administered by a board of directors and subject to the supervision and control of the commissioner.

(b) The system may operate only during the period an order authorizing operation of the system under Section [1501.3021](#) is in effect. The system may not operate after the effective date of an

order of suspension of operation of the system under Section 1501.3022 until a subsequent order authorizing the operation of the system under Section 1501.3021, if any, is effective.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 105 (S.B. 1171), Sec. 1, eff. May 23, 2017.

Sec. 1501.3021. AUTHORIZATION OF OPERATION. (a) The commissioner shall hold a hearing if:

(1) the commissioner believes small employer health benefit plan issuers in this state are threatened with the inability to secure reinsurance coverage in the open market; or

(2) the commissioner receives a petition requesting the hearing from an association of health benefit plan issuers in this state or a group of at least 15 small employer health benefit plan issuers operating in this state.

(b) If, after a hearing under Subsection (a), the commissioner finds that the operation of the system is in the public interest, the commissioner by order shall:

(1) authorize the operation of the system;

(2) appoint a board of directors under Section 1501.303; and

(3) direct the board to develop a plan of operation under Section 1501.306 to ensure the system is fully implemented on a date specified in the order that is not later than the 60th day after the effective date of the order.

(c) Sections 1501.307-1501.326 apply to the operation of the system after the date the system is implemented as described by Subsection (b)(3).

Added by Acts 2017, 85th Leg., R.S., Ch. 105 (S.B. 1171), Sec. 2, eff. May 23, 2017.

Sec. 1501.3022. SUSPENSION OF OPERATION. (a) The commissioner shall hold a hearing if the system is operating or is authorized to operate and:

(1) the commissioner believes small employer health

benefit plan issuers in this state are not threatened with the inability to secure reinsurance coverage in the open market; or

(2) the commissioner receives a petition requesting the hearing from an association of health benefit plan issuers in this state or a group of at least 15 small employer health benefit plan issuers operating in this state.

(b) If, after a hearing under Subsection (a), the commissioner finds that suspension of the operation of the system is in the public interest, the commissioner by order shall direct the board to submit to the commissioner for approval, not later than the 60th day after the date of the order, a plan of suspension of operation of the system.

(c) A plan of suspension under Subsection (b) must:

(1) specify the date after which a health benefit plan issuer that is a risk-assuming health benefit plan issuer on the effective date of the plan of suspension may not:

(A) become a reinsured health benefit plan issuer under Sections [1501.310](#), [1501.311](#), and [1501.312](#); and

(B) reinsure with the system a small employer group, or any risk, covered under any small employer health benefit plan;

(2) specify the date after which a health benefit plan issuer that is a reinsured health benefit plan issuer on the effective date of the plan of suspension may not:

(A) reinsure with the system additional small employer groups in accordance with Section [1501.314](#); or

(B) cede additional eligible lives to the system in accordance with Section [1501.314](#);

(3) provide for:

(A) the filing, receipt, processing, and payment of all claims against and debts of the system, and extinguishment of all liabilities of the system, including balances on any lines of credit that may have been established by or on behalf of the system;

(B) the collection and receipt of all assessments made with respect to reinsured health benefit plan issuers, including any deferred assessments and any final assessment made under Subsection (f); and

(C) a final audit of the system by the state auditor as provided by Subsection (g);

(4) specify that the transactions required by the plan of suspension and addressed in Subdivisions (1)-(3) must be closed not later than the effective date of the suspension of the operation of the system as specified under Subdivision (5);

(5) state the effective date of the suspension of the operation of the system; and

(6) provide for the proportionate distribution of any surplus assets of the system that remain after the date specified under Subdivision (5).

(d) The effective date of the suspension of the operation of the system as specified under Subsection (c)(5) may not be later than the 270th day after the date the commissioner by order approves the plan of suspension.

(e) If the board fails to submit a suitable plan of suspension, the commissioner, after notice and hearing, shall adopt a plan in accordance with Subsection (c).

(f) The board may make a final assessment of the small employer health benefit plan issuers that, for any portion of the last year in which the system operated, were reinsured health benefit plan issuers. An assessment under this subsection may be made only if the board determines the assessment is necessary to recover net losses of the system, as provided in Sections 1501.319-1501.326, including administrative expenses for transactions essential to complete execution of the plan of suspension, and the cost of the final audit by the state auditor.

(g) The transactions necessary to complete execution of the plan of suspension are subject to audit by the state auditor under Chapter 321, Government Code. The state auditor shall report the cost of the final audit conducted under this section to the board and the comptroller, and the board shall remit that amount to the comptroller for deposit to the general revenue fund.

(h) The board serving immediately before the effective date of the suspension of the operation of the system is discharged on the effective date of the suspension of the operation of the system as specified under Subsection (c)(5).

(i) After the effective date of the suspension of the operation of the system as specified under Subsection (c)(5), the commissioner shall take any action necessary under Subsection (c)(6) to distribute the surplus assets of the system until all remaining assets are distributed.

(j) During a period in which the operation of the system is suspended, Sections 1501.307-1501.326 have no effect.

Added by Acts 2017, 85th Leg., R.S., Ch. 105 (S.B. [1171](#)), Sec. 2, eff. May 23, 2017.

Sec. 1501.303. SYSTEM BOARD OF DIRECTORS. (a) The board of directors of the system is composed of:

(1) nine members appointed by the commissioner; and

(2) the commissioner or the commissioner's representative, who serves as an ex officio member.

(b) Five of the appointed members must be representatives of reinsured health benefit plan issuers selected from individuals nominated by small employer health benefit plan issuers in this state according to procedures developed by the commissioner.

(c) Four of the appointed members must represent the public. A member representing the public may not:

(1) be an officer, director, or employee of an insurance company, agency, agent, broker, solicitor, or adjuster or any other business entity regulated by the department;

(2) be a person required to register under Chapter [305](#), Government Code; or

(3) be related to a person described by Subdivision (1) or (2) within the second degree by affinity or consanguinity.

(d) Appointed members serve two-year terms expiring December 31 of each odd-numbered year. A member's term continues until a successor is appointed.

(e) A member of the board may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION. The board is subject to:

(1) the open meetings law, Chapter 551, Government Code; and

(2) the public information law, Chapter 552, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.305. BOARD MEMBER IMMUNITY. (a) A member of the board is not liable for an act performed, or omission made, in good faith in the performance of powers and duties under this subchapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.306. SYSTEM PLAN OF OPERATION. (a) The board shall submit to the commissioner a plan of operation and any amendments to that plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the system.

(b) The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines the plan:

(1) is suitable to ensure the fair, reasonable, and equitable administration of the system; and

(2) provides for the sharing of system gains or losses on an equitable and proportionate basis in accordance with this subchapter.

(c) The plan of operation is effective on the written approval of the commissioner.

(d) The plan of operation must:

(1) establish procedures for:

(A) handling and accounting for system assets and money;

(B) making an annual fiscal report to the commissioner;

(C) selecting an administering health benefit plan issuer or third-party administrator and establishing the

powers and duties of the administering issuer or third-party administrator;

(D) reinsuring risks in accordance with this subchapter; and

(E) collecting assessments from reinsured health benefit plan issuers to fund claims and administrative expenses incurred or estimated to be incurred by the system, including the imposition of penalties for late payment of an assessment; and

(2) provide for any additional matter necessary to implement and administer the system.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.307. SYSTEM POWERS. (a) The system has the general powers and authority granted under state law to an insurer or a health maintenance organization authorized to engage in business, except that the system may not directly issue a health benefit plan.

(b) The system may:

(1) enter into contracts necessary or proper to implement this subchapter, including, with the commissioner's approval, contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured health benefit plan issuer;

(3) take legal action necessary to avoid the payment of improper claims against the system;

(4) issue reinsurance contracts in accordance with this subchapter;

(5) establish guidelines, conditions, and procedures for reinsuring risks under the plan of operation;

(6) establish actuarial functions as appropriate for the operation of the system;

(7) assess reinsured health benefit plan issuers in accordance with Sections 1501.319-1501.323;

(8) appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in:

- (A) the operation of the system;
- (B) policy and other contract design; and
- (C) any other function within the authority of the system; and

(9) borrow money for a period not to exceed one year to accomplish the purposes of the system.

(c) The system is exempt from all taxes.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUER. A note or other evidence of indebtedness of the system that is not in default is a legal investment for a small employer health benefit plan issuer and may be carried as an admitted asset.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.309. SYSTEM AUDIT. (a) The transactions of the system are subject to audit by the state auditor in accordance with Chapter [321](#), Government Code.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller, and the board shall remit that amount to the comptroller.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.310. ELECTION OF STATUS. (a) Each small employer health benefit plan issuer shall notify the commissioner of the issuer's election to operate as a risk-assuming health benefit plan issuer or as a reinsured health benefit plan issuer. An issuer that elects to operate as a risk-assuming health benefit plan issuer shall file an application in accordance with Section [1501.312](#).

(b) A small employer health benefit plan issuer's election under this section is effective until the fifth anniversary of the date of the election.

(c) The commissioner may permit a small employer health benefit plan issuer to modify its election at any time for good

cause shown.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.311. CHANGE IN STATUS. (a) The commissioner shall establish an application process for a small employer health benefit plan issuer that elects to change its status under this subchapter.

(b) A reinsured health benefit plan issuer that elects to change its status to operate as a risk-assuming health benefit plan issuer may not continue to reinsure a small employer health benefit plan with the system. The issuer shall pay a prorated assessment based on business issued as a reinsured health benefit plan issuer for the portion of the year the business was reinsured.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.312. APPLICATION TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. (a) A small employer health benefit plan issuer may apply to operate as a risk-assuming health benefit plan issuer by filing an application with the commissioner in a form and manner prescribed by the commissioner.

(b) In evaluating an application, the commissioner shall consider the small employer health benefit plan issuer's:

- (1) financial condition;
- (2) history of rating and underwriting small employer groups;
- (3) commitment to market fairly to all small employers in the state or in the issuer's established geographic service area; and
- (4) experience managing the risk of small employer groups.

(c) The commissioner shall provide public notice of an application and shall provide at least a 60-day period for public comment before making a decision on the application. If the commissioner does not act on the application before the 90th day after the date the commissioner receives the application, the issuer may request and the commissioner shall grant a hearing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. The commissioner, after notice and hearing, may rescind approval to operate as a risk-assuming health benefit plan issuer if the commissioner finds that the issuer:

(1) is not financially able to support the assumption of risk from issuing coverage to small employers without the protection provided by the system;

(2) has failed to market fairly to all small employers in the state or in the issuer's established geographic service area; or

(3) has failed to provide coverage to eligible small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.314. REINSURANCE. (a) A small employer health benefit plan issuer may reinsure risks covered under a small employer health benefit plan with the system as provided by this subchapter.

(b) The system shall reinsure the level of coverage provided under the small employer health benefit plan.

(c) A small employer health benefit plan issuer may reinsure:

(1) an entire small employer group not later than the 60th day after the date the group's coverage under the small employer health benefit plan takes effect;

(2) an eligible employee of a small employer or the employee's dependent not later than the 60th day after the date the person's coverage takes effect; or

(3) a newly eligible employee of a reinsured small employer group, the employee's dependent, or an individual covered under the small employer health benefit plan not later than the 60th day after the date the individual's coverage takes effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.315. LIMITS ON REINSURANCE. (a) The system may

not reimburse a reinsured health benefit plan issuer for the claims of a reinsured individual until the issuer has incurred an initial level of claims of \$5,000 in a calendar year for that individual for benefits covered by the system. In addition, the reinsured health benefit plan issuer is responsible for 10 percent of the next \$50,000 of benefit payments during a calendar year, and the system shall reinsure the remainder. A reinsured health benefit plan issuer's liability to a reinsured individual may not exceed a maximum of \$10,000 in a calendar year.

(b) The board annually shall adjust the initial level of claims and the maximum liability to be retained by a reinsured health benefit plan issuer under Subsection (a) to reflect increases in:

(1) costs; and

(2) the use of small employer health benefit plans in this state.

(c) An adjustment under Subsection (b) may not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor unless the board proposes and the commissioner approves a lower adjustment factor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.316. TERMINATION OF REINSURANCE. A small employer health benefit plan issuer may terminate reinsurance with the system for one or more reinsured employees or dependents of employees of a small employer on a contract anniversary of the small employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES. Except as provided by the plan of operation, a reinsured health benefit plan issuer shall apply consistently with respect to reinsured and nonreinsured business all managed care procedures, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or

methods of operation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.318. PREMIUM RATES FOR REINSURANCE. (a) As part of the plan of operation, the board shall adopt a method to determine premium rates to be charged by the system for reinsuring small employer groups and individuals under this subchapter.

(b) The method adopted must:

(1) include a classification system for small employer groups that reflects the variations in premium rates allowed by this chapter; and

(2) provide for the development of base reinsurance premium rates that reflect the allowable variations.

(c) Subject to approval by the commissioner, the board shall establish the base reinsurance premium rates at levels that reasonably approximate the gross premiums charged to small employers by small employer health benefit plan issuers for small employer health benefit plans, adjusted to reflect retention levels required under this subchapter.

(d) The board shall periodically review the method adopted under this section, including the classification system and any rating factors, to ensure that the method reasonably reflects the claims experience of the system. The board may propose changes to the method. Any changes are subject to approval by the commissioner.

(e) An entire small employer group may be reinsured at a rate that is 1-1/2 times the base reinsurance premium rate for that group. An eligible employee of a small employer or the employee's dependent covered under a small employer health benefit plan may be reinsured at a rate that is five times the base reinsurance premium rate for that individual.

(f) The board may consider adjustments to the premium rates charged by the system to reflect the use of effective cost containment and managed care arrangements.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.319. DETERMINATION OF NET LOSS. (a) Not later

than March 1 of each year, the board shall determine the system's net loss for the preceding calendar year, including administrative expenses and incurred losses for the year, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into account investment income and other appropriate gains and losses. Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES. (a) The board shall recover any net loss of the system by assessing each reinsured health benefit plan issuer an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsured health benefit plan issuers. With the approval of the commissioner, the board may periodically change the assessment formula as appropriate. The board shall base the assessment formula on each reinsured issuer's share of:

(1) the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in this state; and

(2) the premiums earned in the preceding calendar year from newly issued small employer health benefit plans delivered or issued for delivery during the calendar year by reinsured health benefit plan issuers to small employer groups in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.321. LIMITS ON ASSESSMENTS. (a) The formula established under Section [1501.320\(b\)](#) may not result in an assessment for a reinsured health benefit plan issuer that is less than 50 percent or more than 150 percent of an amount based on the proportion of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery to small employer groups in this state by that issuer to the total premiums earned in the preceding calendar year from

small employer health benefit plans delivered or issued for delivery to small employer groups in this state by all reinsured health benefit plan issuers.

(b) In determining assessments, the board may not consider premiums earned by a reinsured health benefit plan issuer that are less than an amount determined by the board to justify the cost of collecting an assessment based on those premiums.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.322. ADJUSTMENT TO ASSESSMENTS ON FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS. With the commissioner's approval, the board may adjust the formula established under Section 1501.320(b) for a reinsured health benefit plan issuer that is an approved health maintenance organization that is federally qualified under Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), to the extent that any restriction is imposed on that issuer that is not imposed on other issuers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS. (a) The system may make advance interim assessments as reasonable and necessary for organizational and interim operating expenses.

(b) After the end of the fiscal year, the system shall credit an interim assessment made under this section as an offset against regular assessments due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS. The maximum assessment amount payable for a calendar year may not exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND PROTECTION OF SYSTEM. (a) Not later than March 1 of each year, the

board shall file with the commissioner an estimate of the assessments necessary to fund the losses for small employer groups incurred by the system during the preceding calendar year.

(b) If the board determines that the necessary assessments exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in this state, the board shall evaluate the operation of the system and shall report its findings, including any recommendations for changes to the plan of operation, to the commissioner not later than April 1 of the year following the calendar year in which the losses were incurred. The evaluation must:

- (1) include an estimate of future assessments; and
- (2) consider:
 - (A) the administrative costs of the system;
 - (B) the appropriateness of the premiums charged;
 - (C) the level of health benefit plan issuer retention under the system; and
 - (D) the costs of coverage for small employer groups.

(c) If the board fails to timely file a report required by Subsection (b), the commissioner may:

- (1) evaluate the operations of the system; and
- (2) implement amendments to the plan of operation that the commissioner considers necessary to reduce future losses and assessments.

(d) A reinsured health benefit plan issuer may not cede additional eligible lives to the system during a calendar year if the assessment amount payable for the preceding calendar year is at least five percent of the total premiums earned in that calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state.

(d-1) Expired.

(e) A reinsured health benefit plan issuer may not cede additional eligible lives to the system after the board determines

that the expected loss from the reinsurance system for a year will exceed the total amount of assessments payable at a rate of five percent of the total premiums earned for the preceding calendar year. A reinsured health benefit plan issuer may not resume ceding additional eligible lives to the system until the board determines that the expected loss will be less than the maximum established by this subsection.

(e-1) Expired.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 823 (S.B. 805), Sec. 5, eff. September 1, 2005.

Sec. 1501.326. DEFERMENT OF ASSESSMENT. (a) A reinsured health benefit plan issuer may petition the commissioner for a deferment in whole or in part of an assessment imposed by the board.

(b) The commissioner may defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the reinsured health benefit plan issuer to fulfill its contractual obligations.

(c) The board shall assess the amount of a deferred assessment against other reinsured health benefit plan issuers in a manner consistent with the basis for assessment established by this subchapter.

(d) A reinsured health benefit plan issuer that receives a deferment:

(1) is liable to the system for the amount deferred;
and

(2) until the issuer pays the outstanding assessment,
may not:

(A) market, deliver, or issue for delivery a small employer health benefit plan; or

(B) reinsure any individual or group with the system.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER H. MARKETING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.351. MARKETING REQUIREMENTS. (a) Each small employer health benefit plan issuer shall market a small employer health benefit plan to eligible small employers in this state through properly licensed agents.

(b) Each small employer purchasing a small employer health benefit plan must be given a summary, in a format prescribed by the commissioner, of the health benefit plans established by the commissioner under Subchapter F.

(c) An agent shall offer and explain to a small employer on inquiry and request by the employer each health benefit plan established by the commissioner under Subchapter F.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.352. HEALTH STATUS AND CLAIMS EXPERIENCE; PROHIBITED ACTS. (a) A small employer health benefit plan issuer or agent may not, because of the health status or claims experience of the eligible employees of a small employer and those employees' dependents, directly or indirectly encourage or direct the employer to:

(1) refrain from applying for coverage with the issuer;

(2) seek coverage from another issuer;

(3) apply for a particular small employer health benefit plan; or

(4) become or not become a member of a particular small employer health coalition.

(b) A small employer health benefit plan issuer may not directly or indirectly enter into an agreement or arrangement with an agent that provides for or results in compensation paid to the agent for the sale of small employer health benefit plans that varies because of health status or claims experience.

(c) Subsection (b) does not apply to an arrangement that provides compensation to an agent based on a percentage of premium, provided that:

(1) the percentage may not vary because of health status or claims experience; and

(2) the small employer health benefit plan issuer does not:

(A) exclude any additional premium charged to the small employer because of health status or claims experience from the premium amount to which the percentage is applied; or

(B) apply a smaller percentage to any additional premium charged to the small employer because of health status or claims experience than is applied to other premiums charged to the small employer.

(d) A small employer health benefit plan issuer or agent may not encourage a small employer to exclude an eligible employee from health coverage provided in connection with the employee's employment.

(e) A small employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent for a reason related to the health status or claims experience of a small employer group placed by the agent with the issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.059(a), eff. September 1, 2005.

Sec. 1501.353. AGENT COMPENSATION. (a) A small employer health benefit plan issuer shall pay the same commission, percentage of premium, or other amount to an agent for renewal of a small employer health benefit plan as the issuer paid for original placement of the plan, except that the issuer may increase compensation for renewal of a plan to reflect an increase in the cost of living or similar factors.

(b) A small employer health benefit plan issuer may not implement, directly or indirectly, agent commission schedules that vary the level of agent commissions based on the size of the group or otherwise reduce access to small employer health benefit plans.

(c) Notwithstanding Subsection (b), a small employer health benefit plan issuer may:

(1) vary agent commission amounts or percentages based

on group size if the variation in the commission amounts or percentages are inversely related to the size of the group;

(2) vary agent commission amounts or percentages based on the cumulative premium paid by a single small employer over a specific period if the variation in the commission amounts or percentages are inversely related to the cumulative premium paid during the period; or

(3) pay agent commissions as a percentage of premiums charged to a small employer if the commission percentage is based on all premiums paid by the small employer.

(d) A small employer health benefit plan issuer may not use an agent compensation schedule that provides compensation in a specific dollar amount for each individual covered during a specified period or for each group of individuals covered during a specified period.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.059(b), eff. September 1, 2005.

Sec. 1501.354. REQUIRED DISCLOSURES. (a) In connection with offering a small employer health benefit plan for sale, each small employer health benefit plan issuer and agent shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in:

(A) claim costs; or

(B) health status of the employer's employees and their dependents;

(2) provisions concerning the issuer's right to change premium rates and factors other than claims experience that affect changes in premium rates;

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

(4) any preexisting condition provisions.

(b) On request by a small employer, each small employer health benefit plan issuer shall disclose the benefits and premiums available under all small employer coverage for which the employer is qualified.

(c) A small employer health benefit plan issuer is not required to disclose information to a small employer that is proprietary or trade secret information under applicable law.

(d) Information provided under this section to a small employer must be provided in a manner that is:

- (1) understandable by the average small employer; and
- (2) sufficient to reasonably inform a small employer of its rights and obligations under a small employer health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.355. RULES CONCERNING MARKETING AND AVAILABILITY. Rules adopted under Section [1501.010](#) may establish additional standards to provide for the fair marketing and broad availability of small employer health benefit plans to small employers in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.356. REPORTING REQUIREMENTS. (a) In this section, "case characteristics" has the meaning assigned by Section [1501.201](#).

(b) The department may require periodic reports by small employer health benefit plan issuers and agents regarding small employer health benefit plans issued by those issuers and agents. The reporting requirements must include information regarding:

- (1) case characteristics; and
- (2) the number of small employer health benefit plans in various categories that are marketed or issued to small employers.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.357. VIOLATIONS. A violation of Section [1501.352](#) by a small employer health benefit plan issuer or agent is an unfair

method of competition and an unfair or deceptive act or practice under Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.358. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a small employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering small employer health benefit plans to small employers in this state, the third-party administrator is subject to Sections 1501.111, 1501.351-1501.353, and 1501.355-1501.357.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.601. PARTICIPATION CRITERIA. (a) In this subchapter, "participation criteria" means any criteria or rules established by a large employer to determine the employees who are eligible for enrollment or continued enrollment under the terms of a health benefit plan.

(b) The participation criteria may not be based on health status related factors.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.602. COVERAGE REQUIREMENTS. (a) A large employer health benefit plan issuer:

(1) may refuse to provide coverage to a large employer in accordance with the issuer's underwriting standards and criteria;

(2) shall accept or reject the entire group of individuals who meet the participation criteria and choose coverage; and

(3) may exclude only those employees or dependents who decline coverage.

(b) On issuance of a health benefit plan to a large employer, a large employer health benefit plan issuer shall provide coverage to the employees who meet the participation criteria

without regard to an individual's health status related factors.
Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT PROHIBITED. A large employer health benefit plan issuer may not exclude an employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.604. DECLINING COVERAGE. (a) A large employer health benefit plan issuer shall obtain a written waiver from each employee who meets the participation criteria and declines coverage under a health benefit plan offered to a large employer. The waiver must ensure that the employee was not induced or pressured to decline coverage because of the employee's health status related factors.

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

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION REQUIREMENTS. (a) A large employer health benefit plan issuer may require a large employer to meet a minimum contribution or participation requirement as a condition of issuance or renewal in accordance with the issuer's usual and customary practices for all the issuer's employer health benefit plans in this state.

(b) A participation requirement may determine the percentage of eligible employees who meet the participation criteria and who must be enrolled in the health benefit plan.

(c) A large employer health benefit plan issuer may apply a participation requirement to a large employer's eligible employees, but may not apply the requirement to eligible dependents

of those employees.

(d) A participation requirement must be stated in the health benefit plan contract and must be applied uniformly to each large employer offered or issued coverage by a large employer health benefit plan issuer in this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period for employees meeting the participation criteria under a large employer health benefit plan must be at least 31 days, with a 31-day annual open enrollment period.

(b) A large employer may establish a waiting period. The employer shall determine the duration of the waiting period.

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

(1) the date employment begins; or

(2) the date the waiting period established under Subsection (b) expires.

(d) If dependent coverage is offered to the enrollees under a large employer health benefit plan:

(1) the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period; and

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

(A) the date on which the employment begins;

(B) the date the waiting period established under Subsection (b) expires; or

(C) the date the dependent becomes eligible for enrollment.

(e) A late enrollee may be excluded from coverage until the next annual open enrollment period and may be subject to a one-year

preexisting condition provision as described by Section 1501.102. The period during which a preexisting condition provision applies may not exceed 18 months from the date of the initial application. Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN. (a) A large employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless:

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

(2) not later than the 31st day after the date of birth, the large employer health benefit plan issuer receives:

(A) notice of the birth; and

(B) any required additional premium.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) 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 adopted child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

(c) An adopted child of an insured may be enrolled, at the insured's option, not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

(d) Coverage of an adopted child of an insured under this section ends unless the large employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) Any limiting age applicable under a large employer health benefit plan to an unmarried child of an enrollee is 25 years of age.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large employer health benefit plan issuer may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and do not decline coverage.

(b) A large employer health benefit plan issuer may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of a large employer.

(c) Subsection (b) does not restrict the amount that a large employer may be charged for coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.611. MARKETING REQUIREMENTS. On request, each large employer purchasing a health benefit plan shall be given a summary of all plans for which the employer is eligible.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE PROHIBITED. A large employer health benefit plan issuer or agent may not encourage a large employer to exclude an employee who meets the participation criteria from health coverage provided in connection with the employee's employment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.613. AGENTS. A large employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent because of health status related factors of a large employer group placed by the agent with the issuer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The department may require periodic reports by large employer health benefit plan issuers and agents regarding the large employer health benefit plans issued by those issuers. The reporting requirements must:

(1) require information regarding the number of plans in various categories that are marketed or issued to large employers; and

(2) comply with federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a large employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering large employer health benefit plans to large employers in this state, the third-party administrator is subject to this subchapter and Subchapter C.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.