Texas Department of Insurance
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SUBCHAPTER FF. Obligation to Continue Premium Payment and Coverage after Notice of Lost Group Eligibility

28 TAC §§21.4001 - 21.4003

1. INTRODUCTION. The Commissioner of Insurance adopts new Subchapter FF, §§21.4001 - 21.4003, concerning the obligation of certain group health coverage policyholders and contract holders to continue premium payment, and a carrier's corresponding obligation to continue coverage, after notice of an individual's lost group eligibility. The sections are adopted with changes to the proposed text as published in the February 10, 2006 issue of the *Texas Register* (31 TexReg 793).

2. REASONED JUSTIFICATION. These new sections are necessary to implement §§1 and 2 of SB 51, enacted by the 79th Legislature, Regular Session, which added Insurance Code §§843.210 and 1301.0061, effective September 1, 2005. Sections 843.210 and 1301.0061 apply, respectively, to group health maintenance organization contracts and group preferred provider benefit plan policies entered into or renewed on or after January 1, 2006.

Subsequent to the enrollment of SB 51, the Department received requests for formal guidance and procedures necessary to implement this new legislation uniformly. In response, the Department proposed new §§21.4001 - 21.4003. These new sections outline the scope of a group policyholder's or contract holder's liability for premium payment; define relevant terms; and detail means of complying with the statute, including providing notice of late-month terminations and situations involving duplicative or unnecessary coverage. The Department posted an informal draft of the new sections relating to the obligation to continue premium payment and coverage after notice of lost group eligibility on January 12, 2006 and invited public input. Following publication of the proposed new sections in the *Texas Register* on February 10, 2006, the Department held a public hearing on February 21, 2006, and received comments regarding suggested changes to the proposed sections. In response to comments made at the hearing and written comments from interested parties, the Department is adopting these new sections with some changes to the proposal as published. None of these changes introduce new subject matter or affect persons other than those subject to the proposal as originally published. Throughout the adopted rule, the Department has made editorial and grammatical changes to the rule as proposed for ease of reading and clarity and, where necessary, corrected punctuation, references, and typographical errors.

The adopted sections should be read in conjunction with SB 51, §§1 and 2, the Insurance Code, and other statutes and rules as applicable. Additionally, in the section of this adoption entitled Summary of Comments and Agency's Response to Comments, the Department has included some examples to clarify the applicability of certain rule subsections.

§21.4001. A commenter requested clarification regarding the specific situations to which this section's last sentence applies to differentiate between events that do and do not trigger the premium payment and coverage requirements. Another commenter stated that the last sentence of this section appears to make the statute inapplicable when an entire group terminates and a person remains eligible but voluntarily elects to terminate coverage and the commenter requested examples for clarification. The last sentence of this section applies to a person who remains part of the group eligible for coverage. The Department disagrees with one commenter's request to provide examples in this section. The

Department, however, agrees that revising the last sentence of this section is necessary to clarify that the provision applies to a person who remains part of the group eligible for coverage. This clarification should make explanatory examples for this section unnecessary. Therefore, the Department has amended this sentence to replace the phrase "without leaving the group eligible for coverage" with the phrase "while remaining part of the group eligible for coverage," to provide the requested clarification.

§21.4002. A commenter noted that the definition of "health insurer" in proposed paragraph (4) included a reference to Insurance Code Chapter 941, which governs Lloyd's plans and reciprocal and inter-insurance exchanges, which are not subject to Chapter 1301. The Department has revised the definition to delete the reference to Chapter 941. In proposed paragraph (5), in the definition of "health maintenance organization," the Department has added the phrase "as defined in Insurance Code §843.002(14)" for clarification of its statutory derivation and consistency with the definition of "health insurer," which also references its statutory derivation. Several commenters requested a revision to the first sentence in the definition of the term "month." Parties representing the interests of health care providers, insurance carriers, employers, and insurance agents formed an informal workgroup (subsequently referred to as the *workgroup*) to review the proposal and to suggest language for clarification. One of the changes this workgroup suggested was to the definition of "month" in proposed §21.4002(6). According to the workgroup, "there are instances where a month is not necessarily a calendar month and may be defined as greater than 30 days." Accordingly, the workgroup suggested adding the phrase "as provided in the group policy or contract" at the end of the first sentence of the definition of "month" for clarification that the meaning of "month" is specified by language contained within the group policy or contract. A second commenter suggested adding the words "applicable to the policy and as agreed upon by the health carrier and the policyholder or contract holder" after "succeeding calendar month." Another commenter requested making explicit in the Department's introductory explanation that the definition of "month" be set by agreement of both the health carrier and the policyholder or contract holder, and that the same agreed-upon definition of the term "month" should apply with respect to the policy for all enrollees and insureds, rather than applying a different definition with respect to each enrollee or individual insured. The suggestion to add the language "as provided in the group policy or contract" is consistent with the Department's interpretation of the statute, and the Department has revised paragraph (6) accordingly. The Department disagrees with the second recommended change because it is unnecessary; agreement between the carrier and the policyholder or contract holder is included in the concept of the group policy or contract.

§21.4003. In proposed subsection (b), a commenter asked that the word “accepts” be replaced by the word “receives” for clarification and to prevent providers and patients from potential responsibility for payments. Because the term "receives" would imply that the carrier must accept notice by mail, in response to this comment the Department has deleted the word "accepts" in adopted subsection (b) and has replaced it with the phrase "agrees that a group policyholder or group contract holder may tender." This new language clarifies compliance to facilitate notification and to prevent situations in which providers, insureds, or enrollees become responsible for payments. Also in subsection (b) of this section as adopted, the Department added an optional provision that states that evidence of written notifications may be maintained in a mail log in order to provide proof of submission and establish date of receipt. This added provision is modeled on language, in 28 Tex. Admin. Code §21.2816(h) (relating to Date of Receipt) of Subchapter T, the Submission of Clean Claims Rules.

The additional notification period contained in proposed subsection (c) elicited many comments. A commenter suggested that the Department change the additional notification period from five days to the "tenth calendar day of the next policy or contract month" because businesses notify their carriers of terminations at the same time they pay their monthly premiums and their plan receives payment and termination notification by the tenth calendar day of the next contract or policy month. One commenter stated that anything less than five days was not a reasonable amount of time for an additional notification period. Another commenter completely opposed the additional notification period because an individual may

obtain costly services during that time period and carriers may retroactively deny these claims upon learning an employee is no longer part of the group eligible for coverage. The workgroup also agreed upon and suggested language to clarify this subsection as proposed. The workgroup supported the implementation of an additional notification period, as long as it was narrowly drafted to avoid diminishing the impact of SB 51, and suggested a change to the proposed language incorporating a three-day additional notification period. The Department agrees with the commenters who asserted that it is important to reflect the necessarily strict notification standard of the statute to encourage timely notification. Based upon commenters' input and a need to reflect the intent of the statute, the Department has revised the language in subsection (c) of §21.4003 to modify the additional notification period from five days as proposed to three days. The three-day additional notification period provides a reasonable time for employers to deal with end-of-month terminations. This change is necessary to balance various stakeholders' interests, while still providing policyholders and group contract holders needed flexibility to notify health carriers of late-month terminations. The Department effected this change by replacing the entire first sentence in proposed subsection (c) with a new provision stating that if the eligibility at issue ends within seven calendar days prior to the end of the month, the group policyholder or contract holder will be deemed to have notified the carrier that same month, if the health carrier receives notification within the first three days, excluding Saturdays, Sundays, and legal holidays, of the subsequent month. In the second sentence of subsection (c) the same commenters recommended inserting the words "if the notification is sent during" in place of the word "during" and inserting "three-day" before the words "notification period."

A commenter requested that proposed subsection (c) clarify the date that electronic transmissions are sent is the date such transmissions might be opened (e.g., in an email) or otherwise processed by the health carrier. The Department agrees with the commenter and has added language to subsection (c)(2) of this section to clarify that immediate written notification sent via electronic means will be presumed received on the date it is submitted. This new language is modeled on the "date of receipt" language in 28 Tex. Admin. Code §21.2816(b)(2) and (d). Consistent with this change, the Department has also made another modification in this subsection for clarification and to facilitate compliance with the rules and the statutes. The Department has added language in subsection (c)(2) to state that, hand-delivered notifications will be presumed received on the date the delivery receipt is signed.

A few commenters stated that while it was clear that the intent of proposed §21.4003(c), (d), (e), (g), and (h) was to create certain exemptions to the SB 51 requirements as restated in subsection (a) of this section, the effect is that the rule as proposed exempts parties from including provisions in their contracts rather than exempting the parties from the effect of those provisions. These commenters requested that the lead-in sentence to these proposed subsections be revised. The Department has completely revised the first sentence of subsection (c) in response to another comment; thus the commenter's request to change the lead-in sentence language in subsection (c) is moot. The Department otherwise agrees with the commenters and has therefore revised the language in the lead-in sentence in subsections (d), (e), (f), (g), and (h) as adopted to delete the phrase "subsection (a) of this section does not apply," and substitute new language that states "[a] group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums under subsection (a) of this section if . . . ."

In conjunction with the change to the lead-in sentence language of subsections (d) - (h), the Department has also added the phrase "and a health carrier is not obligated to continue coverage" to clarify that since group policyholders and contract holders will not be required to pay premium, health carriers will not be required to continue coverage under subsection (a) if one or more of subsections (d) - (h) are applicable. While this is implied in the proposed subsections, it is not explicit except in proposed subsection (e). In subsection (e), the Department has also deleted the proposed language "and may terminate an individual insured's or enrollee's coverage under a group health benefit plan at the time the individual is no longer a part of the group eligible for coverage under the plan." This language is no longer necessary

because it is redundant of the added language "and a health carrier is not obligated to continue coverage."

The Department has revised the title of §21.4003 from "Group Policyholder Liability for Premiums" to "Group Policyholder, Group Contract Holder, and Carrier Premium Payment and Coverage Obligations" to express more completely and accurately the scope of the section.

A commenter stated that proposed §21.4003(e) was unduly burdensome to an employer who may be unable to meet a carrier's proof requirements and suggested a language change to allow an employer policyholder or contract holder to submit a certification that the individual has obtained new coverage and suggested substituting the phrase "reasonable representation to the health carrier that the individual will have new coverage" for the phrase "proof of the new coverage." While the Department does not find a meaningful substantive difference between the proposed standard and the commenter's suggestion, the Department agrees to substitute the word "verify" for the phrase "provide proof of" to address the commenter's concerns that the provision would be unduly burdensome to employers. Also, in proposed §21.4003(e), a commenter recommended a new paragraph to clarify that the section does not apply to coverage a health carrier extends to an individual "that is immediately followed by continuation coverage elected by or on behalf of an individual insured or enrollee." The Department disagrees that this change is necessary because subsection (e) of the rule allows an employer to end its premium payment obligation under SB 51 when its ex-employee obtains successor coverage, including continuation coverage. The Department, however, has changed the term "new" to "successor" in subsection (e) to clarify this situation. Also, in subsection (e) as adopted, the Department has substituted the phrase "immediately upon termination of coverage under a group health benefit plan" with the phrase "at any time after termination of group eligibility and before the end of the coverage and premium payment period required by Insurance Code §§843.210 and 1301.0061 and subsection (a) of this section" because it is necessary to end the obligation to continue premium payment requirements from the time successor coverage begins whether or not it is immediately upon termination of coverage under the group health benefit plan.

3. HOW THE SECTIONS WILL FUNCTION. Section 21.4001 explains the purpose and scope of the subchapter, clarifying that the subchapter does not impose requirements on a group policyholder, a group contract holder, or a health carrier when an entire group ends coverage under a health benefit plan or when an individual terminates coverage while remaining part of the group eligible for coverage. Section 21.4002 contains definitions relevant to this subchapter; of particular significance is the definition of the term "month," which is defined in a manner that allows the parties to provide by contract the start and end of the monthly period.

Section 21.4003 addresses group policyholder and contract holder liability for the obligation to continue premium payment and coverage requirements after notice of an individual's lost group eligibility. Subsection (a) restates the requirements that SB 51 imposes on a health carrier and a group policyholder or group contract holder under a health benefit plan contract. This subsection outlines the requisite contract language.

Section 21.4003(b) defines a receipt date for notice tendered by mail. This subsection codifies the "mailbox rule," which is the legal principle that a communication regarding a contract, such as notification of employee termination, is deemed received when tendered as authorized to the U. S. Postal Service. Further, subsection (b) provides that evidence of written notifications may be maintained in a mail log in order to provide proof of submission and establish date of receipt.

Section 21.4003(c) provides that if an individual or an enrollee ceases to be a part of the group eligible for coverage within seven calendar days prior to the end of the month, then the group policyholder or contract holder will be deemed to have notified the health carrier in that same month as long as the carrier receives notification within the first three days of the

subsequent month, not including Saturdays, Sundays, and legal holidays. Paragraphs (1) and (2) of subsection (c) further direct that the group policyholder or group contract holder must agree with the health carrier upon a method to transmit the notification under subsection (c), which must provide for immediate written notification, such as an internet portal, electronic mail, or telefacsimile. Subsection (c)(2) also provides that if such notification is sent via electronic means, then it will be presumed received on the date that it is submitted, and that if such notification is hand-delivered, then it will be presumed received on the date the delivery receipt is signed.

Section 21.4003(d) recognizes that in some instances a group policyholder or group contract holder will be able to notify a health carrier that an individual will no longer be part of the group eligible for coverage prior to the date the individual actually leaves the group. Accordingly, this subsection allows for termination of premium payment and coverage on the date the individual leaves the group if the employer provides at least 30 days prior notice.

Section 21.4003(e) clarifies that a group policyholder or group contract holder and a health carrier may eliminate their premium payment and coverage responsibilities if the individual no longer a part of the group eligible for coverage under the plan elects to terminate coverage and obtains coverage under a successor health benefit plan that takes effect after termination of group eligibility and before the end of the coverage and premium payment period required by §21.4003(a) and Insurance Code §§843.210 and 1301.0061. This subsection authorizes a health carrier to require a group policyholder or group contract holder seeking to avoid payment of additional premium for an individual to verify the successor coverage and to agree to be responsible for payment of premium if the individual's successor health benefit plan does not cover the individual for the entire period for which the health carrier and the group policyholder or group contract holder are responsible for premium payment and coverage. This subsection also clarifies that the group policyholder or group contract holder and the health carrier remain responsible for premium payment and coverage should the individual's successor plan fail to provide coverage during the period for which the rule otherwise obligates them to continue premium payment and coverage.

Section 21.4003(f) clarifies that the obligations to pay premium and to provide coverage under subsection (a) do not apply to certain continuation coverage.

Section 21.4003(g) clarifies that the obligations to pay premium and to provide coverage under subsection (a) do not apply to health benefit plans under which the group policyholder or group contract holder does not make any contribution to the payment of premium for individuals covered under the plan.

Section 21.4003(h) clarifies that the obligation to pay premium and to provide coverage under subsection (a) ends upon an individual's demise.

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

General: A commenter raises concerns about the applicability of the proposal to a limited benefits company for part-time employees and the possibility that it may reduce participation in health plans for such companies, which address the problem of the uninsured in Texas.

Agency Response: The Department agrees that finding affordable coverage alternatives for the uninsured in Texas is a vital concern. Section 21.4003(g) clarifies that such plans are not subject to the premium payment and coverage requirements of SB 51 if the group policyholder or contract holder does not contribute any premium for any covered individual. SB 51 does not distinguish part-time employees from other covered individuals, however.

General: A commenter asks about the application of SB 51 and these rules with 28 Tex. Admin. Code §3.3508(b)(4), (b)(5), and (b)(6) (relating to Rules for Coordination of Benefits and Order of Benefits) for determining the primary plan in different scenarios in which an employee has a window of overlapping coverage because the employee started a new job with immediate coverage and the former employer waited until the next month to notify the carrier. In particular, the commenter wants to know whether the SB 51 coverage period counts for determining the length of time a person is covered under a plan.

Agency Response: Section 3.3508(b)(6) provides that the plan that covers an employee member or subscriber longer is the primary plan. If both the old and new plans include a coordination of benefits provision, then the old plan is the primary plan during any overlap of coverage. If one of the two plans does not include a coordination of benefits provision, then the plan that does not include the coordination of benefits provision is the primary plan during any overlap of coverage. Extension of coverage under SB 51 is no different than any other coverage status; therefore, it also extends the length of time a person is covered.

§21.4001: A commenter requests clarification as to the specific situations to which the last sentence in this subsection applies, such as: (1) an employee leaving the eligible class (e.g., end of employment); (2) a dependent becoming ineligible due to age; (3) a dependent spouse becoming ineligible due to divorce; or (4) an employee moving to part-time status. The commenter questions whether the rule applies to coverage terminations such as mid-year election out of coverage due to certain major life events including marriage, birth, and change in residence. Carriers are concerned with differentiating between events that do and do not trigger the requirement given that most employers do not notify them of the specific reasons why an employee is being terminated.

Agency Response: A carrier should comply with the coverage requirements of SB 51 absent the existence of a rule-based exception excusing performance (e.g., death of an employee). Generally, a group policyholder or group contract holder will need to notify the carrier of the exceptional circumstances, and the premium payment requirements of SB 51 will motivate those parties to communicate this information to carriers, where relevant to premium payment obligations. Absent such notification, a carrier should not have to be concerned with differentiating between termination events.

The last sentence of §21.4001 applies to a person who remains part of the group eligible for coverage. Accordingly, the Department has amended this sentence to replace the phrase "without leaving the group eligible for coverage" with the phrase "while remaining part of the group eligible for coverage." With regard to the specific situations about which the commenter inquires, the rule contains two basic qualifications that provide the key to interpretation. An individual must be: (1) a member of the group, and (2) eligible for coverage. An employee leaving the eligible class (e.g., end of employment) is no longer part of the group eligible for coverage and thus the sentence would not apply to the employee's situation. A dependent becoming ineligible due to age is no longer part of the group eligible for coverage because the dependent, while still linked to the group through the dependent's relationship to the primary group member, is no longer eligible for coverage; the same is true of a dependent spouse becoming ineligible due to divorce or an employee moving to part-time status. Accordingly, the sentence would not affect the applicability of SB 51 to each of them. The rule would not require coverage of a person making a mid-year election out of coverage due to certain major life events (e.g., marriage) as long as the person remained part of the group eligible for coverage. If the person obtains successor coverage through, for example, a new spouse's employer, then the person would lose eligibility at the effective date of the new coverage, as provided in the Insurance Code §1501.002(3). Under subsection (e) of §21.4003, the successor coverage would

enable the parties to end coverage and premium payment obligations

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§21.4001: A commenter states that the last sentence of this subsection appears to make the statute inapplicable when the entire group terminates, as well as when a person remains eligible but voluntarily elects to terminate coverage. The commenter requests examples clarifying the status of: (1) an employee covered under an employer plan who chooses to drop such coverage for coverage under their spouse's employer's plan; and (2) an employee's husband who has coverage under his wife's employer's plan, but who is dropped from the plan during open enrollment because he has coverage under his own employer's plan.

Agency Response: While the Department does not agree that it is necessary to add the suggested examples to the rule text, the Department will discuss the suggested examples in this response to enhance compliance as entities conform their practices to the adopted regulation.

Example One: A is an employee of XYZ Company (XYZ Co.) and is covered by XYZ's carrier's health plan (XYZ carrier). During A's spouse's employer's open enrollment period, A chooses to drop coverage under the XYZ carrier plan for coverage under A's spouse's plan. Since A is simply declining coverage and not leaving the group eligible for coverage, the rule clarifies that the statutory requirements for premium payment and coverage do not apply to A.

Example Two: B is A's spouse and is covered under A's employer's plan. During open enrollment, however, A, B's wife, decides to drop B from coverage because B obtains coverage under his employer's separate plan. Since A is simply declining coverage and not leaving the group eligible for coverage, the rule clarifies that the statutory requirements for premium payment and coverage do not apply to A.

§21.4001: Another commenter requests specific exemption language for an entire subgroup ending plan coverage due to a professional employer organization's contract termination or when a business transaction such as a merger involves the group policyholder or group contract holder.

Agency Response: The Department disagrees that incorporating specific exemption language into this section is necessary. Section 21.4003(e) addresses the situation in which the group policyholder or contract holder ends premium payment obligations when the subgroup has obtained new coverage.

§21.4001: Some commenters request clarification of the extra-territorial application of the rules. A commenter requests clarification that the statute and proposed rules apply only to Texas residents covered by a Texas-filed policy and suggests changing the first sentence of this section by adding the words "in Texas" after the words "coverage issued." In the second sentence, the commenter requests that the words "who is a resident of Texas" be added after the words "an individual insured or enrollee." Another commenter states that some plan contracts may have provisions limiting their applicability to Texas employees and that extra-territorial jurisdiction could have unintended consequences when other states may address the issue differently. Another commenter opposes limiting the rule to Texas policies because Insurance Code Article 21.42 extends Texas law to all policies payable in the state and SB 51 regulates policy contracts and applies to all Texans, including those employed by a multi-state entity and covered by a policy entered into and paid for in another state.

Agency Response: The Department disagrees that these changes are necessary to clarify the application of the rule. Moreover, SB 51 would not authorize the suggested changes. Insurance Code Article 21.42 requires that Texas insurance laws govern contracts of insurance payable to citizens or inhabitants of Texas to provide to those individuals the benefits of those laws. Because Article 21.42 applies Texas law only to citizens or inhabitants of Texas, it would not affect the applicability of SB 51 and these rules to an out-of-state individual covered through a Texas group policyholder or contract holder. Additionally, if an individual elects to continue coverage under state or federal law, subsection (e) of §21.4003 allows a group policyholder or group contract holder to limit responsibility for premium payment if it begins the continuation period as of the time the individual is no longer part of the group eligible for coverage.

§§21.4001 and 21.4003(a)(1): A commenter requests that the provision relating to the termination of coverage by an entire group or to the termination of coverage by an individual while remaining part of the group eligible for coverage be amended by adding the words "to enroll" after "group eligible" in the last sentence of §21.4001 and in §21.4003(a)(1), to avoid the interpretation that "group eligible for coverage" means the group comprised of employees or individuals who are permitted to enroll and who are actually enrolled.

Agency Response: The Department disagrees that the recommended change is necessary for clarification, because the persons enrolled in a plan and the persons eligible to enroll in the same plan are two distinct groups, although their membership will overlap and may be identical.

§21.4002(1): A commenter requests a cross reference to the term "blended contract" in §21.4002(1).

Agency Response: The Department disagrees that such a cross reference is necessary. It is not feasible to cross reference every term used in these rules, which implement Insurance Code §§843.210 and 1301.0061. The adopted sections should be read in conjunction with SB 51, §§1 and 2, the Insurance Code, and other statutes and rules as applicable. The definition of "evidence of coverage" is consistent with the definition of the same term in the Insurance Code §843.002(9), and the term "blended contract" is defined at §843.002(3).

§21.4002(4): A commenter notes that the definition of "health insurer" includes a reference to Insurance Code Chapter 941, which governs Lloyd's plans and reciprocal and inter-insurance exchanges, which are not subject to Chapter 1301.

Agency Response: The Department has revised the definition to delete the reference to Chapter 941.

§21.4002(6): Several commenters request revising the first sentence in the definition of the term "month" by adding the words "as provided in the group policy or contract" after "succeeding calendar month," to reference the group policy or contract. Another commenter suggests adding the words "applicable to the policy and as agreed upon by the health carrier and the policyholder or contract holder" after "succeeding calendar month."

Agency Response: The suggestion to add the language "as provided in the group policy or contract" is consistent with the Department's interpretation of the statute, and the Department

has revised the rule accordingly. The Department disagrees with the second recommended change because it is unnecessary; agreement between the carrier and the policyholder or contract holder is included in the concept of the group policy or contract.

§21.4002(6): A commenter requests clarification on how the definition of the term "month" would be implemented, particularly where an individual's coverage takes effect after a waiting period. The commenter is unsure how SB 51 would apply to this employee's termination of coverage.

Agency Response: SB 51 does not affect inception of coverage dates but does affect termination of coverage dates, overriding a contract that previously would have allowed termination of coverage at the same time as termination of group eligibility. The definition of the term "month" as adopted is revised to allow the parties to an insurance contract to agree to a "month" that does not correspond to the calendar month. The parties must set the terms of any such "month" in their contract, and these terms will govern termination dates for all individuals covered under the contract. Accordingly, the date when a particular covered individual begins coverage is irrelevant to the termination of coverage and premium payment obligations under SB 51.

§21.4003: A commenter requests a change to exempt from the coverage requirements loss of coverage by non-employee members receiving coverage under an association health plan. The commenter states that the legislative history of SB 51 indicates that it is intended to apply only to employer-sponsored plans.

Agency Response: The Department disagrees that this change is necessary. While the legislative history of SB 51 does emphasize issues with employer-sponsored coverage, the legislature chose to enact a bill with broader applicability. Subsection (g) of §21.4003 clarifies that the requirements of the statute do not apply to plans for which policyholders or contract holders do not contribute to the payment of premium, a class that includes many member-only associations.

§21.4003: A commenter requests a change to exempt individually underwritten group arrangements from SB 51 requirements, contending that such plans are not true group plans because coverage is not made available to association members on a group basis. The commenter asserts instead that members who wish to enroll in the plan must submit applications to the insurance carrier underwriting the plan. The commenter states that in true group employer-sponsored plans, members are entitled to coverage based upon membership in a certain group without regard to medical underwriting.

Agency Response: The Department disagrees that this change is necessary. Subsection (g) of this section clarifies that the requirements of the statute do not apply to plans for which contract holders or policyholders do not contribute any premiums, which includes member-only associations in which the member pays the premium. While enrollment on a group basis without individual medical underwriting is a characteristic of some groups, it is not a bright line test for group coverage. The Department disagrees with the commenter's characterization of member-only associations as not true group plans.

§21.4003(c), (d), (e), (f), (g), and (h): A commenter states that while it is clear that the intent of the proposed rule is to create certain exemptions to the SB 51 requirements as restated in subsection (a), the effect is that the rule as proposed exempts parties from including provisions in their contracts rather than exempting the parties from their effect. One commenter suggests clarifying the language to indicate that the mandatory provisions in the policy or group contracts must allow for the notice in subsections (c), (d), (e), (g), and (h). Other commenters state that the lead-in sentence language in these subsections as proposed would be more accurate if the phrase "[a] group policyholder or contract holder is not liable for an individual insured's or enrollee's premiums under §21.4003(a) of this section" replaced the phrase "[s] ubsection (a) of this section does not apply," since the contract must contain the statutory language requiring notification but specified situations could except the premium payment and coverage requirements.

Agency Response: The Department agrees with the commenters and has replaced the lead-in sentence language in proposed subsections (d), (e), (g), and (h) to add the phrase "[a] group policyholder or contract holder is not liable for an individual insured's or enrollee's premiums under subsection (a) of this section." In order to make this change consistent in all revised subsections, in subsection (e), the Department deleted the additional language "and may terminate an individual insured's or enrollee's coverage under a group health benefit plan at the time the individual is no longer a part of the group eligible for coverage under the plan," as proposed. Additionally, the first sentence in subsection (c) as adopted and the lead-in sentence to subsection (f) as adopted are also revised for consistency with these requested changes in subsections (d), (e), (g), and (h). In response to another comment, the Department has completely revised the first sentence of subsection (c).

In conjunction with the change to the lead-in sentence language in subsections (d) - (h), the Department has also added the phrase "and a health carrier is not obligated to continue coverage" to clarify that health carriers will not be required to continue coverage under subsection (a) if one or more of subsections (d) - (h) are applicable. While this is implied in the proposed subsections, it is not explicit except in proposed subsection (e). In subsection (e), the Department has also deleted the proposed language "and may terminate an individual insured's or enrollee's coverage under a health benefit plan at the time the individual is no longer part of the group eligible for coverage under the plan." This language is no longer necessary because it is redundant of the added language "and a health carrier is not obligated to continue coverage."

§21.4003(c): Another commenter requests that in the first sentence of subsection (c) the Department replace the phrase "not subject to" with the phrase "presumed to be in compliance with."

Agency Response: In response to another comment, the Department has completely revised the first sentence of subsection (c); because this subsection no longer contains the phrase "not subject to," the commenter's request for the language change is moot.

§21.4003(a)(1): A commenter recommends deleting the words "or group contract holder" in this paragraph so that the paragraph would read "the group policyholder, as described in Insurance Code Chapter 1251. . . ."

Agency Response: The Department disagrees that this change is necessary because the language is consistent with the Insurance Code Chapter 1251, which contains numerous references to "group policy or contract."

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§21.4003(a) - (c): A commenter requests that subsection (c) of this section clarify that electronic transmissions are presumed received the date that electronic transmissions are sent, not the date the health carrier might open or otherwise process such a transmission (e.g., in an email). Except for that clarification, the commenter recommends these subsections remain unchanged as proposed.

Agency Response: The Department agrees with the commenter and has added language to subsection (c)(2) of this section to clarify that immediate written notification sent via electronic means will be presumed received on the date it is submitted. This new second sentence is modeled on the "date of receipt" language, in 28 Tex. Admin. Code §21.2816 (relating to Date of Receipt) of Subchapter T, the Submission of Clean Claims Rules. Consistent with this change, the Department has also made two other modifications in this subsection for clarification and to facilitate compliance with the rules and the statutes. The Department has added language in subsection (c)(2) to state that, hand-delivered notifications will be presumed received on the date the delivery receipt is signed. The Department has also added an optional provision to subsection (b) of this section that states that a transmitter may maintain evidence of written notifications in a mail log to provide proof of submission and establish date of receipt.

§21.4003(b): A commenter states that this subsection only relates to the issue of coverage and payment of premium, and recommends the Department clarify the subsection by adding language to state that the health carrier cannot be charged with knowledge of a coverage termination until notice of the coverage termination actually arrives.

Agency Response: Timely notification ends the SB 51 premium payment and coverage obligations at the end of the notification month, even though the carrier may not receive the notification by the end of that month. Obligating the carrier to representations relating to coverage between the end of the month and the receipt of timely-tendered notice of termination would nullify the effect of the additional notification period, as well as the "mailbox rule." Prudent group policyholders and contract holders will provide notice as early as practicable, and when early notification is not possible, will communicate with their carriers by telephone to inform them of the transmission of notice. While this practice is particularly important when the policyholder or contract holder has transmitted notification by mail, it is also a good idea for a group policyholder or contract holder to confirm receipt of an electronically transmitted notice.

§21.4003(b): A commenter requests a change to this subsection to prevent a provider or patient from becoming responsible for payments. The commenter requests that the word "accepts" in the first sentence be replaced by the word "receives."

Agency Response: The Department has revised the rule to address the commenter's concern and to clarify compliance. However, the Department does not agree that the term "receives" is appropriate because it implies that the carrier must accept notice by mail. Therefore, the Department has replaced the term "accepts" with "agrees that a group policyholder or group contract holder may tender."

§21.4003(b) and (c): Another commenter requests a change to these two subsections to prevent a provider or patient from becoming responsible for payments. The commenter suggests language for a second sentence in each subsection to state that if otherwise covered services are provided during the additional notification period, the health carrier shall process and pay additional premium pro-rated through the date the services were provided.

Agency Response: The Department disagrees with the commenter because this change would

nullify the effect of timely transmission of notice by mail, as well as compliant transmission of notice during the additional notification period. Most individuals losing eligibility for group coverage have the opportunity to elect to continue that coverage under either federal or state laws, which would allow them to avoid undue financial obligation.

§21.4003(b) and (c): A commenter suggests that the Department change the additional notification period from five days to the "tenth calendar day of the next policy or contract month" because businesses notify their carriers of terminations at the same time they pay their monthly premiums and their plan receives payment and termination notification by the tenth calendar day of the next contract or policy month. Another commenter requests extension of the additional notification period to ten days to accommodate employers such as those with multiple worksites but only one business office processing notices of termination.

Agency Response: The Department disagrees that lengthening the additional notification period from five days to ten days is necessary because it is not consistent with a reasonable interpretation of SB 51. The intent of SB 51 is to encourage prompt and timely notification of an individual's loss of group eligibility. For consistency with the intent of SB 51 and in response to the requests of several stakeholders, the Department has shortened the additional notification period from the proposed five days to three days. The additional notification period of three days as adopted is consistent with the period of time to effect notification by mail, encourages the use of means that provide immediate notification, and balances the interests of the various parties. The Department will, however, monitor the ability of group policyholders and group contract holders to tender timely notice under the adopted rule.

§21.4003(c): A commenter opposes the additional notification period because an individual may obtain costly services during that time period and carriers may retroactively deny these claims upon learning an employee is no longer part of the group eligible for coverage. The commenter states that sometimes retroactive denials occur after the expiration of the individual's continuation election period, negating the ability of the provider to encourage the individual to elect continuation. The commenter questions the need for the additional notification period in an era of instant messaging. Other commenters support the additional notification period. Several commenters recommend that the first sentence of this subsection be replaced with the language: "[i]f an individual or enrollee ceases to be part of the group eligible for coverage within seven calendar days prior to the end of the month, the group policyholder or contract holder will be deemed to have notified the health carrier in the month in which the individual or enrollee ceases to be part of the group if the health carrier receives notification within the first three days of the subsequent month, not including Saturdays, Sundays, and legal holidays." In the second sentence of the subsection, the commenters recommend inserting the words "if the notification is sent during" in place of the word "during" and inserting the words "three-day" before the words "notification period."

Agency Response: The Department understands the commenter's concerns regarding services obtained during the additional notification period; however, due to the fact that notifications may be mailed late in the month, a potential always exists for there to be a short period of time between the termination of employment and notification to a carrier. The Department agrees with and has incorporated the suggested change limiting the additional notification period to three days, as well as limiting the additional period to terminations that occur within seven days before the end of the month. The additional three-day "instantaneous method" notification period tracks the mailing period closely and minimizes the risk to a physician or provider while recognizing that some employers may continue to have problems with providing timely notice of late-month terminations. The Department has also minimized the risk to physicians or providers by limiting the use of the three-day additional notification period to terminations that occur within seven days of the end of a month. Since the additional notification period will always occur within a few days of termination of group membership, the individual will always be within

any applicable continuation of coverage election period. While recoupment presents a potential problem, physicians and providers that promptly file claims incurred within the additional notification period should receive a response from the carrier in time to encourage patients to exercise their continuation options. Since the additional notification period is only three days, a carrier's eligibility records should be updated by the time the carrier processes the claim and the physician or provider should get a denial instead of an incorrect payment that may ultimately result in a recoupment request after it is too late for the patient to continue coverage.

§21.4003(c): Another commenter suggests anything less than five days is not a reasonable amount of time for an additional notification period.

Agency Response: The three-day period provides a reasonable time for employers to deal with end-of-month terminations and other extreme circumstances. While there are potentially some group policyholders or contract holders that could not provide notice in three additional days that could in five, the longer the additional notification period, the more likely it will counteract the goal of SB 51 of encouraging timely notification by group policyholders or contract holders. The rule as adopted balances the interests of all affected parties.

§21.4003(c): A commenter requests a change to provide for the fact that any time the terminated member obtains other coverage, the carrier's obligation to pay for coverage would cease, and so would the plan sponsor's obligation to pay premium.

Agency Response: The Department disagrees with the recommended change because unconditional extinction of the carrier's and the plan sponsor's SB 51 obligations would violate the intent of the legislation, which is to provide prompt notification. Subsection (e) of the rule allows a terminated member's newly-obtained coverage to extinguish the group policyholder's or contract holder's obligation to continue premium payments, but only upon satisfaction of certain conditions.

§21.4003(d): Commenters propose reducing the prior notice period from 30 days to a period ranging from five business days to two weeks, since employees typically only give two weeks' notice. One commenter notes that carriers use federally-mandated electronic technologies to receive and update eligibility files, to shorten their eligibility processing times, and to give providers accurate notice of an individual's coverage status. Accordingly, the commenter asserts that these technologies eliminate the issues that SB 51 was designed to address. The commenter recommends substituting the number "five" for "30" and inserting the words "not including a Saturday, Sunday, or legal holiday," before the words "prior to the date."

Agency Response: The Department disagrees with these recommended changes because they are not consistent with a reasonable interpretation of the statute. The statute specifically addresses situations where loss of group eligibility precedes notice (e.g., the individual leaves the group on day one of the month and the group policyholder or contract holder provides notice on day two). In such circumstances, coverage could terminate as late as day 31 of the month. This subsection, however, addresses the reverse situation: when notice precedes loss of group eligibility; the rule's 30-day notice requirement corresponds to the maximum length of coverage under the statute when a group policyholder or group contract holder gives timely notice of termination. The commenter is correct that technical advances mitigate to some extent the issues SB 51 addresses, and the Department will continue to monitor the implementation of those advances and how they affect the accuracy of group health care coverage enrollment

data.

§21.4003(e): A commenter recommends deletion of this provision because it is too complicated and unworkable. The commenter asserts that some employers may not know when an individual is no longer eligible for coverage and that this subsection assumes that the employer knows both when the individual loses eligibility, as well as the existence and effective date of the individual's coverage elsewhere, when such knowledge is unlikely.

Agency Response: The Department understands that this exception will not be practical for all parties in all circumstances, but it is not mandatory. The Department disagrees that this provision should be deleted in its entirety. In response to comments, the Department is adopting this provision to make it available for those able to use it. This provision encompasses options of which employers will likely have knowledge, such as continuation of coverage under COBRA. The Department has revised the subsection as proposed to clarify its application in those situations. The Department has also made other changes to this subsection as proposed for purposes of clarification, consistency, and facilitation of compliance: (i) revised the lead-in sentence language to provide that "[a] group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section and may terminate. . . ."; (ii) changed the term "new" to "successor;" (iii) substituted the term "verify" for the proposed terminology "provide proof of;" and (iv) substituted the phrase "at any time after termination of group eligibility and before the end of the coverage and premium payment period required by Insurance Code §§843.210 and 1301.0061 and subsection (a)" for the proposed language "immediately upon termination of coverage under a group health benefit plan" because it is necessary to end requirements from the time successor coverage begins whether or not it is immediately upon termination of coverage under the group health benefit plan.

§21.4003(e): The commenter asserts that this provision is unduly burdensome to an employer who may be unable to meet a carrier's proof requirements and suggests a revision to allow an employer policyholder or contract holder to submit a certification that the individual has obtained new coverage. The commenter suggests specific language that substitutes the phrase "reasonable representation to the health carrier that the individual will have new coverage" for the phrase "proof of the new coverage" to lessen the burden on former employers when a terminating employee may be unwilling or unable to timely obtain and forward the proof of the subsequent coverage.

Agency Response: While the Department does not see a meaningful substantive difference between the existing standard and the one the commenter suggests, the Department has revised subsection (e) to substitute the word "verify" for the proposed language "provide proof of." This change should address the commenter's concerns. Also, regardless of the rule, the Department expects both parties to provide and accept reasonable evidence in satisfaction of the rule standard. A certification should in most cases suffice to verify the new coverage, particularly in light of the obligation to pay premium if the new coverage fails. More direct evidence from an employer--a coverage document from the new plan, an employee's COBRA election--is always preferable, but not always practicable.

§21.4003(f): A commenter asks whether this subsection removes the premium payment requirements imposed by SB 51 upon employers for those employees who are COBRA participants. The commenter states that COBRA imposes a 30-day grace period and that this

subsection has the potential to wreak an undue financial hardship on employers.

Agency Response: An individual's commencement of coverage under a continuation of coverage option ends a group policyholder's or contract holder's obligation to pay premium. The individual remains eligible to continue group coverage for a statutorily-specified period but is no longer part of the group eligible for coverage.

§21.4003(f): A commenter asks when an "eligibility termination event" is a COBRA qualifying event (QE). COBRA allows employers to choose between starting the COBRA continuation period: as of the date a QE occurs or later when the date coverage actually ends, which is typically is the last day of the month in which a QE occurs. The commenter opines that the new law prohibits carriers from ending coverage until the last day of the month in which the insurer receives notice of the QE from the group policyholder or contract holder and also asserts that carriers will need to adjust (and delay) the "active" coverage termination date and charge the employer instead of the employee for the premium for that period. The commenter asks how the Department reconciles the incongruence between the new law and the employer's usual COBRA practices and requests clarification of how the "end of the month rule" affects the COBRA member's COBRA continuation period and COBRA coverage rights. To the extent that an employer or COBRA administrator "feeds" a mid-month coverage termination date to the insurer, the commenter questions whether the insurer can or must adjust that retroactive, mid-month termination date to the last day of the notice month (subject to the grace period rule).

Agency Response: In response to the commenter's first query, subsection (e) of the rule allows employers to continue to choose between starting COBRA continuation as of the date of the QE or when the date coverage actually ends. In response to the commenter's second query, SB 51, as implemented by this rule, does not interfere with employers' usual COBRA practices. If an employer starts COBRA the last day of the month of a QE, that will correspond to the last day of coverage under SB 51 as long as the employer provides timely notification. If the employer starts COBRA as of the date of the QE, then under subsection (e) of §21.4003, the employer's premium payment obligation ends upon proof to the carrier that the individual is now under successor coverage (the same plan, but with different eligibility standards and obligation for payment of premium).

The contractual coverage period will also direct an insurer's actions regarding billing and initiation of COBRA coverage. If the contract between the carrier and the employer already provides coverage through the end of the month, as is the case in the great majority of situations according to testimony at the hearing on this rule, SB 51 will have no bearing if the group policyholder or contract holder provides timely notification. If coverage terminates on the date employment terminates, carriers and employers will have to determine how to allocate premium between the employer and the ex-employee. To illustrate this principle, assume a company has coverage that terminates at the end of employment, a coverage contract based on a calendar month, and an employee that leaves employment on May 15. SB 51 would obligate the employer to pay premium for this individual through the end of May. If the individual then elects COBRA on June 9, the employer could begin COBRA coverage either at the end of May or as of the earlier QE. If COBRA begins May 15, the employer would be entitled to recoup its premium payment for the remainder of May from the first COBRA payment made by the employee.

§21.4003(f): A commenter requests that this provision either be entirely deleted or limited to situations where the policy is converted from a group policy to an individual policy as permitted by Insurance Code §§1251.256 - 1251.259. The commenter states that if this exception is limited to the group policies, subsection (e), which clarifies that any new coverage should be effective

immediately upon coverage termination under the group health plan, should mirror that language. According to the commenter, while employees who elect COBRA are obligated to pay the premiums, Insurance Code §1251.252 states that an individual is entitled to continuation of group coverage under certain circumstances and would not be terminated from group eligibility in those instances. With COBRA elections, the commenter suggests that the group policyholder or contract holder must still transmit the premium to the carrier and notify the carrier of the termination.

Agency Response: The Department disagrees with the suggested change to delete the entire subsection or limit it to situations where the policy is converted from a group policy to an individual policy. This subsection is necessary to implement and clarify SB 51. While COBRA and other continuation provisions may entitle an individual to continue group coverage for a statutorily-specified period under special eligibility laws, the individual is no longer part of the group eligible for coverage. The Department agrees that a group policyholder or contract holder may retain an obligation to transmit premium and enrollment data to a health carrier; however group policyholders or contract holders had this obligation prior to the enactment of SB 51. Neither the statute nor this rule in any way affects a carrier's rights and remedies against a group policyholder or contract holder that fails to meet its obligations of this nature. The Department has, however, changed the lead-in sentence language of this subsection in response to comments and for clarification. Subsection (f) as adopted contains the following lead-in sentence language: "[a] group policyholder or contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section under coverage a health carrier extends to an individual in compliance. . . ."

§21.4003(f): A commenter recommends the addition of a new paragraph in this subsection to clarify that subsection (a) of this section does not apply to coverage a health carrier extends to an individual "that is immediately followed by continuation coverage elected by or on behalf of an individual insured or enrollee."

Agency Response: The Department disagrees with the commenter's suggested change because subsection (e) allows an employer to end its premium payment obligation under SB 51 when its ex-employee obtains successor coverage, including continuation coverage. The Department has, however, changed the proposed term "new" to "successor" in subsection (e) to clarify this right. Additionally, the Department has made a technical change to the lead-in sentence language of this section for clarification.

§21.4003(f): The commenter interprets the rule to exempt all groups subject to continuation of coverage laws from the effect of SB 51 but expresses understanding that the Department's interpretation is solely to end a group policyholder's or contract holder's obligation once an individual has begun continuation coverage. The commenter states enforcement of SB 51 on employers subject to COBRA, and to a lesser degree Uniformed Services Employment and Reemployment Rights Act (USERRA) and State Continuation, would effectively block an employer's rights granted in U.S. Treasury Department regulation 26 C.F.R. §54.4989B-8, which allows for both retroactive termination and reinstatement of coverage. The commenter urges that SB 51 should only apply to employer groups of less than 20 lives not subject to the USERRA when employees have been on the plan for less than the statutory 90 days to be eligible for state continuation.

Agency Response: The Department disagrees with the suggested change because SB 51 applies to group policyholders and group contract holders regardless of the size of the employer. The commenter's suggestion is over-inclusive in that it would affect even individuals

that do not elect continuation coverage. Subsection (f) provides relief to a group policyholder or contract holder when an individual elects continuation of coverage, but not in all circumstances. Additionally, the cited Treasury Department regulation applies only after inception of COBRA or similar federal continuation of coverage. The rule simply clarifies that the employer no longer has responsibility after the inception of continuation coverage; therefore, the statute and the rule do not conflict with the federal regulations.

§21.4003(f): A commenter requests additional language listing federal health plans not covered by SB 51 (e.g., Medicare, Medicaid, FMLA) and other plans covering federal employees exclusively.

Agency Response: The Department disagrees that this listing is necessary. SB 51 applies to coverage plans issued pursuant to the Insurance Code Chapters 843 and 1301. If a federal employee health plan is not issued pursuant to the authority of one of these two chapters, then SB 51 does not apply to it. The reason the rule specifically addresses continuation coverage is because carriers frequently provide such coverage through Insurance Code Chapter 843 or 1301 plans.

§21.4003(f) - (g): A commenter recommends that these subsections remain as proposed because they relieve the employer from continuing coverage if they do not contribute premium.

Agency Response: The Department agrees with the commenter that the subsections should remain substantively unchanged as proposed. The Department, however, has made a clarifying change to the lead-in sentence language in each of these two subsections as adopted, which reads "[a] group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section if . . . ."

§21.4003(g): A commenter states that this subsection is a desirable provision and specifically requests it remain in the rule.

Agency Response: The Department has retained this subsection in the adoption.

§21.4003(g): A commenter questions the statutory authority for this subsection and states that it would be helpful if the rule included examples. The commenter states that, while some employers make employees fully responsible for premium payments, these employers have established a group plan and will have contracts with health carriers that obligate them to transmit the paid premiums to the carrier and comply with the notice requirements of the law. Another commenter requests that the Department add the following examples to this subsection for clarification of the intent to exempt group policyholders or contract holders who do not have employer relationships or contribute no funds for any covered individual: (1) an association who has no employer-employee relationship and contributes no premium, but provides association dues-paying members the opportunity for coverage and agrees to bill 100% premium to members and remit this to the carrier; (2) an association that contributes to the cost of premium for six full-time employees of the association; and (3) an employer that contributes to the cost of employee premium but not for dependent premium under its group plan.

Agency Response: The statutory authority for this subsection is the plain language of §§843.210 and 1301.0061 of the Insurance Code which provides that in addition to other premiums for which the group policyholder or contract holder is liable, group policyholders or contract holders are responsible for the obligation to continue premium payments and coverage, as well as the rulemaking authority granted to the Commissioner in Insurance Code §§843.151, 1301.007, and 36.001. The Department agrees that a group policyholder or contract holder may retain an obligation to transmit premium and enrollment data to a health carrier; however, group policyholders or contract holders had this obligation prior to the enactment of SB 51. Neither the statute nor this rule in any way affects a carrier's rights and remedies against a group policyholder or contract holder that fails to meet its obligations of this nature. This rule provision operates simply to provide exemption from liability for premium payment imposed by subsection (a) for a group policyholder or contract holder that does not contribute to the premium payment for any individual covered by the policy or contract. If the group policyholder or contract holder does contribute, then the group policyholder or contract holder is not exempt. While the Department does not agree that it is necessary to add the suggested examples to the rule text, the Department will discuss the suggested examples in this response to enhance compliance as entities conform their practices to the adopted regulation. Association group members are eligible for group insurance based upon their membership in a group formed for a purpose other than to obtain insurance coverage (e.g., teachers' or physicians' associations). Under the adopted rule, the group contract holder in example one would be exempt from the premium payment requirements of SB 51, and the issuing carrier would be exempt from the coverage requirement. In examples two and three, the premium contributions would make SB 51 requirements apply. In addition, the plan described in example two, covering employees of the association, would be subject to Chapter 1501 of the Insurance Code and the uniform contribution requirements of Insurance Code §1501.153, so it would not appear that a single plan could cover both employees and association members.

§21.4003(g): Commenters state that this subsection is unfair, could burden business, and adversely impacts access to health coverage because it requires employers to pay all premiums for a former employee and a former employee's dependents if the employer tenders notification outside the "grace period," given that employers voluntarily offer health benefits to employees and often do not contribute any amount to dependent premium. Another commenter recommends substituting the words "to any dependent coverage where the" in place of "a health benefit plan for which a." Another commenter states that the proposal does not address the employer's responsibility for premium payments for the contribution requirement of 50% for terminated employees and 100% for dependents and asks whether they can recoup these contribution amounts by payroll deduction or billing.

Agency Response: The statute requires group policyholders or contract holders to pay premium and carriers to provide coverage. It does not place any obligations on individuals losing group eligibility. Neither does it provide a basis for treating dependents differently than primary group members, such as employees. The Department does not regulate, except in certain specified circumstances, the activities of employers. Accordingly, the Department does not agree with the recommended changes.

§21.4003(g): Another commenter asks that the rule clarify that an employer is not responsible for premium payment for any amounts other than what the employer would have paid for active employees because SB 51 does not require coverage and payment of such amounts.

Agency Response: The Department disagrees with the commenter's assertion that an employer is not responsible for premium payment for any amounts other than what the employer would have paid for active employees because Insurance Code §§843.210(2) and 1301.0061(2), as

added by SB 51, require that group policyholders and contract holders contractually assume liability for premiums until the end of the month in which an enrollee's or individual insured's coverage terminates and the carrier is notified. SB 51 is intended to prevent retroactive recovery of payments for medical services provided in good faith prior to the retroactive disenrollment of the employee by encouraging timely notification by employers. Therefore, the Department does not agree with the requested clarification.

§21.4003(h): A commenter questions the need for the language in this subsection that protects payment for covered services performed after a patient's death.

Agency Response: The Department disagrees with the commenter's suggestion that this subsection is unnecessary. A physician or provider may perform services after a patient's death. For example, a radiologist could interpret an x-ray taken prior to a patient's death before learning that the patient had died.

§21.4003(h): A commenter requests that this subsection be adopted as proposed because in certain instances employers may not immediately learn of the employee's death and should not be responsible for those premiums.

Agency Response: The Department agrees with the commenter and adopts the subsection as proposed with only minor changes for clarification.

§21.4003(h): A commenter requests that the Department consider clarifying the status of dependents left behind by a deceased member. Another commenter notes that the death of an employee does not terminate coverage of dependents.

Agency Response: The subsection affects the obligation to pay premium for and provide coverage to only the deceased individual. An individual's demise does not affect coverage obligations owed to dependents. SB 51 would continue to affect a group policyholder's or contract holder's and carrier's obligation toward any other individuals losing eligibility for group coverage. Therefore, the Department does not agree with the requested clarification.

§21.4003(h): A commenter states that the premium under a group policy is usually payable for an entire contract month. The commenter remarks that mid-month terminations due to death, divorce, or other circumstances would thus not result in unearned premium as the rate is based on the entire month.

Agency Response: As the commenter states, monthly premium arrangements are customary, but they are not exclusive. This subsection does not address or alter contractual premium payment arrangements but rather addresses only a party's obligations under SB 51. If an employer, for example, had contracted with a carrier for coverage that terminates when an employee loses group eligibility (in this instance due to death), this subsection would provide that the premium payment obligation under SB 51 would cease prior to the end of the month of notification. If the contracted coverage terminates only at the end of a month, then the employee's death would have no effect on premium payment or coverage obligations.

Miscellaneous: A commenter requests the addition of a new section to the proposed rule to allow carriers to use current contract amendments until a "reasonable time," to file new amendments. The commenter suggests 60 days after the Commissioner approves these rules. Some contract amendments were effective January 1, 2006, and carriers will need to file new amendments once these rules are adopted.

Agency Response: Insurance Code §§843.210 and 1301.0061 as added by SB 51 became effective September 1, 2005. The Department understands, however, that carriers will need time to effect the changes needed as a result of the adoption of these rules that implement SB 51. The Department disagrees that adding a new section to the rule to specify a particular date for implementing changes is necessary because implementation time may necessarily vary. The Department, however, urges and expects carriers to act expeditiously in updating forms and procedures.

Miscellaneous: Another commenter asks whether the rules apply to eligibility termination events that occurred in 2005, but were not reported until 2006.

Agency Response: According to §5 of SB 51, Insurance Code §§843.210 and 1301.0061 apply only to a contract between an insurer or health maintenance organization and a group policy or contract holder that is entered into or renewed on or after January 1, 2006. A contract entered into or renewed before January 1, 2006, is governed by the law in effect immediately before the SB 51 effective date of September 1, 2005. The rule only applies to eligibility termination events that are governed by SB 51, and no event in 2005 would have occurred under a contract subject to SB 51.

Miscellaneous: A commenter asks whether Insurance Code Chapters 843 and 1301 and SB 51 apply to dental insurance products and vision insurance products that provide access to network providers for eye exams and network retail suppliers.

Agency Response: The scope of SB 51 is expressed by type of plan, not by type of benefits or services. Health care coverage plans issued pursuant to the authority of Insurance Code Chapters 843 and 1301 are subject to SB 51. If a carrier issues a vision or dental coverage contract pursuant to one of these chapters, then the contract is subject to SB 51. Insurance Code §1301.002, however, states that Chapter 1301 does not apply to a provision for dental care benefits in a health insurance policy.

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

For with changes: Administaff, Inc.; Aetna; BlueCross BlueShield of Texas; Humana; Infinisource, Inc.; Insurance Network of Texas; Office of Public Insurance Counsel; The Benefits Office; Texas Association of Business; Texas Association of Health Plans; Texas Association of Health Underwriters; Texas Association of Life and Health Insurers; Texas Hospital Association; Texas Medical Association; Texas & Southwestern Cattle Raisers Association; and Unicare.

Against: None.

6. STATUTORY AUTHORITY. The new sections are adopted under Insurance Code §§843.210, 1301.0061, 843.151, 1301.007, and 36.001. Sections 843.210 and 1301.0061 address the obligation of certain group health coverage policyholders and contract holders to continue premium payment, and a carrier's corresponding obligation to continue coverage, after notice of an individual's lost group eligibility. Section 843.151 provides that the Commissioner may adopt reasonable rules as necessary and proper to fully implement the Insurance Code Chapters 843 and Article 20A (non-substantive revision of Article 20A enacted by the 78th Legislature as Chapter 1271, effective April 1, 2005). Section 1301.007 provides that the Commissioner shall adopt rules as necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider benefits and basic level of benefits to residents of this state. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§21.4001. Purpose and Scope. This subchapter applies to group preferred provider benefit plans and evidences of coverage issued pursuant to Insurance Code Chapters 843 and 1301. The subchapter outlines a group policyholder's or group contract holder's liability for premium payment, and a health carrier's obligation to provide coverage, from the time an individual insured or enrollee loses eligibility for coverage as part of a particular group until the end of the month in which the group policyholder or group contract holder notifies the health carrier that the individual is no longer part of the group eligible for coverage. The subchapter does not impose requirements on a group policyholder, a group contract holder, or a health carrier when an entire group ends coverage under a health benefit plan or when an individual terminates coverage while remaining part of the group eligible for coverage.

§21.4002. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) Evidence of coverage--Any certificate, agreement, or contract, including a blended contract, that:

(A) is issued to an enrollee; and

(B) states the coverage to which the enrollee is entitled.

(2) Health benefit plan--A preferred provider benefit plan or health maintenance organization evidence of coverage or other group health benefit plan issued by a health maintenance organization.

(3) Health carrier--A health insurer issuing a preferred provider benefit plan, as defined in Insurance Code §1301.001(9), or a health maintenance organization, as defined in Insurance Code §843.002(14).

(4) Health insurer--A life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Insurance Code Chapters 841, 842, 884, 885, 982, or 1501 that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

(5) Health maintenance organization--A person who arranges for or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan as defined in Insurance Code §843.002(14).

(6) Month--The period from a date in a calendar month to the corresponding date in the succeeding calendar month, as provided in the group policy or contract. If the succeeding calendar month does not have a corresponding date, the period ends on the last day of the succeeding calendar month.

(7) Preferred provider benefit plan--Any policy or contract issued pursuant to Insurance Code Chapter 1301.

§21.4003. Group Policyholder, Group Contract Holder, and Carrier Premium Payment and Coverage Obligations.

(a) A contract between a health carrier and a group policyholder or group contract holder under a health benefit plan contract must provide that:

(1) the group policyholder or group contract holder, as described in Insurance Code Chapter 1251, is liable for an individual insured's or enrollee's premiums from the time the individual is no longer part of the group eligible for coverage under the plan until the end of the month in which the group policyholder or group contract holder notifies the health carrier that the individual is no longer part of the group eligible for coverage under the plan; and

(2) the individual remains covered under the plan until the end of the period specified in paragraph (1) of this subsection.

(b) If a health carrier agrees that a group policyholder or group contract holder may tender the notice referenced in subsection (a)(1) of this section by mail, the date the group policyholder or group contract holder tenders the notice to the postal service is the date the group policyholder or group contract holder notifies the health carrier. Evidence of written notifications may be maintained in a mail log in order to provide proof of submission and establish date of receipt.

(c) If an individual or an enrollee ceases to be a part of the group eligible for coverage within seven calendar days prior to the end of the month, the group policyholder or group contract holder will be deemed to have notified the health carrier in the month in which the individual or enrollee ceases to be part of the group if the health carrier receives notification within the first three days of the subsequent month, not including Saturdays, Sundays, and legal holidays. If the notification is sent during this additional three-day notification period, the policyholder or contract holder must transmit the notification of an individual's loss of eligibility during the previous month by a method:

(1) agreed upon by the group policyholder or group contract holder and the carrier, and

(2) that provides immediate written notification, such as an internet portal, electronic mail, or telefacsimile. Immediate written notification sent via electronic means will be presumed received on the date it is submitted; hand-delivered notification will be presumed received on the date the delivery receipt is signed.

(d) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section if a group policyholder or group contract holder notifies a health carrier that an individual will no longer be part of the group eligible for coverage at least 30 days prior to the date the individual will no longer be part of the group eligible for coverage.

(e) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section if the individual elects to terminate coverage under the plan and obtains coverage under a successor health benefit plan that takes effect at any time after termination of group eligibility and before the end of the coverage and premium payment period required by Insurance Code §§843.210 and 1301.0061 and subsection (a) of this section. A health carrier may require a group policyholder or group contract holder seeking to avoid payment of additional premium for an individual no longer part of the group eligible for coverage to verify the successor coverage and to agree to be responsible for payment of premium if the individual's successor health benefit plan does not cover the individual from the termination of the health carrier's coverage until the end of the month in which the group policyholder or group contract holder notifies the health carrier that the individual is no longer part of the group eligible for coverage. In addition, the group policyholder or group contract holder and the health carrier remain responsible for compliance with Insurance Code §§843.210 and 1301.0061 if the individual's successor health benefit plan does not cover the individual from the termination of the health carrier's coverage until the end of the month in which the group policyholder or group contract holder notifies the health carrier that the individual is no longer part of the group eligible for coverage.

(f) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section under coverage a health carrier extends to an individual in compliance with 29 U.S.C. §1161 *et seq*. (COBRA), Insurance Code Chapter 1251 Subchapter F, or any other federal or state continuation of coverage requirement that allows an individual insured or enrollee, upon termination of eligibility from a group, to pay premium and extend the period of group health benefit plan coverage after the individual has left employment or otherwise no longer qualifies as a member of the group.

(g) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section if a group policyholder or group contract holder does not contribute to the payment of any individual insured's or enrollee's premium.

(h) A group policyholder or group contract holder is not liable for an individual insured's or an enrollee's premiums, and a health carrier is not obligated to continue coverage, under subsection (a) of this section in the event of the individual insured's or enrollee's death after the later of the date of the individual insured's or enrollee's:

(1) death; or

(2) receipt of the last covered service under the plan.

For more information contact: ChiefClerk@tdi.state.tx.us

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