COVERAGE REQUIREMENTS

UNIFORM PROGRAM (TRS-ACTIVE CARE)

Unless an exemption applies, a district with 500 or fewer employees is required to participate in the uniform group coverage program established under Insurance Code 1579 (TRS-Active Care). A district with more than 500 employees may elect to participate in the program. *Insurance Code 1579.151–.152; Education Code 22.004(a)*

The Teacher Retirement System (TRS) shall implement and administer the uniform group coverage program. TRS shall establish plans of group coverages for employees participating in the program and their dependents. *Insurance Code 1579.051, .101*

EMPLOYEE ELIGIBILITY

Participation in the program is limited to employees of participating districts who are full-time employees and to part-time employees who are participating members in TRS.

A part-time employee who is not a participating member in TRS is eligible to participate in the program only if the employee pays all of the premiums and other costs associated with the health coverage plan selected by the employee.

A participating employee may select coverage in any coverage plan offered by TRS. If the combined state and District contributions [see COST OF COVERAGE, below] exceed the cost of a coverage plan selected by the employee, the employee may use the excess contributions to obtain coverage under a higher tier coverage plan, or to pay all or part of the cost of coverage for the employee's dependents. A married couple, both of whom are eligible for coverage under the program, may pool the amount of contributions to which the couple are entitled under the program to obtain coverage for themselves and dependent coverage.

Insurance Code 1579, Subch. E

OPTIONAL COVERAGES

Districts participating in the uniform group coverage program may enter contracts to provide optional insurance coverages for District employees. *Education Code 22.004(j)*

OTHER PROGRAMS

Districts that do not participate in the uniform group coverage program shall make available to their employees group health coverage provided by a risk pool established by one or more districts under Local Government Code Chapter 172, or under a policy of group insurance or group contract issued by an insurer, a company subject to Insurance Code Chapter 842, or a health maintenance organization under Insurance Code Chapter 843.

FINANCIAL STATEMENT

The District may not contract with an insurer, company, or health maintenance organization to issue a policy or contract for group health insurance, or with any person to assist the District in obtaining or managing the policy or contract unless the insurer, company,

organization, or person provides the District with an audited financial statement.

Education Code 22.004(b), (c)

SMALL EMPLOYER MARKET ELECTION

A district that does not participate in the uniform group coverage program may elect to participate in the small employer market without regard to the number of eligible employees in the District. If the District makes this election, it will be treated as a small employer for the purposes of Article 1501 of the Texas Insurance Code.

A district that is participating in the uniform group coverage program may not renew a health insurance contract obtained in accordance with Article 1501 after the date on which the program of coverages provided under the uniform group coverage program is implemented. This provision does not affect a contract for the provision of optional coverages.

Insurance Code 1501.009

EMPLOYEE ELECTION — SPOUSES

A District employee who is eligible for coverage under a large or small employer health benefit plan providing coverage to the District's employees and who is the spouse of another District employee covered under the plan may elect whether to be treated under the plan as an employee or as the dependent of the other employee. *Insurance Code 1501.0095*

SELF-FUNDED HEALTH CARE PLAN

Except as otherwise provided above, the Board may establish a self-funded health care plan for District employees and their dependents. In implementing the plan, the Board shall establish a fund to pay all or part of plan-authorized costs for health care incurred by program participants. The fund consists of money contributed by the District and money deducted from the employee's salary for coverage, upon the employee's written authorization. *Education Code 22.005*

COMPARABILITY

If the District does not participate in the uniform group coverage plan, the coverage it provides must be comparable to the basic health coverage provided under Insurance Code Chapter 1551 (Texas Employees Group Benefits Act) and must meet the substantive coverage requirements set forth in Education Code 22.004(b).

COMPLIANCE REPORT

The District shall report its compliance with the comparability requirements to TRS by March 1 of each even-numbered year. The report must be based on the District group health coverage plan in effect during the current plan year and must include:

1. Appropriate documentation of:

a. The District's contract for group health coverage, or

b. A Board resolution authorizing a self-insurance plan.

2. The schedule of benefits.

3. The premium rate sheet, including the amount paid by the District and the employee.

4. The number of employees covered by each health coverage plan offered by the District.

5. Information concerning the ease of completing the report, as required by TRS.

6. Any other information considered appropriate by TRS.

The report must be available for review, together with the policy or contract for the group health coverage plan, at the central administrative office of each campus in the District and must be posted on the District's Internet Web site if the District maintains a Web site.

Education Code 22.004(d); 34 TAC 41.91(d)

COST OF COVERAGE

TRS-ACTIVE CARE

The cost of coverage under the uniform group coverage program shall be shared by the state, the District, and the employees, as set forth below.

STATE CONTRIBUTION

The state shall provide for each covered employee the amount of $900 each state fiscal year or a greater amount as provided by the General Appropriations Act. The state contribution shall be distributed through the school finance formulas under Education Code Chapters 41 and 42 and used by districts as provided by Education Code 42.2514 and 42.260. *Insurance Code 1579, Subch. F*

EMPLOYEE CONTRIBUTION

An employee covered by the program shall pay that portion of the cost of coverage selected by the employee that exceeds the amount of the state contribution and the District's contribution.

The District may pay any portion of what otherwise would be the employee share of premiums and other costs associated with the coverage selected by the employee.

Insurance Code 1579.253

OTHER PROGRAMS

If the District does not participate in the uniform group coverage program, the cost of coverage shall be shared by the employees and the District, using the contributions by the state described at Insurance Code Chapter 1579, Subchapter F. [See STATE CONTRIBUTION, above] *Education Code 22.004(c)*

DISTRICT CONTRIBUTION

MINIMUM EFFORT

The District shall, for each fiscal year, pay an amount equal to the number of participating employees multiplied by $1,800.

MAXIMUM EFFORT

Subject to the minimum effort requirement, a district that paid amounts for the 2000–01 school year for employees' health coverage shall, for each fiscal year, continue to pay at least the same amounts for each participating employee, computed as follows: the District shall divide the amount the District paid during the 2000–01 school year for the prior group health coverage plan by the total number of full-time employees in the 2000–01 school year and multiply the result by the number of full-time employees in the fiscal year for which the computation is made.

If, for the 2000–01 school year, the District provided group health coverage to its employees through a self-funded insurance plan, the amount the District paid during that school year for the plan includes only the amount of regular contributions made by the District.

Insurance Code 1581.052

EXCESS FUNDS

If the amount the District is required to pay for maintenance of effort exceeds $1,800 per participating employee, the District may use the excess only to provide employee compensation at a rate greater than the rate of compensation that the District paid an employee in the 2000–01 school year, benefits, or both.

Insurance Code 1581, Subch. B

HEALTH INSURANCE CONTRIBUTIONS FOR REHIRED RETIREES

Each payroll period and for each rehired retiree who is enrolled in TRS Care (retiree group health insurance), the District shall contribute to the TRS Care trust fund any difference between the amount the retiree is required to pay for the retiree and any enrolled dependents to participate in the group program and the full cost of the retiree's and enrolled dependents' participation in the group program, as determined by TRS. [See DEAB]

EXCEPTION

The District is not required to contribute these amounts for a retiree who retired from TRS before September 1, 2005.

Gov't Code 825.4092; Insurance Code 1575.204

DESIGNATION OF COMPENSATION FOR BENEFITS

An employee who is covered by a cafeteria plan or who is eligible to pay health care premiums through a premium conversion plan may elect to designate a portion of the employee's compensation to be used as health care supplementation. [See DEAB]

USE

An employee may use the compensation designated for health care supplementation for any employee benefit, including deposit-

ing the designated amount into a cafeteria plan in which the employee is enrolled or using the designated amount for health care premiums through a premium conversion plan.

Education Code 22.103, .106

CONTINUATION COVERAGE

AFTER RESIGNATION

Notwithstanding any other law, an employee whose resignation is effective after the last day of an instructional year is entitled to participate or be enrolled in the uniform group coverage plan or the group health coverage through the earlier of:

1. The first anniversary of the date participation in or coverage under the uniform group coverage plan or the group health coverage was first made available to District employees for the last instructional year in which the employee was employed by the District; or

2. The last calendar day before the first day of the instructional year immediately following the last instructional year in which the employee was employed by the District.

The District may not diminish or eliminate its contribution [see DISTRICT CONTRIBUTION, above] before the last date on which the employee is entitled to participation or enrollment.

Education Code 22.004(k), (l)

DURING MILITARY LEAVE

An employee who is absent from a position of employment by reason of service in the uniformed services may elect to continue coverage under a health plan. The maximum period of coverage of such a person and the person's dependents shall be the lesser of:

1. The 24-month period beginning on the date on which the person's absence begins; or

2. The day after the date on which the person fails to apply for or return to a position of employment. [See DECB]

38 U.S.C. 4317

DURING FMLA LEAVE

During any period of leave under the Family and Medical Leave Act (FMLA), the District shall allow the employee to maintain coverage under any group health plan for the duration of the leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of the leave. *29 U.S.C. 2614(c); 29 CFR 825.209, .210, .213* [See also DECA]

UPON TERMINATION OR OTHER QUALIFYING EVENT (COBRA)

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the District shall offer continuation coverage under any group health insurance plan established after July 1, 1986, to the following qualified beneficiaries for the stated period of time:

1. To the employee for 18 months after a termination (other than for gross misconduct) or reduction in hours. An employee providing notice of being disabled under Title II or XVI of the Social Security Act before the end of the initial 18 months of coverage shall be offered up to 29 months of continuation coverage.
2. To dependents of the covered employee for 36 months after the employee becomes eligible for Medicare benefits.
3. To dependents of the covered employee for 36 months after the employee's death or the divorce or legal separation of the employee from a spouse.
4. To a dependent child for 36 months after the child ceases to be a dependent under the terms of the plan.

42 U.S.C. 300bb-1, 300bb-2, 300bb-3

PREMIUM

The District may require premium payments not to exceed 102 percent of the usual cost of the plan for continuation coverage. Individuals entitled to 29 months of continuation coverage may be required to pay premiums not to exceed 150 percent of the usual cost for any month after the 18th month. The qualified beneficiary may choose to pay the premiums in monthly installments. In no event may payment be required before the day that is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. *42 U.S.C. 300bb-2(3)*

NOTICE

The District shall notify its group health plan administrator within 30 days of an employee's death, termination or reduction of hours, or becoming eligible for Medicare payments.

The qualified beneficiary is responsible for notifying the plan administrator of a divorce or legal separation from a spouse or of a dependent child's ceasing to be a dependent. A qualified beneficiary who is determined to have been disabled at the time of termination is responsible for notifying the plan administrator of that determination within 60 days of the determination and within 30 days after a subsequent determination that he is no longer disabled.

42 U.S.C. 300bb-6

TERMINATION OF COVERAGE

Coverage of qualified beneficiaries shall end on the earliest of the following dates:

1. The required period of coverage expires.
2. The District ceases to provide any group health plan to any employee.
3. Coverage ceases for failure to pay the premium.
4. The qualified beneficiary becomes covered under any other group plan.
5. The qualified beneficiary becomes entitled to Medicare benefits.

42 U.S.C. 300bb-2(2)

Note: See also DEB for continuation benefits that are available to survivors of District peace officers under certain conditions.

COVERAGE OF PREEXISTING CONDITIONS

Notwithstanding any other law, group health benefit coverage provided by or offered through the District to its employees under any law other than the uniform group coverage program is subject to the requirements of Sections 1501.102–1501.105, Insurance Code, which limit exclusion for preexisting conditions. This requirement applies to all group health benefit coverage provided by or offered through the District to its employees, including a standard health benefit plan issued under the Insurance Code and health and accident coverage provided through a risk pool established under Chapter 172, Local Government Code. *Education Code 22.004(m)*

TRS-ACTIVE CARE

Coverage provided under the uniform group coverage program may not be made subject to a pre-existing condition limitation during the initial period of eligibility. *Insurance Code 1579.105*

FEDERAL LAW

In addition, a group health plan may not impose a preexisting condition exclusion unless:

1. The exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;
2. The exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

3. The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

42 U.S.C. 300gg(a)(1); 45 CFR 146.111(a)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

CERTIFICATE OF CREDITABLE COVERAGE

A group health plan shall provide certification:

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision. This certification may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision;

2. In the case of an individual covered under COBRA, at the time the individual's COBRA coverage ceases; and

3. On the request on behalf of an individual made not later than 24 months after the date of cessation of coverage.

The certification is a written certification of:

1. The period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision; and

2. The waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

To the extent that medical care under a plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirements if any issuer offering the coverage provides for certification.

42 U.S.C. 300gg(e); 45 CFR 146.115

OTHER HIPAA REQUIREMENTS

HIPAA requires plan sponsors to observe certain coverage requirements and restrictions, including:

1. Limitations on preexisting condition exclusion periods;

2. Special enrollment periods for individuals;

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;

4. Standards relating to benefits for mothers and newborns;

5. Parity in the application of certain limits to mental health benefits.

ELECTION TO BE EXEMPTED

The plan sponsor of a nonfederal governmental group health plan may elect to be exempted from the following provisions of HIPAA:

1. Limitations on preexisting condition exclusion periods;
2. Special enrollment periods for individuals;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;
4. Standards relating to benefits for mothers and newborns;
5. Parity in the application of certain limits to mental health benefits;
6. Required coverage for reconstructive surgery and certain other services following a mastectomy under section 2706 of the Public Health Service Act.

FORM OF ELECTION

The election must be in writing and state the name of the plan and the name and address of the plan administrator. The election document must either state that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through insurance. The election must be made in conformity with all the plan sponsor's rules, including any public hearing, if required. The election document must be signed, and must certify that the person signing the election document, including if applicable a third party plan administrator, is legally authorized to do so by the plan sponsor.

TIMING OF ELECTION

The election must be received by the Health Care Financing Administration by the day preceding the beginning date of the plan year. The election applies for a single specified plan year.

An election may be extended through subsequent elections.

CONTENTS OF NOTICE

If this election is made, the plan shall provide for notice to enrollees, on an annual basis and at the time of enrollment under the plan. The notice shall be provided to each participant individually.

42 U.S.C. 300gg-21; 45 CFR 146.180

PRIVACY OF HEALTH INFORMATION

To the extent the District is a covered entity under the Administrative Simplification provisions of HIPAA, the District must maintain the privacy of protected health information in accordance with the Privacy Rule, 45 CFR Part 164. *42 U.S.C. 1320d et seq.*

'COVERED ENTITY' DEFINED

The District is a "covered entity" under the Privacy Rule to the extent it is:

1. A health plan;

2. A health-care clearinghouse; or

3. A health-care provider who transmits any health information in electronic form in connection with a transaction covered by the Privacy Rule.

45 CFR 160.103

'PROTECTED HEALTH INFORMATION' DEFINED

"Protected health information" means individually identifiable health information that is transmitted or maintained in any form or medium, including electronic media and oral communications. "Protected health information" excludes individually identifiable health information in:

1. Education records covered by the Family Educational Rights and Privacy Act (FERPA), as amended.

2. Medical treatment records, as described at 20 U.S.C. 1232g(a)(4)(B)(iv), on a student who is at least 18 years of age.

3. Employment records held by a covered entity in its role as employer.

20 U.S.C. 1232g; 45 CFR 160.102, 164.501 [See FL]

SPONSORS OF GROUP HEALTH PLANS

Before a group health plan may disclose protected health information to the District that is a plan sponsor, the group health plan must ensure that the plan documents restrict uses and disclosures of such information by the District consistent with the requirements of the Privacy Rule. *45 CFR 164.504(f)*

The group health plan may disclose the following information to a district that is a plan sponsor without amending the plan documents:

1. Summary health information, consistent with the requirements of the Privacy Rule; and

2. Enrollment and disenrollment information relating to an individual participating in the plan.

45 CFR 164.504(f)

'PLAN SPONSOR' DEFINED

The term "plan sponsor" includes employers who establish or maintain employee benefit plans, alone or jointly with one or more employers. *29 U.S.C. 1002(16)(B)*

SELF-FUNDED PLANS

A district that is a sponsor of a self-funded group health plan is a covered entity under the Privacy Rule. *45 CFR 160.103*