

Coverage Requirements

Districts with 500 or Fewer Employees

A district with 500 or fewer employees is required to participate in the uniform group coverage program established under Insurance Code 1579 (TRS-ActiveCare). *Insurance Code 1579.151; Education Code 22.004(a)*

Self-Funded Districts

Notwithstanding the above, a district that was individually self-funded on January 1, 2001, may elect not to participate in TRS-ActiveCare. *Insurance Code 1579.151(b)*

Districts with More Than 500 Employees

A district with more than 500 employees may elect to participate in TRS-ActiveCare. The district shall apply for participation in the manner prescribed by TRS rule. *Insurance Code 1579.152; 34 TAC 41.30*

TRS-ActiveCare

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

Eligibility

Full-Time Employees

Participation in TRS-ActiveCare is limited to employees of participating districts who are full-time employees and to part-time employees who are participating members in TRS. A “full-time employee” is a participating TRS member who is currently employed by a district in a position that is eligible for membership in TRS and who is not receiving coverage as an employee or retiree from a uniform group insurance or health benefits program under Insurance Code Chapters 1551, 1601, or 1575 (TRS-Care). *Insurance Code 1579.202; 34 TAC 41.33(2)*

Certain Part-Time Employees

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

1. Is currently employed by a district for ten hours or more each week;
2. Is employed in a position that is not eligible for membership in TRS or is not eligible for membership in TRS because of a service or disability retirement; and
3. Is not receiving coverage as an employee or retiree from a uniform group insurance or health benefits program under Insurance Code Chapters 1551, 1601, or 1575 (TRS-Care).

Insurance Code 1579.204; 34 TAC 41.33(6)

Optional Coverages A district that participates in TRS-ActiveCare may enter contracts to provide optional insurance coverages for district employees. *Education Code 22.004(j)*

Other Health Coverage Programs A district that does not participate in TRS-ActiveCare shall make available to its employees group health coverage provided by a risk pool established under Local Government Code Chapter 172 (“authorized risk pool”), or under a policy of 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. *Education Code 22.004(b)*

Financial Statement A district that does not participate in TRS-ActiveCare 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, before the contract is entered, the insurer, company, organization, or person provides the district with an audited financial statement showing the financial condition of the insurer, company, organization, or person. *Education Code 22.004(f)*

Small Employer Market Election A district that does not participate in TRS-ActiveCare may elect to participate in the small employer market without regard to the number of eligible employees in the district. A district that makes this election will be treated as a small employer for all purposes under Insurance Code Chapter 1501.

A district that is participating in TRS-ActiveCare may not participate in the small employer market and may not renew a health insurance contract obtained in accordance with Insurance Code 1501.009 after the date on which the program of coverages provided under TRS-ActiveCare 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 The board may establish a health-care plan for district employees and their dependents. In implementing the plan, the board shall establish a fund to pay, as authorized under the plan, all or part of the actual costs for health care incurred by employees and any dependent whose participation in the program is being supported by deductions from an employee’s salary. The fund consists of money

contributed by the district and money deducted from salaries of employees for dependent or employee coverage. Money for the fund may not be deducted from an employee's salary unless the employee authorizes the deduction in writing. The plan shall attempt to protect the district against unanticipated catastrophic individual loss, or unexpectedly large aggregate loss, by securing individual stop-loss coverage, or aggregate stop-loss coverage, or both, from a commercial insurer.

The board may amend or cancel the district's health-care plan at any regular or special board meeting. If the plan is canceled, any valid claim against the fund for payment of health-care costs resulting from illness or injury occurring during the time the plan was in effect shall be paid out of the fund. If the fund is insufficient to pay the claim, the costs shall be paid out of other available school district funds.

Education Code 22.005

Comparability

The coverage provided by a district that does not participate in TRS-ActiveCare must meet the substantive coverage requirements of Insurance Code Chapters 1251, Subchapter A, Chapter 1364, and Chapter 1366, Subchapter A, and any other law applicable to group health insurance policies or contracts issued in this state. The coverage must include major medical treatment but may exclude experimental procedures. "Major medical treatment" means a medical, surgical, or diagnostic procedure for illness or injury. The coverage may include managed care or preventive care and must be comparable to the basic health coverage provided under Insurance Code Chapter 1551 (Texas Employees Group Benefits Act).

The following factors shall be considered in determining whether the district's coverage is comparable to the basic health coverage specified above:

1. The deductible amount for service provided inside and outside of the network;
2. The coinsurance percentages for service provided inside and outside of the network;
3. The maximum amount of coinsurance payments a covered person is required to pay;
4. The amount of the copayment for an office visit;
5. The schedule of benefits and the scope of coverage;
6. The lifetime maximum benefit amount; and

7. Verification that the coverage is issued by a provider licensed to do business in this state by the Texas Department of Insurance (TDI) or is provided by an authorized risk pool or that a district is capable of covering the assumed liabilities in the case of coverage provided through district self-insurance.

Education Code 22.004(b)

*Compliance
Report*

A district that does not participate in TRS ActiveCare shall prepare a report addressing its compliance with Education Code 22.004. 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 be posted on the district's internet website if the district maintains a website, 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 with a provider licensed to do business in this state by TDI or an authorized risk pool; or
 - b. A resolution of the board authorizing a self-insurance plan for district employees and of the district's review of district ability to cover the liability assumed;
2. The schedule of benefits;
3. The premium rate sheet, including the amount paid by the district and employee;
4. The number of employees covered by the health coverage plan offered by the district; and
5. Information concerning the ease of completing the report.

Education Code 22.004(d)

Cost of Coverage
TRS-ActiveCare

The cost of coverage under TRS-ActiveCare shall be shared by the state, the district, and the employees, as set forth below. *Education Code 22.004(c)*

*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 48 and 49 and used by districts as provided by Education Code 48.275. *Insurance Code 1579.251(a)*

<i>Employee Contribution</i>	<p>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 a district's contribution.</p> <p>A 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.</p> <p><i>Insurance Code 1579.253</i></p>
Other Health Coverage Programs	<p>The cost of coverage provided by a district that does not participate in TRS-ActiveCare 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] <i>Education Code 22.004(c)</i></p>
District Required Minimum Effort	<p>A district shall, for each fiscal year, use to provide health coverage an amount equal to the number of participating employees of the district multiplied by \$1,800. <i>Insurance Code 1581.052(a)</i></p>
Designation of Compensation for Benefits	<p>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 DEA] <i>Education Code 22.103(a), (c)</i></p>
Use	<p>An employee may use compensation designated for health-care supplementation for any employee benefit, including depositing 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. <i>Education Code 22.106</i></p>
Written Election	<p>Each year, an active employee must elect in writing whether to designate a portion of the employee's compensation to be used as health-care supplementation. An election must be made at the same time that the employee elects to participate in a cafeteria plan, if applicable. <i>Education Code 22.105</i></p>
Continuation Coverage After Resignation	<p>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 TRS ActiveCare or the district's group health coverage through the earlier of:</p> <ol style="list-style-type: none">1. The first anniversary of the date participation in or coverage under TRS ActiveCare or the district's group health coverage was first made available to district employees for the last instructional year in which the employee was employed by the district; or2. 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.

A district may not diminish or eliminate its contribution [see District Required Minimum Effort, above] before the last date on which the employee is entitled to participation or enrollment.

Education Code 22.004(k), (l); 34 TAC 41.38

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(a)

During FMLA Leave

During any period of leave under the Family and Medical Leave Act (FMLA), a district shall 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 C.F.R. 825.209, .210, .213* [See also DECA]

Upon Termination
or Other Qualifying
Event (COBRA)

In accordance with regulations that the Secretary of Health and Human Services shall prescribe, each group health plan that is maintained by any state that receives funds under 42 U.S.C. Chapter 6A, by any political subdivision of such a state, or by any agency or instrumentality of such a state or political subdivision, shall provide, in accordance with 42 U.S.C. Chapter 6A, Subchapter XX, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan in connection with such group.

42 U.S.C. 300bb-1(a), 300bb-2(1)

Qualifying Event

"Qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage

required under 42 U.S.C. Chapter 6A, Subchapter XX, would result in the loss of coverage of a qualified beneficiary:

1. The death of the covered employee.
2. The termination, other than by reason of such employee's gross misconduct, or reduction of hours, of the covered employee's employment.
3. The divorce or legal separation of the covered employee from the employee's spouse.
4. The covered employee becoming entitled to benefits under Medicare, 42 U.S.C. 1395 et seq.
5. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan

42 U.S.C. 300bb-3

Period of Coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

1. In the case of the termination or reduction of hours of a covered employee as described at item 2 at "Qualifying Event" above, the date which is 18 months after the date of the termination or reduction of hours.
2. If a qualifying event occurs during the 18 months after the date of the termination or reduction of hours, the date which is 36 months after the date of the termination or reduction of hours.
3. In the case of a qualifying event other than termination or reduction of hours, the date which is 36 months after the date of the qualifying event.
4. In the case of the termination or reduction of hours of a covered employee as described at item 2 at "Qualifying Event" that occurs less than 18 months after the date the covered employee became entitled to benefits under Medicare, 42 U.S.C. 1395 et seq., the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this provision before the close of the 36-month period beginning on the date the covered employee became so entitled.
5. In the case of a qualified beneficiary who is determined, under Title II or XVI of the Social Security Act, 42 U.S.C. 401 et seq., 1381 et seq. (the Social Security Act), to have been disabled

at any time during the first 60 days of continuation coverage, any reference in item 1 or 2 to 18 months is deemed a reference to 29 months with respect to all qualified beneficiaries, but only if the qualified beneficiary has provided notice of such determination under 42 U.S.C. 300bb-6(3) before the end of such 18 months.

6. The date on which the employer ceases to provide any group health plan to any employee.
7. The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.
8. The date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan that satisfies 42 U.S.C. 300bb-2(2)(D)(i), or entitled to benefits under Title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].
9. In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this subchapter, the month that begins more than 30 days after the date of the final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

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

Premium

The plan may require payments of a premium for any period of continuation coverage, except that such premium shall not exceed 102 percent applicable premium for such period, and may, at the election of the payor, be made in monthly installments. 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. In no event may the plan require payment of any premium 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 employer of an employee under a group health plan must notify the plan administrator of an employee's death, termination, reduction of hours, or eligibility for Medicare payments within 30 days of the date of the qualifying event. *42 U.S.C. 300bb-6(2)-(3)*

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 a district to its employees under any law other than the uniform group coverage program is subject to the requirements of Insurance Code Sections 1501.102–.105, which limit exclusion for preexisting conditions. This provision applies to all group health benefit coverage provided by or offered through a district to its employees, including a standard health benefit plan issued under Insurance Code Chapter 1507 and health and accident coverage provided through a risk pool established under Local Government Code Chapter 172. *Education Code 22.004(m)*

TRS-ActiveCare

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

Federal Law

A group health plan may not impose a preexisting condition exclusion. *42 U.S.C. 300gg-3(a); 45 C.F.R. 146.111, 147.108*

**Health Insurance
Portability and
Accountability Act
(HIPAA)**

The Public Health Service Act (PHS Act) requirements are the following:

1. Limitations on preexisting condition exclusion periods in accordance with section 2701 of the PHS Act as codified before enactment of the Affordable Care Act;
2. Special enrollment periods for individuals and dependents described under section 2704(f) of the PHS Act;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status under section 2705 of the PHS Act, except that the sponsor of a self-funded non-federal governmental plan cannot elect to exempt its plan from requirements under section 2705(a)(6) and 2705(c) through (f) that prohibit discrimination with respect to genetic information;
4. Standards relating to benefits for mothers and newborns under section 2725 of the PHS Act;
5. Parity in mental health and substance use disorder benefits under section 2726 of the PHS Act;
6. Required coverage for reconstructive surgery following mastectomies under section 2727 of the PHS Act; and
7. Coverage of dependent students on a medically necessary leave of absence under section 2728 of the PHS Act.

Exemption Election A sponsor of a non-federal governmental plan may elect to exempt its plan, to the extent the plan is not provided through health insurance coverage (that is, it is self-funded), from one or more of the requirements described in items 4 through 7, above.

42 U.S.C. 300gg-21(a)(2); 45 C.F.R. 146.180(a)

Form of Election The election must meet the following requirements:

1. Be made in an electronic format in a form and manner as described by the U.S. Secretary of Health and Human Services in guidance.
2. Be made in conformance with all of the plan sponsor's rules, including any public hearing requirements.
3. Specify the beginning and ending dates of the period to which the election is to apply. This period is a single specified plan year, as defined in 45 C.F.R. 144.103.
4. Specify the name of the plan and the name and address of the plan administrator, and include the name and telephone number of a person the Centers for Medicare and Medicaid Services (CMS) may contact regarding the election.
5. State that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through health insurance coverage.
6. Specify each requirement described in 45 C.F.R. 146.180(a)(1) of this section from which the plan sponsor elects to exempt the plan.
7. 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.
8. Include, as an attachment, a copy of the notice described in 45 C.F.R. 146.180(f).

42 U.S.C. 300gg-21(a)(2); 45 C.F.R. 146.180(b)

Timing of Election Absent an extension by the U.S. Department of Health and Human Services CMS for good cause, a plan sponsor or entity acting on behalf of a plan sponsor must file an election with CMS before the first day of the plan year.

A plan sponsor may renew an election through subsequent elections.

42 U.S.C. 300gg-21(a)(2); 45 C.F.R. 146.180(c), (f)

<i>Contents of Notice</i>	<p>A plan that makes the election described in these provisions must notify each affected enrollee of the election, and explain the consequences of the election. The notice must be in writing and must be provided to each enrollee at the time of enrollment under the plan, and on an annual basis no later than the last day of each plan year for which there is an election. A plan may meet the notification requirements by prominently printing the notice in a summary plan description, or equivalent description, that it provides to each enrollee at the time of enrollment, and annually. Also, when a plan provides a notice to an enrollee at the time of enrollment, that notice may serve as the initial annual notice for that enrollee. <i>42 U.S.C. 300gg-21(a)(2)(C); 45 C.F.R. 146.180(e)(1)</i></p>
Privacy of Health Information	<p>To the extent a 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 C.F.R. Part 164, Subpart E. <i>42 U.S.C. Chapter 7, Subchapter XI, Part C.</i></p>
Definitions	<p>“Covered entity” means:</p>
<i>Covered Entity</i>	<ol style="list-style-type: none">1. A health plan;2. A health-care clearinghouse; or3. A health-care provider who transmits any health information in electronic form in connection with a transaction covered by 45 C. F. R. Chapter A, Subchapter C. <p><i>45 C.F.R. 160.103</i></p>
<i>Protected Health Information</i>	<p>“Protected health information” means individually identifiable health information that is transmitted by electronic media, maintained by electronic media, or transmitted or maintained in any form or medium. “Protected health information” excludes individually identifiable health information in:</p> <ol style="list-style-type: none">1. Education records covered by the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g.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. <p><i>20 U.S.C. 1232g; 45 C.F.R. 160.103 [See FL]</i></p>

Plan Sponsor

The term “plan sponsor” includes the employer in the case of an employee benefit plan established or maintained by a single employer. *29 U.S.C. 1002(16)(B)*

Sponsors of Group
Health Plans

A group health plan, to disclose protected health information to the plan sponsor or to provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or health maintenance organization (HMO) with respect to the group health plan, must ensure that the plan documents restrict uses and disclosures of such information by the plan sponsor consistent with the requirements of the Privacy Rule.

The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose summary health information to the plan sponsor, if the plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or
2. Modifying, amending, or terminating the group health plan.

The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose to the plan sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan.

45 C.F.R. 164.504(f)