COVERAGE REQUIREMENTS

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). *Insurance Code 1579.151–.152(a); Education Code 22.004(a)*

DISTRICTS WITH 500 OR FEWER EMPLOYEES

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*

EMPLOYEE ELIGIBILITY

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. For these purposes, "full-time" means a district employee who is eligible for membership in TRS based on current full-time service as described by 34 Administrative Code 25.1. *Insurance Code 1579.202; 34 TAC 41.33(2)*

FULL-TIME EMPLOYEES

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. For these purposes, "part-time" means an individual who is currently employed for ten hours or more each week and who is not a full-time employee. *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 PROGRAMS

A district that does not participate in TRS-ActiveCare shall make available to their employees group health coverage provided by a risk pool 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. *Education Code 22.004(b)*

FINANCIAL STATEMENT

A 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(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. If a 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 TRS-ActiveCare 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 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, a board may establish a self-funded health-care plan for district employees and their dependents. In implementing the plan, a 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 a district does not participate in TRS-ActiveCare, 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

A 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 the information set forth at 34 Administrative Code 41.91.

Education Code 22.004(d); 34 TAC 41.91

COST OF COVERAGE

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)*

TRS-ACTIVECARE

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 42.260. *Insurance Code 1579.251*

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 a district's contribution.

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.

Insurance Code 1579.253

OTHER PROGRAMS

If a district does not participate in TRS-ActiveCare, 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

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. *Insurance Code 1581.052(a)*

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 DEA] *Education Code 22.103(a), (c)*

USE

An employee may use the 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. *Education Code 22.106*

WRITTEN ELECTION

Each year, an active employee shall elect in writing whether to designate a portion of the employee's compensation to be used as health-care supplementation. The election must be made at the same time that the employee elects to participate in a cafeteria plan, if applicable. *Education Code 22.105*

CONTINUATION COVERAGE

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:

AFTER RESIGNATION

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.

A 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), a 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 C.F.R. 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), a 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

A 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

A 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. *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. A 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 PRE-EXISTING 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 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 a 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-ACTIVECARE

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 C.F.R. 146.111(a)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A group health plan shall provide certification:

CERTIFICATE OF CREDITABLE COVERAGE

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)

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; and

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; and

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 fund-

ed 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 C.F.R. 146.180

PRIVACY OF HEALTH INFORMATION

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. *42 U.S.C. 1320d et seq.*

'COVERED ENTITY' DEFINED

A 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 C.F.R. 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 C.F.R. 160.102, 164.501 [See FL]

SPONSORS OF GROUP HEALTH PLANS

Before a group health plan may disclose protected health information to a 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.

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 C.F.R. 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 C.F.R. 160.103*