Uniform Group Insurance Program

An institution of higher education, including a college district, shall be covered by the Texas Employees Uniform Group Insurance Program.

The institution shall provide a health care insurance program in compliance with the Employee Retirement System of Texas (ERS) policies and regulations and federal law.

Health Insurance Portability and Accountability Act of 1996, Pub. Law 104-191, 45 C.F.R. 146.111(a); Insurance Code Chapter 1551; 34 TAC Chapter 81

An institution of higher education, including a college district, shall, at the time of employment, notify each of the institution's employees eligible to participate in the group benefits program of the employee's eligibility to participate. *Insurance Code 1551.107(b)*

State Consumer-Directed Health Plan

Each individual eligible to participate in the basic coverage may choose instead to participate in the state consumer-directed health plan, a high deductible health plan described by Insurance Code Chapter 1551, Subchapter J, if the plan enrollee is an eligible individual under Internal Revenue Code 223(c)(1). The dependents of a plan enrollee may participate in the state consumer-directed health plan in accordance with Insurance Code 1551.455. *Insurance Code 1551.452, .454(a)*

Eligibility

Employees and officers shall be eligible to participate in the group benefits program pursuant to Insurance Code, Chapter 1551, Subchapter C and 34 Administrative Code 81.5.

Ineligible Employees

An employee of a public junior college who is employed to perform services outside of this state is not eligible to participate in the group benefits program unless the college elects, under procedures adopted by the ERS board of trustees, to permit the employee to participate in the group benefits program.

An employee is employed to perform services outside of this state if 75 percent or more of the services performed by the employee are performed outside of this state.

A person employed by a public junior college on August 31, 1999, remains eligible to participate in the group benefits program in the same manner as other employees of the college even if the individual's employment by the college is not continuous.

Insurance Code 1551.110(a)–(c)

Current and Former Board Member

Subject to Insurance Code 1551.351, on application to the board of trustees of ERS and arrangement for payment of contributions, an individual participating in the group benefits program on August 31,

2003, as a current or former member of the governing body of an institution of higher education remains eligible for participation in a group health benefit plan offered under Insurance Code Chapter 1551 if a lapse in coverage has not occurred. A participant described by this section may not receive a state contribution for premiums. The governing body of an institution of higher education may pay from local funds part or all of the contributions the state would pay for similar coverage of other participants in the group benefits program. The participant's contribution for coverage under a health benefit plan may not be greater than the contribution for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). *Insurance Code 1551.109; 34 TAC 81.5(i)*

Continuation Coverage

In any case in which a person (or the person's dependents) has coverage under a health plan in connection with the person's position of employment, including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, and such person is absent from such position of employment by reason of service in the uniformed services the plan shall provide that the person may elect to continue such coverage. The maximum period of coverage of such a person and the person's dependents under such an election shall be the lesser of:

During Military Leave

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)(1)

During FMLA Leave

During any period that an eligible employee takes family and medical leave, the employer shall maintain coverage under any "group health plan," as defined in 26 U.S.C. 5000(b)(1), for the duration of such 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 such leave. [See also DECA] *29 U.S.C. 2614(c); 29 C.F.R. 825.209–.210, .213*

Upon Termination or Other Qualifying Event (COBRA)

In accordance with regulations which 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 "QUALIFYING EVENT," 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 "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., to have been disabled at any time during the first 60 days of continuation coverage, any reference in paragraph 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.

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 of the applicable premium for such period, and may, at the election of the payor, be made in monthly installments. In the case of an individual entitled to 29 months of continuation coverage under 42 U.S.C. 300bb-2(2)(A)(vi) the plan may require payment of a premium that shall not exceed 150 percent of the applicable premium for any month after the 18th month. The qualified beneficiary may choose to pay the premiums in monthly installments. In no event may the plan require the 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(2)(A), (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.

Each covered employee or qualified beneficiary is responsible for notifying the plan administrator of a divorce or legal separation from a spouse or a dependent child ceasing to be a dependent within 60 days after the date of the qualifying event and each quali-

fied beneficiary who is determined, under Title II or XVI of the Social Security Act, 42 U.S.C. 401 et seq., 1381 et seq., to have been disabled at any time during the first 60 days of continuation coverage is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination that the qualified beneficiary is no longer disabled.

42 U.S.C. 300bb-6(2)–(3)

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

Preexisting Conditions

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

Health Insurance Portability and Accountability Act (HIPAA)

Election to Be Exempted

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 and certain other services following a mastectomy 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.

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. The election applies for a single specified plan year.

A plan sponsor may renew an election through subsequent elections.

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

Contents of Notice

In accordance with 45 C.F.R. 146.180(f), a plan that makes the election described in this section 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. *42 U.S.C. 300gg-21(a)(2)(C); 45 C.F.R. 146.180(f)*

Privacy of Health Information

To the extent the college district is a covered entity under the Administrative Simplification provisions of HIPAA, the college district must maintain the privacy of protected health information in accordance with the Privacy Rule, 45 C.F.R. Part 164, Subpart E. *42 U.S.C. Chapter 7, Subchapter XI, Part C*

Definitions

“Covered entity” means:

“Covered Entity”

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 45 C.F.R. Subtitle A, Subchapter C.

45 C.F.R. 160.103

“Protected Health Information”

“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:

1. Education records covered by the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g.
2. Medical treatment records 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. 160.103 [See FJ(LEGAL) at "EDUCATION RECORDS" DEFINED]

"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 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)

Pharmacy Benefit Manager Services Contracts

Disclosure

A state agency on request of another state agency shall disclose information relating to the amounts charged by a pharmacy benefit manager for pharmacy benefit manager services provided under a prescription drug program and other requested pricing information related to a contract for pharmacy benefit manager services. A state agency shall provide information requested under this section not later than the 30th day after the date the information is requested.

A state agency is not required to disclose information the agency is specifically prohibited from disclosing under a contract with a pharmacy benefit manager executed before September 1, 2009.

A contract entered, amended, or extended on or after September 1, 2009, may not contain a provision that prohibits a state

agency from disclosing information on the amounts charged by a pharmacy benefit manager for pharmacy benefit manager services provided under a prescription drug program or from disclosing other pricing information related to the contract.

Gov't Code 2158.402

Redisclosure — The information received by a state agency under this section may not be disclosed to a person outside of the state agency or its agents. *Gov't Code 2158.403*

"State Agency" — "State agency" means a board, commission, department, office, or other agency in the executive, legislative, or judicial branch of state government that is created by the constitution or a statute of this state, including an institution of higher education as defined by Education Code 61.003. *Gov't Code 2158.401(a)*