SUBCHAPTER SS. Continuation and Conversion Provisions

Division 1. General Provisions
28 TAC §21.5301 and §21.5302

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1. INTRODUCTION. The Texas Department of Insurance proposes new 28 TAC Chapter 21, Subchapter SS, §§21.5301, 21.5302, 21.5310 - 21.5314, and 21.5320 - 21.5322, concerning Continuation and Conversion Provisions. The new subchapter, along with concurrently proposed amendments to 28 TAC Chapter 11, Subchapter F, and proposed repeal of 28 TAC Chapter 3, Subchapter F, are necessary to conform the department's rules to statutory changes, including HB 710, 75th Legislature, Regular Session (1997) and SB 1771, 81st Legislature, Regular Session (2009), to consolidate the continuation and conversion rules for insured and HMO products to the extent possible so that future changes in continuation or conversion laws will not result in multiple rule projects. Nonsubstantive changes will also conform these sections to the agency's style and usage guidelines.

TDI proposes to replace the concurrently repealed 28 TAC Chapter 3, Subchapter F, and deleted text in 28 TAC Chapter 11, Subchapter F with the proposed new 28 TAC Chapter 21, Subchapter SS. The proposed new subchapter contains

many nonsubstantive changes from the old rules to conform to agency style and usage guidelines. The department provides a brief explanation of the proposed rules below.

Section 21.5301. Section 21.5301 is derived from old §3.501(a) and §11.506, and describes the purpose of the subchapter, which is to address continuation requirements and establish minimum standards for conversion coverage.

Section 21.5302. Section 21.5302 is derived from old §3.502 and §11.2(b), and lays out definitions. Section 21.5302(1)-(2) adds definitions for COBRA and COBRA continuation coverage. Section 21.5302(3) adds a definition of "carrier" to describe entities covered by the subchapter. Section 21.5302(7) adds a definition of "state continuation coverage," relying on Insurance Code Chapters 1251 and 1271.

Section 21.5310. Section 21.5310(a) is derived from old §§3.501(b), 3.519, and 11.506(6), and sets out the applicability of the section. Section 21.5310(b)-(e) are derived from old §§3.504, 3.505(b), 3.514, and 11.506(6), and provide the substantive requirements relating to eligibility and termination of continued coverage. The department notes that §21.5310(d)(5)(D) provides that one basis for terminating continuation coverage is that "similar benefits are provided or available to the insured under any state or federal law other than COBRA continuation coverage," tracking the statutory language in Insurance Code §1251.255(a)(7). The department construes this text to reference state or federal programs such as Medicaid, but not to include the availability of guaranteed issue coverage under the Patient Protection and Affordable

Care Act. The department welcomes comments on this construction. Section 21.5310(f) requires carriers to also comply with additional continuation requirements in Insurance Code Chapter 1251, Subchapter G, for certain family members and dependents in circumstances where the family relationship is severed or in the case of the retirement or death of the group member. The section is also based on Insurance Code §§1251.301, 1251.302, 1251.304(a), 1251.310, and 843.051(b)(3).

Section 21.5311. Section 21.5311 is derived from old §3.506(a) and addresses notification requirements relating to continuation. The section is also based on Insurance Code §§1251.251(a), 1251.260, 1251.304(a), 1251.307, 1251.308, and 843.051(b)(3). The section requires that carriers make timely offers of continuation and specifies some required elements for the notice. The department has made minor modifications to the notice requirements. The section provides that carriers may delegate the notice function to a group policyholder but that the carrier retains ultimate responsibility. The section also specifies when notice may be presumed to be timely given, and requires notice be given prior to the scheduled termination of coverage. In addition, if an individual is eligible for COBRA, the section requires that the continuation notice be given at the initial termination of coverage, and, if it is not elected, again just prior to termination of COBRA coverage.

Section 21.5312. Section 21.5312 is derived from old §3.507(b)-(c) and addresses continuation election and effective dates. The section is also based on Insurance Code §§1251.253, 1251.302, 1251.308(d)-(e), and 843.051(b)(3).

Section 21.5313. Section 21.5313 is derived from old §3.507(b) and §3.509 (b), and addresses continuation premiums. The section is also based on Insurance Code §§1251.254, 1251.305, 1251.308, and 843.051(b)(3).

Section 21.5314. Section 21.5314 is derived from old §11.506(6), and addresses mandatory group continuation provisions. The section is also based on Insurance Code §1251.117(a).

Section 21.5320. Section 21.5320 is derived from old §3.505 and §3.507(a), and addresses offers of conversion coverage. The section is also based on Insurance Code §1251.256 and §1271.306.

Section 21.5321. Section 21.5321 is derived from old §3.506(a) and §11.506(6)(C), and addresses notice of conversion options. The section is also based on Insurance Code §1251.260(b) and §1271.306(a).

Section 21.5322. Section 21.5322 is derived from old §3.511(a), and addresses coverage for children. The section is also based on Insurance Code §§1251.256(c), 1251.258, and 1271.306(c).

2. FISCAL NOTE. Jan Graeber, director and chief actuary, Rate and Form Review Office, in the Life, Accident, and Health Section, has determined that for each year of

the first five years the proposed sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT AND COST NOTE. Ms. Graeber has also determined that for each year of the first five years the proposed sections are in effect, the public benefit anticipated as a result of the proposal is a more compact and consistent body of rules covering insured and HMO products in one place, and conformity of the rules to changes in related statutes.

For the most part, the proposal simply consolidates existing HMO and insurer regulations and reflects statutory changes that have become effective since the rule was last updated. The probable economic cost to persons required to comply with the proposal, above and beyond the statutory requirements, is minimal.

To the extent that the rule may result in additional costs to carriers, they are most likely to result from changes in the way the rule addresses notices to enrollees about the availability of continuation and conversion options. Section 21.5311 requires that a carrier provide a continuation notice prior to the initial termination of coverage and then (if continuation is not elected at that time) requires an additional notice prior to termination of COBRA. The prior rule did not clearly require two separate notices when someone elected COBRA, so some carriers may incur additional administrative costs if they did not previously provide two notices. The department has also made minor modifications to the required content of the notice, which will result in some

administrative costs in modifying the text of the notices carriers are currently issuing. Finally, the prior HMO rule did not clearly require that HMOs issue notices of these options. Instead, Insurance Code §1271.302 merely provided that a request to continue coverage was timely as long as it was made within 60 days of receiving notice of the continuation option. In practice, it appears that HMOs either have given the notice or arranged for the group contract holder to give the notice. Because the proposed rule requires that the HMO provide a timely offer of continuation, some carriers not previously providing such notice might incur administrative costs as a result of the rule.

The department is unable to quantify the amount of additional costs attributable to these changes because it will depend on the number of individuals electing COBRA, and the administrative cost for carriers to send additional notices and modify the text of current notices.

The department posted informal text of the rule that did not materially differ from this proposal and asked carriers for input on any additional costs that they would expect to incur due to the rules, but the department did not receive any responses from carriers indicating that there would be additional costs.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. As required by Government Code §2006.002(c), the department has determined that the proposed new subchapter and amendments may have an adverse economic impact on small and micro business carriers subject to the new 28 TAC Chapter 21, Subchapter SS. Based on product filings since 2010, the department estimates that approximately 44 insurers and nine

HMOs are subject to the subchapter, including carriers issuing employer- or association-sponsored group products. The department does not collect information on the number of individuals employed by licensed carriers, but the department believes that one or more of these entities may be a small or micro business under Government Code §2006.002(c). The adverse economic impact of the proposal on these carriers results from costs associated with the proposed changes to the rule, discussed in the Public Benefit and Cost Note section. The costs will vary for small and large businesses based on the number of enrollees covered by each carrier.

The department considered exempting small and micro business carriers from the requirements of this rule proposal but has concerns about the feasibility of such an exemption and the potential for consumer confusion. Carriers currently do not regularly specifically report their small or micro business status to the department. At any given time, the department would not be able to tell consumers which carriers would be exempt from the rules, and a consumer would only know if a carrier was exempt from the guaranteed issuance requirement of the rules if the carrier informed the consumer. This could result in confusion on the part of consumers and complaints against the carriers denying coverage. Further, the purpose of the applicable statutes is to make continuation and conversion coverage available to consumers, and sets out notice requirements for that coverage. Exempting some carriers from the rules will limit the coverage options and protections available to these consumers.

Even without an exemption, the department anticipates that small or micro business carriers will not be subject to any more requirements than larger carriers.

For these reasons, the department has not included an exemption for small and micro business carriers in the current proposal, but the department is interested in receiving comments on this issue. Those commenting in favor of an exemption should consider discussing in as much detail as possible the benefit of such an exemption to small and micro business carriers, the potential harm to small and micro business carriers of not receiving an exemption, the anticipated impact of such an exemption on the other carriers in the market and on the availability of coverage, any potential lesser exemptions other than a blanket exemption, and potential methods for the department and the public to identify those carriers claiming the exemption.

5. TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and so does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. If you wish to comment or request a hearing on this proposal, you must do so in writing no later than 5 p.m. Central time, August 4, 2014. Send your written comments or hearing request by email to chiefclerk@tdi.texas.gov, or by mail to Sara Waitt, General Counsel, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A hearing request must be on a separate page from any written comments. You must simultaneously submit an additional copy of the comments or hearing request either by

email to lhlcomments@tdi.texas.gov or by mail to Jan Graeber, Director and Chief Actuary, Rate and Form Review Office, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

7. STATUTORY AUTHORITY. The department proposes the new sections under Insurance Code §§36.001, 843.051(b)(3), 843.151, 1251.008, 1251.251, 1251.253, 1251.258, 1251.260, 1271.301(b), 1271.306(c), and 1701.060(a).

Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

Section 843.051(b)(3) states, “(b) A health maintenance organization is subject to (3) Subchapter G, Chapter 1251, and Section 1551.064."

Section 843.151 states, “The commissioner may adopt reasonable rules as necessary and proper to: (1) implement this chapter and Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in this chapter; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Section 1251.008 states, “The commissioner may adopt rules necessary to administer this chapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201.”

Section 1251.251(a) states, “An insurer or group hospital service corporation that issues policies that provide hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense incurred basis shall, as required by this subchapter, provide continuation of group coverage for employees or members and their eligible dependents, subject to the eligibility provisions prescribed by Section 1251.252."

Section 1251.253 states, “An employee, member, or dependent must provide to the employer or group policyholder a written request for continuation of group coverage not later than the 60th day after the later of: (1) the date the group coverage would otherwise terminate; or (2) the date the individual is given, in a format prescribed by the commissioner, notice by either the employer or the group policyholder of the right to continuation of group coverage.”

Section 1251.258 states, “The commissioner by rule shall establish minimum standards for benefits under converted policies issued under this subchapter.”

Section 1251.260 states, “(a) An employer that provides to its employees group accident and health insurance coverage that includes a group continuation or conversion privilege on termination of coverage shall give written notice of the continuation or conversion privileges under the policy to each employee or dependent insured under the group and affected by the termination. (b) The commissioner by rule shall establish minimum standards for the notice required by this section.”

Section 1271.301(b) states, “A health maintenance organization shall provide a group coverage continuation privilege as required by and subject to the eligibility provisions of this subchapter.”

Section 1271.306(c) states, “A conversion contract must meet the minimum standards for services and benefits for conversion contracts. The commissioner shall adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.”

Section 1701.060(a) provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Insurance Code Chapter 1251

Insurance Code Chapter 1271

Insurance Code Chapter 1701

9. TEXT.

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DIVISION 1. GENERAL PROVISIONS

§21.5301. Purpose. The purpose of this subchapter is to:

(1) address continuation requirements; and

(2) establish minimum standards for conversion coverage.

§21.5302. Definitions. The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) COBRA--Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (29 U.S.C. Part 6).

(2) COBRA continuation coverage--Coverage that satisfies an applicable COBRA continuation provision.

(3) Carrier--

(A) An insurer or a group hospital service corporation subject to Insurance Code Chapter 842 that issues policies providing hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense-incurred basis; and

(B) An HMO subject to Insurance Code Chapter 1271.

(4) Department--Texas Department of Insurance.

(5) HMO--A health maintenance organization as defined in Insurance Code §843.002(14).

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

(7) State continuation coverage--Coverage that satisfies an applicable state continuation requirement under Insurance Code Chapter 1251 or 1271.

DIVISION 2. GROUP CONTINUATION PROVISIONS

§21.5310. Mandatory Group Continuation Privilege.

(a) Applicability.

(1) The provisions of this section apply to:

(A) an insurer or a group hospital service corporation subject to Insurance Code Chapter 842 that issues policies providing hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense-incurred basis;

(B) an HMO subject to Insurance Code Chapter 1271.

(2) The provisions of this section do not apply to policies providing benefits for:

(A) a specified disease or diseases only;

(B) accident only;

(C) group Medicare supplement insurance; or

(D) group TRICARE supplement insurance.

(b) Eligibility for continuation of group coverage. Each employee, member, enrollee, or dependent whose group coverage is terminated has the right to continuation of the group coverage provided under and subject to the conditions of Insurance Code §§1251.251, 1251.252, and 1271.301.

(c) Replacement of group coverage. Any person who elects to continue group coverage under applicable state law must be included under any group coverage that replaces the existing group coverage. Coverage under the replacing coverage must be continued until the completion of the state continuation coverage period.

(d) Termination of continued coverage. Under Insurance Code §1251.255 and §1271.304, group continuation coverage may not terminate until the earliest of:

(1) the date the maximum state continuation coverage period provided by law would end, which is:

(A) for any employee, member, dependent, or enrollee not eligible for COBRA continuation coverage, nine months after the date the employee, member, dependent, or enrollee elects to continue the group coverage; or

(B) for any employee, member, enrollee, or dependent, eligible for COBRA continuation coverage, six additional months following any period of COBRA continuation coverage;

(2) the date failure to make timely payments would terminate the group coverage;

(3) the date the group coverage terminates in its entirety;

(4) the date the insured or enrollee is covered for similar benefits by another group plan or program, including a hospital, surgical, medical, or major medical expense insurance policy, a hospital or medical service subscriber contract, or a medical practice or other prepayment plan; or

(5) for a person covered under a group policy of accident, health, or accident and health insurance, including a group contract issued by a group hospital service corporation, the earliest of:

(A) any date in paragraph (1) - (4) of this subsection;

(B) the date the insured is or could be covered under Medicare;

(C) the date the insured is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for people in a group, whether on an insured or uninsured basis; or

(D) the date similar benefits are provided or available to the insured under any state or federal law other than COBRA continuation coverage.

(e) Coverage after COBRA. Any insured person or enrollee who elects to continue group coverage under COBRA may elect state continuation coverage under Insurance Code §§1251.251, 1251.252, and 1271.301 following the period of COBRA continuation coverage, provided the insured or enrollee is otherwise eligible under subsection (b) of this section.

(f) Coverage for Certain Family Members and Dependents. A group policy or contract delivered, issued for delivery, renewed, amended, or extended in this state, including a group contract issued by a group hospital service corporation, that provides insurance for hospital, surgical, or medical expenses incurred as a result of accident or

sickness, or an evidence of coverage under Insurance Code Chapter 843, must include the options for continuation of group coverage for certain family members and dependents prescribed in Insurance Code Chapter 1251, Subchapter G.

§21.5311. Notification Requirement of Insurers, Employer and Group Policyholders, and HMOs.

(a) Each carrier to which this subchapter applies is responsible for the timely offer of state continuation coverage options and must provide the notice for that coverage described in subsections (b) - (e) of this section. If the carrier delegates the responsibility of providing continuation notices to an employer or other group policyholder, the carrier remains responsible if the employer or other group policy or contract holder does not provide notice in compliance with this section. The carrier must provide timely notice of continuation privileges available to each employee, member, dependent, or enrollee whose coverage is terminating.

(b) For purposes of this section, notice is presumed timely if it is given at least 30 days and no more than 60 days prior to the scheduled termination of coverage.

(1) If the employer, group policy or contract holder, or carrier becomes aware, less than 30 days before actual termination, that coverage will terminate, notification must be given to the affected employee, member, dependent, or enrollee within five business days.

(2) The time limits required by this subsection in no way affect or limit notice requirements specified in Insurance Code §1251.307 and §1251.308. When a group policyholder must give notice of continuation under Insurance Code Chapter

1251, Subchapter G, on receipt of written notification of an event triggering the election of a continuation option, the statutory time limits referenced in subsection (e) of this section prevail.

(3) The notice must include:

(A) the time period allocated for making the election to continue coverage prescribed in Insurance Code §§1251.253, 1251.254, and 1271.302;

(B) the premium amount that an employee, member, dependent, or enrollee electing continuation of coverage must pay to the employer or other group policy or contract holder on a monthly basis;

(C) the date on which the employer or other group policy or contract holder must receive the employee's, member's, dependent's, or enrollee's written election to continue coverage and the first premium contribution;

(D) the length of time the eligible employee, member, dependent, or enrollee may continue coverage;

(E) notice of a conversion option, if offered, as required under §21.5321 of this title (relating to Notice of Conversion Options);

(F) an enrollment/election form and signature line;

(G) the following English and Spanish statement at the end of the notice: "If you have questions regarding your rights for continuation of your health insurance, contact (insert name of insurance company) at (insert company toll-free telephone number, or other telephone number if no toll-free number is available). If you have additional questions about continuation or other coverage options that might be available to you, you may contact the Texas Department of Insurance, toll-free, at (800)

252-3439 or visit this Internet site: http://www.tdi.texas.gov/pubs/consumer/cb005.html#losing." "Si usted tiene preguntas sobre sus derechos para continuar con su seguro de salud, comuníquese con (insert name of insurance company) al (insert company toll-free telephone number, or other telephone number if no toll-free number is available). Si usted tiene preguntas adicionales sobre la continuación del seguro u otras opciones de cobertura que podrían estar disponibles para usted, puede comunicarse con el Departamento de Seguros de Texas al número de teléfono gratuito (800) 252-3439 o visite este sitio de Internet: http://www.tdi.texas.gov/pubs/consumer/cb005.html#losing. Se habla español."; and

(H) for HMOs with an enrollee population in which 10 percent or more of the enrollees speak a language other than English or Spanish as their primary language, the translation for the statement in paragraph (2)(G) of this subsection must be in that language.

(c) If an employee, member, dependent, or enrollee is eligible for both COBRA continuation coverage and state continuation coverage, as permitted under §21.5310(e) of this title (relating to Mandatory Group Continuation Privilege), the carrier may send the notice for state continuation coverage with the COBRA continuation notice. If the carrier sends both notices simultaneously, the carrier must allow the employee, member, dependent, or enrollee to elect both COBRA continuation coverage and state continuation coverage, which will be effective at the expiration of COBRA continuation coverage as described in §21.5310(e) of this title. A person's election of only COBRA continuation coverage does not waive the person's right to elect or waive state

continuation coverage at a later date, provided the election is made within the statutory time frame under Insurance Code §1251.253 and §1271.302.

(d) If an employee, member, dependent, or enrollee is eligible for both COBRA and state continuation coverage but only elects COBRA continuation coverage, the carrier must provide a notice of state continuation coverage eligibility at least 30 days and no more than 60 days prior to termination of COBRA continuation coverage. If the employer, group policy or contract holder, or carrier becomes aware less than 30 days before actual termination that COBRA continuation coverage will terminate, notification must be given to the affected employee, member, dependent, or enrollee within five business days.

(e) The written notice of state continuation coverage privileges required by this subsection must also comply with the requirements of Insurance Code Chapter 1251, Subchapter G, and Chapter 1271, Subchapter G.

§21.5312 Continuation Election and Effective Dates.

(a) An employee, member, dependent, or enrollee electing state continuation coverage under §21.5310 of this title (relating to Mandatory Group Continuation Privilege) must make a written election to the employer or group policy or contract holder not later than the 60th day after the later of:

(1) the date of the termination of coverage under the group policy or contract; or

(2) the date the person is given notice of the right to continuation of group coverage.

(b) A dependent under a group insurance policy electing state continuation coverage under Insurance Code Chapter 1251, Subchapter G, must give written notice to the group policyholder or contract holder of the person's desire to exercise the continuation option not later than the 60th day after the date of the:

(1) severance of the family relationship; or

(2) retirement or death of the group employee, member, or enrollee.

(c) Each eligible employee, member, dependent, or enrollee has the right to elect continuation, and such election is not contingent on an identical election of any other family member.

§21.5313. Continuation Premium.

(a) Under Insurance Code §1251.254 and §1271.303, the premium for state continuation coverage elected under §21.5310 of this title (relating to Mandatory Group Continuation Privilege) must be the same premium charged for active employees, members, dependents, or enrollees, including any amount contributed by the employer or group policy or contract holder, plus 2 percent.

(b) The employee, member, dependent, or enrollee electing state continuation coverage under §21.5312 of this title (relating to Continuation Election and Effective Dates) must pay the initial premium not later than the 45th day after the date of the initial election for coverage.

(c) After the first payment following the initial election for coverage under §21.5312 of this title, the employee, member, dependent, or enrollee must pay the premium on the due date of each payment. However, a payment under this subsection

must be considered timely if made on or before the 30th day after the date on which the payment is due.

(d) The premium for state continuation coverage elected under Insurance Code Chapter 1251, Subchapter G, may not be more than the premium charged under the group policy or contract for the person had the family relationship not been severed, except as provided by Insurance Code §1551.064. Under Insurance Code §1251.306, the group policyholder or contract holder may require the person to pay a monthly fee of not more than $5 for administrative costs.

(e) A person covered under state continuation coverage elected under Insurance Code Chapter 1251, Subchapter G, must pay the premium for the coverage directly to the group policyholder or contract holder.

§21.5314 Mandatory Group Continuation Provisions. Each group accident and health policy, certificate, contract, and evidence of coverage required to provide state continuation coverage must contain provisions addressing the state continuation coverage options available to an employee, member, dependent, or enrollee.

DIVISION 3. CONVERSION PROVISIONS

§21.5320. Offer of Conversion

(a) An insurer or group hospital service corporation must offer to any employee, member, or dependent whose insurance under a group policy has been terminated for any reason (except involuntary termination for cause), including discontinuance of the group policy in its entirety or with respect to any insured class, and who has been

continuously insured under the group policy (and under any policy providing similar benefits which it replaces) for at least three consecutive months immediately prior to termination:

(1) a conversion policy providing the same coverage and benefits as provided under the group policy or plan, for an insurance policy or evidence of coverage that was delivered, issued for delivery, or renewed prior to June 1, 1996;

(2) a conversion policy providing similar coverage and benefits as provided under the group policy or plan, for an insurance policy or evidence of coverage that was delivered, issued for delivery, or renewed on or after June 1, 1996, and before July 1, 1997.

(b) An insurer or group hospital service corporation may offer a conversion policy for an insurance policy that is delivered, issued for delivery, or renewed on or after July 1, 1997.

(c) If an insurer or group hospital service corporation offers a conversion policy under subsection (a) or (b) of this section, the insurer or group hospital service corporation must issue a conversion policy without evidence of insurability if a written application for the policy and payment of the first premium are made not later than the 31st day after the date of termination.

(d) An insurer or group hospital service corporation may provide the conversion coverage on an individual or group basis as authorized under Insurance Code §1251.256.

(e) Under Insurance Code §1271.306, an HMO may offer to each enrollee a conversion contract.

§21.5321. Notice of Conversion Options.

(a) An insurer or group hospital service corporation must provide notice of conversion privileges, if any, available to each employee, member, or dependent whose coverage is terminating, at least 30 days and no more than 60 days prior to actual termination of coverage.

(b) An HMO must provide notice of conversion privileges, if any, available to each enrollee whose COBRA or state continuation period is expiring, at least 30 days and no more than 60 days prior to the expiration of the COBRA or state continuation coverage period.

§21.5322. Coverage for Children. A conversion policy or contract must provide for the addition of newborn children, adopted children, and children for whom a court or administrative order has mandated coverage. The policy or contract may provide that coverage terminates when the converted person's coverage terminates.

10. CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on June 17, 2014.

Sara Waitt
General Counsel
Texas Department of Insurance