

No. 2017 - 5210

**Official Order  
of the  
Texas Department of Insurance**

Date: SEP 06 2017

**Subject Considered:**

**Amendments to the Plan of Operation for the Texas Health Reinsurance System**

**General remarks and official action taken:**

This order is in consideration of the amendments to the plan of operation submitted for approval by the board of directors of the Texas Health Reinsurance System on July 5, 2017. The amendments conform its current plan of operation to reflect adoption of a plan of suspension under Section 3 of SB 1171, Act of the 85th Legislature, Regular Session (2017) and is consistent with Insurance Code §1501.306.

**Findings of fact and conclusions of law:**

1. The board of directors of the Texas Health Reinsurance System submitted amendments to the plan of operation to the Texas Department of Insurance for approval on July 5, 2017. The amendments add new Article XIX, titled "Suspension and Reactivation." The amendments reflect the adoption of a plan of suspension under §3 of SB 1171 and are offered under Insurance Code §1501.306.
2. The board approved amendments to the plan of operation on July 5, 2017. The department published the notice of intent to approve the amendments in the *Texas Register* on July 28, 2017, and held a public hearing on August 18, 2017, as required by Insurance Code §1501.306.
3. The department reviewed the plan of operation and the proposed amendments and recommends that it be approved with revisions for clarity and consistency with the department's drafting style. The plan of operation with proposed amendments and the department's revisions is attached as Exhibit 1.
4. The plan of operation with amendments and staff revisions (Exhibit 1) ensure the fair, reasonable, and equitable administration of the Texas Health Reinsurance System.

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5. The amendments and revisions to the plan of operation (Exhibit 1) satisfies the requirements for approval.

The plan of operation with amendments, as submitted by the board of directors of the Texas Health Reinsurance System and revised by department staff (Exhibit 1), is approved to be effective this date.



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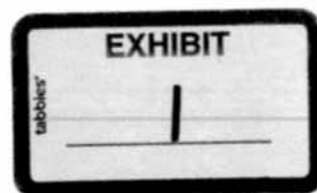
Mark Einfalt  
Deputy Commissioner for the Compliance Division  
Texas Department of Insurance  
Delegation Order 4506

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TEXAS HEALTH REINSURANCE SYSTEM

PLAN OF OPERATION

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**TEXAS HEALTH REINSURANCE SYSTEM  
PLAN OF OPERATION**

**Article I - Name**

The Texas Health Reinsurance System, (system), is a nonprofit entity created to comply with the provisions of Insurance Code Chapter 1501, Subchapter G, the Health Insurance Portability and Availability Act, (Act).

**Article II - Definitions**

As used in this plan, the definitions in Insurance Code §1501.002 and other sections of Chapter 1501, as well as the definitions in Title 28 Texas Administrative Code §26.4 and the definitions below, apply:

- A. Administrator--a third-party administrator.
- B. Advance interim assessments--Assessments made on a basis other than annually, which will offset reasonable and necessary organizational and interim operating expenses. Any advance interim assessments will be credited against future regular assessments.
- C. Anniversary--The date on which a health benefit plan has been in force for a 12-month period.
- D. Board--The board of directors of the system established under Insurance Code §1501.302.
- E. Commissioner--The commissioner of insurance.
- F. Eligible employee--An eligible employee as defined in Insurance Code §1501.002(3).
- G. Health benefit plan--A health benefit plan as defined in Insurance Code §1501.002(5).
- H. Regular assessments--Assessments made on an annual basis, as deemed necessary by the board for the continued fiscal stability of the system. The formula for calculating regular assessments must consider the administrative expenses and incurred losses for the previous calendar year and also the investment income and other appropriate gains and losses.
- I. Reinsurance premium--Amounts payable by a reinsured health benefit plan issuer as a condition of receiving coverage from the system.
- J. Reinsured health benefit plan issuer--A small employer health benefit plan issuer that participates in the system.

- K. Small employer--A small employer as defined in Insurance Code §1501.002(14). A small employer includes an independent school district that elects to participate in the small employer market as provided under Insurance Code §1501.009. Affiliated employers eligible to file a consolidated tax return are considered to be a single employer for purposes of system eligibility, and therefore not an eligible small employer for the purposes of the system if the total number of eligible employees of all affiliates is greater than 50.
- L. Small employer health benefit plan--A health benefit plan developed by the commissioner under Insurance Code Chapter 1501, Subchapter F or any other health benefit plan offered to a small employer in accordance with §1501.252 or §1501.255.
- M. System--The Texas Health Reinsurance System.

### **Article III - Reinsured Health Benefit Plan Issuers**

All reinsured health benefit plan issuers, as defined in §1501.301(3), are subject to assessment. A small employer carrier that elects to be a reinsured health benefit plan issuer will be bound by that election for five years as provided in §1501.310(b).

In accordance with §1501.311(b), a reinsured health benefit plan issuer that elects to change its status to operate as a risk-assuming health benefit plan issuer may not continue to reinsure a small employer health benefit plan with the system.

A reinsured health benefit plan issuer that applies to change its status to operate as a risk-assuming health benefit plan issuer must notify the Texas Health Reinsurance System Board and the system administrator at the same time it files its application with the commissioner of insurance.

### **Article IV - Purposes**

The purposes of the system include:

- A. promoting the availability of health insurance coverage to small employers regardless of health status or claim experience;
- B. providing for reinsurance as a mechanism to fairly share the risk; and
- C. carrying out the provisions of the Act and its related regulations.

### **Article V - Powers and Duties of the System**

The system will have the general powers and authority granted to insurers and health maintenance organizations authorized to engage in business under the laws of Texas, except that the system may not directly issue a health benefit plan. The system may:

- A. enter into contracts necessary or proper to carry out the provisions and purposes of the Act, including, with the approval of the commissioner, contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of accounting, legal, operational, and administrative functions;
- B. sue or be sued, including taking any legal actions necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured health benefit plan issuer;
- C. take legal actions necessary to avoid paying improper claims against the system;
- D. issue reinsurance contracts in accordance with the Act;
- E. establish guidelines, conditions, and procedures about the reinsurance of reinsured health benefit plan issuers' risks by the system;
- F. establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the system;
- G. assess reinsured health benefit plan issuers in accordance with the provisions of §§1501.319 – 1501.323 and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Liability for all assessments survives the assessed reinsured health benefit plan issuer's participation in the system. Interim assessments paid will be credited as offsets against any regular assessments due following the close of the system's fiscal year;
- H. appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the system, policy, and contract design; and any other function within the authority of the system;
- I. borrow money for a period not to exceed one year to accomplish the purposes of the system, provided that any notes or other evidence of indebtedness of the system not in default are legal investments for reinsured health benefit plan issuers and may be carried as admitted assets; and
- J. take any other action not otherwise prohibited by statute but necessary for the administration of the system.

The system is exempt from all taxes.

#### **Article VI - Plan of Operation**

The system must perform its functions under this plan and in accordance with the Act.

The plan of operation must ensure the fair, reasonable, and equitable administration of the system, and provide for the sharing of system gains or losses on an equitable and proportionate basis in accordance with the Act. The plan will become effective on written approval by the commissioner, as provided in §1501.306(c).

### **Article VII - Board of Directors and Annual Meeting**

- A. The system is administered by a board of directors and operates subject to the supervision and control of the commissioner.
1. The board is made up of nine members appointed by the commissioner, plus the commissioner or the commissioner's designated representative, who serves as an ex officio member of the board.
    - a. In selecting the board members, the commissioner will include representatives of reinsured health benefit plan issuers and other individuals deemed qualified. At least five board members must be representatives of reinsured health benefit plan issuers and must be selected from individuals nominated who live in Texas in accordance with procedures and guidelines developed by the commissioner. Four members must represent the public. A member representing the public may not be:
      - (1) an officer, director, or employee of an insurance company, agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the department;
      - (2) a person required to register with the Texas Ethics Commission under Chapter 305, Government Code; or
      - (3) related to a person described by subdivision (1) or (2) of this subsection within the second degree of affinity.
    - b. The members appointed by the commissioner serve two-year terms. The terms expire on December 31 of each odd-numbered year. A member's term continues until a successor is appointed.
    - c. A board member may not be compensated for serving on the board, but members are entitled to reimbursement from the system for reasonable and actual expenses incurred in performing functions as a board member.
    - d. The board is subject to the open meetings law and the open records law, as set out in Texas Government Code §551.001 *et seq.* and §552.001 *et seq.*
  2. The commissioner will elect candidates to fill board vacancies. The commissioner may remove a member from serving on the board for cause.
  3. A reinsured health benefit plan issuer may, on written notice to the commissioner, replace a director of the board representing that reinsured health benefit plan issuer with a different representative acceptable to the

commissioner, as needed.

- B. The directors of the board must annually elect a chair, secretary, vice-chair, and other officers as they deem appropriate. The chair must notify the commissioner of the board's elections within 30 days of the elections.
- C. The votes of the board must be on a "one person, one vote" basis, with the commissioner or the commissioner's designated representative voting only in the case of a tie.
- D. A majority of the directors constitutes a quorum for the transaction of business. A director or the director's designated alternate must be present at the meeting to be counted for a quorum. The acts of the majority of the directors present or voting by proxy at a meeting at which a quorum is present will be the acts of the board. The board must consider and implement, after receiving advice from consultants deemed necessary by the board, a conflict of interest policy as it relates to matters or votes before the board. Directors are required to disclose any potential conflict of interest before voting on a particular issue. The chair will decide whether the director with the potential conflict may vote; however, the chair may delegate this function to a committee and must delegate it to a committee if the conflict of interest involves the chair. If so delegated, the majority vote of the members of this committee prevails.
- E. An annual meeting of reinsured health benefit plan issuers and the board will be held at a place designated by the board on the second Tuesday of each February, unless a majority of the board, with at least 30 days' notice to all directors, designates some other date or place. Costs of conducting meetings of the system and its board will be borne by the system.
- F. At each annual meeting the board must:
  - 1. Review this plan of operation and submit proposed amendments, if any, to the commissioner for approval;
  - 2. Review reports of the administrator, including audited financial reports, reports on outstanding contracts and obligations, and all other material matters;
  - 3. Review reports of the committees established by the board;
  - 4. Determine whether to recommend any technical corrections or amendments to the Act to the commissioner;
  - 5. Review and consider the performance of the system in support of the goals of the Act;
  - 6. Review the rates for reinsurance coverages, benefit plan design, and communication programs. Adjustments to rates may reflect the use of cost containment and managed care arrangements;
  - 7. Review the net reinsurance premiums, the system administration expenses,



and the incurred losses for the year, taking into account investment income and other appropriate gains and losses;

8. Determine if an assessment is necessary for the proper administration of the system;
  9. Review and adjust, if needed, the initial level of benefits and maximum liability limit to be retained by reinsured health benefit plan issuers to reflect increases in costs and utilization for small employer health benefit plans in Texas. Any adjustment must not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the U.S. Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor; and
  10. Review, consider, and act on any matters deemed by the board to be necessary and proper for the administration of the system.
- G. Not later than March 1 of each year, the board must determine and report to the commissioner the system's net loss, if any, for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.
- H. Not later than March 1 of each year, the board must determine and file with the commissioner an estimate of the assessments needed to fund any losses incurred by the system in the previous calendar year. If the estimate exceeds the 5 percent calculation specified in §1501.325(b), then the board must perform the evaluation and prepare the report to the commissioner as specified in §1501.325(b).
- I. The board may hold other meetings on the request of three or more directors, at the times and in the manner and frequency as the board deems appropriate. Notice of a meeting and its purpose must be provided to the directors at least seven calendar days before the meeting, unless the notice is waived by unanimous consent of all directors, and as long it complies with the requirements of the Texas Open Meeting Act.
- J. Advise the commissioner, as requested or if the board deems it essential, on any petition by a reinsured health benefit plan issuer to defer an assessment imposed by the board.
- K. The board may establish administrative procedures of the system consistent with the Act and this plan of operation.
- L. A written record of the proceedings of each board meeting must be made and submitted to the commissioner. The original of the record must be retained by the administrator.

### **Article VIII - Committees**

The chair may appoint representatives of reinsured health benefit plan issuers and other

qualified individuals to any committee set forth below or otherwise established by the board. Each committee must have as its members at least one private and one public representative from the board. The chair, at the chair's discretion, may combine committees for the purpose of a single objective or appoint special committees. A written record of the proceedings of each committee must be maintained by a secretary appointed from the members of each committee.

A. Actuarial Committee

The mission of the actuarial committee is to:

1. Recommend to the board appropriate reinsurance premium rates, methodologies, rate schedules, rate adjustments, and rate classifications for individuals and small employer groups reinsured with the system;
2. Recommend to the board the reports to be made by reinsured health benefit plan issuers and the administrator;
3. Provide reports and other recommendations as directed by the board;
4. Determine the system's incurred claim losses, including amounts for incurred but not reported claims;
5. Recommend assessment methodology and assessments; and
6. Assist the board in any other actuarial-related matters that the board deems necessary.

B. Operations and Appeals Committee

The mission of the operations and appeals committee is to:

1. periodically review the small employer health benefit plans and the system investments and make recommendations to the board;
2. provide administrative interpretation as to the intent of the plan and to provide administrative direction on issues referred to it by the board or the administrator and reinsured health benefit plan issuers. This committee must provide administrative assistance in communicating the spirit and purpose of the Act;
3. identify items that necessitate operating rules and to propose them for adoption by the board;
4. assist the board in borrowing money, when necessary;
5. consider and recommend to the board a conservative investment plan for the system, and to annually evaluate and recommend necessary amendments to the investment plan;

6. establish objective procedures for the resolution of disputes and appeals from reinsured health benefit plan issuers. The committee must review each dispute or appeal of a system action and make a report that includes the recommendation of the committee to the board, for its consideration and action, following completion of review of the appeal or dispute; and
7. Assist the board in any other matters that the board deems necessary.

C. Audit Committee

The mission of the audit committee is to:

1. develop a uniform regular audit program to be used by independent auditors in their review of each reinsured health benefit plan issuer with regard to items related to reinsurance with the system and assessments;
2. recommend to the board if any target examinations or audits should be conducted. Develop the standards for any target examinations or audits and the form of the report;
3. establish standards of acceptability for the selection of independent auditors with regard to subsections (1) and (2) of this section;
4. assist the board in the selection of an independent auditor for the annual audit of the system operations;
5. assist the board in the review of the reports prepared by the independent auditors in conjunction with subsections (1) through (3) of this section;
6. establish adequate internal accounting and record keeping controls after receiving advice from its independent auditor; and
7. assist the board on any other audit or accountant related matters the board deems necessary.

D. Access Committee

The mission of the access committee is to:

1. recommend to the board methods for carrying out certain additional responsibilities;
2. establish monitoring and evaluation procedures for the system, so that recommendations for improvements can be made to the commissioner; and
3. advise the board as requested in various other requirements of the Act, such as:

- a. the determination of baseline and ongoing information, obtained through surveys or other methods, to assess the effectiveness of the system; and
- b. the development of marketing and communicating plans for the system, as needed.

**Article IX - Administrator**

- A. The administrator is jointly responsible, along with the board and the reinsured health benefit plan issuers, for the fair, equitable, economical, and reasonable administration of the system.
- B. The board must select the administrator from the proposals submitted to the board. The proposals must be in writing and provide, at a minimum, a detailed explanation of the work to be performed, the capabilities of the applicant, and the costs anticipated.

Periodically, the board will review or audit the activities of the administrator to determine if it is operating in a fair, equitable, economical, and efficient fashion. Once every five years, or more often if there is a need, the board will decide whether to select a new administrator. The board has the right to terminate a contract with the administrator without cause.

- C. The administrator must perform the following functions as directed by the board:
  1. Establish procedures and install the systems needed to properly administer the operations of the system in accordance with the Act and this plan of operation;
  2. Establish, on behalf of the system, one or more bank accounts for the transaction of system business, with such bank accounts approved by the board;
  3. Accept, on behalf of the system, risks that are ceded by reinsured health benefit plan issuers;
  4. Collect reinsurance premiums for ceded risks, collect all other amounts due to the system on a timely basis, and pursue collections with diligent efforts;
  5. Deposit, on a timely basis, all cash collected on behalf of the system in the established bank accounts;
  6. Provide reimbursement for claims paid on ceded risks;
  7. Issue checks or drafts on and approve charges against bank accounts of the system;
  8. Keep all accounting, administrative, and financial records of the system in

- accordance with this plan;
9. Act as a communications resource for reinsured health benefit plan issuers in reviewing their administrative operation under the Act and this plan;
  10. Calculate assessments and recommend the assessment to the board for approval, in accordance with a methodology developed by the board that is consistent with this plan, and collect appropriate amounts due;
  11. Invest available cash in marketable securities as specified in the investment plan approved by the board;
  12. Perform other necessary functions as directed by the board;
  13. Prepare an annual estimate of operating costs for the administration of system operations; and
  14. Perform other functions as agreed between the board and the administrator.
- D. The administrator must maintain all records of premiums, reimbursements, and administrative expenses for a calendar year for a period of seven years following the end of such calendar year.
- E. The administrator will serve, on terms acceptable to the board, until the substitution by the board of a successor, its resignation, or as otherwise removed by the board without cause. The board must give the administrator 45 days' written notice of its decision to remove the administrator, unless there is evidence of gross negligence or intentional misconduct, which constitute grounds for immediate removal.
- F. The administrator will be reimbursed for its reasonable costs of administration in accordance with any agreement approved by the board.
- G. The administrator may not subcontract for services related to its duties as the administrator without the prior approval of the board.
- H. Subject to disclosure requirements in this plan of operation in performing its duties, the administrator must maintain the confidentiality of all information about insureds and reinsured health benefit plan issuers in accordance with all applicable statutes, regulations, and principles of common law about confidentiality and trade secrets. Confidential information and data received by the administrator may be used only for the purposes necessary for the operation of the system and must be strictly segregated from other records, data, or operations of the administrator.
- I. The books and records required to be created or maintained under this plan of operation or any board-approved administrative services agreement between the system and the administrator are and remain the property of the system. The maintenance or transfer of these books and records are governed by the provisions of this plan of operation and any board-approved administrative services agreement between the system and the administrator.

## **Article X - Eligibility for Reinsurance and Other Reinsurance Guidelines**

Reinsurance is available only for coverage of eligible employees and eligible dependents under small employer health benefit plans issued by reinsured health benefit plan issuers to small employers, subject to the provisions in the Act and its related regulations. A reinsured health benefit plan issuer may reinsure with the system the coverage of individual eligible employees and eligible dependents. Alternatively, a reinsured health benefit plan issuer may reinsure coverage for a small employer's entire group.

### A. Identifying eligible small employers, eligible employees, and eligible dependents:

1. Small employer status must be established by a reinsured health benefit plan issuer in accordance with the definition of "small employer" set out in this plan. Small employer status is determined as of the effective date of a small employer carrier's coverage of a small employer health benefit plan.
2. The determination of the number of eligible employees must be in accordance with the definition of "eligible employees" as set out in this plan and must be based on the most recent Texas Workforce Commission Employers Quarterly Report and any other information necessary to determine eligibility. Any employees listed on the report who are not eligible employees should be identified along with the reason they are not eligible. Any employees not included in the report should be listed in an attachment to the report. If a Texas Workforce Commission Employers Quarterly Report is not available, other verifiable information may be used if it is acceptable to the reinsured health benefit plan issuer and the administrator. The reinsured health benefit plan issuer must provide to the administrator a copy of the most recent Texas Workforce Commission Employers Quarterly Report and any attachments. Texas Workforce Commission Reports should be provided for all employers in the case of an affiliated employer arrangement.
3. The reinsured health benefit plan issuer must also obtain from each small employer a completed Small Employer Certification Form as set out in this subsection. The Small Employer Certification Form must provide adequate information for an employer to understand and comply with Texas law regarding the determination of the number of eligible employees and any other factors used in determining eligible small employer groups. The Small Employer Certification Form must also require any other information necessary for the board and the administrator to determine eligibility, and for administration of the system, including the employer tax identification number, affiliated employer information, and whether the employer offers other health benefit coverage. A copy of the Small Employer Certification Form may be obtained from the administrator. The reinsured health benefit plan issuer must provide to the administrator a copy of the completed and signed Small Employer Certification Form.
4. The reinsured health benefit plan issuer is also responsible for completing and must provide to the administrator a signed and sworn Reinsured Health

Benefit Plan Issuer Certification Form. The Reinsured Health Benefit Plan Issuer Certification Form must state that the carrier has obtained adequate information from the employer, as required by the system, to document it as a small employer and that adequate information has been obtained from each employer to document its determination of eligibility of each individual employee and each dependent. The Small Employer Certification Form must also state that the reinsured health benefit plan issuer has not issued any other health benefit plan coverage to the employer or any affiliated employers. A copy of the Reinsured Health Benefit Plan Issuer Certification Form may be obtained from the administrator. An initial certification of "small employer" status need not be recertified at subsequent renewal anniversaries so long as the reinsured health benefit plan issuer, at each renewal anniversary date, renews the then-current health benefit plan for the initially certified small employer.

5. Each Reinsured Health Benefit Plan Issuer is responsible for obtaining and updating the information and certifications required in subsections (1) through (4) of this section, at each small employer group's contract anniversary and for providing the updated information to the administrator within 30 days of the contract anniversary. The system may conduct random reviews of all information and certifications required in subsections (1) through (4) of this section. Random reviews may be conducted by the administrator or by a third party retained by the system for that purpose. All costs associated with these reviews must be borne by the reinsured health benefit plan issuer whose records are being reviewed.
6. Each reinsured health benefit plan issuer is ultimately responsible for determining whether a person is an eligible small employer and that each specific individual to be reinsured is an eligible employee or eligible dependent. Reinsured health benefit plan issuers reinsuring ineligible persons are subject to administrative charges. Before completing the Reinsured Health Benefit Plan Issuer Certification Form, reinsured health benefit plan issuers should carefully review the employer and employee enrollment applications, federal and state filings required in addition to the Texas Workforce Reports (for example, the Form 5500 Annual Return/Report of Employee Benefit Plan, if applicable), waivers of coverage, and the documents required under this section.
7. Reinsured health benefit plan issuers must, on request by the board, make available to the board and the administrator all eligibility documents required by the system and any other information used to determine eligibility.
8. Reinsurance coverage for an individual will not be effective until the administrator determines that all required documents have been received and are complete.
9. If a reinsured health benefit plan issuer, while acting in good faith, erroneously certifies a person to be a small employer, reinsurance of any employees of that person or their dependents will be terminated as of the first date of ineligibility.

10. Any material statement or omission by an employer or employee that falsely certifies as to a specific individual's eligibility for coverage constitutes cause for termination of reinsurance, without penalty to the reinsured health benefit plan issuer. Prompt notice of the discovery must be given to the administrator, and reinsurance of any such individuals will be terminated as of the first date of ineligibility.
11. A small employer that, subsequent to initial eligibility, employs more than 50 eligible employees ceases to be eligible for reinsurance coverage in the system unless the employer satisfies the renewal provisions of Title 28 Texas Administrative Code §26.5(i), relating to the employer's renewal of its current health plan subsequent to its employment of more than 50 eligible employees.
12. Ineligibility resulting from a small employer, subsequent to initial eligibility, employing more than 50 eligible employees must become effective on the plan anniversary date immediately following such occurrence.

B. Reinsurance ceding rules and premium levels:

1. A reinsured health benefit plan issuer must notify the administrator of its intent to reinsure a specific individual covered under a small employer's plan as an eligible employee or an eligible dependent within 60 days of the initial effective date of that individual's coverage; or, for a newly eligible employee or eligible dependent, within 60 days of the commencement of that individual's coverage.
2. Availability of individual reinsurance is subject to the following rules:
  - a. The group must be a small employer group at the effective date of reinsurance;
  - b. The individual may only be reinsured for the coverage provided under a small employer health benefit plan as provided in §1501.252 or §1501.255;
  - c. Each individual whose coverage is reinsured must be an eligible employee or an eligible dependent;
  - d. The reinsured health benefit plan issuer may reinsure coverage of an eligible employee without reinsuring coverage of any specific eligible dependent of that eligible employee, or may reinsure coverage of a specific eligible dependent without reinsuring coverage of the eligible employee or any other of his or her eligible dependent(s), except that a newborn child or children may be reinsured only if the mother is a reinsured individual at the time that reinsurance of the child or children by the system is sought;
  - e. If a reinsured health benefit plan issuer has previously withdrawn



reinsurance of coverage for any individual, the same reinsured health benefit plan issuer cannot reinsure that individual again at any time in the future; and

- f. The 60-day period within which a reinsured health benefit plan issuer must reinsure any eligible employee or eligible dependent must be used to review underwriting requirements to determine ceding to the system. Only underwriting requirements may be used by a reinsured health benefit plan issuer in determining whether to reinsure any eligible employee and his or her eligible dependents.
3. A reinsured health benefit plan issuer must notify the administrator of its intent to cede all eligible employees and eligible dependents (the whole small employer group) for reinsurance of coverage under a plan covering eligible employees of a small employer within 60 days of the initial effective date of the small employer's plan.
  4. Availability of whole small employer group reinsurance is subject to the following rules:
    - a. The small employer's health benefit plan, on a whole-group basis, can only be reinsured for the coverage provided under a health care plan required or permitted by §1501.252 or §1501.255 or up to a level of a health care plan required or permitted by §1501.252 or §1501.255.
    - b. Subject to payment of premium, all new entrants eligible to be reinsured will also be reinsured at the effective dates of their coverage.
    - c. If a member has previously withdrawn reinsurance of coverage for any small employer group, the reinsured health benefit plan issuer cannot again reinsure the withdrawn small employer group but may reinsure timely new entrants that are eligible to be reinsured on an individual basis, as described in section 1 of this subsection.
    - d. An amendment rider or other change in the small employer plan must not constitute a change in initial effective date.
    - e. Reinsured health benefit plan issuers acquiring business from other small employer carriers doing business in Texas may not cede to the system these acquired small employer groups. Reinsured health benefit plan issuers are urged to conduct comprehensive due diligence and expansive negotiations when considering the acquisition of another reinsured health benefit plan issuer's block of business. This provision is not intended to restrict a small employer carrier's ability to reinsure a new whole small employer group or individual eligible employee, eligible dependent, or a timely new entrant to an acquired eligible small employer group.

- f. Risks that were previously ceded and whose reinsurance is in force from the previous carrier may continue reinsurance at the option of the acquiring carrier.
5. When the administrator rejects a reinsured health benefit plan issuer's notification to reinsure an individual for failure to file the notification within the 60-day period, the reinsured health benefit plan issuer may file a petition with the board requesting a waiver of the 60-day period. The petition must describe the circumstances that caused the notification to be filed after the end of the 60-day period. If the board determines that the failure to timely file the notification was caused by circumstances beyond the knowledge or control of the reinsured health benefit plan issuer, the board may waive the 60-day period if it finds such waiver would be equitable.
6. A reinsured health benefit plan issuer may not cede additional eligible lives to the system during the calendar year if the assessment amount payable for the preceding calendar year is at least 5 percent of the total premiums earned in that calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state.

C. Period of reinsurance:

1. Reinsurance may continue as long as coverage under the small employer health benefit plan for the covered eligible employees and eligible dependents remains in effect subject to the regulations passed under the Act.
2. A reinsured health benefit plan issuer that is subsequently approved to operate as a risk-assuming health benefit plan issuer must notify the administrator immediately of that change in status. On approval to operate as risk assuming health benefit plan issuer, all reinsurance with the system will be terminated, effective on the date of approval.
3. A reinsured health benefit plan issuer may terminate reinsurance with the system for one or more of the reinsured employees or dependents of employees of a small employer on a contract anniversary of the small employer health benefit plans. Written notice must be provided to the system at least 30 days in advance of the withdrawal.
4. Reinsurance of an individual's coverage under a small employer's health benefit plan ceases at the termination of the individual's status as an eligible employee or eligible dependent, except to the extent that coverage continues as required by law. If the reinsured health benefit plan issuer provides coverage for persons beyond either of the dates indicated above, for contractual or other reasons, reinsurance will be continued for a maximum of 30 days beyond that date.
5. Reinsurance of an individual covered under a small employer's health

benefit plan (including an individual whose coverage under that plan has continued as required by law) ceases at termination of the reinsured health benefit plan issuer's coverage of the small employer group in which that individual was previously covered as an eligible employee or eligible dependent.

D. Determination of reinsurance premium:

1. Tables of reinsurance premium rates for reinsured health benefit plan issuers, as calculated by the actuarial committee, and approved by the board, will be communicated to reinsured health benefit plan issuers. Separate tables will be prescribed for HMOs and will reflect the provisions in §1501.213.
2. For any reinsured individual, the reinsurance premium may be up to 500 percent of the base reinsurance premium rate established by the system for that classification or individual within a small employer group with similar case characteristics and coverage. The reinsured health benefit plan issuer will calculate the reinsurance premium for each individual reinsured based on the tables of reinsurance premium rates established by the system.
3. For any reinsured small employer group, the reinsurance premium may be up to 150 percent of the base reinsurance premium rate established by the system for small employer groups with similar case characteristics and coverage. The reinsured health benefit plan issuer will calculate the reinsurance premium for each small employer group reinsured based on the table of reinsurance premium rates established by the system.
4. Premium rates charged by the system may reflect the use of effective cost containment and managed care arrangements.

E. Billing and payment:

1. Monthly, the reinsured health benefit plan issuer will provide the administrator with a listing of the individuals and whole groups reinsured, the premium for each individual, and any other information as may be required by the system. It is the reinsured health benefit plan issuer's responsibility to notify the administrator of any corrections to previous transactions. When notified, the administrator will make any necessary corrections and send a corrected statement to the reinsured health benefit plan issuer.
2. Payment of reinsurance premium must be received by the administrator before the related reinsurance transactions will be processed.
3. The reinsurance premiums charged by the system for each individual will be determined by the table of rates in effect on the later of the effective date of the small employer's health benefit plan with the reinsured health benefit plan issuer or the most recent plan anniversary.

4. Premiums are determined as of the first of the month and are due by the 20th of the month. If premiums are not paid by the 20th of the month, then the reinsured health benefit plan issuer's participation in the system may be terminated.
5. Reinsurance premium amounts are to be paid based on whole month increments only. If reinsurance is effective between the first and the 15th of the month, the entire month's premium must be paid in full. When reinsurance becomes effective between the 16th and the last day of the month, no premiums will be payable until the first of the month following the effective date.
6. Conversely, reinsurance terminations effective between the first and the 15th of the month will be considered for premium refunds for the entire month. Reinsurance terminations effective between the 16th and the last day of the month will not be allowed premium refunds.
7. Reinsurance premium is due monthly to the system regardless of a reinsured health benefit plan issuer's ability to charge back or collect the small employer's premiums. The system has no responsibility for the collection of small employer's premiums.
8. Reinsurance claims may not be netted against reinsurance premium due.

F. Reinsurance claim section:

1. Statement of reinsurance:

The system will indemnify a reinsured health benefit plan issuer for the covered claims incurred with respect to employees and dependents whose coverage with the reinsured health benefit plan issuer is reinsured with the system as described in the Act and subject to the following:

- a. The system will reimburse a reinsured health benefit plan issuer for covered claims on a monthly basis. The chair may direct the administrator to withhold or suspend reimbursements if the chair determines that there is reason to believe a reinsured health benefit plan issuer has violated this Plan of Operation.
- b. For the purposes of this section, "covered claims" means only amounts that are actually paid by reinsured health benefit plan issuers for benefits provided for individuals reinsured by the system, but covered claims must not include:
  - (1) claim expenses or salaries paid to reinsured health benefit plan issuers' employees who are not providers of health care services;
  - (2) court costs, attorney's fees or other legal expenses;

- (3) any amount paid by the reinsured health benefit plan issuers for:
    - (i) punitive or exemplary damages; or
    - (ii) compensatory or other damages awarded as a result of the conduct of the reinsured health benefit plan issuers in the investigation, trial, or settlement of any claim or failure to pay or delay in payment of any benefits under any policy; or the operation of any managed care, cost containment, or related programs; and
  - (4) any statutory penalty imposed on a reinsured health benefit plan issuer on account of any unfair trade practice or any unfair insurance practice.
- c. The initial level of benefits paid has been set at \$5,000 plus 10 percent of the next \$50,000 in claims for each reinsured individual in a calendar year for all small employer health benefit plans. A reinsured health benefit plan issuer's maximum liability limit may not exceed \$10,000 with respect to any reinsured individual during one calendar year. The initial level of benefit and the maximum liability limit amounts to be retained by a reinsured health benefit plan issuer will be adjusted by the board annually in accordance with §1501.315(b).
  - d. No reinsurance will be provided until the initial level of benefits paid has been met during a calendar year for a reinsured eligible employee or eligible dependent.
2. General requirements:
- a. Reinsured health benefit plan issuers will promptly investigate, settle, or defend all claims arising under the risks reinsured and will forward promptly to the system copies of any reports of investigation that may be requested by the system.
  - b. Reinsured health benefit plan issuers will adjudicate all claims on ceded risks.
  - c. Reinsured health benefit plan issuers must, with respect to reinsured and nonreinsured business, consistently apply all managed-care procedures including, but not limited to, utilization review, individual case management, and preferred provider programs, as well as other managed-care processes or methods of operation. The failure to follow the procedures will result in the denial or reduction of reinsurance reimbursements, as determined by the board and approved by the commissioner.

- d. The system has the right, at its own expense, to participate jointly with a reinsured health benefit plan issuer in the investigation, adjustment, or defense of any claim. Reinsured health benefit plan issuers will be required to ensure that their claim-management practices are consistent between reinsured and nonreinsured risks. The failure to follow consistent practice procedures will result in the denial or reduction of reinsurance reimbursements, as determined by the board and approved by the commissioner.
- e. The system has the right to inspect the records of a reinsured health benefit plan issuer in connection with the risks reinsured with the system. The reinsured health benefit plan issuer must submit to the system any additional information it may require in connection with claims submitted to the system for reimbursement in the format specified by the board. Reinsured health benefit plan issuers must secure necessary authorizations from reinsured individuals for this purpose.
- f. All information disclosed to the system by a small employer carrier or to a reinsured health benefit plan issuer by the system, in connection with this plan, will be considered to be privileged information by the reinsured health benefit plan issuers, the system, and the administrator.
- g. If any payment is made by the system to a reinsured health benefit plan issuer and the reinsured health benefit plan issuer is reimbursed by another party for the same expenses (benefits paid), the system must be reimbursed or subrogated to the extent that the reinsured health benefit plan issuer is reimbursed. The reinsured health benefit plan issuer must execute and deliver instruments and do whatever is necessary to preserve and secure these reimbursement rights.
- h. Reinsured health benefit plan issuers must certify, at the designated location on the system claim submission form, that their claim processing practices and procedures are in compliance with all applicable provisions of Article X, Section F.
- i. HMOs that pay for certain provider services on a basis other than fee for service will be allowed reimbursement for those costs on reinsured persons from the system through a methodology approved by the board.
- j. Except as approved by the board, reinsurance will be provided only for covered claims submitted within two years from the date on which the claims expenses were incurred. Except as approved by the board, for claim expenses incurred on or after October 1, 2007, reinsurance will be provided only for covered claims submitted within 12 months from the date on which the claims expenses were incurred.

3. Claims reporting:

- a. Within 20 days after the close of each calendar month reporting period, the reinsured health benefit plan issuers must furnish to the system the following information with respect to reinsured claims submitted to the system by the reinsured health benefit plan issuer during said reporting period:
  - (1) The small employer's identification number;
  - (2) The employee's name and unique identification number;
  - (3) The claimant's name and date of birth;
  - (4) The claim incurred date and paid date;
  - (5) The reinsurance claim amount;
  - (6) The claim coding as required by the board (for example, CPT and ICD9); and
  - (7) Where appropriate, the relationship of the reinsured individual to the eligible employee.
- b. Reinsured health benefit plan issuers must notify the system as soon as reasonably possible of all claims or potential claims for a reinsured eligible employee or eligible dependent where the claims expected to be paid by the reinsured health benefit plan issuer will exceed \$100,000 in the aggregate.

**Article XI - Audit Functions**

- A. The transactions of the system are subject to audit by the state auditor in accordance with Government Code Chapter 321.
- B. The state auditor will report the cost of each audit conducted under this article to the board and the Texas Comptroller's Office, and the system must remit that amount to the Texas Comptroller's Office for deposit into the general revenue fund.

**Article XI.1. - External Audit Functions**

- A. Each reinsured health benefit plan issuer must undergo a regular audit at least once every five years. The board may also require a target examination or audit of a reinsured health benefit plan issuer whenever it determines it is reasonable and appropriate to ensure compliance with the system. The reinsured health benefit plan issuer will be selected on the basis of the amount of premium volume in the Texas small employer market, the dollar amount of claims reimbursed by the system, errors

related to reinsurance, and any other factors determined by the audit committee. The cost of all regular audits and any target examinations or audits of a reinsured health benefit plan issuer must be borne by that reinsured health benefit plan issuer. Target examinations or audits may also be subject to administrative charges.

- B. The board at its discretion may contract with an independent auditor to conduct any audits or target examinations or audits under this article or may allow a reinsured health benefit plan issuer to contract directly with an approved independent auditor.
- C. A reinsured health benefit plan issuer contracting directly with an independent auditor must hire a certified public accountant or other party approved by the board to conduct the audit. To be acceptable, the auditor must be independent, in accordance with standards established by the audit committee. The audits must be made in accordance with generally accepted auditing standards as adopted by the membership of the American Institute of Certified Public Accountants.
- D. All regular audits must be conducted in accordance with a uniform audit program for system members, as approved by the board. This audit must clearly specify all items to be audited. It must include a certification statement form, to be completed by the auditor, to verify the completion of all prescribed audit procedures as dictated by the audit. Also, details regarding the number and types of records reviewed and any errors found must be submitted in a report that accompanies the certification statement. A copy of this report and the certification statement must be submitted to the board by the auditor. The audit committee will review all audit reports and report its findings to the board.
- E. The regular audit must include, but not be limited to, detail testing of representative samples of the following items:
  - 1. Reinsurance claims submitted to the system, in particular:
    - a. Eligibility of claimants and their small employers for reinsurance by the system; and
    - b. Proper determination of reinsurance claim amount by the reinsured health benefit plan issuer.
  - 2. Reinsurance premiums submitted to the system, including:
    - a. Eligibility of those lives for whom premium is paid for reinsurance by the system; and
    - b. Proper determination of reinsurance premium amounts paid.
  - 3. Data submitted to the system for use in the calculation of member assessments for net losses.
- F. Any target examinations or audits required by the board must be conducted under standards developed by the audit committee.



- G. Random audits of provider bills or other records must be conducted as deemed necessary by the audit committee to verify the accuracy and appropriateness of reinsurance claim submissions.
- H. The board has the right to conduct such additional audits of reinsured health benefit plan issuer as it deems appropriate.
- I. All information disclosed in the course of the audit of a reinsured health benefit plan issuer will only be released in compliance with applicable federal and state privacy requirements.
- J. The system must have an annual audit of its operations conducted by an independent certified public accountant, as approved by the board. The board must file this annual audit with the commissioner for his or her review. This audit must encompass at least the following items:
  - 1. The handling and accounting of assets and money for the system;
  - 2. The annual fiscal report of the system;
  - 3. The calculation of the premium rates charged for reinsurance by the system;
  - 4. The calculation and the collection of any assessments of reinsured health benefit plan issuers for net losses; and
  - 5. The reinsurance premiums due to the system and the claim reimbursements made to the reinsured health benefit plan issuers.

**Article XII - Assessments**

A. Assessments:

- 1. Not later than March 1 of each year, the board must determine and report to the commissioner the system net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. Any net loss for the year must be recouped by assessments on reinsured health benefit plan issuers. Each reinsured health benefit plan issuer's assessment must be determined annually by the board based on annual statements and other reports required by the board and filed with the board. The board establishes a formula by which to make assessments against reinsured health benefit plan issuers. With the approval of the commissioner, the board may, as it determines appropriate, modify or otherwise change this assessment formula. The board must base the assessment formula on each reinsured health benefit plan issuer's share of:
  - a. the total premiums earned in the preceding calendar year from the small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in

Texas; and

- b. the premiums earned in the preceding calendar year from newly issued small employer health benefit plans delivered or issued for delivery during the calendar year by reinsured health benefit plan issuers to small employer groups in Texas.
2. The administrator must deliver to each reinsured health benefit plan issuer a form approved by the actuarial committee for the reporting of small employer health benefit plan premium and any other information necessary for calculation of assessments. Each reinsured health benefit plan issuer must accurately complete and timely submit the reporting form.
3. The formula established under subsection 1 of this subsection may not result in an assessment share for a reinsured health benefit plan issuer that is less than 50 percent or more than 150 percent of an amount based on the proportion of the total premium earned in the preceding calendar year from the small employer health benefit plans delivered or issued for delivery to small employer groups in Texas by that reinsured health benefit plan issuer to the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery to small employer groups in Texas by all reinsured health benefit plan issuers.
4. With the approval of the commissioner, the board may adjust the assessment formula for reinsured health benefit plan issuers that are approved health maintenance organizations and federally qualified under Subchapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), to the extent that the restrictions imposed on those health maintenance organizations are not imposed on other health carriers.
5. A reinsured health benefit plan issuer that is approved to operate as risk-assuming health benefit plan issuer must pay a prorated assessment based on business issued as a reinsured health benefit plan issuer for the portion of the year the business was reinsured.

B. Deferment of assessment:

1. A reinsured health benefit plan issuer may petition the commissioner for a deferment, in whole or in part, of an assessment imposed by the board under §1501.326. A reinsured health benefit plan issuer must notify the chair and the administrator of such petition at the time the petition is filed with the commissioner.
2. The commissioner may defer all or part of the assessment of a reinsured health benefit plan issuer if the commissioner determines that the payment of the assessment would endanger the ability of the reinsured health benefit plan issuer to fulfill its contractual obligations. A reinsured health benefit plan issuer must immediately notify the chair and the administrator if a partial or whole deferment is granted or if the petition is denied.

3. If an assessment against a reinsured health benefit plan issuer is deferred, the amount deferred must be assessed against the other reinsured health benefit plan issuers in a manner consistent with the basis for assessment established by the Act.
4. A reinsured health benefit plan issuer receiving a deferment is liable to the system for the amount deferred and is prohibited from marketing, delivering, or issuing for delivery a small employer health benefit plan or reinsuring any individual or small employer group with the system until it pays the outstanding assessment.

C. Interim assessments:

The system may make advance interim assessments as reasonable and necessary for the organizational and interim operations; and the advance interim assessments must be credited as offsets against regular assessments due after the close of the fiscal year of the system.

D. Objections to assessments:

A reinsured health benefit plan issuer that disagrees with any assessment for any reason must submit its objections in writing to the administrator within 14 calendar days of the billing date of the assessment.

1. A committee appointed by the chair will review the issuer's objections and, with input from the administrator, make recommendations concerning the issuer's assessment liability at the next regularly scheduled board meeting.
2. Recommendations of the appointed committee may include, but are not limited to, denial of the appeal in whole or in part and an adjustment increasing or decreasing the issuer's assessment liability amount.
3. The board will take final action on the issuer's objections to its assessment liability and complete the appeals process no later than six months following receipt by the administrator of the written objections. If the board does not take final action on the issuer's written objections within nine months following receipt by the administrator of the objections, the appeal must be deemed to have been denied.
4. Any assessment liability amount not timely paid following final action by the board on the issuer's objections will be subject to accrual of interest and assessment of late fees under Section G of this article, and applicable provisions of Article XV, Section A.

E. Prohibition to reinsure:

Reinsured health benefit plan issuers may not cede additional eligible lives to the system after the board determines that the expected loss of the system for a year will exceed the total amount of assessments payable at a rate of 5 percent of the total premiums earned for the preceding calendar year. Reinsured health benefit

plan issuers may not resume ceding additional eligible lives to the system until the board determines the expected loss is less than the 5 percent maximum described above.

F. De Minimis assessments:

Any assessment of less than \$100 will not be billed to a reinsured health benefit plan issuer, but will be accumulated and billed when the cumulative amount is at least \$100. Any assessment of less than \$10 will be forgiven.

G. Late payments:

Assessments will be due and payable when billed. If the assessment is not received by the administrator within 30 days of the billing date, the administrator will bill the reinsured health benefit plan issuer every 30 days, and the reinsured health benefit plan issuer must pay interest on the assessment from the billing date at the annual rate of prime plus 3 percent.

H. Definition of small employer health benefit plan premium:

Premium will be the payments the reinsured health benefit plan issuer earned under small employer health benefit plans during the accounting period. It does not include premiums for the following coverages:

1. Accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;
2. Credit-only insurance coverage;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select benefit plans regulated in accordance with federal law;
7. Long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single-service health maintenance organization;
10. Workers' compensation insurance coverage or similar insurance coverage;
11. Coverage provided through a jointly managed trust authorized under 29 U.S.C. §141 et seq. that contains a plan of benefits for employees that is

negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U. S.C. §157;

12. Hospital indemnity or other fixed indemnity insurance coverage;
13. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
14. Short-term major medical contracts;
15. Liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;
16. Coverage for on-site medical clinics;
17. Coverage that provides other limited benefits specified by federal regulations; or
18. Other coverage that:
  - a. is similar to the coverage described by this section under which benefits for medical care are secondary or incidental to other coverage benefits; and
  - b. is specified by federal regulations.

Additionally, premium does not include premiums for policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the small employer carrier offering the policies or certificates has certified that the policies or certificates are being offered and marketed as supplemental health insurance and not as a substitute for small employer health benefit plans.

### **Article XIII - Reports of Reinsured Health Benefit Plan Issuer and Administrator**

- A. Unless otherwise specified by the board, the following information must be required from reinsured health benefit plan issuers for reinsured risks:
  1. Identification of the reinsured health benefit plan issuer;
  2. Name, date of birth, sex, and the reinsured health benefit plan issuer unique identification number of the individual being reinsured;
  3. Identification of the reinsured as an eligible employee, spouse, or child;
  4. Employee name (if different) and unique identification number;
  5. Contract anniversary date;

6. Employer's name, address, ZIP code, and SIC code;
  7. Plan version;
  8. Effective date of the small employer coverage;
  9. Effective date of the reinsurance;
  10. Date of applicable employee's employment; and
  11. Other information required by the board.
- B. Changes in reinsurance coverage require that the following information be provided by reinsured health benefit plan issuers of the system:
1. The reinsured's name and identification number;
  2. The eligible employee's name (if different) and unique identification number;
  3. Effective date of the status change; and
  4. Other information required by the board.

#### **Article XIV - Financial Administration**

A. Books and records:

The administrator must maintain the books and records of the system so that financial statements can be prepared to satisfy the Act. These books should be kept in an order as to satisfy any additional requirements that may be deemed necessary to meet the needs of the board and the outside auditors, including the following requirements:

1. The receipt and disbursement of cash by the system must be recorded as it occurs.
2. Non-cash transactions must be recorded when the asset or the liability should be realized by the system in accordance with generally accepted accounting principles.
3. Assets and liabilities of the system, other than cash, must be accounted for and described in itemized records.
4. The net balance due to and from the system must be calculated for each reinsured health benefit plan issuer and confirmed with reinsured health benefit plan issuers as deemed appropriate by the board or when requested by the respective reinsured health benefit plan issuer. These balances should be supported by a record of each individual reinsured health benefit plan issuer's financial transactions with the system. These records include:

- a. Assessments, if applicable to the particular reinsured health benefit plan issuer;
- b. Allocated net earnings and losses of the system based on the assessments methodology contained in this plan;
- c. Any adjustments to assessments as explained in this plan;
- d. The amount of reinsurance premium due to the system for risks reinsured and accepted by the system;
- e. The amount of reimbursement due from the system for claims paid by the reinsured health benefit plan issuer for risks previously reinsured and accepted by the system;
- f. Adjustment to the amount due to and from the system based on corrections to the reinsured health benefit plan issuer submissions;
- g. Interest charges due from the reinsured health benefit plan issuer for late payment of amounts owed to the system; and
- h. Any other records as may be required by the board.

5. The administrator must maintain a general ledger whose balances are used to produce the system's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger must agree with the corresponding balances in subsidiary ledgers or journals. The administrator must provide financial statements to the board at a frequency determined by the board.

B. Handling and accounting of assets and money:

Money and marketable securities must be kept in bank accounts and investment accounts as approved by the board. The administrator must deposit receipts and make disbursements from these accounts.

C. Bank accounts:

All bank accounts must be established in the name of the Texas Health Reinsurance System, and must be approved by the board. Authorized check signers must be approved by the board and two signatures are required on all checks.

D. Lines of credit:

All lines of credit must be established in the name of the Texas Health Reinsurance System and must be approved by the board. Lines of credit may only be used as authorized by the board.

E. Investment policy:

All cash must be invested in available investment vehicles deemed appropriate by the board.

**Article XV - Administrative Charges, Adjustments, and Dispute Resolution**

A. Administrative charges and adjustments:

1. Given numerous factual determinations and tasks to be performed by reinsured health benefit plan issuers relative to their participation in the system, it is expected that all reinsured health benefit plan issuers will exercise the highest degree of good faith and due diligence in all aspects of their relationship with the system. Errors may occur, and it is appropriate that the sanctions applicable to such errors be detailed.
2. Errors related to reinsurance:
  - a. Reinsuring ineligible small employers or ineligible employees or ineligible dependents: Reinsurance coverage for the individuals involved will be terminated as of the first date of ineligibility. Reinsurance claims paid by the system in excess of reinsurance premiums received are to be returned by the reinsured health benefit plan issuer to the system with interest. Reinsurance premiums paid in excess of reinsurance claims will be refunded without interest. The board may assess an administrative charge in these situations. The administrative charge will be the greater of \$5,000 or 10 percent of the claims paid by the system for those individuals.
  - b. Reinsuring eligible employees or eligible dependents at the incorrect reinsurance premium rate: Reinsurance premiums for the individuals involved will be recalculated and immediate payment of additional premiums must be made, plus interest and any administrative charges assessed by the board. Excess payments will be refunded without interest, subject to the limitation on premium refund provision.
  - c. Reinsuring incorrect plan: Reinsurance premiums will be recalculated on the basis of the correct plan and all additional premiums due will be paid immediately, with interest and any administrative charges assessed by the board. Excess premiums will be refunded without interest and subject to the limitation on premium refunds provision.
  - d. Submitting incorrect claims: The claim will be recalculated and any amount due to the system will be repaid immediately, with interest and any administrative charges assessed by the board. Adjustments of claim payments for amounts recovered by the reinsured health benefit plan issuer under coordination of benefit, subrogation or similar provisions may not be considered errors for which interest or any administrative charge are due.



3. Errors related to assessments: All reinsured health benefit plan issuer errors related to the assessment require the immediate payment of additional amounts due plus interest calculated from the date the sum should have been paid, plus any administrative charges assessed by the board.
  4. Excess assessments: If assessments exceed net losses of the system, the excess must be credited to the reinsured health benefit plan issuers in proportion to the amount of the assessments to the carriers for the year in question.
  5. Errors not listed: All additional sums due to the system as a result of errors made by reinsured health benefit plan issuers other than those listed above must be paid immediately, with interest plus any applicable administrative charge.
  6. Gross negligence and intentional misconduct: If the board determines that the nature or extent of the errors related to the use of the reinsurance mechanism or otherwise by a particular reinsured health benefit plan issuer evidences gross negligence or intentional misconduct, the board may terminate some or all current reinsurance for the reinsured health benefit plan issuer and suspend the right of the reinsured health benefit plan issuer to use the reinsurance mechanism for an appropriate period, as determined by the board. All such actions require the approval of the commissioner before becoming effective. The board will ensure, to the extent possible, that the suspension or termination of reinsurance for the reinsured health benefit plan issuer will not adversely affect individuals already insured by the reinsured health benefit plan issuer.
  7. Interest and administrative charges: All interest payments required under this section will be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment. The annual rate of interest will be prime plus 3 percent. The administrative charges will be determined by the operations and appeals committee and recommended to the board for consideration and approval.
  8. Limitation on premium refunds: Except as provided in subsection 2(a) of this section, all premium refunds due under this Article will be limited to a period of 12 months from the date the error was corrected unless otherwise agreed to by the board.
- B. Reinsured health benefit plan issuer appeal of disputes to the board:

The administrator will act on behalf of the board in the attempt to resolve disputes between a reinsured health benefit plan issuer and the system. As to unresolved disputes, reinsured health benefit plan issuers may appeal each dispute to the board under the board's procedures. No further appeal to the commissioner is allowed.

#### **Article XVI - Indemnification**

- A. Neither participation in the system as reinsured health benefit plan issuers, the establishment of rates, forms or procedures, nor any other joint or collective action required by the Act can be the basis of any legal action, criminal or civil liability or penalty against the system or any of its reinsured health benefit plan issuers.
- B. Persons or reinsured health benefit plan issuers made a party to any action, suit, or proceeding because the person or reinsured health benefit plan issuer serves on the board or on a committee or was an officer or employee of the system will be held harmless and be indemnified by the system against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit, or proceeding. This indemnification will not be provided on any matter in which the person or reinsured health benefit plan issuer is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification will be prorated and paid for by all reinsured health benefit plan issuers.

#### **Article XVII - Amendment**

Amendments to this plan may be suggested by any reinsured health benefit plan issuer and may be made by the board at any time. Amendments to this plan are subject to the approval of the commissioner and will be effective on such approval.

#### **Article XVIII - Termination**

The system will continue in existence subject to termination in accordance with applicable requirements of the laws of Texas and the United States. In case of enactment of a law or laws that, in the determination of the board and the commissioner, result in the termination of the system, the system must terminate and conclude its affairs in a manner to be determined by the board with the approval of the commissioner. Any funds or assets of any nature held by the system following termination, and the payment of all claims and expenses of the system, will be distributed to the reinsured health benefit plan issuers existing at that time in accordance with the then-existing assessment formula.

#### **Article XIX - Suspension and Reactivation**

- A. To comply with amended §1501.302, which allow for suspending the system's operations by order of the commissioner, the plan of suspension for the system that is in effect will govern the affairs of the system. To the extent that any duties or obligations described in this plan of operation, are in conflict with an approved plan of suspension or are not consistent with suspending the operations of the system during the times designated for suspension by the commissioner, the duties or operations are considered to be and are suspended and the duties and obligations contained within the then-approved plan of suspension will control the affairs of the system.

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- B. Suspension of the system does not mean "termination," as described under Article XVIII "Termination," because the system is subject to being reactivated by further order of the commissioner, and as described at §1501.302.