# Consumer Information Data Call Instructions for First Quarter 2011

Pursuant to Article VIII, Rider 12, of the 2010 - 2011 General Appropriations Act, the Texas Department of Insurance (TDI) must prepare a quarterly *Consumer Information Report* that contains the following information for each insurer that writes a line of insurance in Texas: market share; profits and losses; average rate; average loss ratio; and change in rate over the previous 12, 24 and 36 months.

In order for TDI to collect this information, insurers and health maintenance organizations (HMOs) must submit a *Consumer Information Data Call* to TDI each calendar quarter. **This data call is limited to life, accident, health, long-term care, Medicare supplement, and credit insurance; annuity coverage; and HMO coverage.**

**The first quarter 2011 *Consumer Information Data Call* will capture experience experience from January 1 – March 31, 2011, and reported experience should be valued as of March 31, 2011. This data call has a firm deadline of May 20, 2011, and no extensions will be granted. Each subsequent data call will capture year-to-date experience as of the last day of the applicable quarter. Following are the reporting periods and due dates for the data calls that are due through calendar year 2011:**

| Calendar Quarter | Reporting Period | Value Experience as of: | Data Call Due Date |
|---|---|---|---|
| 1st Quarter 2011 | January 1 - March 31, 2011 | March 31, 2011 | May 20, 2011 |
| 2nd Quarter 2011 | January 1 - June 30, 2011 | June 30, 2011 | August 19, 2011 |
| 3rd Quarter 2011 | January 1 - September 30, 2011 | September 30, 2011 | November 21, 2011 |
| 4th Quarter 2011 | January 1 – December 31, 2011 | December 31, 2011 | March 6, 2012 |

**Each insurance company and HMO licensed to write one or more of the lines of coverage outlined above in Texas is required to submit the *Consumer Information Data Call* each calendar quarter, unless the company has been granted an exemption from TDI during a previous reporting period.** Licensed companies may be granted an exemption if a company representative sends an email to HealthSurveys@tdi.state.tx.us stating that the company meets both of the following criteria:

1. The company has no business in force for any of the lines of coverage captured by the data call in Texas, and
2. The company does not intend to enter these markets in the future.

Exemptions are only approved upon written confirmation by TDI. However, if a company had written premium in Texas during 4th quarter 2010 for a line of coverage captured by the data call after previously receiving an exemption, that company will no longer be exempt from the data call.

**Responding companies must submit data for each line of coverage for which the company had written premium in Texas during first quarter 2011. Companies should follow the detailed methodology described in NAIC's Schedule T to determine Texas business.**

The *Quarterly Consumer Information Data Call* consists of the following **four** tables:

- Table 1: Accident and Health (A&H) Coverage (Non-HMO)
- Table 2: HMO Coverage
- Table 3: Life, Annuity and Credit Coverage
- Table 4: Profits and Losses

Following is additional information on the lines of coverage and data elements included in the *Quarterly Consumer Information Data Call*, as well as instructions for completing and submitting the interactive PDF form. **Pease note that full citations from the Texas Insurance Code (TIC) and Texas Administrative Code (TAC) are provided starting on page 12 of these instructions.**

## Lines of Coverage for Table 1 (A&H Coverage – Non-HMO)

The following lines of coverage (rows 1-5) are contained in Table 1, which applies only to A&H reporting. **Only licensed A&H carriers should report experience in Table 1**. Also, please note that this data applies only to fully insured plans.

| Line of Coverage | | Notes |
|---|---|---|
| 1) | **Group Health Benefit Plan (HBP) Coverage (Non-HMO)** | See TIC §1501.002(5) |
| | a) Large Employer Health Benefit Plans | See TIC §1501.002(8) and (9) and 28 TAC §26.4(26) and (28) |
| | b) Small Employer Health Benefit Plans | See TIC §1501.002 (14) and (15) and 28 TAC §26.4(54) and (56) |
| | c) Cooperative / Coalition Health Benefit Plans | All private purchasing cooperative, health group cooperative, and small employer coalition HBPs |
| | d) Other Group Health Benefit Plans | All other group HBPs, including blanket, association, etc. |
| 2) | **Non-HBP Group Health Coverage (Non-HMO)** | Commercial group *accident and* health coverage that does not meet the definition of a health benefit plan as specified in TIC §1501.002(5). *Includes group dental, vision, disability, AD&D, and other non-HBP medical benefits.* |
| | a) Employer-Based Plans | Employer-based plans, including cooperative / coalition plans, that were not reported in line 1(a-c) |
| | b) Other Group Plans | Non-employer-based group plans that were not reported in line 1(d) |
| 3) | **Individual Health Coverage (Non-HMO)** | |
| | a) Basic Hospital Expense | See 28 TAC §3.3071 |
| | b) Basic Medical-Surgical Expense | See 28 TAC §3.3072 |
| | c) Hospital Confinement Indemnity | See 28 TAC §3.3073 |
| | d) Major Medical Expense | See 28 TAC §3.3074 |
| | e) Disability Income Protection | See 28 TAC §3.3075 |
| | f) Accident Only | See 28 TAC §3.3076 |
| | g) Specified Disease | See 28 TAC §3.3077 |
| | h) Specified Accident | See 28 TAC §3.3077 |
| | i) Limited Benefit | See 28 TAC §3.3079 |
| 4) | **Long-Term Care Coverage** | See 28 TAC §3.3804(b)(20) |
| 5) | **Medicare Supplement Coverage** | See 28 TAC §3.3303(19) |

## Lines of Coverage for Table 2 (HMO Coverage)

The following lines of coverage (rows 6-9) are contained in Table 2, which applies only to HMO reporting. **Only licensed HMOs should report experience in Table 2**. Please note that this data applies only to fully insured plans. Also, all Medicare, Medicaid and CHIP coverage should be reflected on row 9.

| Line of Coverage | | Notes |
|---|---|---|
| 6) | **Commercial Group Health Benefit Plan (HBP) Coverage (HMO)** | See TIC §1501.002(5). Excludes all limited service HMO plans and single service HMO plans. |
| | a) Large Employer Health Benefit Plans | See TIC §1501.002(8) and (9) and 28 TAC §26.4(26) and (28) |
| | b) Small Employer Health Benefit Plans | See TIC §1501.002 (14) and (15) and 28 TAC §26.4(54) and (56) |
| | c) Cooperative / Coalition Health Benefit Plans | All private purchasing cooperative, health group cooperative, and small employer coalition HBPs |
| | d) Other Group Health Benefit Plans | All other group HBPs, including blanket, association, etc. |
| 7) | **Non-HBP Commercial Group Coverage (HMO)** | Commercial group HMO plans that do not meet the definition of a health benefit plan. |
| | a) Basic Service plans | Commercial group coverage for Basic Service HMOs (including cooperative / coalition plans) that was not reported in line 6(a-d) |
| | b) Limited Service plans | Commercial group coverage for Limited Service HMOs, which commonly provide behavioral health and/or or chemical dependency coverage; See TIC §843.002(17) and (18). |
| | c) Single Service plans | Commercial group coverage for Single Service HMOs, which commonly provide only dental or vision coverage; See TIC §843.002(25) and (26). |
| 8) | **Commercial Individual Coverage (HMO)** | |
| | a) Basic Service plans | Commercial individual coverage for Basic Service HMOs |
| | b) Limited Service plans | Commercial individual coverage for Limited Service HMOs, which commonly provide behavioral health and/or chemical dependency coverage; See TIC §843.002(17) and (18). |
| | c) Single Service plans | Commercial individual coverage for Single Service HMOs, which commonly provide only dental or vision coverage; See TIC §843.002(25) and (26). |
| 9) | **Governmental Coverage (HMO)** | |
| | a) Medicaid plans | Title XIX, Social Security Act |
| | b) CHIP plans | Title XXI, Social Security Act |
| | c) Medicare plans | Title XVIII, Social Security Act. Includes Medicare Advantage and Medicare Part D plans. |

## Data Elements for Table 1 (A&H Coverage) and Table 2 (HMO Coverage)

Table 1 and Table 2 contain the following data elements (columns A - H) that are to be completed for each applicable line of coverage outlined above. Table 1 relates only to A&H (Non-HMO) coverage, while Table 2 relates only to HMO coverage.

- **Total Individual Contracts or Group Certificates In Force** (columns 1A and 2A)

  For applicable lines of coverage relating to **individual business,** companies should report the number of individual **contracts** in force in Texas on the last day of the reporting period (including those newly issued, issued for delivery, or renewed).

  For applicable lines of coverage relating to **group business,** companies should report the number of group **certificates** in force in Texas on the last day of the reporting period (including those newly issued, issued for delivery, or renewed). For employer-based plans, each enrolled employee represents one group certificate. For non-employer-based plans, each primary enrollee represents one group certificate.

- **Total Number of Lives Insured (column 1B) and Total Number of** Enrollees (column 2B)

  For each applicable line of **A&H coverage**, provide the total number of lives covered under individual contracts or group certificates reported in column 1A. All covered family members (employee or enrollee, spouse and all dependents) must be included in these calculations.

  For each applicable line of **HMO coverage**, provide the total number of enrollees covered under individual contracts or group certificates reported in column 2A. All covered family members (employee or enrollee, spouse and all dependents) must be included in these calculations.

- **Direct Premiums Written** (columns 1C and 2C)

  For each applicable line of coverage, provide the total direct premiums written during 1st quarter 2011. Written premium is the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the coverage provided by the terms of the insurance contract. For health contracts without fixed contract periods, premiums written will be equal to the amount collected during the reporting period plus uncollected premiums at the end of the period less uncollected premiums at the beginning of the period. This amount should be reported on a direct basis, without any allowance for premiums ceded to reinsurers.

- **Direct Claims Incurred** (column 1D) and **Direct Medical Expenses Incurred** (column 2D)

  For each applicable line of **A&H coverage**, provide the direct claims incurred during 1st quarter 2011. Incurred claims should be calculated as claims paid during the reporting period plus the change in claim reserves.

  For each applicable line of **HMO coverage**, provide the direct medical expenses incurred during 1st quarter 2011. Incurred medical expenses should be calculated as medical expenses paid during the reporting period plus the change in claim reserves.

For additional instruction, please refer to Exhibit 8, Part 2, of NAIC's Life, Accident and Health blank.

- **Average Annual Premium Cost per Person for Most Popular Plan** (columns 1E and 2E)

  For each applicable line of coverage, provide the average annual premium cost per person for your company's most popular plan over the past 12 months (April 1, 2010 – March 31, 2011). For the purpose of this data call, the most popular plan is the plan with the highest number of lives covered on March 31, 2011.

**The next three columns (F, G and H) capture rate change information for your company's most popular plan during the 1st quarter 2011. These rate changes should only consider contract renewals that occurred during the 1st quarter 2011. TDI is requesting an average rate increase during the quarter, as well as the range of rate changes (minimum and maximum) experienced by enrollees. Please report all rate change information on the policy level. Please note that rate decreases should be entered as a negative value.**

**If these numbers are not applicable to a line of coverage for which you reported experience in 1st quarter 2011 because your company is either entering or withdrawing from the market, you should enter 0% for all three values (minimum, average and maximum). However, you must include an explanation in the "Comments and Explanations" text box on page 2 of form LHL640. Please see page 10 of these instructions for additional information.**

- **Minimum Rate Increase** (columns 1F and 2F)

  For each applicable line of coverage, identify the lowest rate increase that was applied to a policy upon renewal in your most popular plan during 1st quarter 2011. If one or more applicable policies experienced a rate decrease upon renewal during 1st quarter 2011, you should report the largest rate decrease in this field.

- **Average Rate Increase** (columns 1G and 2G)

  For each applicable line of coverage, identify the average rate increase applied to policies in your most popular plan. This average rate increase should consider the rate changes for all renewals in your most popular plan during 1st quarter 2011.

- **Maximum Rate Increase** (columns 1H and 2H)

  For each applicable line of coverage, identify the highest rate increase that was applied to a policy upon renewal in your most popular plan during 1st quarter 2011. If all applicable policies experienced a rate decrease upon renewal during 1st quarter 2011, you should report the smallest rate decrease in this field.

- **Calculated Field: Quarterly Pure Direct Loss Ratio**

  Form LHL640 will automatically calculate a "quarterly pure direct loss ratio" based on the direct premiums written and direct claims incurred (or direct medical expenses incurred) that your company has already entered into the form. For A&H Coverage (Table 1), this field will be calculated as follows:

$$\frac{\text{Direct Claims Incurred}}{\text{Direct Premiums Written}}$$

For HMO coverage (Table 2), this column will be similarly calculated as follows:

$$\frac{\text{Direct Medical Expenses Incurred}}{\text{Direct Premiums Written}}$$

## Lines of Coverage for Table 3 (Life, Annuity and Credit Coverage)

The following lines of coverage (rows 10 - 12) are contained in Table 3, which applies only to Life, Annuity and Credit reporting.

| Line of Coverage | | Notes |
|---|---|---|
| 10) | Life Coverage | Includes all group and individual Life coverage |
| 11) | Credit Coverage | Includes Credit Life and Credit A&H coverage |
| 12) | Annuities | Includes all group and individual Annuity contracts |

## Data Elements for Table 3 (Life, Annuity and Credit Coverage)

Table 3 contains the following data elements (columns 3A-3D) that relate only to Life, Annuity and Credit coverage.

- **Total Number of Policies or Contracts in Force** (column 3A)

  For each applicable line of coverage, provide the total number of single payment and periodic payment policies or contracts in force in Texas on the last day of the reporting period.

- **Direct Premiums and Considerations Written** (column 3B)

  For each applicable line of coverage, provide the total direct premiums and considerations written during 1st quarter 2011. This number should be reported on a gross basis, and should be consistent with the methodology described on Schedule T.

- **Direct Claims Paid** (column 3C)

  For each applicable line of coverage, provide the total value of direct claims paid during 1st quarter 2011.

## Table 4: Profits and Losses for A&H Coverage and HMO Coverage

The third quarter 2010 Consumer Information Data Call required respondents to provide a net income or loss for each line of coverage identified in the data call. Beginning in 4th quarter 2010, companies are only required to report net income (loss) figures for the following four coverage categories: Accident and Health Coverage, HMO Coverage, Life and Annuity Coverage, and Credit Coverage.

Reported net income (loss) for each coverage category should represent the net result of all revenue, claims incurred, expenses, investment results, anticipated future claims costs (or benefit payments), taxes (including federal income taxes), and write-offs, and it should be reported net of

reinsurance. This number should reflect year-to-date experience, and it should be valued as of the last day of the reporting period.

Companies may use a logical allocation base to derive Texas net income (loss) if Texas data is not already calculated separately. TDI will leave it to each company's discretion to determine the most logical allocation base.

**Following are descriptions of each net income (loss) category:**

- **Net Income (Loss) for Accident and Health Coverage** (Table 4, Line 13)

  Insurance companies must report a single net income figure that captures 1st quarter 2011 Texas experience for the lines of A&H coverage contained in Table 1 (survey lines 1 - 5). Companies that didn't report any experience in Table 1 should leave this field blank.

- **Net Income (Loss) for HMO Coverage** (Table 4, Line 14)

  HMOs must report a single net income figure that captures 1st quarter 2011 Texas experience for the lines of HMO coverage contained in Table 2 (survey lines 6-9). Companies that didn't report any experience in Table 2 should leave this field blank.

- **Net Income (Loss) for Life and Annuity Coverage** (Table 4, Line 15)

  Insurance companies must report a single net income figure that captures 1st quarter 2011 Texas experience for Life Coverage (survey line 10) and Annuities (survey line 12). Companies that didn't report any experience on line 10 or line 12 should leave this field blank.

- **Net Income (Loss) for Credit Coverage** (Table 4, Line 16)

  Insurance companies must report a single net income figure that captures 1st quarter 2011 Texas experience for Credit Life and Credit A&H Coverage (survey line 11). Companies that didn't report any experience on line 11 should leave this field blank.

## Data Entry Instructions

Data for the Quarterly Consumer Information Data Call will be collected using an interactive PDF form that is available on the TDI website under the designation "LHL640". This interactive PDF form contains form fields that company representatives must complete on-screen. All responses must be submitted using this prescribed PDF form, which contains a "submit by email" button. **Companies are required to submit their data to TDI via email in XML format as described in the "Data Submission Instructions" on page 10.**

**Please carefully review the following information, which explains how to obtain and correctly complete form LHL640:**

1. Download form LHL640 from the TDI website, and open the form using Adobe Reader. Companies must use Adobe Reader 9.0 or higher to enter data into form LHL640.

2. Select the Hand tool  or use the tab key to navigate between form fields.

3. If you want to make form fields easier to identify in the PDF file, do you can do either of the following in the Document Message Bar:

    - To display a light blue color in the background of all form fields, select *Highlight Fields*.
    - To display a red outline around all form fields that you're required to fill, select *Highlight Required Fields*. Leaving required fields blank will not allow you to submit your report.

4. Follow the detailed methodology described in NAIC's Schedule T to determine Texas business.

5. All companies must complete the "Company Information", "Respondent Information" and "Filing Information" sections at the top of the form, as well as the "Data Certification" section at the end of the form.

6. In Tables 1-3, companies must report data for each line of coverage for which the company had written premium in Texas during 1st quarter 2011. Responses should reflect year-to-date experience and should be valued as of March 31, 2011.

7. Companies should only enter data for the lines of coverage (rows 1-12) for which the company has experience to report.

8. **If your company <u>has no 1st quarter 2011 experience to report for any line of coverage captured by the data call</u>, check the box labeled "No Data to Report During Quarter?" at the top of the form. Leave tables 1 - 4 blank, and complete the "Data Certification" section at the bottom of the form as described on page 10 of these instructions. <u>Do not enter zeros throughout the form, as this will cause script errors.</u>**

9. **If your company <u>has 1st quarter 2011 experience for one or more lines of coverage captured by the data call</u>, complete the form as follows:**

    - **If your company <u>has 1st quarter 2011 experience for a specific line of coverage</u>, you must complete all requested data elements for that line of coverage. If the response to a specific data element (column) is zero, you must enter a zero for that data element in the form.** You will not be able to submit the form if you have not completed all requested data elements for an applicable line of coverage. If you leave a required data element blank, you will receive an error message when you attempt to submit your data.

    - **If your company <u>does not have year-to-date experience for a specific line of coverage</u>, you should leave all requested data elements for that line of coverage blank. Do not enter zeros for all data elements (columns) applicable to a single line of coverage.** As an example, if your company has experience to report for Limited Benefit coverage (line 3i) but does not have experience to report for any other line of Individual Health Coverage (line 3a-3h), leave lines 3a-3h blank in your response.

10. The form fields are pre-formatted, and the correct formatting will appear when you tab to the next field. The following examples demonstrate the correct data entry format.

    - **Number fields** should be entered without any formatting as follows:

        - 1,500 contracts or certificates should be entered as **1500**
        - 5,750,800 lives should be entered as **5750800**

    - **Currency fields** should be rounded to the nearest dollar, and they should be entered without any formatting as follows:

        - A net **income** of $500,000 should be entered as **500000**
        - A net **loss** of $250,000 should be entered as **-250000**

    - **Percentage fields** should be rounded to the nearest one tenth of one percent, and they should be entered without any formatting as follows:

        - A rate **increase** of 12.5 percent should be entered as **0.125**
        - A rate **decrease** of 1.5 percent should be entered as **-0.015**

11. If your company reported 2011 year-to-date experience for any line of coverage in Table 1 (A&H Coverage), you must provide a combined net income (loss) for these lines of coverage on Table 4, line 13.

12. If your company reported 2011 year-to-date experience for any line of coverage in Table 2 (HMO Coverage), you must provide a combined net income (loss) for these lines of coverage on Table 4, line 14.

13. If your company reported 2011 year-to-date experience for Life Coverage (survey line 10) or Annuities (survey line 12), you must provide a combined net income (loss) for these lines of coverage on Table 4, line 15.

14. If your company reported 2011 year-to-date experience for Credit Coverage (survey line 11) you must provide a net income (loss) for this line of coverage on Table 4, line 16.

15. **Please note the shaded cells on form LHL640, which represent row/column combinations that are not required. Specific examples include the following:**

    - In Table 1, columns 1E, 1F, 1G, and 1H are not required for the following lines of A&H coverage:

        - Non-HBP Group Health Coverage for Employer-based Plans (line 2a);
        - Non-HBP Group Health Coverage for Other Group Plans (line 2b);
        - Long-Term Care Coverage (line 4); and
        - Medicare Supplement Coverage (line 5).

    - In Table 2, columns 2A, 2E, 2F, 2G, and 2H are not required for the following lines of Governmental HMO coverage:

        - Medicaid Plans (line 9a);
        - CHIP Plans (line 9b); and
        - Medicare Plans (line 9c).

- In Table 3, column 3C is not required for companies reporting Annuity experience.

16. Form LHL640 includes buttons that will allow you to clear data that has been entered in specified fields, as follows:

    - "Clear Table 1" – clears all data and calculated fields in Table 1;
    - "Clear Table 2" – clears all data and calculated fields in Table 2;
    - "Clear Table 3" – clears all data and calculated fields in Table 3; and
    - "Clear Form" – clears all data that has been entered into the form.

17. Form LHL640 includes a "Comments and Explanations" text field at the bottom of page 2. This field allows you to provide any necessary notes regarding the data contained in your submission. **If the rate change information requested in columns F-H is not applicable for a specific line of coverage for which you reported experience in 1st quarter 2011, you must provide an adequate explanation in this field.** Also, you may use this field to explain the allocation methodology used to derive the net income figures contained in your submission.

18. Please note the value that appears in the calculated field (with a red column heading) after you enter your company's premiums and claims for a specific line of coverage in Table 1 or Table 2. This number represents a "pure direct loss ratio", and you should verify this number to ensure that you entered your data correctly.

19. TDI will only accept survey data that is returned in XML format as described in the "Data Submission Instructions" below. Any survey returned in a different format, including scanned PDF files, will not be accepted.

## Data Certification Instructions

**After you have completed entering your data, you must complete the Data Certification fields at the bottom of page 2 of form LHL640.** This certification replaces the signed affidavit that was required for 3rd Quarter 2010, and you will not be able to submit your data if the Data Certification fields are incomplete.

After checking the box next to the attestation statement, you must enter the name and title of a person with the authority to certify your company's data. This individual should be a corporate officer, actuary, attorney, or accountant. If an authorized agent is completing the data call on behalf of this individual, you should include both parties in the "Name" field at the bottom of the form. (For example, you could enter "Bob Jones, on behalf of Pam Smith"). However, the "Title" field should specify the title of the person with the authority to certify your company's data.

## Data Submission Instructions

After you have filled in the PDF form as described above, print the form for your records by clicking either *File -> Print* or by clicking the printer icon. Please note that you will not be able to save the completed form. Then, submit the file to TDI as follows:

1. If you are using a desktop email application, open your applicable e-mail application before attempting to submit the form. Then, click the "Submit by Email" button located at the bottom of the form. A new email message with an XML file attachment should appear. The message should be sent to HealthSurveys@tdi.state.tx.us, and the subject of the message should read "Quarterly Consumer Information Data Call" followed by your company's NAIC number.

2. If you are using an internet-based email application (i.e., Gmail, Hotmail, etc.), the Select Email Client dialog box will appear after you click the “Submit by Email” button located at the bottom of the form. Select the “Internet Email” option, and then click OK. Save the survey file as an XML file using the default filename (lhl640.xml). Then, open your internet-based email application and attach the XML file to your email. Address the message to HealthSurveys@tdi.state.tx.us, and enter “Quarterly Consumer Information Data Call” as the subject of the message. Please include your company’s name and NAIC number in the body of the message.

**As stated previously, you will not be able to submit form LHL640 if you have not completed all required data elements for each applicable line of coverage. If you leave one or more required data element blank, you will receive an error message and a red border will appear around the data element(s) that must be completed. Once all such data elements are completed, you may try to submit your data again using the “Submit by Email” button on the form.**

**To ensure that your data complete and harvested accurately by TDI, we will only accept surveys returned in XML format as described above. Any survey returned in a different format, including scanned PDF files, will not be accepted.**

**All questions concerning the Consumer Information Data Call should be sent via email to HealthSurveys@tdi.state.tx.us.**

# Texas Insurance Code and

# Texas Administrative Code Citations

## Part 1 – Accident and Health Coverage (Non-HMO)

**Health Benefit Plan: Survey line 1**

**TIC §1501.002(5)**

"Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include the following:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select benefit plans regulated in accordance with federal law;

(G) 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;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) workers' compensation insurance coverage or similar insurance coverage;

(K) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 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. Section 157;

(L) hospital indemnity or other fixed indemnity insurance coverage;

(M) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(N) short-term major medical contracts;

(O) 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;

(P) coverage for on-site medical clinics;

(Q) coverage that provides other limited benefits specified by federal regulations; or

(R) other coverage that:

(i) is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) is specified by federal regulations.

**Large Employer Health Benefit Plan: Survey line 1a**

**TIC §1501.002(8) and (9)**

(8) "Large employer" means a person who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, to Chapter 1578, or to Chapter 177, Local Government Code, that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(9) "Large employer health benefit plan" means a health benefit plan offered to a large employer.

**28 TAC §26.4(26) and (28)**

(26) Large employer--An employer who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the policy year. For purposes of this definition, a partnership is the employer of a partner.

(28) Large employer health benefit plan--A health benefit plan offered to a large employer.

**Small Employer Health Benefit Plan: Survey line 1b**

**TIC §1501.002(14) and (15)**

(14) "Small employer" means a person who employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, to Chapter 1578, or to Chapter 177, Local Government Code, that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(15) "Small employer health benefit plan" means a health benefit plan developed by the commissioner under Subchapter F or any other health benefit plan offered to a small employer in accordance with Section 1501.252(c) or 1501.255.

**28 TAC §26.4(54) and (56)**

(54) Small employer--An employer that employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the policy year. For purposes of this definition, a partnership is the employer of a partner. A small employer includes an independent school district that elects to participate in the small employer market as provided under Insurance Code Article 26.036.

(56) Small employer health benefit plan--A health benefit plan offered to a small employer under the Insurance Code, Chapter 26, Subchapter E.

**Basic Hospital Expense: Survey line 3a**

**28 TAC §3.3071**

"Basic hospital expense insurance" is a policy of accident and health insurance which provides coverage for a period of not less than 31 days during any one period of confinement for each person insured under the policy for the expense incurred for necessary treatment and services rendered as a result of an injury or sickness for at least the following:

(1) daily hospital room and board in an amount not less than:

(A) 80% of the charges for semi-private room accommodations; or

(B) $30 per day;

(2) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during the period of continuous hospital confinement in an amount not less than either 80% of the charges incurred up to at least $1,000 or 10 times the daily hospital room and board benefit rate;

(3) hospital outpatient services:

(A) hospital services on the day surgery is performed in an amount not less than $50; and

(B) hospital services rendered within 72 hours after accidental injury, in an amount not less than $50; and

(C) x-ray and laboratory tests to the extent that benefits for such services would have been provided, in an amount not less than $100, if rendered to an inpatient of the hospital;

(4) benefits provided under paragraphs (1) and (2) of this section may be provided subject to a combined deductible amount not in excess of $100 per period of confinement;

(5) if hospital confinement maternity benefits are included within the scope of policy coverage then the amount of the minimum benefits for each covered pregnancy shall be the actual expenses incurred according to the policy terms up to an amount that is equal to 10 times the minimum daily hospital room and board benefit.

**Basic Medical-Surgical Expense: Survey line 3b**

**28 TAC §3.3072**

"Basic medical-surgical expense coverage" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) surgical services:

(A) in amounts not less than those provided on a fee schedule based on the relative values contained in the 1969 California Relative Value Schedule or other acceptable value scale of surgical procedures, up to a maximum of at least $500 for any on e procedure; or

(B) not less than 80% of the usual, customary and reasonable charges. Surgical schedules shall include a provision stipulating coverage for procedures not specifically listed in the schedules and not otherwise excluded by the policy, and benefits therefore shall be consistent with the benefits for comparable procedures;

(2) anesthetic services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his or her assistant) performing the surgical services:

(A) in an amount not less than 80% of the usual, customary and reasonable charges; or

(B) 15% of the "surgical services" benefit;

(3) in-hospital medical services, consisting of attending physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than:

(A) 80% of the usual, customary and reasonable charges; or

(B) $5.00 per call, one call per day, for at least 21 such calls during "one period of confinement";

(4) if obstetrical-surgical benefits are included within the scope of policy coverage then the benefits for each covered pregnancy for obstetrical-surgical expenses

incurred shall be based upon the relative value scale of surgical procedures referred to in paragraph (1) of this section.

**Hospital Confinement Indemnity: Survey line 3c**

**28 TAC §3.3073**

"Hospital Confinement Indemnity Coverage" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $15 per day or $100 per week and not less than 31 days during any "one period of confinement" for each person insured under the policy. A one day or two day elimination period may be used when "one period of confinement" is not less than 31 days and not more than 364 days. A three day elimination period may be used when "one period of confinement" is 365 days or more. If a hospital confinement policy, whether styled as an indemnity policy or however styled, includes confinement for pregnancy within the scope of its coverage, then the minimum benefits payable for each covered pregnancy shall be the insured loss or expense up to an amount no less than 10 times the minimum daily benefit of the policy.

**Major Medical Expense: Survey line 3d**

**28 TAC §3.3074**

"Major Medical Expense Coverage" is an accident and sickness insurance policy which provides hospital, medical, and surgical expense coverage as follows:

(1) an aggregate maximum of not less than $10,000;

(2) a co-payment by the covered person, shall not exceed 20% of covered charges in policies providing aggregate maximum benefits of $10,000 and 25% in all other policies;

(3) a deductible stated on a basis of one or more of the following:

(A) per person;

(B) per family;

(C) per illness;

(D) per benefit period; or

(4) policies which contain a variable deductible provision, i.e., a provision which in addition to a stated basic or minimum deductible amount chosen by the policyholder, includes a deductible amount to the extent of any other medical and hospital expense benefits available to the policyholder under any other policy, if any, shall conform to the following criteria:

(A) the right of renewal shall be no more limited than the applicable minimum standards for renewability set forth in §3.3020 of this title (relating to Policy Definition of Guaranteed Renewable and Limited Guarantee of Renewability);

(B) the policy provides for an increase in the maximum amount of benefits in a sum of at least $3.00 for each $1.00 of other medical expense benefits used as part of the deductible.

(5) benefits shall be provided under major medical expense coverage for each covered person for at least:

(A) daily hospital room and board expenses, prior to application of the co-payment percentage, for not less than $50 daily (or in lieu thereof the average daily cost of semi-private room rate in the area where the insured is confined) for a period of not less than 31 days during continuous hospital confinement;

(B) miscellaneous hospital services, prior to application of the co-payment percentage, for an aggregate maximum of not less than $1500 or 15 times the daily room and board rate if specified in dollar amounts;

(C) surgical fees, prior to application of co-payment percentage, to a maximum of not less than $600 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

(D) anesthesia services, prior to application of the co-payment percentage, for a maximum of not less than 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

(E) doctor visits, in or out of the hospital, with minimum dollar amounts per visit, prior to application of the co-payment percentage, equal to not less than $10 per visit, covering at least one visit per day and for an aggregate maximum of such covered charges of not less than $600;

(F) out-of-hospital diagnostic x-ray and tests, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than $600;

(G) no fewer than three of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of such covered of not less than $1,000:

(i) in-hospital private duty registered nurse services;

(ii) convalescent nursing home care;

(iii) diagnosis and treatment by a radiologist or physiotherapist;

(iv) rental of special medical equipment, as defined by the insurer in the policy;

(v) artificial limbs or eyes, casts, splints, trusses, or braces;

(vi) treatment for functional nervous disorders, and mental and emotional disorders;

(vii) out-of-hospital prescription drugs and medications;

(6) if hospital confinement maternity benefits are included within the scope of policy coverage then the amount of the minimum benefits for each covered pregnancy, prior to application of the co-payment percentage, shall be the actual expenses incurred according to the policy terms up to an amount that is equal to 10 times the minimum daily hospital room and board benefit.

**Disability Income Protection: Survey line 3e**

**28 TAC §3.3075**

"Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or accident or a combination thereof, which:

(1) provides for periodic payments in an amount of at least $100 per month payable at ages through 62 and $50 per month at ages after 62;

(2) contains an elimination period no greater than:

(A) 90 days in the case of a coverage providing a benefit period of one year or less;

(B) 365 days if the benefit is payable for not less than two years and is payable in an amount of at least $200 per month; or

(C) 180 days in all other cases during the continuance of disability resulting from sickness or injury;

(3) has a maximum period of time for which it is payable during disability of at least six months;

(4) this section does not apply to those policies providing business buy out coverage.

**Accident Only: Survey line 3f**

**28 TAC §3.3076**

"Accident only coverage" is a policy of accident insurance which provides coverage, singularly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Such coverage provided shall meet the following criteria.

(1) Accidental death and double dismemberment amounts shall be at least $1,000.

(2) Single dismemberment amounts shall be at least $500.

(3) Accidental death and dismemberment benefits shall be payable if the loss occurs within a period of time not less than 90 days from the date of the accident, irrespective of total disability.

(4) Specific dismemberment(s) benefit(s) may not be provided in lieu of other benefits unless the specific dismemberment(s) benefit(s) equals or exceeds the other benefit.

(5) Disability income benefits, where provided, may not require the loss to commence less than 30 days after the date of accident nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force and the disability commenced within the time limit specified in the policy.

**Specified Disease: Survey line 3g**

**28 TAC §3.3077(a)**

"Specified disease coverage" is a policy written on a guaranteed renewable basis as prescribed in §3.3050(b) of this title (relating to Standards for Renewability Provisions) which meets one of the following definitions.

(1) A policy which provides coverages for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not to exceed 5.0% of the aggregate maximum benefit and an overall aggregate benefit limit of no less than $5,000 per person and a benefit period of not less than two years. If the benefits are subject to be scheduled inside dollar limits, such limits shall meet the minimum requirements for major medical coverage as prescribed in §3.3074 of this title (relating to Minimum Standards for Major Medical Expense Coverage).

(2) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount and an overall aggregate benefit limit of not less than $25,000 payable at the rate of not less than $50 a day while confined in a hospital and a benefit period of not less than 500 days.

(3) In lieu of the minimum benefits specified in paragraphs (1) and (2) of this subsection, a specified disease policy or rider, limited to cancer, may provide minimum benefits not less than the following:

(A) $50 a day for the first 10 days of hospitalization without any elimination period, deductible or coinsurance factor and $30 a day for each day of continuous hospitalization thereafter with no limit on the number of days of hospitalization;

(B) x-ray, radium, and cobalt therapy up to a total of $1,500;

(C) attending physician(s) charges in hospital (other than the operating surgeon) of $7.50 per day up to a total of $500;

(D) surgical charges in accordance with the 1969 California Relative Value Schedule or other acceptable relative value scale of surgical procedure, up to a maximum of at least $600;

(E) anesthetist services for an operation in an amount not less than:

(i) 80% of the usual, customary and reasonable charges; or

(ii) 15% of the surgical charges benefit;

(F) nursing expenses of $24 per shift for not less than one shift per day up to $750;

(G) blood transfusions and plasma up to $500;

(H) prescribed drugs and medicine up to $250. If an overall aggregate limit on all benefits is used, it shall be not less than $10,000 per person.

**Specified Accident: Survey line 3h**

**28 TAC §3.3077(b)**

"Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, disability or hospital and medical care with a benefit amount not less than $1,000 for accidental death; $1,000 for double dismemberment and $500 for single dismemberment.

**Limited Benefit: Survey line 3i**

**28 TAC §3.3079**

Limited benefit coverage is a policy of accident and sickness insurance providing the types of coverage set forth in §3.3071 of this title (relating to Minimum Standards for Basic Hospital Expense Coverage), §3.3072 of this title (relating to Minimum Standards for Basic Medical-Surgical Expense Coverage), and §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage), but the types and/or amounts of benefits are less than those prescribed in such sections. Such policies delivered or issued for delivery in this state in addition to meeting all other applicable requirements of these sections must prominently display at the top of the outline of coverage and on the face page of the policy in no less than 14 point type the notice set out in §3.3091 of this title (relating to Notice Requirements for Outline of Coverage of Limited Benefit, Supplemental and Nonconventional Coverages).

**Long-Term Care: Survey line 4**

**28 TAC §3.3804(b)(20)**

(20) Long-term care insurance--

(A) Any insurance policy, group certificate, rider to such policy or certificate, or evidence of coverage that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, per diem or other basis for one or more necessary or medically necessary services of the following types, administered in a setting other than an acute care unit of a hospital: diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care. The term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance. The term also includes a policy, certificate, or rider that

provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance.

(B) The term "long-term care insurance" shall not include any insurance policy, group certificate, subscriber contract, or evidence of coverage that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or asset-related protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(C) With regard to life insurance, this term does not include life insurance policies:

(i) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(ii) that provide the option of a lump-sum payment for those benefits; and

(iii) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(D) Notwithstanding any other provision of this subchapter, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this subchapter.

**Medicare Supplement: Survey line 5**

**28 TAC §3.3303(19)**

(19) Medicare supplement policy--A group or individual policy of accident and sickness insurance or a subscriber contract of a hospital service corporation subject to the Insurance Code, Chapter 20, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, which policy, subscriber contract, or such evidence of coverage is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. The term does not include:

(A) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or

combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(B) a policy or health care benefit plan including a policy or contract of group insurance or group contract of a hospital service corporation subject to the Insurance Code, Chapter 20, or group evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, when such policy or plan is not marketed or held to be a Medicare supplement policy or benefit plan; or

(C) an individual or group evidence of coverage issued pursuant to a contract under the Federal Social Security Act, §1876 (42 U.S.C. §§1395, et seq.) by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapters 20A and 843);

(D) a Medicare Advantage plan established under Medicare Part C;

(E) an Outpatient Prescription Drug plan established under Medicare Part D; or

(F) a Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Federal Social Security Act (42 U.S.C. §§1395, et seq.)

## Part 2 – HMO Coverage

**Health Benefit Plan: Survey line 6**

See previous definition

**Large Employer Health Benefit Plan: Survey line 6a**

See previous definition

**Small Employer Health Benefit Plan: Survey line 6b**

See previous definition

**Basic Service HMO: Survey lines 7a and 8a**

**TIC §843.002(2)**

"Basic health care services" means health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.

**28 TAC §11.2(8)**

Basic health care service--Health care services which an enrolled population might reasonably require to maintain good health, as prescribed in §§11.508 and 11.509 of this title (relating to Mandatory Benefit Standards: Group, Individual and

Conversion Agreements, and Additional Mandatory Benefit Standards: Group Agreement Only).

**Limited Service HMO: Survey lines 7b and 8b**

**TIC §843.002(17) and (18)**

(17) Limited health care service plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of limited health care services; and

(B) that consists in part of providing or arranging for limited health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of limited health care services.

(18) "Limited health care services" means:

(A) services for mental health, chemical dependency, or mental retardation, or any combination of those services; or

(B) an organized long-term care service delivery system that provides for diagnostic, preventive, therapeutic, rehabilitative, and personal care services required by an individual with a loss in functional capacity on a long-term basis.

**Single Service HMO: Survey lines 7c and 8c**

**TIC §843.002(25) and (26)**

(25) "Single health care service" means a health care service:

(A) that an enrolled population may reasonably need to be maintained in good health with respect to a particular health care need to prevent, alleviate, cure, or heal human illness or injury of a single specified nature; and

(B) that is provided by one or more persons licensed or otherwise authorized by the state to provide that service.

(26) "Single health care service plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of a single health care service;

(B) that consists in part of providing or arranging for the single health care service on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of that service; and

(C) that does not include arranging for the provision of more than one health care need of a single specified nature.