CHAPTER 607

H.B. No. 2055

AN ACT

relating to health insurance and health costs and the availability of health insurance coverage for certain individuals and small employers.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. The Insurance Code is amended by adding Chapter 26 to read as follows:

CHAPTER 26. HEALTH INSURANCE AVAILABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Art. 26.01. SHORT TITLE. This chapter may be cited as the Small Employer Health Insurance Availability Act.

Art. 26.02. DEFINITIONS. In this chapter:

(1) "Affiliated employer" means a person connected by commonality of ownership with a small employer. The term includes a person that owns a small employer, shares directors with a small employer, or is eligible to file a consolidated tax return with a small employer.

(2) "Agent" means a person who may act as an agent for the sale of a health benefit plan under a license issued under Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or under Subchapter A, Chapter 21, of this code.

(3) "Base premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for small employer health benefit plans with the same or similar coverage.

(4) "Board of directors" means the board of directors of the Texas Health Reinsurance System.

(5) "Case characteristics" means, with respect to a small employer, the geographic area in which that employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification as determined by the small employer carrier, the number of employees and dependents, and other objective criteria as established by the small employer carrier that are considered by the small employer carrier in setting premium rates for that small employer. The term does not include claim experience, health status, duration of coverage since the date of issuance of a health benefit plan, or whether a covered person is or may become pregnant.

(6) "Class of business" means all small employers or a separate grouping of small employers established under this chapter.

(7) "Dependent" means:

(A) a spouse;

(B) a newborn child;

(C) a child under the age of 19 years;

(D) a child who is a full-time student under the age of 23 years and who is financially dependent on the parent;

(E) a child of any age who is medically certified as disabled and dependent on the parent; and

(F) any person who must be covered under:

(i) Section 3D or 3E, Article 3.51–6, of this code; or

(ii) Section 2(L), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70–2, Vernon's Texas Insurance Code).

(8) "Eligible employee" means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include:

(A) an employee who works on a part-time, temporary, or substitute basis; or

(B) an employee who is covered under:

(i) another health benefit plan; or

(ii) an employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

(9) "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:

(A) accident-only insurance coverage;

(B) credit insurance coverage;

(C) disability insurance coverage;

(D) specified disease coverage or other limited benefit policies;

(E) coverage of Medicare services under a federal contract;

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

(G) long-term care insurance coverage;

(H) coverage limited to dental care;

(I) coverage limited to care of vision;

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

(K) insurance coverage issued as a supplement to liability insurance;

(L) insurance coverage arising out of a workers' compensation system or similar statutory system;

(M) automobile medical payment insurance coverage;

(N) jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain 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;

(O) hospital confinement indemnity coverage; or

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

(10) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including

an insurance company, a group hospital service corporation under Chapter 20 of this code, a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and a stipulated premium company under Chapter 22 of this code.

(11) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(12) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan after the expiration of the initial enrollment period established under the terms of the first plan for which that employee or dependent was eligible through the small employer. An eligible employee or dependent is not a late enrollee if:

(A) the individual:

(i) was covered under another employer health benefit plan at the time the individual was eligible to enroll;

(ii) declines in writing, at the time of the initial eligibility, stating that coverage under another employer health benefit plan was the reason for declining enrollment;

(iii) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, the death of a spouse, or divorce; and

(iv) requests enrollment not later than the 31st day after the date on which coverage under another employer health benefit plan terminates;

(B) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made not later than the 31st day after issuance of the date on which the court order is issued.

(13) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate that is charged or offered or that could be charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(14) "Person" means an individual, corporation, partnership, association, or other private legal entity.

(15) "Plan of operation" means the plan of operation of the system established under Article 26.55 of this code.

(16) "Preexisting condition provision" means a provision that denies, excludes, or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(17) "Premium" means all amounts paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with a health benefit plan.

(18) "Rating period" means a calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(19) "Reinsured carrier" means a small employer carrier participating in the system.

(20) "Risk-assuming carrier" means a small employer carrier that elects not to participate in the system.

(21) "Small employer" means a person that is actively engaged in business and that, on at least 50 percent of its working days during the preceding calendar year, employed at least three but not more than 50 eligible employees, including the employees of an affiliated employer, the majority of whom were employed in this state.

(22) "Small employer carrier" means a health carrier, to the extent that that carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to this chapter under Article 26.06(a) of this code.

(23) "Small employer health benefit plan" means the preventive and primary care benefit plan, the in-hospital benefit plan, or the standard health benefit plan described by Subchapter E of this chapter or any other health benefit plan offered to a small employer in accordance with Article 26.42(d) of this code.

(24) "System" means the Texas Health Reinsurance System established under Subchapter F of this chapter.

Art. 26.03. AFFILIATED CARRIERS. (a) For purposes of this chapter, health carriers that are affiliates or that are eligible to file a consolidated tax return are considered to be one carrier, and a restriction imposed by this chapter applies as if the health benefit plans delivered or issued for delivery to small employers in this state by the affiliates were issued by one carrier.

(b) An affiliate that is a health maintenance organization is considered to be a separate health carrier for purposes of this chapter.

(c) In this article, "affiliate" has the meaning assigned by Article 21.49–1 of this code.

Art. 26.04. RULES. The board shall adopt rules to implement this chapter.

Art. 26.05. STATUTORY REFERENCES. A reference in this chapter to a statutory provision applies to all reenactments, revisions, or amendments of that statutory provision.

Art. 26.06. APPLICABILITY. (a) An individual or group health benefit plan is subject to this chapter if it provides health care benefits covering three or more eligible employees of a small employer and if it meets any one of the following conditions:

(1) a portion of the premium or benefits is paid by or on behalf of a small employer;

(2) a covered individual is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for a portion of the premium; or

(3) the health benefit plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162).

(b) Except as provided by Subsection (a) of this article, this chapter does not apply to an individual health insurance policy that is underwritten individually.

(c) Except as expressly provided in this chapter, a small employer health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit.

Art. 26.07. CERTIFICATION. (a) Not later than March 1 of each year, each health carrier shall certify to the commissioner whether, as of January 1 of that year, it is offering a health benefit plan subject to this chapter under Article 26.06(a) of this code.

(b) The certification shall list each other health insurance coverage that:

(1) the health carrier is offering, delivering, issuing for delivery, or renewing to or through small employers in this state; and

(2) is not subject to this chapter because it is listed as excluded from the definition of a health benefit plan under Article 26.02 of this code.

(c) The certification shall include a statement that the carrier is not offering or marketing to small employers as a health benefit plan the coverage listed under Subsection (b) of this article and that the health carrier is complying with this chapter to the extent it is applicable to the carrier.

Art. 26.08. COST CONTAINMENT. (a) A small employer carrier may use cost containment and managed care features in a small employer health benefit plan, including:

(1) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) case management, including discharge planning and review of stays in hospitals or other health care facilities;

(3) selective contracting with hospitals, physicians, and other health care providers;

(4) reasonable benefit differentials applicable to health care providers that participate or do not participate in restricted network arrangements;

(5) precertification or preauthorization for certain covered services; and

(6) coordination of benefits.

(b) A provision of a small employer health benefit plan that provides for coordination of benefits must comply with this chapter and guidelines established by the commissioner.

(c) Utilization review performed for any cost containment, case management, or managed care arrangement must comply with Article 21.58A of this code.

SUBCHAPTER B. PURCHASING COOPERATIVES

Art. 26.11. DEFINITIONS. In this subchapter:

(1) "Board of trustees" means the board of trustees of the Texas cooperative.

(2) "Board of directors" means the board of directors elected by a private purchasing cooperative.

(3) "Cooperative" means a purchasing cooperative established under this subchapter.

(4) "Texas cooperative" means the Texas Health Benefits Purchasing Cooperative established under Article 26.13 of this code.

Art. 26.12. APPLICABILITY OF OTHER LAWS. (a) Section 1(a), Article 3.51–6, of this code, does not limit the type of group that may be covered by a group health benefit plan issued through a cooperative.

(b) The Texas cooperative is subject to the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252–17a, Vernon's Texas Civil Statutes).

Art. 26.13. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. (a) The Texas Health Benefits Purchasing Cooperative is a nonprofit organization established to make health care coverage available to small employers and their eligible employees and eligible employees' dependents.

(b) The Texas cooperative is administered by a six-member board of trustees appointed by the governor with the advice and consent of the senate. Three members must represent employers, two members must represent employees, and one member must represent the public. The executive director of the Texas Department of Commerce shall serve as a nonvoting ex officio member of the board of trustees.

(c) The appointed members of the board of trustees serve staggered six-year terms, with the terms of two members expiring February 1 of each odd-numbered year.

(d) A member of the board of trustees may not be compensated for serving on the board of trustees but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board of trustees as provided by the General Appropriations Act.

(e) The board of trustees shall employ an executive director. The executive director may hire other employees as necessary.

(f) The board of trustees may develop regional subdivisions of the Texas cooperative and may authorize each subdivision to separately exercise the powers and duties of a cooperative.

(g) Salaries for employees of the Texas cooperative and related costs may be paid from administrative fees collected from employers and participating carriers or other sources of funding arranged by the Texas cooperative.

(h) A member of the board of trustees, the executive director, and an employee or agent of the Texas cooperative are not liable for an act performed in good faith in the execution of duties in connection with the Texas cooperative.

(i) The Texas cooperative may not use money appropriated by the state to pay or otherwise subsidize any portion of the premium for a small employer insured through the cooperative.

Art. 26.14. PRIVATE PURCHASING COOPERATIVE. (a) Two or more small employers may form a cooperative for the purchase of small employer health benefit plans. A cooperative must be organized as a nonprofit corporation and has the rights and duties provided by the Texas Non-Profit Corporation Act (Article 1396–1.01 et seq., Vernon's Texas Civil Statutes).

(b) The board of directors shall file annually with the commissioner a statement of all amounts collected and expenses incurred for each of the preceding three years.

Art. 26.15. POWERS AND DUTIES OF TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE AND PRIVATE PURCHASING COOPERATIVES. (a) A cooperative:

(1) shall arrange for small employer health benefit plan coverage for small employer groups who participate in the cooperative by contracting with small employer carriers who meet the criteria established by Subsection (b) of this article;

(2) shall collect premiums to cover the cost of:

(A) small employer health benefit plan coverage purchased through the cooperative; and

(B) the cooperative's administrative expenses;

(3) may contract with agents to market coverage issued through the cooperative;

(4) shall establish administrative and accounting procedures for the operation of the cooperative;

(5) shall establish procedures under which an applicant for or participant in coverage issued through the cooperative may have a grievance reviewed by an impartial person;

(6) may contract with a small employer carrier or third-party administrator to provide administrative services to the cooperative;

(7) shall contract with small employer carriers for the provision of services to small employers covered through the cooperative;

(8) shall develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in coverage through, the cooperative; and

(9) may negotiate the premiums paid by its members.

(b) A cooperative may contract only with small employer carriers who desire to offer coverage through the cooperative and who demonstrate:

(1) that the carrier is a health carrier or health maintenance organization licensed and in good standing with the department;

(2) the capacity to administer the health benefit plans;

(3) the ability to monitor and evaluate the quality and cost effectiveness of care and applicable procedures;

(4) the ability to conduct utilization management and applicable procedures and policies;

(5) the ability to assure enrollees adequate access to health care providers, including adequate numbers and types of providers;

(6) a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints; and

(7) financial capacity, either through financial solvency standards as applied by the commissioner or through appropriate reinsurance or other risk-sharing mechanisms.

(c) A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan.

(d) A cooperative shall comply with federal laws applicable to cooperatives and health benefit plans issued through cooperatives.

Art. 26.16. COOPERATIVE NOT INSURER. (a) A cooperative is not an insurer and the employees of the cooperative are not required to be licensed under Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or Subchapter A, Chapter 21, of this code.

(b) An agent or third-party administrator used and compensated by the cooperative must be licensed as required by Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or Subchapter A, Chapter 21, of this code.

SUBCHAPTER C. GUARANTEED ISSUE AND RENEWABILITY

Art. 26.21. SMALL EMPLOYER HEALTH BENEFIT PLANS; EMPLOYER ELECTION. (a) Each small employer carrier shall provide the small employer health benefit plans without regard to claim experience, health status, or medical history. Each small employer carrier shall issue the plan chosen by the small employer to each small employer that elects to be covered under that plan, agrees to make the required premium payments, and agrees to satisfy the other requirements of the plan.

(b) Coverage under a small employer health benefit plan is not available to a small employer unless the small employer pays at least 75 percent of the insurance premium for its eligible employees who elect to be covered by at least one of the small employer health benefit plans selected by the small employer. Coverage is available under a small employer health benefit plan if at least 90 percent of a small employer's eligible employees elect to be covered. A small employer is not required to pay any amount with respect to an employee who elects not to be covered. The small employer may elect to pay the premium cost for additional coverage. This chapter does not require a small employer to purchase health insurance coverage for the employer's employees.

(c) An eligible employee may obtain coverage in addition to coverage purchased by the employer if at least 40 percent of the eligible employees elect to obtain the same additional coverage. Subject to insurability, any number of eligible employees may otherwise obtain coverage in addition to coverage purchased by the employer. The additional coverage may be paid for by the employer, the employee, or both.

(d) The initial enrollment period for the employees and their dependents must be at least 30 days.

(e) A small employer may establish a waiting period during which a new employee is not eligible for coverage. A waiting period established as provided by this subsection may not exceed 90 days from the first day of employment.

(f) A new employee of a covered small employer and the dependents of that employee may not be denied coverage if the application for coverage is received by the small employer carrier not later than the 31st day after the date on which the employment begins.

(g) A late enrollee may be excluded from coverage for 18 months from the date of application or may be subject to a 12-month preexisting condition provision as described by Articles 26.49(b), (c), (d), and (e) of this code. If both a period of exclusion from coverage and a preexisting condition provision are applicable to a late enrollee, the combined period of exclusion may not exceed 18 months from the date of the late application.

(h) A small employer carrier may not exclude any eligible employee or dependent, including a late enrollee, who would otherwise be covered under a small employer group.

(i) A small employer health benefit plan issued by a small employer carrier may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases as permitted under Article 26.49 of this code.

(j) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an employee under this subsection terminates on the 31st day after the date of the birth of the child unless:

(1) dependent children are eligible for coverage; and

(2) notification of the birth and any required additional premium are received by the small employer carrier not later than the 30th day after the date of birth.

(k) If the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272, 100 Stat. 222) does not require continuation or conversion coverage for dependents of an

employee, a dependent who has been covered by that small employer for at least one year or is under one year of age may elect to continue coverage under a small employer health benefit plan, if the dependent loses eligibility for coverage because of the death, divorce, or retirement of the employee, as required by Section 3B, Article 3.51-6, of this code.

Art. 26.22. GEOGRAPHIC SERVICE AREA. (a) A small employer carrier is not required to offer or issue the small employer health benefit plans:

(1) to a small employer that is not located within a geographic service area of the small employer carrier;

(2) to an employee of a small employer who neither resides nor works in the geographic service area of the small employer carrier; or

(3) to a small employer located within a geographic service area with respect to which the small employer carrier demonstrates to the satisfaction of the commissioner that the small employer carrier reasonably anticipates that it will not have the capacity to deliver services adequately because of obligations to existing covered individuals.

(b) A small employer carrier that refuses to issue a small employer health benefit plan in a geographic service area may not offer a health benefit plan to a group of not more than 50 individuals in the affected service area before the fifth anniversary of the date of the refusal.

(c) A small employer carrier must file each of its geographic service areas with the commissioner. The commissioner may disapprove the use of a geographic service area by a small employer carrier.

(d) A small employer carrier that is unable to offer coverage in a geographic service area in accordance with a determination made by the commissioner under Subsection (a)(3) of this article may not offer a small employer benefit plan in the applicable geographic service area before the 180th day after the later of:

(1) the date of the refusal; or

(2) the date the carrier demonstrates to the satisfaction of the commissioner that it has regained the capacity to deliver services to small employers in the geographic service area.

(e) If the commissioner determines that requiring the acceptance of small employers under this subchapter would place a small employer carrier in a financially impaired condition, the small employer carrier is not required to provide coverage to small employers for a period to be set by the commissioner.

Art. 26.23. RENEWABILITY OF COVERAGE; CANCELLATION. (a) Except as provided by Article 26.24 of this code, a small employer carrier shall renew the small employer health benefit plan for any covered small employer at the option of the small employer, except for:

(1) nonpayment of a premium as required by the terms of the plan;

(2) fraud or misrepresentation of a material fact by the small employer; or

(3) noncompliance with small employer health benefit plan provisions.

(b) A small employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or misrepresentation of a material fact by that individual.

(c) A small employer carrier may not cancel a small employer health benefit plan except for the reasons specified for refusal to renew under Subsection (a) of this article. A small employer carrier may not cancel the coverage of an eligible employee or dependent except for the reasons specified for refusal to renew under Subsection (b) of this article.

Art. 26.24. REFUSAL TO RENEW. (a) A small employer carrier may elect to refuse to renew each small employer health benefit plan delivered or issued for delivery by the small employer carrier in this state or in a geographic service area approved under Article 26.22 of this code. The small employer carrier must notify the commissioner of the election not later than the 180th day before the date coverage under the first small employer health benefit plan terminates under this subsection.

(b) The small employer carrier must notify each affected covered small employer not later than the 180th day before the date on which coverage terminates for that small employer.

(c) A small employer carrier that elects under Subsection (a) of this article to refuse to renew all small employer health benefit plans in this state or in an approved geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date of notice to the commissioner under Subsection (a) of this article.

Art. 26.25. NOTICE TO COVERED PERSONS. Not later than the 30th day before the date on which termination of coverage is effective, a small employer carrier that cancels or refuses to renew coverage under a small employer health benefit plan under Article 26.23 or 26.24 of this code shall notify the small employer of the cancellation or refusal to renew. It is the responsibility of the small employer to notify enrollees of the cancellation or refusal to renew the coverage.

SUBCHAPTER D. UNDERWRITING AND RATING

Art. 26.31. ESTABLISHMENT OF CLASSES OF BUSINESS. (a) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claim experience or administrative costs related to the following reasons:

(1) the small employer carrier uses more than one type of system for the marketing and sale of small employer health benefit plans to small employers;

(2) the small employer carrier has acquired a class of business from another health carrier; or

(3) the small employer carrier provides coverage to one or more employer-based association groups.

(b) A small employer carrier may establish up to nine separate classes of business under this article.

(c) The commissioner may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with Subsection (b) of this article in the instance of acquisition of an additional class of business from another small employer carrier.

(d) The commissioner may approve the establishment of additional classes of business on application to the commissioner and a finding by the commissioner that the establishment of additional classes would enhance the efficiency and fairness of the insurance market for small employers.

Art. 26.32. INDEX RATES. (a) The premium rates for a small employer health benefit plan are subject to this article.

(b) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20 percent.

(c) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business, may not vary from the index rate by more than 25 percent.

Art. 26.33. PREMIUM RATES; ADJUSTMENTS. (a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(2) any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(3) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(b) Adjustments in premium rates for claim experience, health status, or duration of coverage may not be charged to individual employees or dependents. Such an adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of the small employer.

(c) A health carrier may use the industry classification to which a small employer belongs as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than 15 percent.

Art. 26.34. EFFECT OF PRIOR COVERAGE. For a health benefit plan delivered or issued for delivery before September 1, 1993, a premium rate for a rating period may exceed the ranges set forth in Articles 26.32 and 26.33 of this code until September 1, 1995. The percentage increase in the premium rate charged to a small employer under this article for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; and

(2) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

Art. 26.35. RATE ADJUSTMENT IN CLOSED PLAN. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate to adjust rates under Articles 26.33(a)(1) and 26.34(1) of this code. The portion of change in rates computed under those subdivisions may not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

Art. 26.36. PREMIUM RATES; NONDISCRIMINATION. (a) A small employer carrier shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(b) A small employer carrier shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) A small employer carrier may not use case characteristics without the prior approval of the commissioner other than the geographic area in which the small employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification, and the number of employees and dependents.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessments paid or payable by small employer carriers.

(e) The board may adopt rules to implement this article and to ensure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including rules that ensure that differences in rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design.

(f) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in that class of business without regard to case characteristics, claim experience, health status, or duration of coverage since the issuance of the health benefit plan.

Art. 26.37. RESTRICTED PROVIDER NETWORKS. For purposes of this subchapter, a small employer health benefit plan may use a restricted provider network to provide the benefits under the plan. A plan that uses a restricted provider network does not provide similar coverage to a small employer health benefit plan that does not use a restricted provider network, if the use of the network results in reduced premiums to the small employer or substantial differences in claim costs.

Art. 26.38. HEALTH MAINTENANCE ORGANIZATION; APPROVED HEALTH BENEFIT PLAN. The premium rates for a state-approved health benefit plan offered by a health maintenance organization under Article 26.48 of this code must be established in accordance with formulas or schedules of charges filed with the department.

Art. 26.39. ENFORCEMENT. If the commissioner finds that a small employer carrier subject to this chapter exceeds the applicable rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Section 7, Article 1.10, of this code.

Art. 26.40. DISCLOSURE. In connection with the offering for sale of any small employer health benefit plan, each small employer carrier and each agent shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in claim costs or the actual or expected variation in health status of the employees of the small employer and their dependents;

(2) provisions concerning the small employer carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(3) provisions relating to renewability of policies and contracts; and

(4) any preexisting condition provision.

Art. 26.41. REPORTING REQUIREMENTS. (a) Compliance with the underwriting and rating requirements of this chapter shall be demonstrated through actuarial certification. Small employer carriers offering a small employer health benefit plan shall file annually with the commissioner an actuarial certification stating that the underwriting and rating methods of the small employer carrier:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with the provisions of this chapter.

(b) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based on commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(c) A small employer carrier shall make the information and documentation described in Subsection (b) of this article available to the commissioner on request. Except in cases of violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

SUBCHAPTER E. COVERAGE

Art. 26.42. SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) A small employer carrier shall offer the following three health benefit plans:

(1) the preventive and primary care benefit plan;

(2) the in-hospital benefit plan; and

(3) the standard health benefit plan.

(b) A small employer carrier may offer to a small employer additional benefit riders to the standard health benefit plan.

(c) A small employer carrier may not offer to a small employer benefit riders to:

(1) the preventive and primary care benefit plan, except as provided by Article 26.45(d) of this code; or

(2) the in-hospital benefit plan, except as provided by Article 26.46(e) of this code.

(d) Subject to the provisions of this chapter, a small employer carrier may also offer to small employers any other health benefit plan authorized under this code. Article 26.06(c) does not apply to a health benefit plan offered to a small employer under this subsection.

Art. 26.43. POLICY FORMS. (a) The commissioner shall promulgate the benefits section of the preventive and primary benefit plan, the in-hospital benefit plan, and the standard health benefit plan policy forms. For all other portions of these policy forms, a small employer carrier shall comply with Article 3.42 of this code as it relates to policy form approval. A small employer carrier may not offer these three benefit plans through a policy form that does not comply with this article.

(b) A health carrier may not issue and the commissioner may not approve a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy unless it is written in plain language.

(c) Each provision of a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy relating to renewal of coverage, conditions of coverage, or per occurrence or aggregate dollar limitations on coverage must be clearly explained in plain language.

(d) A health carrier may not use and the commissioner may not approve a health benefit plan application form unless it is in plain language.

(e) Subsections (b) through (d) of this article do not apply if the specific language to be used is mandated by federal law or state statute or by rules implementing federal law.

(f) For purposes of Subsections (b) through (e) of this article, a health benefit plan certificate or policy, a rider to or a provision of a health benefit plan certificate or policy, or a health benefit plan application form is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner.

(g) The provisions of Subsections (b) through (f) of this article requiring the use of plain language do not apply to a health benefit plan group master policy or to a policy application or enrollment form for a health benefit plan group master policy.

Art. 26.44. RIDERS; FILING WITH COMMISSIONER. (a) A small employer carrier shall file with the commissioner, in a form and manner prescribed by the commissioner, riders to the small employer health benefit plans as allowed under Article 26.42 of this code to be used by the small employer carrier. A small employer carrier may use a rider filed under this article after the 30th day after the date the rider is filed unless the commissioner disapproves its use.

(b) The commissioner, after notice and an opportunity for a hearing, may disapprove the continued use by a small employer carrier of a rider if the rider does not meet the requirements of this chapter and other applicable statutes.

Art. 26.45. PREVENTIVE AND PRIMARY CARE BENEFIT PLAN. (a) The preventive and primary care benefit plan must include coverage for the health services described by Subsections (b) and (c) of this article when those services are provided within the scope of their practice by a physician, physician assistant, advanced nurse practitioner, or another licensed practitioner, including any practitioner required to be covered under Article 21.52 of this code or under Section 2, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70–2, Vernon's Texas Insurance Code).

(b) Coverage for the following preventive care must be provided on an appropriate medical schedule without copayment or deductible:

(1) childhood immunizations;

(2) Pap tests;

(3) mammography, as required by Section 2, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70–2, Vernon's Texas Insurance Code);

(4) colo-rectal screening;

(5) prostate cancer screening; and

(6) vision and hearing tests for children under 19 years of age.

(c) Coverage must include the following:

(1) outpatient hospital care and up to five days per policy year of inpatient hospital care;

(2) emergency care, as defined by Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70–2, Vernon's Texas Insurance Code), and Section 2(t), Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code);

(3) maternity-related care, including prenatal, delivery, and postnatal care and high-risk pregnancy care;

(4) well-child care, as defined by the Texas Department of Health based on the standards of the American Academy of Pediatrics or its successor organization;

(5) outpatient clinic or office visits for treatment of illness or injury;

(6) one physical examination per policy year;

(7) diagnostic examinations and laboratory and X-ray services, with a limit of $5,000 per policy year;

(8) mental health services, including outpatient evaluation, crisis intervention, and services for treatment of serious mental illness as described by Section 1, Article 3.51–14, of this code, for five days of inpatient services and 40 outpatient visits per policy year;

(9) evaluation and treatment for the abuse of or addiction to alcohol or drugs, for five days of inpatient services and 40 outpatient visits per policy year;

(10) home health services, as defined by Section 1, Article 3.70–3B, of this code subject to a maximum of 40 visits per policy year; and

(11) physical therapy performed by a qualified licensed physical therapist, occupational therapy performed by a qualified licensed occupational therapist, or speech-language therapy performed by a qualified licensed speech-language pathologist, including outpatient diagnostic services and 40 outpatient treatment visits per policy year.

(d) A preventive and primary care benefit plan may include a rider for coverage of prescription drugs but may not include any other rider.

(e) A preventive and primary care benefit plan must include a total benefit cap of $15,000 per policy year.

(f) Except as provided by Subsection (b) of this article, a preventive and primary care benefit plan may require a deductible of not more than $250 per policy year and must pay at least 80 percent of covered charges after the deductible has been satisfied. After an insured's copayments have reached $1,000 in a policy year, the plan must pay 100 percent of covered charges for the remainder of that policy year.

(g) A small employer carrier may waive the limit on home health services if the waiver will result in less expensive treatment.

Art. 26.46. IN-HOSPITAL BENEFIT PLAN. (a) The in-hospital benefit plan must include coverage for:

(1) diagnostic, treatment, and rehabilitative services provided through inpatient hospital services; and

(2) outpatient care necessary as a follow-up to the inpatient hospital services until the 90th day after the date of discharge from the hospital.

(b) The in-hospital benefit plan is not subject to any law requiring the reimbursement, use, or consideration of a specific category of a licensed or certified health care practitioner.

(c) The in-hospital benefit plan must provide lifetime benefits of $1 million with a total benefit cap of $100,000 per policy year.

(d) The in-hospital benefit plan may include deductible and copayment requirements.

(e) The in-hospital benefit plan may include a primary and preventive care rider that includes the coverage required by Article 26.45 of this code other than the coverage required by Subsection (c)(1) of that article. The in-hospital benefit plan may also include a supplementary accident benefit plan, but may not include other riders or supplementary benefit plans.

Art. 26.47. STANDARD HEALTH BENEFIT PLAN. (a) The standard health benefit plan shall include coverage for:

(1) health care services, including consulting and referral services, provided within the scope of their practice by a physician, a physician assistant, an advanced nurse practitioner, or another licensed practitioner, including any practitioner required to be covered under Article 21.52 of this code or under Section 2, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70–2, Vernon's Texas Insurance Code);

(2) care in the following facilities:

(A) inpatient hospitals;

(B) outpatient hospitals;

(C) skilled nursing facilities, subject to a maximum benefit of $10,000 per policy year; and

(D) hospice facilities, subject to a maximum lifetime benefit of $10,000;

(3) emergency care, as defined by Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70–2, Vernon's Texas Insurance Code), and Section 2(t), Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code);

(4) maternity-related care, including prenatal, delivery, and postnatal care and high-risk pregnancy care;

(5) well-child care, as defined by the Texas Department of Health based on the standards of the American Academy of Pediatrics or its successor organization;

(6) outpatient clinic or office visits for treatment of illness or injury;

(7) one physical examination per policy year;

(8) mental health services, including coverage described by Section 2(F), Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70–2, Vernon's Texas Insurance Code), and Article 3.72 of this code, subject to a limit of:

(A) 90 days of inpatient psychiatric care per policy year; and

(B) 40 outpatient visits per policy year, subject to a maximum benefit of $100 for each visit;

(9) medical treatment and referral services for the abuse of or addiction to alcohol or drugs, as required by Article 3.51–9 of this code;

(10) inpatient and outpatient evaluation, crisis intervention, and other treatment for serious mental illness as described by Section 1, Article 3.51–14, of this code;

(11) diagnostic examinations and laboratory and X-ray services;

(12) physical therapy performed by a qualified licensed physical therapist, occupational therapy performed by a qualified licensed occupational therapist, or speech-language therapy performed by a qualified licensed speech-language pathologist, subject to a maximum benefit of $10,000 per policy year;

(13) home health services as required by Article 3.70–3B of this code, subject to a maximum limit of $10,000 per policy year; and

(14) prescription drugs subject to a copayment of not more than 50 percent.

(b) Coverage for the following preventive care must be provided without copayment or deductible:

(1) childhood immunizations;

(2) Pap tests;

(3) mammography, as required by Section 2, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70–2, Vernon's Texas Insurance Code);

(4) colo-rectal screening;

(5) prostate cancer screening; and

(6) vision and hearing tests for children under 19 years of age.

(c) The standard health benefit plan shall provide lifetime benefits of $1 million with a total benefit cap of at least $250,000 per policy year.

(d) Except for services excluded from deductible and copayment requirements by Subsection (b) of this article, a standard health benefit plan may include deductible and copayment requirements.

(e) A small employer carrier may waive the limit on home health services if the waiver will result in less expensive treatment.

(f) The board may adopt rules to implement this article.

Art. 26.47A. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. The employees of a small employer group may accept and small employer carriers may offer the preventive and primary care benefit plan or the standard health benefit plan without providing coverage for alcohol and substance abuse benefits if:

(1) at least 50 percent of the employees waive, in writing, the benefits, and indicate in writing that they have undergone alcoholism or substance abuse treatment or counseling within the last three years; and

(2) the exclusion from coverage of alcohol and substance abuse applies only to those employees.

Art. 26.48. HEALTH MAINTENANCE ORGANIZATION PLANS. Instead of the small employer health benefit plans described by this subchapter, a health maintenance organization may offer a state-approved health benefit plan that complies with the requirements of Title XI, Public Health Service Act (42 U.S.C. Section 300e et seq.) and rules adopted under that Act.

Art. 26.49. PREEXISTING CONDITION PROVISIONS. (a) Except as provided by Article 26.21(g) of this code, a preexisting condition provision in a small employer health benefit plan may not apply to expenses incurred after the first anniversary of the effective date of coverage.

(b) A preexisting condition provision in a small employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition:

(1) for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the effective date of coverage; or

(2) that would have caused an ordinary, prudent person to seek medical advice, diagnosis, care, or treatment during the six months before the effective date of coverage.

(c) A preexisting condition provision in a small employer health benefit plan may not apply to an individual who was continuously covered for a minimum period of 12 months by a health benefit plan that was in effect up to a date not more than 60 days before the effective date of coverage under the small employer health benefit plan.

(d) A preexisting condition provision may exclude coverage for a pregnancy existing on the effective date of the coverage, except as provided by Subsection (c) of this article.

(e) In determining whether a preexisting condition provision applies to an individual covered by a small employer health benefit plan, the small employer carrier shall credit the time the individual was covered under a previous health benefit plan if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under a small employer health benefit plan. If the previous coverage was issued by a health maintenance organization, any waiting period that applied before that coverage became effective also shall be credited against the preexisting condition provision period.

Art. 26.50. COORDINATION WITH FEDERAL LAW. The board by rule may modify a small employer benefit plan described by this subchapter or adopt a substitute for that plan to the extent required to comply with federal law applicable to the plan. The board shall use the Texas Health Benefits Purchasing Cooperative in the implementation of this article.

SUBCHAPTER F. REINSURANCE

Art. 26.51. ELECTION TO BE RISK-ASSUMING OR REINSURED CARRIER; NOTICE TO COMMISSIONER. (a) Each small employer carrier shall notify the commissioner of the carrier's election to operate as a risk-assuming carrier or a reinsured carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application under Article 26.52 of this code.

(b) A small employer carrier's election under Subsection (a) of this article is effective until the fifth anniversary of the election. The commissioner may permit a small employer carrier to modify its decision at any time for good cause shown.

(c) The commissioner shall establish an application process for small employer carriers seeking to change their status under this article.

(d) A reinsured carrier that elects to change its status to operate as a risk-assuming carrier may not continue to reinsure a small employer health benefit plan with the system. The carrier shall pay a prorated assessment based on business issued as a reinsured carrier for any portion of the year that the business was reinsured.

Art. 26.52. APPLICATION TO BECOME A RISK-ASSUMING CARRIER. (a) A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

(b) In evaluating an application filed under Subsection (a) of this article, the commissioner shall consider the small employer carrier's:

(1) financial condition;

(2) history of rating and underwriting small employer groups;

(3) commitment to market fairly to all small employers in the state or in its established geographic service area; and

(4) experience managing the risk of small employer groups.

(c) The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a 60-day period for public comment before making a decision on the application. If the application is not acted on before the 90th day after the date the commissioner received the application, the carrier may request and the commissioner shall grant a hearing.

(d) The commissioner, after notice and hearing, may rescind the approval granted to a risk-assuming carrier under this article if the commissioner finds that the carrier:

(1) is not financially able to support the assumption of risk from issuing coverage to small employers without the protection afforded by the system;

(2) has failed to market fairly to all small employers in the state or its established geographic service area; or

(3) has failed to provide coverage to eligible small employers.

Art. 26.53. TEXAS HEALTH REINSURANCE SYSTEM. (a) The Texas Health Reinsurance System is created as a nonprofit entity.

(b) The system is administered by a board of directors and operates subject to the supervision and control of the commissioner.

Art. 26.54. BOARD OF DIRECTORS. (a) The board of directors is composed of nine members appointed by the commissioner. The commissioner or the commissioner's representative shall serve as an ex officio member. Five members must be representatives of reinsured carriers selected from individuals nominated by small employer carriers in this state according to procedures developed by the commissioner. Four members must represent the general public. A member representing the general public may not be:

(1) an officer, director, or employee of an insurance company, agency, agent, broker, solicitor, or 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 or consanguinity.

(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 member of the board of directors may not be compensated for serving on the board of directors but is entitled to reimbursement for actual expenses incurred in performing

functions as a member of the board of trustees as provided in the General Appropriations Act.

(d) The board of directors is subject to the open meetings law, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252–17, Vernon's Texas Civil Statutes), and the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252–17a, Vernon's Texas Civil Statutes).

Art. 26.55. PLAN OF OPERATION. (a) Not later than the 180th day after the date on which a majority of the members of the board of directors have been appointed, the board of directors shall submit to the commissioner a plan of operation and thereafter any amendments necessary or suitable to ensure the fair, reasonable, and equitable administration of the system. The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines the plan is suitable to ensure the fair, reasonable, and equitable administration of the system and provides for the sharing of system gains or losses on an equitable and proportionate basis in accordance with the provisions of this subchapter. The plan of operation is effective on the written approval of the commissioner.

(b) If the board of directors fails to timely submit a suitable plan of operation, the commissioner, after notice and hearing, shall adopt a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board of directors and approved by the commissioner.

(c) The plan of operation must:

(1) establish procedures for the handling and accounting of system assets and money and for an annual fiscal report to the commissioner;

(2) establish procedures for the selection of an administering carrier or third-party administrator and establish the powers and duties of that administering carrier or third-party administrator;

(3) establish procedures for reinsuring risks in accordance with the provisions of this article;

(4) establish procedures for collecting assessments from reinsured carriers to fund claims and administrative expenses incurred or estimated to be incurred by the system, including the imposition of penalties for late payment of an assessment; and

(5) provide for any additional matters necessary for the implementation and administration of the system.

Art. 26.56. POWERS AND DUTIES OF SYSTEM. The system has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except that the system may not directly issue health benefit plans. The system is exempt from all taxes. The system may:

(1) enter into contracts necessary or proper to carry out the provisions and purposes of this subchapter and may, with the approval of the commissioner, enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal actions necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured carrier;

(3) take legal action necessary to avoid the payment of improper claims against the system;

(4) issue reinsurance contracts in accordance with the requirements of this subchapter;

(5) establish guidelines, conditions, and procedures for reinsuring risks under the plan of operation;

(6) establish actuarial functions as appropriate for the operation of the system;

(7) assess reinsured carriers in accordance with the provisions of Article 26.60 of this code and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses, provided that any interim assessments shall be credited as offsets against regular assessments due after the close of the fiscal year;

(8) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the system, policy and other contract design, and any other function within the authority of the system; and

(9) borrow money for a period not to exceed one year to effect the purposes of the system, provided that any notes or other evidence of indebtedness of the system not in default shall be legal investments for small employer carriers and may be carried as admitted assets.

Art. 26.57. AUDIT BY STATE AUDITOR. (a) The state auditor shall conduct annually a special audit of the system under Chapter 321, Government Code. The state auditor's report shall include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this article to the board of directors and the comptroller, and the board of directors shall remit that amount to the comptroller for deposit to the general revenue fund.

Art. 26.58. REINSURANCE. (a) A small employer carrier may reinsure risks covered under the small employer health benefit plans with the system as provided by this article.

(b) The system shall reinsure the level of coverage provided under the small employer health benefit plans.

(c) A small employer carrier may reinsure an entire small employer group not later than the 60th day after the date on which the group's coverage under the small employer health benefit plans takes effect. A small employer carrier may reinsure an eligible employee of a small employer or the employee's dependent not later than the 60th day after the date on which that individual's coverage takes effect. A newly eligible employee or dependent of a reinsured small employer group or an individual covered under the small employer health benefit plans may be reinsured not later than the 60th day after the date on which that individual's coverage takes effect.

(d) The system may not reimburse a reinsured carrier for the claims of any reinsured individual until the carrier has incurred an initial level of claims for that individual in a calendar year of $5,000 for benefits covered by the system. In addition, the reinsured carrier is responsible for 10 percent of the next $50,000 of benefit payments during a calendar year, and the system shall reinsure the remainder. A reinsured carrier's liability to any insured individual may not exceed a maximum of $10,000 in any one calendar year for that individual.

(e) The board of directors annually shall adjust the initial level of claims and the maximum to be retained by the carrier established under Subsection (d) of this article to reflect increases in costs and in use for small employer health benefit plans in this state. The adjustment may not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor unless the board of directors proposes and the commissioner approves a lower adjustment factor.

(f) A small employer carrier 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.

(g) Except as provided in the plan of operation, a reinsured carrier shall apply consistently with respect to reinsured and nonreinsured business all managed care procedures, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation.

Art. 26.59. PREMIUM RATES. (a) As part of the plan of operation, the board of directors shall adopt a method to determine premium rates to be charged by the system for reinsuring small employer groups and individuals under this subchapter.

(b) The method adopted must include classification systems for small employer groups that reflect the variations in premium rates allowed in this chapter and must provide for the development of base reinsurance premium rates that reflect the allowable variations. The base reinsurance premium rates shall be established by the board of directors, subject to the approval of the board, and shall be set at levels that reasonably approximate the gross premiums charged to small employers by small employer carriers for the small employer

health benefit plans, adjusted to reflect retention levels required under this subchapter. The board of directors periodically shall review the method adopted under this subsection, including the classification system and any rating factors, to ensure that the method reasonably reflects the claim experience of the system. The board of directors may propose changes to the method. The changes are subject to the approval of the board.

(c) An entire small employer group may be reinsured at a rate that is 1½ times the base reinsurance premium rate for that group. An eligible employee of a small employer or the employee's dependent covered under the small employer health benefit plans may be reinsured at a rate that is five times the base reinsurance premium rate for that individual.

(d) The board of directors may consider adjustments to the premium rates charged by the system to reflect the use of effective cost containment and managed care arrangements.

Art. 26.60. ASSESSMENTS. (a) Not later than March 1 of each year, the board of directors shall 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 carriers. Each reinsured carrier's assessment shall be determined annually by the board of directors based on annual statements and other reports required by the board of directors and filed with that board. The board of directors shall establish, as part of the plan of operation, a formula by which to make assessments against reinsured carriers. With the approval of the commissioner, the board of directors may change the assessment formula from time to time as appropriate. The board of directors shall base the assessment formula on each reinsured carrier's share of:

(1) the total premiums earned in the preceding calendar year from the small employer health benefit plans delivered or issued for delivery by reinsured carriers to small employer groups in this state; and

(2) 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 carriers to small employer groups in this state.

(b) The formula established under Subsection (a) of this article may not result in an assessment share for a reinsured carrier 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 this state by that reinsured carrier 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 this state by all reinsured carriers. Premiums earned by a reinsured carrier that are less than an amount determined by the board of directors to justify the cost of collection of an assessment based on those premiums may not be considered by the board of directors in determining assessments.

(c) With the approval of the commissioner, the board of directors may adjust the assessment formula for reinsured carriers that are approved health maintenance organizations that are federally qualified under Subchapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), to the extent that any restrictions are imposed on those health maintenance organizations that are not imposed on other health carriers.

Art. 26.61. EVALUATION OF SYSTEM. (a) Not later than March 1 of each year, the board of directors shall file with the commissioner an estimate of the assessments necessary to fund the losses for small employer groups incurred by the system during the previous calendar year.

(b) If the board of directors determines that the necessary assessments exceed five percent of the total premiums earned in the previous calendar year from small employer health benefit plans delivered or issued for delivery by reinsured carriers to small employer groups in this state, the board of directors shall evaluate the operation of the system and shall report its findings, including any recommendations for changes to the plan of operation, to the commissioner not later than April 1 of the year following the calendar year in which the losses were incurred. The evaluation must include an estimate of future assessments and must consider the administrative costs of the system, the appropriateness of the premiums

charged, the level of insurer retention under the system, and the costs of coverage for small employer groups.

(c) If the board of directors fails to timely file a report, the commissioner may evaluate the operations of the system and may implement amendments to the plan of operation as considered necessary by the commissioner to reduce future losses and assessments.

(d) Reinsured carriers may not write small employer health benefit plans on a guaranteed issue basis during a calendar year if the assessment amount payable for the previous calendar year is at least five percent of the total premiums earned in that calendar year from small employer health benefit plans delivered or issued for delivery by reinsured carriers in this state.

(e) Reinsured carriers may not write small employer health benefit plans on a guaranteed issue basis after the board of directors determines that the expected loss from the reinsurance system for a year will exceed the total amount of assessments payable at a rate of five percent of the total premiums earned for the previous calendar year. Reinsured carriers may not resume writing small employer health benefit plans on a guaranteed issue basis until the board of directors determines that the expected loss will be less than the maximum established by this subsection.

(f) The maximum assessment amount payable for a calendar year may not exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured carriers in this state.

Art. 26.62. DEFERMENT OF ASSESSMENT. (a) A reinsured carrier may petition the commissioner for a deferment in whole or in part of an assessment imposed by the board of directors.

(b) The commissioner may defer all or part of the assessment of a reinsured carrier if the commissioner determines that the payment of the assessment would endanger the ability of the reinsured carrier to fulfill its contractual obligations.

(c) If an assessment against a reinsured carrier is deferred, the amount deferred shall be assessed against the other reinsured carriers in a manner consistent with the basis for assessment established by this subchapter.

(d) A reinsured carrier 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 group with the system until it pays the outstanding assessment.

SUBCHAPTER G. MARKETING

Art. 26.71. FAIR MARKETING. (a) Each small employer carrier shall market the small employer health benefit plan through properly licensed agents to eligible small employers in this state. Each small employer purchasing a small employer health benefit plan must affirm that the agent who sold the plan offered and explained all three plans to that employer.

(b) The department may require periodic demonstration by small employer carriers and agents that those carriers and agents are marketing or issuing small employer health benefit plans to small employers in fulfillment of the purposes of this article.

(c) The department may require periodic reports by small employer carriers and agents regarding small employer health benefit plans issued by those carriers and agents. The reporting requirements shall include information regarding case characteristics and the numbers of small employer health benefit plans in various categories that are marketed or issued to small employers.

Art. 26.72. HEALTH STATUS AND CLAIMS EXPERIENCE; PROHIBITED ACTS. (a) A small employer carrier or agent may not, directly or indirectly:

(1) encourage or direct a small employer to refrain from applying for coverage with the small employer carrier because of health status or claim experience of the eligible employees and dependents of the small employer;

(2) encourage or direct a small employer to seek coverage from another health carrier because of health status or claim experience of the eligible employees and dependents of the small employer; or

(3) encourage or direct a small employer to apply for a particular small employer health benefit plan because of health status or claim experience of the eligible employees and dependents of the small employer.

(b) A small employer carrier may not, directly or indirectly, enter into an agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of the small employer health benefit plans to be varied because of health status or claim experience.

(c) Subsection (b) of this article does not apply to an arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage may not vary because of health status or claim experience.

(d) A small employer carrier or agent may not encourage a small employer to exclude an eligible employee from health coverage provided in connection with the employee's employment.

Art. 26.73. AGENTS. (a) A small employer carrier shall pay the same commission, percentage of premium or other amount to an agent for renewal of a small employer health benefit plan as the carrier paid for original placement of the plan. Compensation for renewal of a plan may be adjusted upward to reflect an increase in the cost of living or similar factors.

(b) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status or claim experience of a small employer group placed by the agent with the carrier.

Art. 26.74. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW. Denial by a small employer carrier of an application for coverage from a small employer or a cancellation or refusal to renew must be in writing and must state the reason or reasons for the denial, cancellation, or refusal.

Art. 26.75. RULES. The board may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of small employer health benefit plans to small employers in this state.

Art. 26.76. VIOLATION. (a) A violation of Article 26.72 of this code by a small employer carrier or an agent is an unfair method of competition and an unfair or deceptive act or practice under Article 21.21 of this code.

(b) If a small employer carrier enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to the offering of small employer health benefit plans to small employers in this state, the third-party administrator is subject to this subchapter.

SECTION 2. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.52C to read as follows:

Art. 21.52C. UNIFORM CLAIM BILLING FORMS. (a) In this article:

(1) "Health benefit plan" means a group, blanket, or franchise insurance 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.

(2) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 20 of this code, a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and a stipulated premium company authorized under Chapter 22 of this code.

(3) "Provider" means a person who provides health care under a license issued by this state, including a person listed in Section 2(B), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), or in Article 21.52 of this code.

(b) A provider seeking payment or reimbursement under a health benefit plan and the health carrier that issued that plan must use uniform claim billing form UB-82/HCFA or HCFA 1500, or their successors, as developed by the National Uniform Billing Committee or its successor.

SECTION 3. Section 1(d)(3), Article 3.51-6, Insurance Code, is amended to read as follows:

(3) Any insurer or group hospital service corporation subject to Chapter 20, Insurance Code, who issues policies which provide hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense incurred basis, but not a policy which provides benefits for specified disease or for accident only, shall provide a conversion or group continuation privilege as required by this subsection. Any employee, member, or dependent whose insurance under the group policy has been terminated for any reason except involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy and under any group policy providing similar benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to such privilege as outlined in Paragraph (A), (B), or (C) below. Involuntary termination for cause does not include termination for any health-related cause.

(A)(i) *An insurer shall first offer to each employee, member, or dependent a conversion policy without evidence of insurability if written application for and payment of the first premium is made not later than the 31st day after the date of the termination. The converted policy shall provide the same coverage and benefits as provided under the group policy or plan. The lifetime maximum benefits shall be computed from the initial date of the employee's, member's, or dependent's coverage with the group. An insurer shall offer and an employee, member, or dependent may elect lesser coverage and benefits.* [~~Coverage under an individual policy or group conversion policy of accident and health insurance without evidence of insurability if written application and payment of the first premium is made within 31 days after such termination.~~] An employee, member, or dependent shall not be entitled to have a converted policy *or plan* issued if termination of the insurance [~~under the group policy~~] occurred because: (aa) such person failed to pay any required premium; or (bb) any discontinued group coverage was replaced by similar group coverage within 31 days.

(ii) An insurer shall not be required to issue a converted policy covering any person if: (aa) such person is or could be covered by Medicare; (bb) such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; (cc) such person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; *or* (dd) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law[~~; or (ee) the benefits provided under the sources herein enumerated, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner of insurance prior to their use in denying coverage~~]. The board shall issue rules and regulations to establish minimum standards for benefits under policies issued pursuant to this subsection.

(B)(i) Policies subject to Paragraph (A) above shall provide at the [~~insurer's~~] option *of the employee, member, or dependent* in lieu of the requirements of Paragraph (A) continuation of group coverage for employees or members and their eligible dependents subject to the eligibility provisions of Paragraph (A).

(ii) Continuation of group coverage [~~need not include dental, vision care, or prescription drug benefits and~~] must be requested in writing within *31* [~~21~~] days following the later of: (aa) the date the group coverage would otherwise terminate; or (bb) the date the employee is given notice of the right of continuation by either the employer or the group policyholder.

(iii) In no event may the employee or member elect continuation more than 31 days after the date of such termination.

(iv) An employee or member electing continuation must pay to the group policyholder or employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, *plus two percent of* [~~but not more than~~] the group rate for the insurance being continued under the group policy on the due date of each payment.

(v) The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within 31 days of the date coverage would otherwise terminate.

(vi) Continuation may not terminate until the earliest of: (aa) six months after the date the election is made; (bb) failure to make timely payments; (cc) the date on which the group coverage terminates in its entirety; (dd) or one of the conditions specified in items (aa) through *(dd)* [~~(ee)~~] of Subparagraph (ii), Paragraph (A) above is met by the covered individual.

(C) The insurer may elect to provide *the conversion coverage on an individual or group basis* [~~group insurance coverage in lieu of the issuance of a converted policy under Paragraph (A) above~~].

The premium for the converted policy issued under Paragraph (A) of this subdivision *shall* [~~or the group coverage under Paragraph (C) of this subdivision, should~~] be determined in accordance with the insurer's table of premium rates *for coverage that was provided under the group policy or plan. The premium may be based on the age and geographic location of each person to be covered and the type of converted policy. The premium for the same coverage and benefits under a converted policy may not exceed 200 percent of the premium determined in accordance with this paragraph. The premium must be based on the type of converted policy and the coverage provided by the policy* [~~applicable to the age and class of risk of each person to be covered under that policy and the type and amount of insurance provided~~].

SECTION 4. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.52D to read as follows:

Art. 21.52D. REVIEW OF MANDATED COVERAGE IN HEALTH BENEFIT PLANS

Sec. 1. DEFINITIONS. In this article:

(1) "Commissioner" means the commissioner of insurance.

(2) "Health benefit plan" means:

(A) an individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness; or

(B) an evidence of coverage or group subscriber contract issued by a health maintenance organization.

(3) "Mandated benefit provision" means a provision of law that requires a health benefit plan to:

(A) cover a particular health care service or provide a particular benefit;

(B) cover a particular class of persons; or

(C) provide for the reimbursement, use, or consideration of a particular category of health care practitioners.

(4) "Panel" means the mandated benefit review panel appointed under this article.

Sec. 2. MANDATED BENEFIT REVIEW PANEL. (a) The mandated benefit review panel is composed of three senior researchers appointed by the commissioner. Two members of the panel must be experts in health research or biostatistics and must serve on the faculty of a university located in this state.

(b) Members of the panel serve staggered six-year terms, with the term of one member expiring February 1 of each odd-numbered year. If there is a vacancy during a term, the

commissioner shall appoint a replacement who meets the qualifications of the vacated office to fill the unexpired term.

(c) A member of the panel is not entitled to compensation but is entitled to reimbursement for actual and necessary expenses incurred in performing duties as a member of the panel at the rate provided for that reimbursement by the General Appropriations Act.

(d) The department shall provide staff for the panel in accordance with legislative appropriation.

Sec. 3. REFERRAL OF BILL; REPORT. (a) The presiding officer of either house of the legislature shall refer a bill proposing a mandated benefit provision or an amendment to a mandated benefit provision to the panel for a review and report in accordance with this article.

(b) Not later than the 30th day after the date the bill is referred to the panel, the panel shall issue a report.

(c) The panel shall provide a summary and copy of the panel's report to the presiding officer of each house of the legislature and to the commissioner.

(d) The summary must include:

(1) a brief description of the mandated benefit provision;

(2) the panel's conclusion on the necessity, cost, cost effectiveness, and medical efficacy of the provision;

(3) research evidencing the medical efficacy of the health care service; and

(4) the manner in which similar mandated benefit provisions enacted in other states have affected health care and health insurance costs in those states.

Sec. 4. REPORT ON EXISTING MANDATED BENEFIT PROVISIONS. (a) Not later than February 1, 1995, the panel shall issue a report on each mandated benefit provision that is in effect on the date the report is issued.

(b) The panel shall provide a copy of the panel's report to the presiding officer of each house of the legislature and to the commissioner.

(c) The panel's report under this section must include:

(1) a brief description of each mandated benefit provision;

(2) the panel's conclusion on the necessity, cost, cost effectiveness, and medical efficacy of each provision;

(3) research evidencing the medical efficacy of each health care service; and

(4) the manner in which similar mandated benefit provisions enacted in other states have affected health care and health insurance costs in those states.

SECTION 5. HEALTH INSURANCE ACCESS STUDY. (a) A comprehensive study of guaranteed issue as a feature of health insurance reform shall be conducted on behalf of the legislature.

(b) The study shall be conducted by a committee composed of:

(1) two members of the senate appointed by the lieutenant governor;

(2) two members of the house of representatives appointed by the speaker of the house of representatives;

(3) a representative of the business community in this state appointed by the lieutenant governor;

(4) a representative of the business community in this state appointed by the speaker of the house of representatives;

(5) a representative of the insurance industry appointed by the lieutenant governor;

(6) a representative of the insurance industry appointed by the speaker of the house of representatives;

(7) a representative of health care providers appointed by the lieutenant governor;

(8) a representative of health care providers appointed by the speaker of the house of representatives;

(9) a representative of consumer groups appointed by the lieutenant governor; and

(10) a representative of consumer groups appointed by the speaker of the house of representatives.

(c) A member of the committee is entitled to reimbursement for expenses incurred in carrying out official duties as a member of the committee at the rate specified in the General Appropriations Act.

(d) The committee shall:

(1) investigate and evaluate the experience of other jurisdictions in which guaranteed issue of health benefit plans has been required;

(2) collect and evaluate data regarding the effect of guaranteed issue requirements on health insurance availability and accessibility; and

(3) collect and evaluate data regarding the effect of guaranteed issue requirements on health insurance rates.

(e) Not later than January 1, 1995, the committee shall prepare and present its report. The report shall include recommended statutory or rule changes to implement the committee's recommendations. The committee shall file copies of the report with the Legislative Reference Library, the governor's office, the secretary of the senate, the chief clerk of the house of representatives, the Texas Department of Insurance, and the Office of Public Insurance Counsel.

(f) On request of the committee, the Texas Legislative Council, senate, and house of representatives shall provide staff as necessary to carry out the duties of the committee.

(g) The operating expenses of the committee shall be paid from available funds of the legislature.

SECTION 6. REINSURANCE STUDY. (a) The Texas Department of Insurance shall initiate a comprehensive study of the reinsurance system established by Subchapter F, Chapter 26, Insurance Code, as added by this Act.

(b) The department shall review and analyze, from an actuarial standpoint, the potential cost of catastrophic losses to the system and recommend funding methods to adequately finance any anticipated losses to the system. The department shall also develop an actuarial model for the system's operation. The department shall fully investigate the experience of other states with health reinsurance systems.

(c) The department shall report its findings to the governor, lieutenant governor, and speaker of the house of representatives not later than January 1, 1995.

SECTION 7. (a) Not later than November 1, 1993, each health carrier subject to Chapter 26, Insurance Code, as added by this Act, shall file a report with the commissioner that states the carrier's gross premiums derived from health benefit plans delivered, issued for delivery, or renewed to small employers in 1992.

(b) Not later than November 1, 1994, each health carrier subject to Chapter 26, Insurance Code, as added by this Act, shall file with the commissioner an update to the report required by Subsection (a) of this section.

SECTION 8. Not later than July 1, 1995, a small employer carrier subject to Chapter 26, Insurance Code, as added by this Act, shall notify the commissioner of its initial election to operate as a risk-assuming or reinsured carrier under Article 26.51, Insurance Code, as added by this Act.

SECTION 9. In making the initial appointments to the board of trustees of the Texas Health Benefits Purchasing Cooperative established under Subchapter B, Chapter 26, Insurance Code, as added by this Act, the governor shall appoint two members for terms expiring February 1, 1995, two members for terms expiring February 1, 1997, and two members for terms expiring February 1, 1999.

SECTION 10. (a) Except as otherwise provided by this section, this Act takes effect September 1, 1993.

(b) A health carrier is not required to offer, deliver, or issue for delivery a small employer health benefit plan, as required by Subchapter E, Chapter 26, Insurance Code, as added by this Act, before January 1, 1994.

(c) The Texas Health Reinsurance System may not reinsure a risk in accordance with Subchapter F, Chapter 26, Insurance Code, as added by this Act, before September 1, 1995.

(d) Article 21.52C, Insurance Code, as added by this Act, applies only to the use of a claim billing form on or after January 1, 1994.

(e) Section 1(d)(3), Article 3.51–6, Insurance Code, as amended by this Act, applies only to conversion of a policy delivered, issued for delivery, or renewed on or after January 1, 1994. Conversion of a policy that was delivered, issued for delivery, or renewed before January 1, 1994, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for this purpose.

(f) Article 26.21(a), Insurance Code, as added by this Act, is effective September 1, 1995.

SECTION 11. In making the initial appointments to the mandated benefit review panel created under Article 21.52D, Insurance Code, as added by this Act, the commissioner of insurance shall appoint one member for a term expiring February 1, 1995, one member for a term expiring February 1, 1997, and one member for a term expiring February 1, 1999.

SECTION 12. To the extent that any provision of this law conflicts with Article 20.11, 21.52, 21.52B, or 21.53, Insurance Code, or with Section 14, Texas Health Maintenance Organization Act (Article 20A.14, Vernon's Texas Insurance Code), the provisions of Article 20.11, 21.52, 21.52B, or 21.53, Insurance Code, or Section 14, Texas Health Maintenance Organization Act (Article 20A.14, Vernon's Texas Insurance Code), as appropriate, shall prevail.

SECTION 13. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

Passed by the House on April 29, 1993, by a non-record vote; the House refused to concur in Senate amendments to H.B. No. 2055 on May 28, 1993, and requested the appointment of a conference committee to consider the differences between the two houses; the House adopted the conference committee report on H.B. No. 2055 on May 29, 1993, by a non-record vote; passed by the Senate, with amendments, on May 25, 1993, by a viva-voce vote; at the request of the House, the Senate appointed a conference committee to consider the differences between the two houses; the Senate adopted the conference committee report on H.B. No. 2055 on May 29, 1993, by a viva-voce vote.

Approved June 15, 1993.

Effective Sept. 1, 1993, except as provided by § 10.