DISCLAIMER

This document is a comparison between the pre-2016 and revised Chapter 11 released by TDI in conjunction with the publication in the *Texas Register* of the adoption of the repeal and replacement of 28 TAC Chapter 11. This document is not intended to be, nor should it be used as, the authoritative version. The version maintained by the Secretary of State, including the publication of the adoption in the April 21, 2017, Texas Register and a correction in the May 26, 2017, Texas Register, is the official version on which interested parties should rely. This document is simply a tool which may aid in evaluating the proposed chapter.

TDI can only vouch that the document attached was prepared in the manner described below, and parties using it should do whatever they need to do to assure themselves that the document accurately represents what it claims to represent.

This document is a Microsoft Word comparison of:

- **the pre-2016 Chapter 11, assembled from a version from the Secretary of State's Office; and**
- **the Chapter 11 adoption, assembled by editing out the preamble, repeal, and statutory authority and cross-reference sections of the adoption accepted by the Secretary of State's Office.**

This document is released in .pdf format. TDI has attempted to suppress notes on formatting changes to make the document shorter and more comprehensible.

~~Chapter~~CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

~~Subchapter~~

SUBCHAPTER A. GENERAL PROVISIONS

§11.1. ~~Purpose~~General Provisions.

~~This chapter implements the Insurance Code Chapters 843, 1271, 1272, 1367, and 1452, and other applicable insurance laws of this state that apply to HMOs.~~

~~(1~~ (a) Severability. ~~Where any terms or sections of this chapter are determined by~~If a court of competent jurisdiction ~~to~~holds that any provision of this chapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this chapter that can be ~~inconsistent with~~given effect without the ~~Insurance Code Chapters 843, 1271, 1272, 1367, or 1452, or other applicable insurance laws of~~invalid provision or application. To this ~~state that apply to HMOs, the applicable chapters of the Insurance Code will apply, but the remaining terms and~~end, all provisions of this chapter ~~will continue in effect.~~

~~(2~~are severable.

(b) Effect of rules. The sections in this chapter are prescribed to govern the performance of appropriate statutory and regulatory functions and are not to be construed as limitations ~~upon~~on the exercise of statutory authority by the commissioner of insurance~~.~~

~~(3) Violation of rules. A violation of the lawful rules or orders of the commissioner made pursuant to this chapter constitutes a violation of the Insurance Code Chapters 843, 1271, 1272, 1367, and 1452 and other applicable insurance laws of this state that apply to HMOs~~.

(c) Effective date. This chapter is effective on August 1, 2017. Actions taken before the effective date of this chapter are governed by the regulations in effect on the date the action was taken, and the former regulations are continued in effect for that purpose.

§11.2. Definitions.

(a) ~~The definitions found~~ Except as otherwise provided, words and terms defined in ~~the~~ Insurance Code ~~§~~Chapters 823 (concerning Insurance Holding Company Systems), 843~~.002 are incorporated into this chapter.~~
(concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), 1272 (concerning Delegation of Certain Functions of Health Maintenance Organizations), 1367 (concerning Coverage of Children), 1452 (concerning Physician and Provider Credentials), 1501 (concerning Health Insurance Portability and Availability Act), and 1507 (concerning Consumer Choice of Benefits Plans) have the same meanings when used in this subchapter.

(b) The following words and terms, when used in this chapter, ~~shall~~ have the ~~following meanings~~meaning indicated below unless the context clearly indicates otherwise~~.~~
:

(1) Admitted assets--~~All assets~~Assets as defined by statutory accounting principles, as permitted and valued ~~in accordance with §~~under Chapter 11~~.803~~, Subchapter I, of this title (relating to ~~Investments, Loans, and Other Assets).~~
Financial Requirements).

(2) Adverse determination--A determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or ~~are not appropriate.~~ appropriate, or are experimental or investigational. The

term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

(3) Affiliate--A person ~~that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.~~ defined as an affiliate in §7.202 of this title (relating to Definitions).

(4) Agent--A person ~~who may~~licensed under the Insurance Code to act as an agent for the sale of a health benefit plan ~~under a license issued under the Insurance Code.~~ .

(5) ANHC or approved nonprofit health corporation--A nonprofit health corporation certified under ~~the~~ Occupations Code §162.001~~, as amended.~~

~~(6) Annual financial statement--The annual statement to be used by HMOs, as promulgated by the NAIC~~ (concerning Certification by Board) and ~~as adopted by the commissioner under the~~ defined in Insurance Code Chapter ~~802 and §843.155.~~

~~(7) Authorized control level--The number determined under the RBC formula in accordance with the RBC instructions.~~

~~(8)~~ 844 (concerning Certification of Certain Nonprofit Health Corporations).

(6) Basic health care service--~~Health~~A health care ~~services which~~service that an enrolled population might reasonably require to maintain good health, as prescribed in ~~§§§~~11.508 and §11.509 of this title (relating to Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements~~,~~; and relating to Additional Mandatory Benefit Standards: Individual and Group ~~Agreement Only).~~

~~(9~~Agreements).

(7) Clinical director--~~Health~~A health professional who ~~meets the following criteria:~~

~~(A) is~~is:

(A) appropriately-licensed~~;~~ and credentialed in compliance with §11.1606 of this title (relating to Organization of an HMO);

(B) ~~is~~ an employee of, or party to a contract with, ~~a health maintenance organization; and~~ an HMO; and

(C) ~~is~~ responsible for clinical oversight of the utilization review program, the credentialing of professional staff, and quality improvement functions.

~~(10) Code--The Texas Insurance Code.~~

~~(11~~

(8) Consumer choice health benefit plan--A health benefit plan authorized by ~~the~~ Insurance Code Chapter 1507~~,~~ and ~~as~~ described in Chapter 21, Subchapter AA ~~of Chapter 21,~~ of this title (relating to Consumer Choice Health Benefit Plans).

~~(12~~

(9) Contract holder--An individual, association, employer, trust, or organization to which an individual or group contract for health care services has been issued.

~~(13~~

(10) Control--As defined in ~~the Insurance Code §§823.005 and 823.151.~~

~~(14) Controlled HMO--An HMO controlled directly or indirectly by a holding company.~~

~~(15) Controlled person--Any person, other than an HMO, who is controlled directly or indirectly by a holding company.~~

~~(16~~§7.202 of this title.

(11) Copayment--A charge, which may be expressed in terms of a dollar amount or a percentage of the contracted rate, in addition to premium attributed to an enrollee for a service ~~which~~that is not fully prepaid.

~~(17~~

(12) Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a physician or provider to determine eligibility to deliver health care services.

~~(18~~

(13) Dentist--An individual provider licensed to practice dentistry by the Texas State Board of Dental Examiners.

~~(19~~

(14) Department--Texas Department of Insurance.

(15) Emergency care--As defined in Insurance Code §843.002 (concerning Definitions).

(16) Facility-based physician--A radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(17) Freestanding emergency medical care facility--A facility, licensed under Health and Safety Code Chapter 254 (concerning Freestanding Emergency Medical Care Facilities), structurally separate and distinct from a hospital, that receives an individual and provides emergency care as defined in Insurance Code §843.002.

(18) General hospital--~~A licensed~~An establishment ~~that:~~
, licensed under Health and Safety Code Chapter 241 (concerning Hospitals), that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(B) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

~~(20~~

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

~~(21~~.

(20) Health status~~-~~related factor--Any of the following in relation to an individual:

(A) health status;

(B) medical condition (including both physical and mental illnesses);

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability (including conditions arising out of acts of domestic violence, including family violence as defined by ~~the~~ Insurance Code Chapter 544, Subchapter D~~;~~ (concerning Family Violence); or

(H) disability.

~~(22~~

(21) Individual provider--Any person, other than a physician or institutional provider, who is licensed or otherwise authorized to provide a health care service. ~~Includes~~This includes, but is not limited to, licensed ~~doctor~~doctors of chiropractic, ~~dentist~~dentists, registered ~~nurse~~nurses, advanced practice ~~nurse~~registered nurses, physician ~~assistant, pharmacist, optometrist, registered optician~~assistants, pharmacists, optometrists, and ~~acupuncturist.~~ acupuncturists.

(22) Insert page--A page used to replace an existing page of a previously approved or reviewed evidence of coverage or written plan description, including a member handbook.

(23) Institutional provider--A provider that is not an individual~~. Includes~~, such as any medical or health related service facility caring for the sick or injured or providing care or supplies for other coverage ~~which~~that may be provided by the HMO. ~~Includes~~This includes, but is not limited to:

(A) ~~General~~general hospitals~~,~~ ;

(B) ~~Psychiatric~~psychiatric hospitals~~,~~ ;

(C) ~~Special~~special hospitals~~,~~ ;

(D) ~~Nursing~~nursing homes~~,~~ ;

(E) ~~Skilled~~skilled nursing facilities~~,~~

;

(F) ~~Home~~home health agencies~~,~~

;

(G) ~~Rehabilitation~~rehabilitation facilities~~,~~

;

(H) ~~Dialysis~~dialysis centers~~,~~

;

(I) ~~Free~~free-standing surgical centers~~,~~

;

(J) ~~Diagnostic~~diagnostic imaging centers~~,~~

;

(K) ~~Laboratories,~~

laboratories;

(L) ~~Hospice~~hospice facilities~~,~~

;

(M) ~~Residential~~residential treatment centers~~,~~

;

(N) ~~Community~~community mental health centers~~,~~;

(O) pharmacies; and

~~(O) Pharmacies.~~

(P) freestanding emergency medical care facilities.

(24) Insurance Code--The Texas Insurance Code.

(25) Limited provider network--A subnetwork within an HMO delivery network in which contractual relationships ~~exist~~ between physicians, certain providers, independent physician associations ~~and/or~~, physician groups ~~which~~, or any combination thereof, limit ~~the~~ enrollees' access to only the physicians and providers in the subnetwork.

~~(25~~ (26) Limited service HMO--An HMO ~~which~~that has been issued a certificate of authority to issue a limited health care service plan as defined in ~~the~~ Insurance Code §843.002.

~~(26~~

(27) Matrix filing--A filing consisting of individual provisions, each with its own unique identifiable form number, ~~that~~which allows an HMO the flexibility to create multiple evidences of coverage by using combinations of approved individual provisions.

~~(27~~

(28) NAIC--The National Association of Insurance Commissioners.

~~(28~~

(29) NAIC UCAA--The National Association of Insurance Commissioners' Uniform Certificate of Authority Application.

(30) NCQA--The National Committee for Quality Assurance.

(31) Net worth--The amount by which total admitted assets exceed total liabilities, excluding liability for subordinated debt issued in compliance with Insurance Code Chapter 427 (concerning Subordinated Indebtedness).

(32) Out of area benefits or services--Benefits or services that ~~the~~an HMO covers when ~~its~~ enrollees are outside the geographical limits of the HMO service area.

~~(29) Pathology services--Services provided by a licensed laboratory which has the capability of evaluating tissue specimens for diagnoses in histopathology, oral pathology, or cytology.~~

~~(30~~

(33) Pharmaceutical services--Services, including dispensing prescription drugs, under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, ~~as amended,~~Chapters 551 - 569 (concerning Pharmacy and Pharmacists), that are ordinarily and customarily rendered by a pharmacy or pharmacist.

~~(31~~

(34) Pharmacist--An individual provider licensed to practice pharmacy under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, ~~as amended.~~

~~(32~~Chapters 551 - 569.

(35) Pharmacy--A facility licensed under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, ~~as amended.~~

~~(33~~Chapters 551 - 569.

(36) Preauthorization--As defined in Insurance Code §843.348(a) (concerning Preauthorization of Health Care Services).

(37) Premium--All amounts payable by a contract holder as a condition of receiving coverage from a carrier, including any fees or other contributions associated with a health benefit plan.

~~(34~~

(38) Primary care physician or primary care provider--A physician or individual provider who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

~~(35~~

(39) Primary HMO--An HMO that contracts directly with, and issues an evidence of coverage to, individuals or organizations to arrange for or provide a basic, limited, or single health care service plan to enrollees on a prepaid basis.

~~(36~~

(40) Provider HMO--An HMO that contracts directly with a primary HMO to provide or arrange to provide health care services on behalf of the primary HMO within the primary HMO's defined service area.

~~(37~~

(41) Psychiatric hospital--A licensed hospital ~~which~~that offers inpatient services, including treatment, facilities, and beds for use beyond 24 hours, for the primary purpose of providing psychiatric assessment ~~and~~, psychiatric diagnostic services ~~and~~, psychiatric inpatient care, and treatment for mental illness. ~~Such~~The services must be more intensive than room, board, personal services, and general medical and nursing care. Although substance abuse services may be offered, a majority of beds must be dedicated to the treatment of mental illness in adults ~~and/or children.~~

~~(38) Qualified HMO--An HMO which has been federally approved under Title XIII of the Public Health Service Act, Public Law 93-222, as amended.~~ , children, or both.

~~(39) Quality~~ (42) QI or quality improvement ~~(QI)~~ --A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

~~(40) RBC--Risk-based capital.~~

~~(41) RBC formula--NAIC risk-based capital formula.~~

~~(42) RBC Report--Health Risk-Based Capital Report including Overview and Instructions for Companies~~

~~published by the NAIC and adopted by reference in §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank).~~

(43) Recredentialing--The periodic process by which:

(A) qualifications of physicians and providers are reassessed;

(B) performance indicators, including utilization and quality indicators, are evaluated; and

(C) continued eligibility to provide services is determined.

(44~~) Reference laboratory--A licensed laboratory that accepts specimens for testing from outside sources and depends on referrals from other laboratories or entities. HMOs may contract with a reference laboratory to provide clinical diagnostic services to their enrollees.~~

~~(45) Reference laboratory specimen procurement services--The operation utilized by the reference laboratory to pick up the lab specimens from the client offices or referring labs, etc. for delivery to the reference laboratory for testing and reporting.~~

~~(46~~) Schedule of charges--Specific rates or premiums to be charged for enrollee and dependent coverages.

~~(47~~

(45) Service area--A geographic area within which direct service benefits are available and accessible to HMO enrollees who live, reside, or work within that geographic area and ~~which~~that complies with §11.1606 of this title ~~(relating to Organization of an HMO).~~

~~(48.~~

(46) Single service HMO--An HMO ~~which~~that has been issued a certificate of authority to issue a single health care service plan as defined in ~~the Insurance Code §843.002.~~

~~(49) Special hospital--A licensed establishment that:~~

~~(A) offers services, facilities and beds for use for more than 24 hours for two or more unrelated individuals who are regularly~~ Insurance Code §843.002.

~~admitted, treated~~ (47) Special hospital--An establishment, licensed under Health and Safety Code Chapter 241 (concerning Hospitals), that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care;

(B) has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment;

(C) has a medical staff in regular attendance; and

(D) maintains records of the clinical work performed for each patient.

~~(50~~

(48) Specialists--Physicians or individual providers who set themselves apart from the primary care physician or primary care provider through specialized training and education in a health care discipline.

~~(51~~

(49) State-mandated health benefit plan--~~As~~An accident or sickness insurance policy or evidence of coverage that provides state-mandated health benefits as defined in §21.3502 of this title (relating to Definitions).

~~(52) Statutory surplus--Admitted assets minus accrued uncovered liabilities.~~

~~(53~~

(50) Subscriber--~~If~~For conversion or individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO~~; or if~~. For group coverage, the individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

~~(54) Subsidiary--An affiliate controlled by a specified person directly or indirectly through one or more intermediaries.~~

~~(55) Telehealth service--As defined in Section 57.042, Utilities Code.~~

~~(56~~ (51) Subsidiary--As defined in §7.202 of this title.

(52) Telehealth service--As defined in Government Code §531.001 (concerning Definitions).

(53) Telemedicine medical service--As defined in ~~Section 57.042, Utilities Code.~~

~~(57) Total adjusted capital--An HMO's statutory capital and surplus/total net worth as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed pursuant to the Insurance~~Government Code~~, and such other items, if any, as the RBC instructions provide.~~

~~(58~~ §531.001.

(54) Urgent care--Health care services provided in a situation other than an emergency ~~which~~that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable ~~period of time would result in serious deterioration of the condition of his or her health.~~

~~(59) Utilization review--A system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.~~

~~(60) Voting security--As defined in the Insurance Code §823.007, including any security convertible into or evidencing a right to acquire such security~~time would result in serious deterioration of the condition of his or her health.

~~Subchapter~~

(55) Utilization review--As defined in Insurance Code §4201.002 (concerning Definitions).

(56) Utilization review agent or URA--As defined in Insurance Code §4201.002.

SUBCHAPTER B. NAME APPLICATION PROCEDURE

§11.101. How ~~To~~to Obtain Forms.

~~The~~ A name application form and ~~all~~ other HMO forms may be obtained by contacting the Company Licensing and Registration ~~Division~~Office, Mail Code ~~305 2C~~103-CL, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~.~~, or from the department's website at www.tdi.texas.gov.

§11.102. Information Required.

The name application form may be submitted with or at any time ~~prior to submission of~~before submitting the application for certificate of authority, together with a $100 filing fee.

(1) The name, address, and title or relationship to the proposed HMO of each organizer must be shown on the name application form, along with the same information about any affiliated organization~~(s).~~

~~(2) Organizations making application for a certificate of authority as HMOs or existing HMOs are prohibited from using the following words in its name, contracts, and literature: insurance, casualty, surety, or mutual.~~

~~(3) A proposed HMO's name application form may be accepted by the commissioner before its basic organizational document is filed with the Office of the Secretary of State. The same exact name must be used with both state agencies.~~

~~(4) The certificate of authority will not be granted until the name has been accepted~~.

(2) An organization applying for a certificate of authority as an HMO or an existing HMO is prohibited from using the following words in its name, contracts, or literature: "insurance," "casualty," "surety," or "mutual."

(3) A name application form may be accepted by the commissioner before the proposed HMO's basic organizational document is filed with the Texas secretary of state. Applicants must use the same exact name when filing with the commissioner and the secretary of state.

(4) A certificate of authority will not be granted until the name has been accepted.

§11.104. Criteria.

The commissioner will review requests for reservation of names in the ~~same~~ manner ~~as for insurance companies according to~~provided for the review of corporate names under Chapter 7, Subchapter G, of this title (relating to Review of Corporate Names).

§11.105. Use of the Term "HMO," Service ~~Mark~~Marks, Trademarks, ~~d/b/a~~and Assumed Name.

(a) While in the process of planning or development, the term "HMO" may be used as a part of the proposed HMO's name as long as the developmental status of the proposed HMO is made clear in all dealings with employers, individuals, prospective contract holders, news media, ~~etc.~~

~~(b) If a trademark, service mark or d/b/a is to be used it must first be filed with and approved by the commissioner.~~

~~(c) After the certificate of authority is issued, the name as it appears on the certificate of authority must be used by the HMO on all advertising and forms distributed to the public~~and others.

(b) A trademark, service mark, or assumed name must be filed with and approved by the commissioner before use.

(c) After the commissioner issues a certificate of authority, the HMO must use the name as it appears on the certificate of authority on all advertising and forms distributed to the public.

(d) After the commissioner issues a certificate of authority, the HMO must file any new trademark or service mark, or any changes to an existing trademark or service mark, with the commissioner.

§11.106. Time Limits; Extension Requirements.

~~The~~ Names reserved for use by a proposed HMO are subject to the following time limits and extension requirements~~ have been established for names reserved for use by a proposed HMO.~~ :

(1) ~~The~~A requested name is reserved for 365 days from the date the name is accepted by the commissioner.

(2) Before the end of this 365-day period, a proposed HMO ~~which~~that has not submitted an application for a certificate of authority may request that the name reservation be extended for an additional 365~~ day period~~ days by submitting the following:

(A) a letter of request for extension; and

(B) a statement explaining the current status of the proposed HMO and the estimated date on which an application for a certificate of authority will be filed.

(3) Extension requests may not be submitted more than 30 days before the end of the 365-day period for which the name is reserved.

(4) If the information detailed in paragraph (2) of this section is not received before the expiration of 365 days, then the name reservation expires~~,~~ and the proposed HMO must wait 30 days before filing a new name application form.

(5) If the extension request is received before the expiration of 365 days and if the statement of status sufficiently explains why the proposed HMO has not yet filed an application for a certificate of authority, then the name reservation may be extended for another 365~~ day period.~~ days.

(6) The requirements of paragraph (2) of this section must be met every 365 days until an application for certificate of authority is filed~~.~~, or the extension expires and the proposed HMO must wait 30 days before filing a new name application form.

§11.107. Effect of Filing for or Receiving Certificate of Authority.

Once a proposed HMO has filed an application for a certificate of authority~~ has been filed~~, the name application no longer must be extended. ~~If~~If the commissioner denies a certificate of authority~~ is denied,~~ then the name application is ~~cancelled~~canceled on the date the denial order becomes final. If a certificate of authority is granted, then the name is reserved for use by the HMO as long as the certificate of authority is in effect.

§11.108. Effect of Withdrawing Application for Certificate of Authority.

If an application is filed and then withdrawn or delayed at the request of ~~the~~a proposed HMO, then at the time of the withdrawal or request for ~~a~~ delay, the proposed HMO must request that the

name continue to be reserved and estimate the date ~~upon~~on which the application will be refiled. If a 365-day name application period expires during the withdrawal period, then the requirements ~~specified in~~of §11.106(2) of this title (relating to Time Limits; Extension Requirements) must be met in order for the name application to be continued.

§11.109. Situations in Which Name Applications Will Cease.

A name will cease to be reserved ~~in the following situations:~~

~~(1)~~ when:

(1) a proposed HMO fails to request extension before the end of a 365-day name application period;

(2) ~~when~~the commissioner denies an application for a certificate of authority ~~is denied~~; or

(3) ~~when~~the commissioner revokes or cancels a certificate of authority ~~is revoked or cancelled.~~ .

~~Subchapter~~

SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY

§11.201. Filing Fee.

~~The~~ A filing fee required by Insurance Code §843.154~~,~~ (concerning Fees), as determined by §7.1301 of this title (relating to Regulatory Fees), must accompany ~~the~~an application~~.~~ for a certificate of authority, unless the filing is made electronically through the NAIC's System for Electronic Rate and Form Filing, in which case the fees may not be attached to the filing. For filings made electronically, the department will send an invoice for the fees, and the HMO must pay, as provided in §7.1302 of this title (relating to Billing System). The fee is ~~non-refundable~~nonrefundable.

§11.202. Binding, Indexing, and Numbering Requirements.

(a) ~~An original of the~~ A proposed HMO may submit an application for a certificate of authority in electronic format, by electronic file transmission or in a data storage format acceptable to the department, or by paper.

(b) If an HMO submits an application in paper format, the applicant must ~~be submitted in one or more~~submit three separate copies of the application in separate three-ring binders, so that pages may be easily replaced when necessary.

~~(b) Dividers~~Paper applications must include dividers with identifying subject tabs ~~must precede~~preceding each separate exhibit.

~~(c~~

(c) Applications submitted in an electronic format must include separate file folders with names identifying each exhibit.

(d) Each application must contain a table of contents.

~~(d~~

(e) All pages must be clearly legible and numbered.

~~(e) Identical items~~

(f) An HMO should not ~~be used~~use identical items in more than one section of the application. Instead of using the same information in more than one place, an application must refer to the file or page ~~or pages~~ on which the required form or list may be found.

~~(f) The~~

(g) An original application becomes the charter file~~.~~

~~(g~~ once the applicant submits all required revisions and the commissioner approves the application.

(h) The application is subject to ~~the~~ Government Code Chapter 552 (concerning Public Information ~~Act, Chapter 552, Texas Government Code.~~

~~(h)~~.

(i) Each item in the application must be identified by a unique number as more fully described in §11.301(2) of this title (relating to Filing Requirements).

§11.203. Revisions ~~during~~During Review Process.

(a) Revisions during the review of ~~the~~an application for a certificate of authority must be addressed to: Company Licensing and Registration ~~Division~~Office, Mail Code ~~305-2C~~103-CL, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~.~~, or submitted electronically as instructed by the department. The applicant must include ~~an original of the~~a transmittal letter~~, plus the original of~~ and any revision specified in this subchapter.

(b) Each revision to the basic organizational ~~document~~documents, bylaws, or officers and employees bond must be accompanied by ~~the~~a notarized certification of the corporate secretary or corporate president of the applicant that the revision submitted is true, accurate, and complete, and, if the item is a copy, by a notarized certification that the copy is a true, accurate, and complete copy of the original.

(c) If ~~a~~ an electronic file or page is to be revised or replaced, the ~~complete new page~~modified document must be submitted with the changed item or information clearly designated ~~on all copies except the "original" page, which is placed in the charter file copy~~.

(d) Staff will conduct a review of the application~~.~~

~~(d) Staff shall conduct qualifying examinations~~ and notify the applicant of the need for revisions necessary to meet the requirements of ~~the~~ Insurance Code Chapter 843~~,~~ (concerning Health Maintenance Organizations), this chapter, and other applicable insurance laws and regulations of this state ~~that apply to HMOs.~~. If the applicant does not make the necessary revisions, the department ~~shall~~will deny the application.

(e) If the time required for the revisions will exceed the time limits set out in §1.809 of this title (relating to HMO Certificate of Authority), the applicant must request additional time within which to make the revisions. The applicant must specifically set out the length of time requested, which may not exceed 90 days. The commissioner may grant or deny the request for an extension of time at ~~his or her~~the commissioner's discretion under §1.809 of this title. ~~Additional extensions~~

(f) The applicant may ~~be requested. The~~ request ~~for any~~ additional ~~extension~~extensions, but must set out in writing the need for the additional time~~, in writing, in~~ for each requested extension. A request must provide sufficient detail for the commissioner to determine if good cause for the extension exists.

The commissioner may grant or deny any additional request for an extension of time at ~~his or her~~the commissioner's discretion.

§11.204. Contents.

~~Contents of the application must include the items in the order listed in this section. The applicant must submit two additional copies of the application along with the original application.~~

The application for a certificate of authority must contain the following, in this order:

(1) a completed name application form along with any certificate of reservation of corporate name issued by the secretary of state;

(2) a completed ~~application for a~~ certificate of authority~~;~~ application form;

(3) the basic organizational documents and all amendments~~ thereto~~, complete with the original incorporation certificate with charter number and seal indicating certification by the secretary of state, if applicable;

~~(4) the bylaws, rules, or any similar document regulating the conduct of the internal affairs~~

(4) the bylaws, rules, or any similar document regulating the conduct of the internal affairs of the applicant;

(5) information about officers, directors, and staff~~:~~, including:

(A) a completed officers and directors page;~~ and~~

(B) NAIC UCAA biographical data forms for all persons who are to be responsible for the day-to-day conduct of the applicant's affairs~~ of the applicant~~, including all members of the board of directors, board of trustees, executive committee or other governing body or committee, the principal officers, and controlling shareholders of the applicant if the applicant is a corporation, or all partners or members ~~in~~if the ~~case of~~applicant is a partnership or association~~. Any relationship between~~

~~the HMO~~; and ~~any affiliate or other organization in which a shareholder with 10% or more interest also has an interest must be clearly identified;~~

(C) a complete set of fingerprints for each person to whom the fingerprint requirements of Chapter 1 of this title (relating to General Administration) apply;

(6) ~~separate~~ organizational ~~charts or list~~information, as ~~described in subparagraphs (A) - (C) of this paragraph:~~
follows:

(A) a chart or list clearly identifying the relationships between the applicant and any affiliates, and a list of any currently outstanding loans or contracts to provide services between the applicant and the affiliates;

(B) a chart showing the internal organizational structure of the applicant's management and administrative staff;

~~(C) a chart showing contractual arrangements of the health care delivery system;~~

~~(7) fidelity bond or deposit for officers and employees, which must comply with either subparagraph (A) or (B) of this paragraph, as appropriate.~~ and

~~(A) A bond must be in compliance with Insurance Code §843.402, and must be either the original bond or~~

(C) a ~~copy of the bond. The bonds shall~~ chart showing contractual arrangements of the HMO's delivery network;

(7) a fidelity bond or deposit for officers and employees that must be:

(A) an original or copy of a bond complying with Insurance Code §843.402 (concerning Officers' and Employees' Bond), which must not contain a deductible~~.~~
; or

(B) ~~A~~a cash deposit ~~must be~~ held ~~by the Comptroller of the State of Texas~~under Insurance Code §843.402 or as provided by Insurance Code §423.004 (concerning Statutory Deposits with Department) in the same amount and subject to the same conditions as ~~a~~the bond~~.~~
described in this paragraph;

(8) information ~~related~~relating to out-of-state licensure and service of legal process for all applicants must be submitted by using the attorney for service form~~.~~
; provided that:

(A) ~~An~~if the applicant ~~licensed as an HMO~~is domiciled in another ~~state~~ jurisdiction, an agent for service of legal process must be appointed in compliance with Insurance Code Chapter 804 (concerning Service of Process) using Form FIN 312 (rev. 04/00), and the applicant must furnish a copy of the certificate of authority from the domiciliary ~~state's~~jurisdiction's licensing authority~~, and a power of attorney executed by the applicant appointing an agent for service, other than the commissioner as the attorney of such applicant in and for the state, upon whom all lawful processes in any legal action or proceedings against the HMO on a cause of action arising in this state may be served.~~ ; and

(B) ~~All applicants~~the applicant must furnish a statement acknowledging that all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this state is valid if served as provided in ~~accordance with~~ Insurance Code Chapter 804~~.~~

;

(9) the evidence of coverage to be issued to enrollees~~;~~ and any group agreement ~~which~~that is to be issued to employers, unions, trustees, or other organizations as described in Chapter 11, Subchapter F, of this ~~chapter~~title (relating to Evidence of Coverage);

(10) financial information, consisting of the following:

(A) a ~~current~~ financial statement~~, including~~ that includes a balance sheet reflecting the required net worth, assets, and any liabilities~~, statement of income and expenses, and sources and application of funds;~~

.

(B) ~~projected financial statements for the 24-month period from the start of operations using quarterly~~ if the applicant is newly formed, a balance sheet ~~projections based on calendar quarters, quarterly cash flow schedules~~ reflecting ~~capital expenditures, and monthly revenue and expense projections, such financial statements must include~~ the HMO's proposed initial funding;

(C) projected financial statements using the NAIC UCAA ProForma Financial Statements for Health Companies, commencing with the proposed beginning of operations and containing at least two full calendar year projections, and including the identity and credentials of the

person ~~making~~preparing the projections; and

~~(C~~

(D) the most recent audited financial statements of the HMO's immediate parent company, the ultimate holding company parent, and any sponsoring organization;

(11) the schedule of charges ~~as defined in §11.2 of this title (relating to Definitions) to be used through the first 12 months of operation including~~ , excluding any charges for Medicaid products~~. If any HMO proposes to write Medicaid and the maximum rates allowed by contracting state agency are proposed to be charged, then the rates published by the contracting state agency must be included with~~ , with an actuarial certification and supporting documentation ~~showing these rates are adequate in relation to benefits provided. If lesser rates are to be charged~~meeting the qualifications specified in §11.702 of this title (relating to Actuarial Certification);

(12) if the applicant proposes to write Medicaid products, an actuarial certification and supporting documentation ~~must be included evidencing that the rates are adequate for the benefits to be provided. If contracting state agency Medicaid rates are not available, then the anticipated rates used in determining the applicant's financial projections must be disclosed with an actuarial certification and supporting documentation showing that the anticipated rates are reasonable in relation to the expected benefits to be provided. If a provider HMO proposes to contract to provide prepaid services to a primary HMO, the provider HMO must submit an actuarial certification and supporting documentation evidencing that the anticipated prepayments to be received from the primary HMO are adequate to pay for services to be provided to the primary HMO. All actuarial certifications must meet~~meeting the qualifications specified in §11.702 of this title ~~(relating to Actuarial Certification).~~

~~(12)~~ , and noting whether the proposed rates are the maximum rates allowed by the contracting state agency, if rates less than the maximum rates allowed are being proposed or if the contracting state agency rates are not available;

(13) a description and a map of the applicant's proposed service area, with key and scale, which ~~shall~~must identify the county ~~and~~or counties, or portions ~~thereof~~of counties, to be served~~. If~~; provided that all copies of the map ~~is~~must be in color, if the ~~original~~HMO submits a map on paper and ~~all four copies must also be~~ in color;

~~(13~~

(14) the form of any contract or monitoring plan between the applicant and:

(A) any person listed on the officers and directors page;

(B) any physician, medical group, association of physicians, ~~delegated entity, as described in the Insurance Code Chapter 1272, delegated network, as described in the Insurance Code Chapter 1272, or any other provider, plus~~or any other provider, and the form of any subcontract between ~~such~~those entities and any physician, medical group, association of physicians, or any other provider to provide health care services~~. All~~ , provided that contracts ~~shall include a~~ , including subcontracts between physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees, must include a hold-harmless provision~~, as specified in~~ and comply with all other provisions of §11.901~~(a)(1)~~ of this title (relating to Required and Prohibited Provisions~~). Such clause shall be no less favorable to enrollees than that outlined in §11.901(a)(1) of this title.~~

~~(C) any~~);

(C) any affiliated exclusive agent or agency;

(D) any affiliated person who will perform ~~management,~~ marketing, administrative, data processing services, or claims processing services~~. A bond or deposit~~;

(E) any affiliated person who will perform management services, together with a deposit or the original or a copy of a bond with no deductible meeting the requirements of Insurance Code §843.105~~, is required for management contracts. If submitting a bond, the original or a copy shall be submitted. The bond shall not include a deductible;~~

~~(E)~~ (concerning Management and Exclusive Agency Contracts);

(F) an ANHC ~~which~~that agrees to arrange for or provide health care services, other than medical care or services ancillary to the practice of medicine, or a provider HMO ~~which~~that agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of a primary HMO as part of the primary HMO delivery network~~. A~~; together with a monitoring plan, as required by §11.1604 of this title (relating to Requirements for Certain Contracts ~~between~~Between Primary HMOs and ANHCs and Between Primary

HMOs and Provider HMOs~~) must also be submitted; and~~

~~(F)~~;

(G) any insurer or group hospital service corporation to offer indemnity benefits under a point~~-~~of~~-~~service contract~~.~~

~~(14~~; and

(H) any delegated entity or delegated network, as those terms are described in Insurance Code Chapter 1272 (concerning Delegation of Certain Functions by Health Maintenance Organization);

(15) a description of the quality improvement program and work plan that includes a process for medical peer review required by Insurance Code ~~§§§~~843.082 ~~and 843.~~(concerning Requirements for Approval of Application) and §843.102~~. Arrangements~~ (concerning Health Maintenance Organization Quality Assurance); provided that arrangements for sharing pertinent medical records between physicians~~ and/or,~~ providers, or both, contracting or subcontracting ~~pursuant to~~under paragraph (~~13~~14)(B) of this section with the HMO and ~~assuring~~ensuring the~~ record's~~ confidentiality of the records must be explained;

~~(15~~

(16) insurance, guarantees, and other protection against insolvency:

(A) any affiliated reinsurance agreement and any other affiliated agreement described in Insurance Code §843.082(4)(C), covering excess of loss, stop-loss, ~~and/or~~ catastrophes~~. The agreement~~, or any combination thereof, which must provide that the commissioner and HMO will be notified no less than 60 days ~~prior to~~before termination or reduction of coverage by the insurer;

(B) any conversion policy or policies ~~which~~that will be offered by an insurer to an HMO enrollee in the event of the ~~HMO's~~applicant's insolvency;

(C) any other arrangements offering protection against insolvency, including guarantees, as specified in §11.~~806 of this title (relating to Liabilities), §11.808 of this title (relating to Guarantee from a Sponsoring Organization), and §11.1804 of this title (relating to Guarantees);~~

~~(16) authorization for disclosure to the commissioner of the financial records of the applicant. Disclosure of financial records of affiliates may also be required. The individual to be contacted for a qualifying~~

~~examination must be identified;~~

~~(17) the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO pursuant to~~ 808 of this title (relating to Liabilities) and §11.810 of this title (relating to Guarantee from a Sponsoring Organization);

(17) authorization for bank disclosure to the ~~requirements~~commissioner of the applicant's initial funding;

(18) the written description of health care plan terms and conditions made available by:

(A) an HMO other than an HMO offering a Children's Health Insurance Program (CHIP) plan to any current or prospective group contract holder and current or prospective enrollee of the applicant under Insurance Code §§843.201 (concerning Disclosure of Information About Health Care Plan Terms), 843.078 (concerning Contents of Application), and 843.079 (concerning Contents of Application; Limited Health Care Service Plan), and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees);

~~(18~~

(B) an HMO offering a CHIP plan in the form of the member handbook, for information only, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook;

(19) network configuration information for each of the HMO's physician or provider networks, including limited provider networks, along with:

(A) maps for each product type demonstrating the location and distribution of the physician, dentist, and provider network within the proposed service area by county~~(ies) or ZIP code(s);~~, with each specialty represented in one map that includes the radii mileage requirements described in §11.1607 of this title (relating to Accessibility and Availability Requirements);

(B) lists ~~of~~ for each product type of credentialed and contracted physicians, dentists, and individual providers, in an Excel-compatible format, specifying:

(i) last name;

(ii) first name;

(iii) business address;

(iv) city;

(v) state;

(vi) county;

(vii) Texas license number;

(viii) specialty;

(ix) name of the HMO contracted facility, including ~~license type and specialization and~~hospital(s), in which the physician or individual provider has privileges;

(x) date of last credentialing or recredentialing; and

(xi) an indication of whether they are accepting new patients~~, and institutional providers;~~

~~(19~~;

(C) lists for each product type of credentialed and contracted facilities, including hospitals, in an Excel-compatible format, specifying:

(i) name of facility;

(ii) business address;

(iii) city;

(iv) state;

(v) county;

(vi) type of facility;

(vii) name of national accrediting body, if applicable; and

(viii) date of last credentialing or recredentialing;

(D) lists for each product type of hospital-based physicians that are contracted with the HMO, in an Excel-compatible format, specifying:

(i) last name;

(ii) first name;

(iii) business address;

(iv) city;

(v) state;

(vi) county;

(vii) Texas license number;

(viii) hospital-based specialty; and

(ix) name of each HMO contracted hospital in which the hospital-based physician practices;

(20) a written description of the types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made or to be made with physicians and providers in exchange for the provision of~~,~~ or the arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers; ~~such compensation arrangements shall be confidential and not subject to the open records law, Chapter 552, Government Code;~~

~~(20) documentation demonstrating that the HMO will pay for emergency care services performed by non-network physicians or providers at the negotiated or usual and customary rate and that the health care plan contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement with the entity to provide items or services to enrollees, the following provisions and procedures for coverage of emergency care services:~~

~~(A) any medical screening examination or other evaluation required by state or federal law which is necessary to determine whether an emergency medical condition exists will be provided to enrollees in a hospital emergency facility or comparable facility;~~

~~(B) necessary emergency care services will be provided to enrollees, including the treatment and stabilization of an emergency medical condition; and~~

~~(C) services originating in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition will be provided to covered enrollees as approved by the HMO, provided that the HMO is required to approve or~~ provided that such compensation arrangements are confidential under Insurance Code §843.078(l) and not subject to Government Code Chapter 552 (concerning Public Information);

~~deny coverage of post stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from the time of the request; the HMO must respond to inquiries from the treating physician or provider in compliance with this provision in the HMO's plan.~~

~~(21) a description of the procedures by which:~~

(21) documentation demonstrating that the applicant will pay for emergency care services performed by non-network physicians or providers as provided by Insurance Code §1271.155 (concerning Emergency Care);

(22) a description of the procedures by which:

(A) a member handbook and materials relating to the complaint and appeal process and the independent review process will be provided to enrollees in languages other than English, ~~pursuant to~~in compliance with Insurance Code §843.205~~;~~ (concerning Member's Handbook; Information About Complaints and

~~(B) access to a member handbook~~Appeals); and ~~materials~~

(B) access to a member handbook and materials relating to the complaint and appeal process and the independent review process will be provided to an enrollee who has a disability affecting communication or reading, ~~pursuant to~~in compliance with Insurance Code §843.205~~.~~

~~(22;~~

(23) notification of the physical address in Texas of all books and records described in §11.205 of this title (relating to Additional Documents ~~To Be~~to be Available for ~~Qualifying Examinations);~~

~~(23~~Review);

(24) a description of the HMO's information systems, management structure, and personnel that demonstrates the applicant's capacity to meet the needs of enrollees and contracted physicians and providers, and to meet the requirements of regulatory and contracting entities; ~~and~~

~~(24) a notarized certification bearing the original~~

~~signature of the corporate secretary or corporate president of the applicant that the documents provided in compliance with paragraphs (3), (4) and (7) of this section, and paragraph (13) of this section if applicable, are true, accurate and complete copies of the original documents.~~

(25) a written

~~**§11.205.** Documents To Be Available for Qualifying Examinations.~~

~~(a) The following documents must be available for review at the HMO's office located within the State of Texas:~~

~~(1) administrative: policy and procedure manuals; physician and provider manuals; enrollee materials; organizational charts; key personnel information, e.g., resumes and job descriptions; and other items as requested;~~

~~(2) quality improvement: program~~ description ~~and work plan as required by §11.1902~~of the utilization management and utilization review program;

(26) the URA name and certificate or registration number if the applicant performs utilization review under Insurance Code Chapter 4201 (concerning Utilization Review Agents) and Chapter 19, Subchapter R, of this title (relating to ~~Quality Improvement Program for Basic and Limited Services HMOs);~~

~~(3) utilization management: program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and IRO logs;~~

~~(4) complaints and appeals: policies and procedures, examples of letters and examples of~~Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy), or the URA name and certificate number of the certified URA that will perform utilization review on behalf of the applicant if the applicant delegates utilization review;

(27) complaint and appeal ~~logs. On or after January 1, 2006,~~procedures, templates of letters, and logs, including the complaint log, which must categorize each complaint ~~shall be categorized as one or more of~~using the following ~~types of~~categories and noting all that are applicable to the complaint:

(A) quality of care or services;

(B) accessibility~~/~~ and availability of services;

(C) utilization review or management;

(D) complaint procedures;

(E) physician and provider contracts;

(F) group subscriber contracts;

(G) individual subscriber contracts;

(H) marketing;

(I) claims processing; and

(J) miscellaneous;

~~(5~~and

(28) documentation of claim systems and procedures that demonstrates the HMO's ability to pay claims timely and comply with applicable claim payment statutes and rules.

§11.205. Additional Documents to be Available for Review.

(a) The following documents must be made available for review at the applicant's office in Texas or another location within Texas agreed to by the department and on request during the application process:

(1) administrative: policy and procedure manuals;

(2) health information systems: policies and procedures for accessing enrollee health records and a plan to provide for confidentiality of those records ~~in accordance~~complying with applicable law;

~~(6) network configuration information, as outlined in §11.204(18) of this title (relating to Contents) demonstrating adequacy of the physician, dentist and provider network;~~

~~(7~~

(3) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

~~(8~~

(4) executed physician and provider contracts: a copy of the first page, including the form number, and signature page ~~of individual provider contracts and group provider contracts;~~

~~(9~~;

(5) executed subcontracts: a copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

~~(10)~~

(6) manuals: current physician manual and current provider manual ~~which shall be~~ provided to each contracting physician ~~and other~~or provider~~. The manuals shall~~, which must contain details of the ~~requirements by which~~provisions that govern the physicians and providers ~~will be governed;~~

~~(11~~;

(7) credentialing files: as specified in §11.1902(4) of this title (relating to Quality Improvement Program for Basic, Single Service, and Limited ~~Services~~Service HMOs~~) and §11.2207(d)(4) of this title (relating to Quality~~); ~~Improvement Structure and Program for Single Service HMOs);~~

~~(12) a copy of all printed materials to be presented to prospective enrollees, an enrollee handbook, and an evidence of coverage;~~

~~(13)~~ (8) reporting system: the statistical reporting system developed and maintained by the ~~HMO which~~applicant that allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of services, and the accessibility and availability of services;

~~(14~~

(9) claims systems: policies and procedures that demonstrate the capacity to pay claims timely and to comply with all applicable statutes and rules;

~~(15~~

(10) financial records: financial information, including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments, and debts; and

~~(16~~

(11) any other records: demonstrating compliance with applicable statutes and rules, including audits or examination reports by other entities, including governmental authorities or accrediting agencies.

~~(b) The following documents may be maintained outside the State of Texas if the HMO has received prior approval by the commissioner pursuant to Insurance Code §803.003:~~

~~(1) financial records, including ledgers;~~

~~(2) checkbooks;~~

~~(3) inventory records;~~

~~(4) evidence of expenditures, investments, and debts; and~~

~~(5) the minutes of the HMO organizational meetings which indicate the type and date of each meeting, and the officer or officers who are responsible for the handling of the funds of the applicant; the minutes of meetings of the HMO board of directors; management committee meeting minutes.~~

(b) After approval of the application, the following documents may be maintained outside Texas if the HMO has received prior approval by the commissioner in compliance with Insurance Code §803.003 (concerning Authority to Locate Out of State):

(1) the financial records listed in subsection (a)(10) of this section;

(2) minutes of HMO organizational meetings, which indicate the type and date of each meeting and the officer or officers who are responsible for the handling of the funds of the applicant;

(3) minutes of meetings of the HMO board of directors; and

(4) management committee meeting minutes.

§11.206. Review of Application; Examination.

(a) ~~The~~An application for a certificate of authority will be processed ~~pursuant to~~in compliance with §1.809 of this title (relating to HMO Certificate of Authority).

(b) After completion of the department's review of documents, the department ~~shall~~may perform ~~the qualifying~~ quality of care and financial examinations. If a hearing is held in ~~accordance~~compliance with §1.809 of this title, then the ~~qualifying~~ examinations must occur ~~prior to~~before the date of the hearing. ~~For~~The commissioner may request a copy of the most recent financial examination report issued by the domiciliary regulator of an applicant that is a foreign HMO, ~~in lieu~~instead of conducting a financial ~~qualifying examination, a copy of the report on the most recent~~ examination ~~performed by the regulatory agency of its state of domicile may be requested.~~

~~(c) Following the completion of the qualifying examinations, if a hearing is scheduled, then it will be scheduled under the provisions of Insurance Code §843.081. The hearing may be waived, if agreed to by the applicant and the department and if no reasonable request for a hearing by any other person has been received~~.

§11.207. Withdrawal of an Application.

(a) ~~Upon~~On written notice to the department, an applicant may request withdrawal of an application for a certificate of authority from consideration by the department.

(b) The department may ~~withdraw~~close an application if the department determines that the applicant has failed to respond in a timely manner to requests made by the department for additional information or if the application is incomplete.

~~Subchapter~~SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO ~~SUBSEQUENT TO~~AFTER ISSUANCE OF CERTIFICATE OF AUTHORITY

§11.301. Filing Requirements.

~~Subsequent to~~ After the ~~issuance of a~~commissioner issues an HMO's certificate of authority, ~~each~~the HMO is required to file ~~certain information~~ with the commissioner, either for approval ~~prior to effectuation~~before effect or for information only, any items specified in §11.204 of this title (relating to Contents) that the HMO has deleted, amended, or revised as outlined in paragraphs (4) and (5) of this section and any items specified in §11.302 of this title (relating to Service Area Expansion or Reduction Applications). These requirements include filing changes ~~necessitated~~ made necessary by federal or state law or regulations.

All requirements in this section apply to both electronic and paper filings unless stated otherwise.

(1) Completeness and format of filings.

(A) The department ~~shall~~will not accept a filing for review until the filing is complete. An application to modify ~~the~~an approved application for a certificate of authority ~~which~~that requires the commissioner's approval ~~in accordance with the~~under Insurance Code §843.080 ~~and~~(concerning Modification or Amendment of Application Information) or Insurance Code Chapter 1271, Subchapter C, (concerning Commissioner Approval) is considered complete when all information

required by this section~~,~~; §11.302 ~~of this title,~~; and §§Chapter 11~~.1901 - 11.1902~~, Subchapter T, of this title (relating to Quality of Care) that is applicable and reasonably necessary for the department to make a final determination ~~to be made by the department,~~ has been filed.

(B) ~~Filings shall:~~

Unless otherwise required by this chapter or the Insurance Code, an HMO may submit a filing electronically through the NAIC's System for Electronic Rate and Form Filing or through any other method acceptable to the department.

(C) Unless otherwise required by this chapter or the Insurance Code, paper filings must:

(i) be submitted on 8-1/2- by 11-inch paper;

(ii) not be submitted in bound booklets;

(iii) be legible;

(iv) be in typewritten, computer generated, or printer's proof format; and

(v) except for maps, not contain any color highlighting unless accompanied by a clean copy without highlighting.

(D) As provided in this section, an HMO may submit some filings as provided in §7.201 of this title (relating to Forms Filings).

(E) As provided in this section, an HMO may submit some filings as provided in §11.203(a) of this title (relating to Revisions During Review Process).

(2) Identifying form numbers required. Each item required to be filed ~~pursuant to~~by paragraphs (4) and (5) of this section must be identified by a printed unique form number, adequate to distinguish it from other items. ~~Such~~The identifying form numbers ~~shall~~must be composed of a total of no more than 40 letters, numbers, symbols, ~~and~~or spaces.

(A) The identifying form number must appear in the lower left-hand corner of the page. In the case of a multiple-page document, the identifying form number must only appear on the lower left-hand corner of the first page. Page, and page numbers should appear on subsequent pages.

(B) If an item is to be replaced or revised subsequent toafter issuance of a certificate of authority, a new identifying form number must be assigned.

(i) A change in address or phone number on a form will not require a new identifying form number.

(ii) A new edition date added to the original identifying form number is an acceptable way of revising the number so that it is identifiable from any previously approved item; e.g.,for example, if "G-100" was the originally approved number, then the revision may be numbered "G-100 12/79. Changing the case of the suffix is not considered to be a change in the number, e.g., "ED" and "ed" or "REV" and "rev" are the same for form numbering purposes.

(3) Attachments for filings. The filings required in paragraphs (4) and (5) of this section must be accompanied by the following:

(A) one original of the HMO certification and transmittal form for each new, revised, or ."

(iii) Changing the case of the suffix is not considered to be a change in the number; for example, "ED" and "ed," or "REV" and "rev" are the same for form numbering purposes.

(3) Attachments for filings. Filings required by paragraphs (4)(A) and (B) and (5)(A) and (B) of this section must be accompanied by the following:

(A) an HMO certification and transmittal form for each new, revised, or replaced item;

(B) one original of suchthe supporting documentation as considered necessary by the commissioner forto review of the filing, along with and, for filings submitted on paper, a cover letter which includes the following:

(i) company name;

(ii) form numbers that are being submitted; and

(iii) a paragraph that describes the type of filing being submitted, along with any additional information that would aid in processing the filing~~.~~
, including the reasons for submitting the filing; and

(C) ~~except for the filings outlined in paragraphs (4)(A), (B), and (L), and (5)(C), (G), (K), (M), and (N) of this section,~~ the applicable filing fee ~~for other filings as required by Insurance Code §843.154,~~ as determined by §7.1301 of this title (relating to Regulatory Fees~~). The filings outlined~~), unless the filing is made electronically through the NAIC's System for Electronic Rate and Form Filing, in ~~paragraphs (4)(A), (B), and (L), and (5)(C), (G), (K), (M), and (N) of this section are subject to the fee amounts described in §7.1301(g) of this title, but such~~ which case the fees ~~shall~~should not be attached ~~with the filing. Instead, the submission of such fee(s) is subject to the billing provisions of §7.~~to the filing. For filings made electronically, the department will send an invoice for the fees, and the HMO must pay, as provided in §7.1302 of this title (relating to Billing System).

(4) Filings requiring approval. ~~Subsequent to the~~After issuance of a certificate of authority, each HMO ~~shall~~must file ~~for approval~~ with the commissioner ~~information required by any amendment to items~~, using the method specified ~~in §11.204 of this title (relating to Contents) if such information has not previously been filed and approved by the commissioner. In addition, an HMO shall file with the commissioner~~below, a written request to implement or modify the following operations or documents and receive the commissioner's approval ~~prior to effectuating such~~before putting the modifications~~:~~
~~(A) the~~ into effect:

(A) electronically through the NAIC's System for Electronic Rate and Form Filing:

(i) evidence of coverage filings, as described in §11.501 of this title (relating to ~~Forms Which Must Be Approved Prior to Use);~~
~~(B~~Contents of the Evidence of Coverage);

(ii) a description and a map of the service area, with key and scale, which ~~shall~~must identify the county or counties or portions ~~thereof~~of counties to be served;

(iii) the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO, including the member handbook for all plans other than Children's Health Insurance Program (CHIP) plans in compliance with the requirements of Insurance Code §843.201 (concerning Disclosure of Information About Health Care Plan Terms) and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees); and

(iv) any material change in the HMO's emergency care procedures;

(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department:

(i) any material change in network configuration; and

(ii) if a material change in the network configuration results in the HMO's inability to comply with the network adequacy standards described in §11.1607 of this title (relating to Accessibility and Availability Requirements), an access plan that complies with that section;

(C) as provided in §7.201 of this title:

(i) the form of all contracts described in §11.204(~~13~~14)(A), (C~~) and~~), (D), and (E) of this title, including any amendments to those contracts ~~described in §11.204(13)(A), (C) and (D) of this title~~ and prior notification of the cancellation of any management contracts in §11.204(~~13)(D~~14)(E) of this title;

~~(D) any change in more than 10%~~

(ii) the form of ~~control~~all contracts or subcontracts between affiliated physician and provider groups with the individual members of the ~~HMO, as specified in the definition of "control"~~groups providing health care services to the HMO's enrollees described in §11.~~2(b~~204(14)(B) of this title ~~(relating to Definitions);~~

~~(E) transactions with affiliates related to the purchase, construction, or renovation of hospitals, medical facilities, administrative offices, or any other property which represent more than one-half of 1.0% of admitted assets of the HMO, as well as transactions involving the lease, operation, or maintenance of hospitals, medical facilities, administrative offices, or any other property from or by an affiliate if the monthly cost for such transaction exceeds one-half of 1.0% of all the monthly expenses of the HMO or such agreement places a lien on~~ , including any ~~property owned by the HMO;~~

~~(F) dividends which do not meet the requirements specified in §11.807 of this title (relating to~~

~~Dividends);~~

~~(G~~amendments to those contracts;

(iii) any new or revised loan agreements~~,~~ or amendments ~~thereto, evidencing~~documenting loans made by the HMO to any affiliated person or to any medical or other health care physician or provider, whether providing services currently, previously, or potentially in the future; and any guarantees of any affiliated person's, physician's, or ~~health care~~ provider's obligations to any third party;

~~(H)~~

(iv) any agreement by which an affiliate agrees to handle an HMO's investments under §11.806 of this title (relating to Investment Management by Affiliate Corporation);

(v) any change in the physical address of the books and records described in §11.205 of this title (relating to Additional Documents to be Available for Review);

(vi) any change to any of the requirements for guarantees under §11.810 of this title (relating to Guarantee from a Sponsoring Organization);

(vii) any insurance contracts or amendments, guarantees, or other protection against insolvency, including the stop-loss or reinsurance agreements, if changing the carrier or description of coverage, between the HMO and affiliates, as described in §11.204(16) of this title; and

(viii) modifications to any type of affiliate compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made to physicians and providers in exchange for the provision of, or the arrangement to provide health care services to, enrollees, including any financial incentives for physicians and providers;

(D) as provided in §11.203(a) of this title, a copy of any proposed amendment to basic organizational documents~~. If~~, bylaws, rules, or any similar document regulating the conduct of the internal affairs of the applicant and, if the approved amendment must be filed with the secretary of state, ~~an original, or~~ a certified copy of ~~such document~~ the amendment with the ~~original~~ file mark of the secretary of state~~, shall be filed with the commissioner;~~

~~(I) a copy of any amendments to bylaws of the HMO, with a notarized certification bearing the original signature of the corporate secretary of the HMO that it is a true, accurate, and complete copy of the~~

~~original;~~

~~(J) any~~ ; and

(E) as provided in Chapter 11, Subchapter B, of this title (relating to Name Application Procedure), any name~~,~~ or assumed name~~,~~ on a form, as specified in §11.105 of this title (relating to Use of the Term "HMO," Service ~~Mark~~Marks, Trademarks, ~~d/b/a);~~

~~(K) any agreement by which an affiliate agrees to handle an HMO's investments pursuant to §11.804 of this title (relating to Investment Management by Affiliate Companies);~~

~~(L) any material change in the HMO's emergency care procedures; and~~ Assumed Name).

~~(M) any original guarantees, modifications to existing guarantees specified in §11.808 of this title (relating to Guarantee from a Sponsoring Organization) and guarantees relating to Medicaid business as specified in §§11.1801 - 11.1806 of this title (relating to Solvency Standards for Managed Care Organizations Participating in Medicaid).~~

~~(5) Filings for information.~~ (5) Filings for information. Material filed under this paragraph is not to be considered approved, but may be subject to review for compliance with Texas law and consistency with other HMO documents. Each item filed under this paragraph must be accompanied by a completed HMO certification and transmittal form in addition to those attachments required under paragraph (3) of this section. Within 30 days of the effective date, an HMO must file with the commissioner, for information ~~only~~, deletions and modifications to the following previously approved or filed operations and documents:

(A) electronically through the ~~list of officers~~NAIC's System for Electronic Rate and ~~directors and a biographical data sheet for each person listed~~ Form Filing:

(i) the formula or method for calculating the schedule of charges as specified in Chapter 11, Subchapter H, of this title (relating to Schedule of Charges);

(ii) any modification of drug coverage under Insurance Code §~~843.078(b), on the officers~~1369.0541 (concerning Modification of Drug Coverage Under Plan); and

(iii) the member handbook for CHIP plans, together with a certification from the HMO that the handbook has been approved by the Texas Health and ~~directors page~~Human Services Commission and ~~biographical affidavit~~a copy of the document approving the handbook;

(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department:

(i) a copy of the form of any new contract or subcontract or any substantive change to previously filed copies of forms of all contracts between the HMO and any physician or provider described in §11.204(~~5)(A) and (B) of this title;~~ ~~(B)~~14)(B) of this title, and copies of forms of all contracts between the HMO and an insurer or group hospital service corporation to offer indemnity benefits, whether used with all contracts or on an individual basis. All copies of amended contracts must be marked to indicate revisions. In addition, the HMO must answer all questions listed on the HMO certification and transmittal form;

(ii) a copy of the executed agreement between the HMO and any delegated entities and delegated networks as defined in §11.2602 of this title (relating to Definitions); and

(iii) any change in the quality assurance program, including the peer review program, as required by Insurance Code §843.082(1) (concerning Requirements for Approval of Application) or §843.102 (concerning Health Maintenance Organization Quality Assurance), with descriptions of arrangements for sharing pertinent medical records between physicians and providers contracting or subcontracting under §11.204(14)(B) of this title with the HMO and ensuring the records' confidentiality;

(C) as provided in §7.201 of this title, a copy of any notice of cancellation of fidelity bonds, new fidelity bonds, or amendments ~~thereto~~to fidelity bonds, for officers and employees, including notarized certification by the corporate secretary or corporate president that the material is true, accurate, and complete, as described in §11.204(7) and (~~13~~14)(D) of this title;

~~(C) the formula or method for calculating the schedule of charges, as defined in §11.2(b) of this title. The filing must include the HMO reconciliation of benefits to schedule of charges form as described in §11.701 of this title (relating to Must be Filed Prior to Use);~~
~~(D) any change in the physical address of the books and records described in §11.205 of this title (relating to Documents To Be Available for Qualifying Examinations);~~
~~(E) any change of the certificate of authority for a domestic or foreign HMO. If the HMO is a foreign HMO, a certified copy of the certificate of authority and power of attorney must be submitted;~~
~~(F) any new trademark or service mark, or any changes to an existing trademark or service mark;~~
~~(G) a copy of the form of any new contract or subcontracts or any substantive changes to previously filed copies of forms of all contracts between the HMO and any physicians, delegated entities and delegated networks as defined in §11.2602 of this title (relating to Delegated Entities), or other providers described in §11.204(13)(B) of this title, and copies of forms of all contracts between the HMO and an insurer or group hospital service corporation to offer indemnity benefits, whether utilized with all contracts or on an individual basis. If such contracts are amended, each copy of such agreement must be marked to indicate revisions. In addition, questions listed on the HMO certification and transmittal form,~~

~~must be answered;~~

~~(H) any insurance contracts or amendments thereto, guarantees, or other protection against insolvency, including the stop-loss or reinsurance agreements, if changing the carrier or description of coverage, as described in §11.204(15) of this title;~~

~~(I) changes to any of the requirements mandated for guarantees pursuant to §11.808 of this title;~~

~~(J) any change in the affiliate chart as described in §11.204(6)(A) of this title;~~

~~(K) the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO, including the enrollee handbook, pursuant to the requirements of Insurance Code §843.201 and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees);~~

~~(L) modifications to any types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made to physicians and providers in exchange for the provision of, or the arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers;~~

~~(M) any material change in network configuration; and~~

~~(N) a description of the quality assurance program, including a peer review program, as required by Insurance Code §§843.082(1) and 843.102. Descriptions of arrangements for sharing pertinent medical records between physicians and/or providers contracting or subcontracting pursuant to paragraph (13)(B) of §11.204 of this title with the HMO and assuring the records' confidentiality must also be provided.~~

(D) as provided in §11.203(a) of this title:

(i) a list of officers and directors and a biographical data sheet for each person listed on the officers and directors page under Insurance Code §843.078(b) (concerning Contents of Application) and biographical data forms in §11.204(5)(A), (B), and (C) of this title; and

(ii) any change of the certificate of authority for a domestic or foreign HMO, and, if a foreign HMO, a certified copy of the certificate of authority and power of attorney.

(6) Approval ~~time~~ period. Any modification for which the commissioner's approval is required ~~is~~may be considered approved, unless it is disapproved within 30 days from the date the filing is determined by the department to be complete. The commissioner may postpone the action for a period not to exceed 30 days, as necessary for proper consideration. ~~The HMO will be notified by letter of any postponement.~~

~~(7) Filing review procedure. Within 20 days from the department's receipt of an initial filing for~~

~~commissioner's approval under this section, the~~The department ~~shall determine whether the filing is complete or incomplete for purposes of acceptance for review and, if found to be incomplete, the department shall issue a written or electronic notice to the HMO of its incomplete filing. A filing under this subchapter that is subject to the billing provisions of §7.1302 of this title and which, upon receipt by the department, fails to comply with the requirements of that section, will be deemed to be incomplete for purposes of this subchapter.~~

~~(A) Incomplete filing. The written notice of an incomplete filing shall state that the filing is not complete and has not been accepted for review. In addition, the notice shall specify the information, documentation and corrections necessary to make the filing complete, as provided in paragraph (1) of this section. If a filing is resubmitted, in whole or in part, and is still incomplete, an additional written notice shall be issued. Such notice shall specify the corrections or information necessary for completeness, and state that the 30 day deemer will not begin until the date the department determines the filing to be complete. If a filing is not resubmitted within 30 days of the date of the written notice of incompleteness, then the filing shall be considered withdrawn by the department and closed.~~

~~(B) Processing of complete filing. The department shall~~ will notify the HMO in writing ~~approve or disapprove a complete filing within the period of time set forth in paragraph (6) of this section, beginning on the date the filing is determined to be complete. The HMO may waive in writing the statutory deemer.~~

~~(C) Pending status. Complete filings~~if it postpones a decision on a modification.

(7) Approval, disapproval, and pending.

(A) Filings requiring approval under paragraph (4)(A)(i) – (iii) of this section will be approved or disapproved in writing within the ~~statutory deemer~~ period set forth in paragraph (6) of this section unless, ~~prior to~~before the department's issuance of notice of proposed negative action ~~pursuant to~~under §1.704(a) of this title (relating to Summary Procedure; Notice), the HMO has been contacted by the department regarding corrections or additional information necessary for commissioner's approval, and files ~~with the department~~ a written consent to waive the ~~statutory deemer. The deemer shall be waived upon the department's~~ approval period with the department.

(B) The department may waive the approval period on its receipt of the HMO's written consent.

(C) The department may hold the filing ~~shall be held~~ in a pending status for ~~45~~a reasonable period, but not more than 15 calendar days ~~from~~after the date of the department's request.

(D) If the HMO has not addressed the department's request for corrections or additional information within 15 calendar days, then the HMO may withdraw the filing before the end of the applicable ~~statutory deemer,~~ review period, which is either ~~on~~ the 30th ~~or~~day after filing or the 60th day ~~from the date the filing is complete. If the necessary corrections or additional information have not been filed by the end of 45 days the filing shall be considered withdrawn.~~ after filing for an extended review period.

§11.302. Service Area Expansion or Reduction Applications.

(a) An HMO ~~shall~~must file an application ~~for approval~~ with the department for approval before the HMO may expand an existing service area, reduce an existing service area, or add a new service area.

(b) ~~If any of the following items are changed by a service area expansion or reduction application, the new item or any amendments to an existing item must be submitted for approval or filed for information, as specified in §11.301 of this title (relating to Filing Requirements):~~
For the purposes of an application to expand an existing service area, reduce an existing service area, or add a new service area, an HMO must file the following items:

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area as required by §11.204(~~12~~13) of this title (relating to Contents);

~~(2) a form of any new contracts or amendment of any existing contracts in the new area, as described in §11.204(13) of this title;~~

~~(3~~

(2) network configuration information, as required by §11.204(~~18) of this title;~~

~~(4) a brief narrative description of the administrative arrangements, organizational charts as described in §11.204(6) of this title, and other pertinent information;~~

~~(5) biographical data sheets for any new management staff assigned to the new area;~~

~~(6) any new or amended evidence of coverage to be used in the new area, in accordance with the requirements of Subchapter F of this chapter (relating to Evidence of Coverage);~~

~~(7) the formula or method for calculating the schedule of charges for any new or amended evidence of~~

~~coverage in accordance with Subchapter H of this chapter (relating to Schedule of Charges);~~

~~(8) copies of leases, loans, agreements and contracts to be used in the proposed new area, including information described in §11.301(4)(C), (E), and (G) of this title;~~

~~(9) separate and~~ 19) of this title;

(3) combined ~~sources of financing and~~ financial projections as described in §11.204(10~~)~~ ~~of this title;~~

~~(10) any new or amended officers' and employees' fidelity bonds, in accordance with §11.204(7) and (13)(D) of this title;~~

~~(11) any new or amended reinsurance agreements, insurance or other protection against insolvency, as specified in §11.204(15) of this title; and~~

~~(12) a description of the method by which the complaint procedure, as specified in the Insurance Code §843.251, et seq. and related regulations, will be made reasonably available in the new service area or division, including a toll free call, and the information and complaint telephone number required by the Insurance Code §521.102, where applicable. For HMOs subject to the Insurance Code §521.102, the toll free call required by this rule and the toll free information and complaint number required by the Insurance Code §521.102 may be the same number.~~

)(B) of this title, including a breakdown of the income statement for existing business, and the effect of the proposed service area expansion or reduction; and

(4) if any of the items specified in §11.301 of this title (relating to Filing Requirements) are changed by a service area expansion or reduction application, the new item or any amendments to an existing item must be filed for approval or filed for information, as outlined in §11.301(4) and (5) of this title.

(c) The department ~~shall~~will not accept an application for review until the application is complete. An application to modify the certificate of authority that requires the commissioner's approval ~~in accordance with the~~under Insurance Code §843.080 ~~and~~ (concerning Modification or Amendment of Application Information) or Chapter 1271 Subchapter C, (concerning Commissioner Approval) is considered complete when all information required by §11.301 of this title~~,~~; this section~~,~~; and ~~§§~~Chapter 11.~~1901 - 11.1902~~, Subchapter T, of this title (relating to Quality of Care) that is reasonably necessary for a final determination by the department~~,~~ has been filed with the department.

(d) Before consideration of a service area expansion or reduction application, ~~the~~an HMO must ~~be in compliance~~comply with the requirements of ~~§§~~Chapter 11~~.1901 - 11.1902~~, Subchapter T, of this title, in the existing service areas and in the proposed service areas.

§11.303. Examination.

~~**§11.303. Examination.**~~

(a) The department has authority to conduct examinations of HMOs under Insurance Code ~~§§843.251 and 843.~~Chapters 401 (concerning Audits and Examinations) and 751 (concerning Market Conduct Surveillance), and Insurance Code §843.156~~. Such~~ (concerning Examinations) and §843.251 (concerning Complaint System Required; Commissioner Rules and Examination). The department will conduct examinations ~~may be conducted~~ to determine the financial condition ~~("~~("financial exams~~"),~~), quality of health care services ~~("~~("quality of care exams~~"),~~), or compliance with laws affecting the conduct of business ~~("~~("market conduct exams~~" or "complaint exams").~~

~~(b) On-site financial, market conduct examinations, complaint or quality of care exams shall be conducted pursuant to Insurance Code Article 1.15 and §7.83 of this title (relating to Appeal of Examination Reports).~~

~~(c)~~.

(b) The following documents must be available for review at the HMO's office located within ~~the~~Texas or at a location approved by the department under Insurance Code §803.003 (concerning Authority to Locate Out of State ~~of Texas: ~~):

(1) administrative: policy and procedure manuals; physician and provider manuals; enrollee materials; organizational charts; key personnel information, ~~e.g.,~~for example, resumes and job descriptions; and other items as requested;

(2) quality improvement: program description, work plans, program evaluations, and committee and subcommittee meeting minutes;

(3) utilization management: program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(4) complaints and appeals: policies and procedures and templates of letters; ~~and~~ complaint and appeal logs, including documentation and details of actions taken~~. On or after January 1, 2006, all complaints shall be categorized according to §11.205(a)(4)(A) - (J) of this title (relating to Documents to be Available for Qualifying Examinations);~~; and complaint and appeal files;

(5) satisfaction surveys: enrollee, physician, and provider satisfaction surveys, and enrollee disenrollment and termination logs;

(6) health information systems: policies and procedures for accessing enrollee health records and a plan to provide for confidentiality of those records;

~~(7) network configuration information as required by §11.204(18) of this title (relating to Contents) demonstrating adequacy of the physician, dentist and provider network;~~

(7) network configuration information: as required by §11.204(19) of this title (relating to Contents) demonstrating adequacy of the physician, dentist, and provider network;

(8) executed agreements~~:~~, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements~~.~~

;

(9) executed physician and provider contracts: copy of the first page, including form number, and signature page ~~of individual provider contracts and group provider contracts;~~

;

(10) executed subcontracts: copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

(11) credentialing: credentialing policies and procedures and credentialing files;

(12) reports: any reports submitted by the HMO to a governmental entity;

(13) claims systems: policies and procedures and systems~~/~~ or processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers, and enrollees;

(14) financial records: financial information, including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments and debts; and

(15) other: any other records ~~demonstrating~~requested by the department to demonstrate compliance with applicable statutes and rules.

~~(d) Quality~~

(c) The department will conduct quality of care ~~examinations shall be conducted pursuant to the following protocol:~~

exams as follows:

(1) Entrance conference. The examination team or assigned examiner ~~shall~~may hold an entrance conference with the HMO's key management staff or their designee before beginning the examination.

(2) Interviews. Examination team members or the examiner ~~shall~~may conduct interviews with key management staff or their designated personnel.

(3) Exit conference. ~~Upon~~On completion of the examination, the examination team or examiner ~~shall~~may hold an exit conference with the HMO's key management staff or their designee.

(4) Written report of examination. The examination team or examiner ~~shall~~will prepare a written report of the examination. The department ~~shall~~will provide the HMO with the written report, and if any significant deficiencies are cited, ~~then~~ the department ~~shall~~will issue a letter outlining the ~~timeframes~~time frames for ~~the~~a corrective action plan and corrective actions.

(5) ~~Serious deficiencies cited and~~Corrective action plan ~~of correction.~~. If the examination team or examiner cites ~~serious~~significant deficiencies, the HMO ~~shall provide the examination team or examiner with a signed plan to correct deficiencies within one business day of written notice of deficiencies. The HMO's plan of correction shall allow up to 12 days for correction of the deficiencies in accordance with severity of the deficiencies.~~

~~(6) Plan of correction. Except as provided in paragraph (5) of this subsection, if the examination team or examiner cites deficiencies, then the HMO shall~~must provide a signed corrective action plan ~~of correction~~ to the department no later than 30 days from receipt of the written examination report. The HMO's plan must provide for correction of these deficiencies no later than 90 days from the receipt of the written examination report.

~~(7) Verification of correction. The department shall verify the correction of deficiencies by submitted documentation or by on-site examination.~~

(6) Verification of correction. The department will verify the correction of deficiencies by submitted documentation or by on-site examination.

SUBCHAPTER F. EVIDENCE OF COVERAGE

§11.501. ~~Forms Which Must Be Approved Prior to Use~~**Contents of the Evidence of Coverage.**

(a) ~~No~~An evidence of coverage or an amendment ~~thereto~~to an evidence of coverage may not be issued, delivered, or used in Texas unless it has been filed for review and has received the approval of the commissioner. The following forms are always considered to be part of the evidence of coverage:

(1) group agreement;

(2) certificate issued to each subscriber who is enrolled through a group~~. (The~~ (the same form may be used as both the group agreement and the group certificate);

(3) conversion and individual agreements;

(4) group, conversion, and individual applications for coverage;

(5) group subscriber enrollment form;

(6) riders, endorsements, amendments, and letters of agreement;

(7) matrix filings;

(8) schedule of benefits; and

~~(8~~

(9) any other form attached to or made a part of the evidence of coverage.

(b) Each of the forms described in subsection (a~~)(1) - (8~~) of this section ~~shall~~must be identified with a unique form number and ~~shall be~~ individually approved by the commissioner before being issued, delivered, or used in Texas. Each ~~of the forms~~form described in subsection (a~~)(1) - (8~~) of this section ~~shall~~will be considered a separate evidence of coverage filing and, except as provided in subsection (c) of this section, ~~shall be~~is subject to the filing fee prescribed in §7.1301(g)(4) of this title (relating to Regulatory Fees) for initial submissions. ~~Each form that is resubmitted after withdrawal or disapproval will be assessed a fee of $50.~~

~~(c) Notwithstanding the fee requirements prescribed in subsection (b) of this section, a fee of $50 per individual evidence of coverage provision, with a maximum fee of $500, is required for matrix filings, as listed in subsection (a)(7) of this section, whether the filing be an initial filing or a resubmission.~~

(c) The filing fee for matrix filings is $100 per individual evidence of coverage provision, with a maximum fee of $500, whether the filing is an initial submission or a resubmission.

§11.502. Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority.

~~Filing~~ (a) The filing and formatting requirements ~~for the~~of §11.301(1)(B) and (2)(A) of this title (relating to Filing Requirements) apply to an evidence of coverage, when filed as part of the application for a certificate of authority~~, are as follows:~~

~~(1) Proposed forms must be neatly typed.~~

~~(2) The department will notify the applicant of the department's action in accordance with §1.704 of this title (relating to Summary Procedure; Notice).~~

~~(3)~~ .

(b) During the review period, an applicant must submit ~~the original of~~ each new page or form reflecting any revisions.

(c) No later than the 10th calendar day after approval or issuance of a certificate of authority, an HMO must file a clean, final version of the evidence of coverage with revisions and a copy of the original version of the evidence of coverage showing the new or revised text as redlined. The submission must include:

(1) an explanation that the evidence of coverage was submitted as part of the application for a certificate of authority and is being submitted in compliance with subsection (c) of this section;

(2) a certification that the forms are without deviation and are the exact final evidence of coverage versions that resulted in approval of the certificate of authority application; and

(3) the final version of an approved service area description and map as attached to the evidence of coverage, with key and scale, which must identify the county or counties or portions of counties to be served.

(d) Any discrepancy in content between the final document to be issued and the approved version is grounds for revocation of a certificate of authority.

§11.503. Filing Requirements for Evidence of Coverage ~~Subsequent to~~ after Receipt of Certificate of Authority.

~~Subsequent to~~ (a) After receipt of a certificate of authority, no evidence of coverage filing may be amended or altered in any manner, and no new evidence of coverage filing may be used, unless the proposed new or revised evidence of coverage filing has been filed for review and has received the approval of the commissioner. ~~Filing requirements for the evidence of coverage filing when filed subsequent to receipt of a certificate of authority are as follows:~~

~~(1) The HMO must submit the original of the revised or new evidence of coverage filing, transmittal letter and the HMO transmittal and certification form, addressed to the Texas Department of Insurance, Life, Health & HMO Intake Unit, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104.~~ The evidence of coverage must be filed as provided in §11.301 of this title (relating to Filing Requirements).

~~(2~~ (b) The department will notify the HMO of the department's action in ~~accordance~~compliance with §1.704 of this title (relating to Summary Procedure; Notice).

~~(3~~

(c) The department will base its approval or disapproval on the content of drafts submitted to the department. ~~Printing~~Filings must comply with the specifications described in §11.505 of this title (relating to Specifications for the Evidence of Coverage~~).~~ and Matrix Filings). Any discrepancy in content between the final ~~print~~document to be issued and the approved draft is grounds for revocation of the certificate of authority.

~~(4~~

(d) The review period for an evidence of coverage filing ~~filed~~ begins on the date ~~on which~~ an acceptable, typed draft of the form is received.

~~(5~~

(e) The review period may be extended ~~upon~~on 30 days written notice of ~~such~~ extension to the HMO before the expiration of the initial review period.

~~(6~~

(f) At the end of the review period, the evidence of coverage filing is considered approved unless it has already been ~~either~~withdrawn, affirmatively approved, or disapproved by the commissioner.

§11.504. Disapproval of an Evidence of Coverage.

(a) If the department disapproves any portion of ~~any~~an evidence of coverage, the department

will specify the reason for the disapproval. The department ~~is authorized to~~may disapprove any form or withdraw any previous approval ~~for any of the following reasons:~~

if a form:

(1) ~~it~~ fails to meet the requirements of ~~the~~ Insurance Code Chapter 1271~~, these sections~~ (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, or other applicable statutes and regulations;

(2) ~~it~~ does not properly describe the services and benefits;

(3) ~~it~~ contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate ~~the~~ Insurance Code Chapters 541~~,~~ (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542~~,~~ (concerning Processing and Settlement of Claims), 543~~,~~ (concerning Prohibited Practices Related to Policy or Certificate of Membership), 544~~, and~~ (concerning Prohibited Discrimination), or 547~~, in accordance with the Insurance Code §1271.005 or any regulations thereunder~~ (concerning False Advertising by Unauthorized Insurers), or any other applicable law~~;~~

or regulations;

(4) ~~it~~ provides services or benefits that are too restrictive to achieve the purpose for which the form was designed;

(5) ~~it~~ fails to attain a reasonable degree of readability, simplicity, and conciseness;

(6) ~~it~~ provides services or benefits or contains other provisions that would endanger the solvency of the issuing HMO; or

(7) ~~it~~ is contrary to the law or policy of this state.

(b) If the department disapproves a form, the HMO may file a written request for a hearing on the matter~~. The department will schedule a hearing within 30 days from the date it receives the request.~~

under Insurance Code §1271.102 (concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval).

§11.505. Specifications for ~~the~~ Evidence of Coverage Including Insert Pages and Matrix Filings.

(a) The filing and formatting requirements of §11.301 of this title (relating to Filing Requirements) apply to an evidence of coverage ~~must be printed on paper of quality suitable for file-marking (not slick-faced) and filing for permanent record.~~

.

(b) ~~For the conversion, individual, and group agreements and group certificates and all amendments, type must be light-faced, uniform sized, common-style not less than 10-points in height and with a lowercase unspaced alphabet length not less than 120-points. For other forms, type must be legible.~~ ~~(c)~~ The style, arrangement, and overall appearance ~~shall~~ of documents must give no undue prominence to any portion of the text. The text of the group, individual, and conversion agreements, the certificate, and all amendments include all printed matter except:

(1) the HMO's name, address, website address, and phone number ~~of the HMO;~~

;

(2) the name or title of the form;

(3) the captions and subcaptions; and

(4) any brief introduction to or description of the evidence of coverage.

~~(d~~

(c) Each evidence of coverage must indicate by example information ~~which~~that will appear in any blanks~~,~~ with the exception of single-case forms, which must be filed complete and ready for use.

~~(e~~

(d) An HMO must identify each form by a ~~printed~~ unique form number in ~~accordance~~compliance with §11.301(2) of this title ~~(relating to Filing Requirements).~~ Any change in form number is considered a change in the form and requires approval as a new form.

~~(f~~

(e) Certain language ~~shall~~must not be varied or changed without resubmitting a form for the commissioner's approval. Changeable language must be enclosed in brackets ~~and shall~~, include the range of variable information or amounts~~.~~

~~(g,~~ and include an explanation of how and under what circumstances the information will vary.

(f) Each evidence of coverage must meet the readability standards of §3.601 ~~and §3.602~~ of this title (relating to Purpose~~,~~ and Scope, Applicability, and Definitions Used in This Subchapter~~, and~~) and §3.602 of this title (relating to Plain Language Requirements).

~~(h) Matrix Filings.~~

(g) A matrix filing must comply with the filing requirements in this section and §11.301 of this ~~chapter (relating to Filing Requirements).~~title. In addition, an HMO submitting a matrix filing:

(1) ~~shall~~must identify each provision with a unique form number that is sufficient to distinguish
it as a matrix filing; and

(2) may use the same provision filed under one form number for all HMO products, provided that the language is applicable to each HMO product; however, any changes in the language to comply with the requirements for each HMO product will require a unique form number.

(h) Evidences of coverage, agreements, and contracts may be submitted with insert pages, or an insert page may be filed subsequent to the approval of an evidence of coverage, agreement, or contract.

(i) Any HMO submitting an insert page filing:

(1) must identify each insert page with a unique form number located on the lower left hand corner of the page;

(2) may use the same insert page filed under one form number for all plans, provided the language is applicable to each plan type; however, any changes in the language to comply with the requirements for each plan type will require a unique form number;

(3) may use the same insert page to replace an existing page of a previously approved or reviewed evidence of coverage, agreement, or contract. However, if used in this manner, the replaced page, as originally filed, must reflect a unique form number that distinguishes it from the other pages of the form or contract; and

(4) must list the form number for each insert page on the transmittal checklist and provide a statement indicating how the insert page will be used and the type of plan for which the insert page will be used.

(j) In addition to providing the appropriate certification on the transmittal checklist, an HMO submitting a filing as a matrix filing or as an insert page must provide certifications certifying that, when issued, the evidences of coverage, certificates, contracts, riders, or applications created from the forms comply in all respects with all applicable statutes and regulations with regard to the final plan document that will be issued.

§11.506. Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate.

(a) Each enrollee residing in ~~this state~~Texas is entitled to an evidence of coverage under a health care plan. ~~By agreement between the issuer of the evidence of coverage and the enrollee, the evidence of coverage approved under this subchapter and required by this section may be delivered~~An HMO may deliver the evidence of coverage electronically~~.~~ but must provide a paper copy on request.

(b) Each group, individual, and conversion contract and group certificate must contain the following provisions~~.~~

~~(1) Name~~:

(1) Face page. Where applicable, the name, address, website address, and phone number of the HMO~~—~~ must appear. The toll-free number referred to in ~~the~~ Insurance Code §521.102~~, where applicable, must~~ (concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints) must appear on the face page.

(A) The face page of an agreement is the first page that contains any written material.

(B) If the agreements or certificates are in booklet form, the first page inside the cover is considered the face page.

(C) The HMO must provide the information regarding the toll-free number referred to in ~~the~~ Insurance Code Chapter 521, Subchapter C, ~~in accordance~~(concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints), in compliance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

(2) Benefits~~—~~. A schedule of all health care services that are available to enrollees under the basic, limited, or single ~~health care~~ service plan~~, including~~ must be included, together with any copayments or deductibles and a description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The ~~copayment~~ schedule must clearly indicate the benefit to which it applies.

(A) Copayments. An HMO may require copayments to supplement payment for health care services.

(i) Each basic health care service HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50 percent of the total cost of services provided.

(ii) A basic health care service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total ~~two hundred~~200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

(iii) The HMO ~~shall~~must state the copayment, the limit on enrollee copayments, and the enrollee reporting responsibility in the group, individual, or conversion agreement and group certificate.

(B) Deductibles. A deductible ~~shall~~must be for a specific dollar amount of the cost of the basic, limited, or single health care service. ~~An~~Except for a consumer choice benefit plan authorized by Insurance Code Chapter 1507 (concerning Consumer Choice of Benefits Plans), an HMO ~~shall~~may not charge a deductible ~~only~~for services received in the HMO's delivery network. Except in

cases involving emergency care and services that are not available in the HMO's delivery network, as described in §11.1611, an HMO may charge an out-of-network deductible for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

(C) Facility-based Physicians. In compliance with Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), a statement that:

(i) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network;

(ii) the non-network facility-based physician or other health care practitioner may balance bill the enrollee for amounts not paid by the health benefit plan; and

(iii) if the enrollee receives a balance bill, the enrollee should contact the HMO.

(D) Immunizations. An HMO ~~shall~~may not charge a copayment or deductible for immunizations as described in ~~the~~ Insurance Code Chapter 1367, Subchapter B, (concerning Childhood Immunizations) for a child from birth through the date the child is six years of age, except that a small employer health benefit plan~~,~~ as defined by ~~the~~ Insurance Code §1501.002~~,~~ (concerning Definitions) that covers ~~such~~the immunizations may charge a copayment ~~or~~, and a consumer choice benefit plan under Insurance Code Chapter 1507 may charge a copayment and a deductible.

(3) Cancellation and ~~non-renewal~~ nonrenewal. A statement specifying the following grounds for cancellation and ~~non-renewal~~nonrenewal of coverage and the minimum notice period that will apply.

(A) ~~An~~Unless otherwise prohibited by law, an HMO may cancel coverage of a subscriber in a group and the subscriber's enrolled dependents under circumstances described in ~~clauses (i) - (vii) of~~ this subparagraph, so long as the circumstances do not include health status~~-~~-related factors:

(i) ~~For~~for nonpayment of amounts due under the contract, ~~coverage may be cancelled~~ after not less than 30 ~~-~~ days written notice, except no additional written notice will be required for failure to pay premium~~.~~

;

(ii) ~~In~~after not less than 15-days written notice, in the case of fraud or intentional misrepresentation of a material fact, except as described in paragraph (~~14~~13) of this ~~section, coverage may be cancelled~~ subsection;

(iii) after not less than 15 ~~-~~ days written notice~~.~~

~~(iii) In~~, in the case of fraud in the use of services or facilities~~, coverage may be cancelled after not less than 15 days written notice.~~

;

(iv) ~~For~~immediately, subject to continuation of coverage and conversion privilege provisions, if applicable, for failure to meet eligibility requirements other than the requirement that the subscriber reside, live, or work in the service area~~, coverage may be cancelled immediately, subject to continuation of coverage and conversion privilege provisions, if applicable.~~

~~(v) In the case of misconduct detrimental to safe plan operations and the delivery of services, coverage may be cancelled immediately.~~

~~(vi) For failure of the enrollee and a plan physician to establish a satisfactory patient-physician relationship if it is shown that the HMO has, in~~ ; and

~~good faith, provided the enrollee with the opportunity to select an alternative plan physician, the enrollee is notified in writing at least 30 days in advance that the HMO considers the patient-physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and the enrollee has failed to make such changes, coverage may be cancelled at the end of the 30 days.~~

~~(vii) Where the subscriber neither resides, lives, or works in the service area of the HMO,~~

(v) after not less than 30-days written notice, where the subscriber does not reside, live, or work in the service area of the HMO or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, ~~coverage may be cancelled after 30 days written notice. An~~except that an HMO ~~shall~~may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area.

(B) An HMO may cancel a group under circumstances described ~~in clauses~~ below, unless otherwise prohibited by law:

(i) ~~(vi) of this subparagraph:~~

~~(i) For~~for nonpayment of premium, ~~all coverage may be cancelled~~ at the end of the grace period as described in paragraph (~~13~~12) of this ~~section.~~ subsection;

(ii) ~~In~~in the case of fraud on the part of the group, ~~coverage may be cancelled~~ after 15~~-~~ days written notice~~.~~ ;

(iii) ~~For~~for employer groups, for violation of participation or contribution rules, ~~coverage may be cancelled in accordance with~~under §26.8(h) ~~and §26.303(j)~~ of this title (relating to Guaranteed Issue; Contribution and Participation Requirements ~~and~~) and §26.303(j) of this title (relating to Coverage Requirements~~).~~);

(iv) ~~For~~for employer groups, ~~in accordance with §26.16~~under §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market) and §26.309 of this title (relating to Refusal to Renew and Application to Reenter ~~Small Employer Market and Refusal to Renew and Application to Reenter~~ Large Employer Market~~), coverage may be cancelled upon~~) on discontinuance of:

(I) each of its small or large employer coverages; or

(II) a particular type of small or large employer coverage~~.~~ ;

(v) ~~Where~~where no enrollee resides, lives, or works in the service area of the HMO~~,~~ or area for which the HMO is authorized to do business, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees~~, the HMO may cancel the coverage~~ after 30~~-~~ days written notice~~.~~ ; and

(vi) ~~If~~if membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, ~~the HMO may cancel the coverage~~ after 30~~-~~-days written notice.

(C) ~~In~~A group or individual contract holder may cancel a contract in the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees ~~pursuant to~~under this chapter or other law~~, a group or individual contract holder may cancel the contract~~ after not less than 30~~-~~-days written notice to the HMO.

(D) An HMO may cancel an individual contract under circumstances described ~~in clauses~~ below, unless otherwise prohibited by law:

(i) ~~(vi) of this subparagraph.~~

~~(i) For~~for nonpayment of premiums ~~in accordance with~~under the terms of the contract, including any timeliness provisions, ~~coverage may be cancelled~~ without written notice, subject to paragraph (~~13~~12) of this ~~section.~~
subsection;

(ii) ~~In~~in the case of fraud or intentional material misrepresentation, except as described in paragraph (~~14~~13) of this ~~section, the HMO may cancel coverage~~subsection, after not less than 15~~-~~-days written notice~~.~~
;

(iii) ~~In~~in the case of fraud in the use of services or facilities, ~~the HMO may cancel coverage~~ after not less than 15~~-~~-days written notice~~.~~
;

(iv) ~~Where~~after not less than 30-days written notice where the subscriber ~~neither resides, lives~~does not reside, live, or ~~works~~work in the service area of the HMO~~,~~ or area ~~for~~in which the HMO is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, ~~coverage may be cancelled after 30 days written notice. An~~except that an HMO ~~shall~~may not cancel ~~the~~ coverage for a child who is the subject of a medical support order because the child does not reside, live~~,~~ or work in the service area~~.~~
;

(v) ~~In~~in case of termination by discontinuance of a particular type of individual coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, ~~the HMO may cancel coverage~~ after 90 ~~-~~ days written notice, in which case the HMO must offer to each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by the HMO in that service area~~.~~

; and

(vi) ~~In~~in case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, ~~the HMO may cancel coverage~~ after 180 ~~-~~ days written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance at the last coverage not renewed.

(4) Claim payment procedure~~—~~. A provision that sets forth the procedure for paying claims, including any time frame for payment of claims ~~which must be in accordance with the Insurance Code Chapter 542 Subchapter B and §1271.005 and the applicable rules.~~

~~(5) Complaint and appeal procedures - A description of the HMO's complaint and appeal process available to complainants.~~

~~(6) Continuation of coverage - Group agreements must contain a provision providing for mandatory continuation of coverage for enrollees who were continuously covered under a group certificate for three months prior to termination of the group coverage, or newborn or newly adopted children of enrollees with three months prior continuous coverage, that is no less favorable than provided by the Insurance Code Chapter 1271 Subchapter G.~~

~~(A) An enrollee shall have the option to continue coverage as provided for by the Insurance Code Chapter 1271 Subchapter G upon completion of any continuation of coverage provided under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law Number 99-272, 100 stat. 222) and any amendments thereto.~~

~~(B) A dependent, upon completion of any continuation of coverage provided under the Insurance Code Chapter 1251 Subchapter G, shall have the privilege to continue coverage for the six months prescribed by the Insurance Code Chapter 1271 Subchapter G.~~

~~(C) If an HMO offers conversion coverage, it must be offered to the enrollee not less than 30 days prior to the expiration of the COBRA or the Insurance Code Chapter 1251 Subchapter G continuation coverage period.~~ that must comply with Insurance Code Chapter 542, Subchapter B, (concerning Prompt Payment of Claims); Insurance Code §1271.005 (concerning Applicability of Other Law); and rules adopted under these Insurance Code provisions.

~~(D)~~ (5) Complaint and appeal procedures. A ~~basic service HMO shall notify the enrollee not less than 30 days before the end~~description of the ~~six months from the date continuation~~HMO's complaint and appeal process available to complainants, including internal adverse determination appeal and independent review procedures under ~~the~~ Insurance Code Chapter ~~1271~~4201 (concerning Utilization Review Agents) and Chapter 19, Subchapter ~~G was elected that the enrollee may be eligible~~R, of this title (relating to Utilization Reviews for ~~coverage under the Texas~~Health Care Provided Under a Health Benefit Plan or Health Insurance ~~Risk Pool, as provided under the Insurance Code Chapter 1506, and shall provide the address and toll-free number of the pool.~~

~~(7)~~ Policy).

(6) Definitions~~—~~. A provision defining any words in the evidence of coverage ~~which~~that have other than the usual meaning. Definitions must be in alphabetical order.

~~(8~~

(7) Effective date~~—~~. A statement of the effective date requirements of various kinds of enrollees.

~~(9~~

(8) Eligibility~~—~~. A statement of the eligibility requirements for membership~~, including:~~

~~(A)~~ .

(A) The statement must provide that the subscriber must reside, live, or work in the service area and the legal residence of any enrolled dependents must be the same as the subscriber, or the subscriber must reside, live, or work in the service area and the residence of any enrolled dependents must be:

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of ~~such~~the dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility

for the health care of ~~such~~the dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of ~~such~~the dependents;

(iii) in the service area with the subscriber's spouse; or

(iv) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

~~(B)~~

(B) The statement must provide the conditions under which dependent enrollees may be added to those originally covered~~;~~

~~(C)~~.

(C) The statement must describe any limiting age for subscriber and dependents~~;~~

~~(D)~~.

(D) The statement must provide a clear statement regarding the coverage of newborn children~~:~~

.

(i) No evidence of coverage may contain any provision excluding or limiting coverage for a newborn child of the subscriber or the subscriber's spouse.

(ii) Congenital defects must be treated the same as any other illness or injury for which coverage is provided.

(iii) The HMO may require that the subscriber notify the HMO during the initial 31 days after the birth of the child and pay any premium required to continue coverage for the newborn child.

(iv) ~~An~~The HMO ~~shall~~may not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency~~,~~ or born in a non-network facility to a mother who does not have HMO coverage~~. The HMO~~, but may require that the newborn be transferred to a network facility at the HMO's expense and, if applicable, to a network provider when ~~such~~the transfer is medically appropriate as determined by the newborn's treating physician.

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 31 days following birth. The HMO ~~shall~~must allow an enrollee 31 days after the birth of the child to notify the HMO, either verbally or in writing, of the addition of the newborn as a covered dependent.

~~(E)~~

(E) The statement must include a clear statement regarding the coverage of the enrollee's grandchildren ~~up to the age of 25 under the conditions under which such coverage is required by the~~that complies with Insurance Code §1201.062 (concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program) and §1271.006~~.~~

~~(10~~ (concerning Benefits to Dependent Child and Grandchild).

(9) Emergency services~~—~~. A description of how to obtain services in emergency situations including:

(A) what to do in case of an emergency occurring outside or inside the service area;

(B) a statement of any restrictions or limitations on out-of-area services;

(C) a statement that the HMO will provide for any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists in a hospital emergency facility or comparable facility;

(D) a statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition; ~~and~~

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or in a comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to ~~such~~ stabilization ~~shall~~must be provided to enrollees as approved by the HMO, provided that:

(i) the HMO ~~is required to~~must approve or deny coverage of poststabilization care as requested by a treating physician or provider~~. An~~; and

(ii) the HMO ~~shall~~must approve or deny ~~such~~the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case ~~shall~~may approval or denial exceed one hour from the time of the request~~.~~ ; and

(F) ~~For~~for purposes of this paragraph, "comparable facility" includes the following:

(i) any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics ~~which have licensed and/or certified~~ that have licensed or certified or both licensed and certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002 (concerning Definitions);

~~personnel and equipment to provide Advanced Cardiac Life Support (ACLS) consistent with American Heart Association (AHA) and American Trauma Society (ATS) standards of care;~~

(ii) for purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:

~~(I) a facility operated by the Texas Department of State Health Services;~~

~~(II) a private mental hospital licensed by the Texas Department of State Health Services;~~

~~(III) a community center as defined by the Texas Health and Safety Code, §534.001;~~

~~(IV) a facility operated by a community center or other entity the Texas Department of State~~

(I) a facility operated by the Texas Department of State Health Services;

(II) a private mental hospital licensed by the Texas Department of State Health Services;

(III) a community center as defined by Texas Health and Safety Code §534.001 (concerning Establishment);

(IV) a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;

(V) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or

(VI) a hospital operated by a federal agency.

~~(11~~

(10) Entire contract, amendments~~—~~. A provision stating that the form, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

~~(12~~ (11) Exclusions and limitations~~—~~. A provision setting forth any exclusions and limitations on basic, limited, or single health care services.

~~(13~~

(12) Grace period~~—~~. A provision for a grace period of at least 30 days for the payment of any premium ~~falling~~ due after the first premium payment during which the coverage remains in effect. ~~A~~An HMO may add a charge ~~may be added~~ to the premium ~~by the HMO~~ for late ~~payment~~payments received within the grace period.

(A) If payment is not received within the 30 days, coverage may be ~~cancelled~~canceled after the 30th day and the terminated members may be held liable for the cost of services received during the grace period, if this requirement is disclosed in the agreement.

~~(14~~

(B) Despite subparagraph (A) of this paragraph, provisions regarding the liability of group contract holder for an enrollee's premiums must comply with Insurance Code §843.210 (concerning Terms of Enrollee Eligibility) and §21.4003 of this title (relating to Group Policyholder, Group Contract Holder, and Carrier Premium Payment and Coverage Obligations).

(13) Incontestability:

(A) All statements made by the subscriber on the enrollment application ~~shall be~~are considered representations and not warranties. The statements are considered ~~to be~~ truthful and ~~are~~ made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or ~~non-renew~~nonrenew an enrollee's coverage or reduce benefits unless:

(i) it is in a written enrollment application signed by the subscriber; and

(ii) a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.

(B) An individual contract ~~may only be contested because of fraud~~ or ~~intentional misrepresentation of material fact made on the enrollment application. A~~ group certificate may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application. For small employer coverage, the misrepresentation ~~shall~~must be other than a misrepresentation related to health status.

(C) For a group contract or certificate, the HMO may increase its premium to the appropriate level if the HMO determines that the subscriber made a material misrepresentation of health status on the application. The HMO must provide the contract holder 31 days prior written notice of any premium rate change.

~~(15~~

(14) Out-of-network services~~—~~. Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the

HMO must, ~~upon~~on the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and ~~shall~~must fully reimburse the non-network provider at the usual and customary or an agreed rate.

(A) For purposes of determining whether medically necessary covered services are available through network physicians or providers, the HMO ~~shall~~must offer its entire network, rather than limited provider networks within the HMO delivery network.

(B) The HMO ~~shall~~may not require the enrollee to change ~~his or her~~ primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network.

(C) Each contract must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

~~(16~~

(15) Schedule of charges~~—~~. A statement that discloses the HMO's right to change the rate charged with 60~~-~~days written notice ~~pursuant to the~~under Insurance Code §843.2071 (concerning Notice of Increase in Charge for Coverage) and Insurance Code Chapter 1254~~.~~

~~(17~~ (concerning Notice of Rate Increase for Group Health and Accident Coverage).

(16) Service area~~—~~. A description and a map of the service area, with key and scale, ~~which shall identify~~that identifies the county, or counties, or portions ~~thereof,~~of counties to be served, and indicating primary care physicians, hospitals, and emergency care sites. A ZIP code map and a physician and provider list may be used to meet the requirement.

~~(18~~

(17) Termination due to attaining limiting age~~—~~. A provision that a child's attainment of a limiting age does not operate to terminate the child's coverage ~~of the child~~ while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly

dependent ~~upon~~on the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of ~~such~~ incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of ~~such limiting age.~~

~~(19) Termination due to student dependent's change in status. Each group agreement and certificate that conditions dependent coverage for a child twenty-five years of age or older on the child's being a full-time student at an educational institution shall contain a provision in accordance with the Insurance Code Chapter 1503.~~

~~(20) Conformity with state law. A provision that if the agreement or certificate contains any provision not in conformity with the Insurance Code Chapter 1271 or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws.~~

~~(21) Conformity with Medicare supplement minimum standards and long-term care minimum~~ the limiting age.

(18) Termination due to student dependent's change in status. A provision regarding coverage of student dependents that complies with Insurance Code Chapter 1503 (concerning Coverage of Certain Students), if applicable.

(19) Conformity with state law. A provision that if the agreement or certificate contains any provision or part of a provision not in conformity with Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges) or other applicable laws, the remaining provisions and parts of provisions that can be given effect without the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

(20) Conformity with Medicare supplement minimum standards~~.~~ and long-term care minimum standards. Each group, individual, and conversion agreement, and group certificate must comply with Chapter 3, Subchapter T, of this title (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y, of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the

Medicare supplement ~~rules and/~~or ~~the~~ long-term care rules, or both, and the HMO rules, the Medicare supplement ~~rules~~ or long-term care rules ~~shall~~will govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO ~~shall~~must follow ~~both~~ the Medicare supplement ~~rules and/or~~, the long-term care rules, and the HMO rules where applicable.

~~(22~~

(21) Nonprimary care physician specialist as primary care physician~~--~~. A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to ~~utilize~~use a nonprimary care physician specialist as a primary care physician as set ~~forth~~out in ~~the~~ Insurance Code §1271.201~~.~~

~~(23~~ (concerning Designation of Specialist as Primary Care Physician).

(22) Selected obstetrician or gynecologist~~- Individual,~~. Group, individual, and conversion agreements, and group ~~agreements and~~ certificates, except small employer health benefit plans as defined by ~~the~~ Insurance Code §1501.002~~,~~ (concerning Definitions), must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of ~~the~~ Insurance Code Chapter 1451, Subchapter F~~.~~,(concerning Access to Obstetrical or Gynecological Care). An HMO ~~shall~~may not ~~preclude~~prevent an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO ~~shall~~must permit an enrollee who selects an obstetrician or gynecologist direct access to the health care services of the selected obstetrician or gynecologist without a referral by the enrollee's primary care physician or prior authorization or precertification from the HMO.

~~(B) The access to health care services of an obstetrician or gynecologist, includes:~~

(B) Access to the health care services of an obstetrician or gynecologist includes:

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

(iv) diagnosis, treatment, and referral to a specialist within the HMO's network for any disease or condition within the scope of the selected professional practice of a properly credentialed obstetrician or gynecologist, including treatment of medical conditions concerning breasts.

(C) An HMO may require an enrollee who selects an obstetrician or gynecologist to select the obstetrician or gynecologist from within the limited provider network to which the enrollee's primary care physician belongs.

(D) An HMO may require a selected obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. However, the HMO ~~shall~~may not impose any penalty, financial or otherwise, ~~upon~~on the obstetrician or gynecologist ~~by the HMO~~ for failure to provide this information if the obstetrician or gynecologist has made a reasonable and good~~-~~-faith effort to provide the information to the primary care physician.

(E) An HMO may limit an enrollee in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. ~~Such~~The limitation ~~shall~~must not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO ~~shall~~must include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in ~~the~~ Insurance Code Chapter 1451, Subchapter F. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from ~~her~~the enrollee's primary care physician or primary care provider. ~~Such~~The enrollee ~~shall~~must have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) An enrollee ~~that~~who elects to receive obstetrical or gynecological services from a primary care physician (~~i.e.,~~ a family physician, internal medicine physician, or other qualified physician) ~~shall~~must adhere to the HMO's standard referral protocol when accessing other specialty obstetrical or gynecological services.

~~(24~~

(23) Diagnosis of Alzheimer's disease~~--~~. An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease under Insurance Code Chapter 1354 (concerning Eligibility for Benefits for Alzheimer's Disease) by a physician licensed in this state ~~pursuant to the Insurance Code Chapter 1354 shall satisfy~~satisfies any requirement for demonstrable proof of organic disease.

~~(25~~

(24) Drug Formulary~~--A group~~. An agreement ~~and certificate, except small employer plans as defined by the Insurance Code §1501.002,~~ that covers prescription drugs and uses one or more formularies must comply with ~~the~~ Insurance Code Chapter 1369, Subchapter B, (concerning Coverage of Prescription Drugs Specified by Drug Formulary) and Chapter 21, Subchapter ~~-~~V, of this title (relating to Pharmacy Benefits).

~~(26~~

(25) Inpatient care by ~~non-primary~~nonprimary care physician~~--~~. If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility ~~(e.g.,~~ for example, hospital or skilled nursing facility~~),~~, a provision that ~~upon~~on admission to the inpatient facility a physician other than the primary care physician may direct and oversee the enrollee's care.

§11.507. Additional Mandatory Contractual Provisions: Conversion and Individual Agreements.

Conversion and individual agreements must contain the following additional mandatory provisions~~.~~

:

(1) Reinstatement~~--~~. A provision ~~that~~ clearly ~~sets~~setting forth the requirements for reinstatement and ~~discloses~~disclosing how reinstatement changes or affects the rights and coverages

originally provided. New evidence of insurability may be required.

(2) Ten days to examine agreement~~—~~. A provision stating that the contract holder ~~to whom the contract is issued shall be permitted to~~may return the contract within 10 days of receiving it and ~~to~~ have the premium paid refunded if, after examination of the contract, ~~such~~the contract holder is not satisfied with it for any reason. If ~~such~~the contract holder~~, pursuant to such provision,~~ returns the contract to the issuing HMO or to the agent through whom it was purchased, ~~it~~then the contract is considered void from the beginning and the parties are in the same position as if no contract had been issued. If services are rendered or claims paid by the HMO during the 10 days, the subscriber is responsible for repaying the HMO for ~~such services or claims.~~

~~(3) Consideration. The original consideration including premiums, application fee, and any other amounts to be paid for coverage must be expressed in the agreement or in the application.~~

~~(4) Continuance of coverage due to change in marital status. A provision stating that if a person loses coverage due to a change in marital status, that person shall be issued coverage in accordance with §21.407 of this title (relating to Continuance of Coverage).~~the services or claims.

(3) Consideration. The original consideration, including premiums, application fee, and any other amounts to be paid for coverage, must be expressed in the agreement or in the application.

(4) Continuance of coverage due to change in marital status. A provision stating that if a person loses coverage due to a change in marital status, that person will be issued coverage in compliance with §21.407 of this title (relating to Continuance of Coverage).

§11.508. Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements.

(a) Each evidence of coverage providing basic health care services ~~shall~~must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set ~~forth~~out in §11.506(~~10~~b)(9) or (~~15~~§11.506(b)(14) of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate):

~~(1) Outpatient services, including the following:~~

~~(A) primary care and specialist physician services;~~

~~(B) outpatient services by other providers;~~

~~(C) diagnostic services, including laboratory, imaging and radiologic services;~~

~~(D) therapeutic radiology services;~~

(1) outpatient services, including the following:

(A) primary care and specialist physician services;

(B) outpatient services by other providers;

(C) diagnostic services, including laboratory, imaging, and radiologic services;

(D) therapeutic radiology services;

(E) prenatal services, if maternity benefits are covered;

(F) outpatient rehabilitation therapies including physical therapy, speech therapy, and occupational therapy;

(G) home health services, as prescribed or directed by the responsible physician or other authority designated by the HMO;

(H) preventive services, including:

(i) periodic health examinations for adults as required ~~in the~~by Insurance Code §1271.153~~;~~ (concerning Periodic Health Evaluations);

(ii) immunizations for children as required ~~in the~~by Insurance Code §1367.053~~;~~ (concerning Coverage Required);

(iii) well-child care from birth as required ~~in the~~by Insurance Code §1271.154~~;~~ (concerning Well-Child Care From Birth);

(iv) cancer screenings as required ~~in the~~by Insurance Code ~~Chapter~~Chapters 1356 ~~relating to mammography;~~

~~(v) cancer screenings as required in the Insurance Code Chapter~~(concerning Low-Dose Mammography),

1362 ~~relating to screening~~(concerning Certain Tests for ~~prostate cancer;~~

~~(vi) cancer screenings as required in the Insurance Code Chapter~~Detection of Prostate Cancer), and 1363 ~~relating to screening~~(concerning Certain Tests for ~~colorectal cancer;~~

~~(vii~~Detection of Colorectal Cancer);

(v) eye and ear examinations for children through age 17, to determine the need for vision and hearing correction ~~in accordance~~complying with established medical guidelines; and

~~(viii~~

(vi) immunizations for adults ~~in accordance with~~under the United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions, or its successor~~.~~

;

(I) ~~no less than 20~~ coverage for outpatient mental health ~~visits per enrollee per year as may be necessary and appropriate for short-term evaluative or crisis stabilization~~ services~~, which must have~~ complying with the ~~same cost-sharing and benefit maximum provisions as any physical~~mental health ~~services; and~~

parity requirements in Chapter 21, Subchapter P, of this title (relating to Mental Health Parity); and

(J) emergency services as required by ~~the~~ Insurance Code §1271.155~~.~~ (concerning Emergency Care), including emergency transport in an emergency medical services vehicle licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), which is considered emergency care if it is provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus;

(2) ~~Inpatient~~inpatient hospital services, including room and board, general nursing care, meals and special diets when medically necessary~~,~~; use of operating room and related facilities~~,~~; use of intensive care unit and services~~, x~~; X-ray services~~,~~; laboratory and other diagnostic tests~~,~~; drugs,

medications, biologicals, anesthesia, and oxygen services~~, special~~; private duty nursing when medically necessary~~,~~; radiation therapy~~,~~; inhalation therapy~~,~~; whole blood including cost of blood, blood plasma, and blood plasma expanders, that are not replaced by or for the enrollee; administration of whole blood and blood plasma~~,~~; and short-term rehabilitation therapy services in the acute hospital setting~~.~~

;

(3) ~~Inpatient~~inpatient physician care services, including services performed, prescribed, or supervised by physicians or other health professionals including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services~~.~~

; and

(4) ~~Outpatient~~outpatient hospital services, including treatment services; ambulatory surgery services; diagnostic services, including laboratory, radiology, and imaging services; rehabilitation therapy; and radiation therapy.

(b) ~~In addition to the basic health care services in subsection (a) of this section, each~~Each evidence of coverage ~~shall~~must also include coverage for services as follows:

(1) breast reconstruction as required by federal law if the plan provides coverage for mastectomy~~. Breast reconstruction~~, which is subject to the same deductible or copayment applicable to mastectomy~~. Breast reconstruction~~, and which may not be denied because the mastectomy occurred ~~prior to~~before the effective date of coverage;

(2) prenatal services, delivery, and postdelivery care for an enrollee and her newborn child as required by federal law, if the plan provides maternity benefits; and

~~(3) diabetes self-management training, equipment and supplies as required in the Insurance Code Chapter 1358 Subchapter B.~~

(3) diabetes self-management training, equipment, and supplies as required by Insurance Code Chapter 1358, Subchapter B, (concerning Diabetes).

(c) ~~The benefits~~Benefits described in this section that do not apply to small employer plans are not required to be included in ~~such~~those plans.

(d) A state-mandated health benefit plan ~~defined in §11.2(b) of this title (relating to Definitions) shall~~must provide coverage for ~~the~~ basic health care services as described in subsection (a) of this section, as well as all state-mandated benefits as described in ~~§§21.3516 - 21.3518~~Insurance Code Chapter 1507 (concerning Consumer Choice of ~~this title (relating to State-mandated Health Benefits in Individual HMO Plans, State-mandated Health Benefits in Small Employer HMO Plans, and State-mandated Health Benefits in Large Employer HMO~~Benefit Plans), and must provide the services without limitation as to time and cost, other than ~~those~~ limitations specifically prescribed in this subchapter.

(e) Nothing in this title ~~shall require~~requires an HMO, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates ~~its~~the HMO's, physician's, or provider's religious convictions. An HMO that limits or denies health care services under this subsection ~~shall~~must set ~~forth such~~out the limitations in its evidence of coverage.

§11.509. Additional Mandatory Benefit Standards: Individual and Group ~~Agreement Only~~Agreements.

~~Group~~ Individual and group agreements must contain the following additional mandatory provisions~~.~~ as applicable:

(1) Certificate. ~~Provisions~~Group agreements must include provisions that the contract holder must be provided with subscriber certificates to be delivered to each subscriber~~; that~~, the certificate is a part of the group contract as if fully incorporated ~~therein;~~, and ~~that~~ any direct conflict between the group agreement and the certificate will be resolved according to the terms ~~which are~~ most favorable to the subscriber. If the same form is used as both the group contract and the certificate, a copy of the group contract must be delivered to each subscriber.

(2) New enrollees. ~~A~~Group agreements must include a provision specifying the conditions under which new enrollees may be added to those originally covered, including effective date requirements. For coverage issued to employers, ~~a provision for special enrollment in accordance with 45 C.F.R. 146.117 (Health Insurance Portability and Accessibility Act).~~

~~(3) Chemical dependency. A provision to provide benefits for the necessary care and treatment of~~

~~chemical dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors is required for state-mandated health benefit plans defined in §11.2(b) of this title (relating to Definitions). Dollar or durational limits which are less favorable than for physical illness generally may be set only if such limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under the Insurance Code Chapter 1368, including §§3.8001 - 3.8022 of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).~~

~~(A) Coverage for chemical dependency may be limited to a lifetime maximum of three separate series of treatment for each covered individual as described by the Insurance Code §1368.006.~~

~~(B) Benefits provided shall be determined as if necessary care and treatment in a chemical dependency treatment center were care and treatment in a hospital.~~

~~(4) Osteoporosis. A provision that provides coverage to a qualified individual as defined in the Insurance Code Chapter 1361 for medically accepted bone mass measurement for the detection of low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis is required for state-mandated health benefit plans defined in §11.2(b) of this title.~~

~~(5) Serious mental illness. Group agreements, except for contracts issued to small employer plans, must include a provision for the treatment of serious mental illness, as required in the Insurance Code Chapter 1355 Subchapter A. Small employer plans must be offered coverage for serious mental illness as required in the Insurance Code Chapter 1355 Subchapter A. Serious mental illness benefits are also subject to the provisions of the Insurance Code Chapter 1355 Subchapters B and C.~~

~~(6) Conditions affecting the temporomandibular joint.~~ group agreements must include a provision for special enrollment under 45 C.F.R. §146.117 (concerning Special Enrollment Periods).

(3) Agreements must comply with the benefit, offer, coverage, and notice requirements contained in Insurance Code Title 8, Subtitle E, (concerning Benefits Payable Under Health Coverages), as applicable.

(4) Inability to undergo dental treatment. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans ~~defined in §11.2(b) of this title must include a provision that provides coverage for a condition affecting the temporomandibular joint as required by the Insurance Code Chapter 1360.~~

~~(7) Inability to undergo dental treatment. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans defined in §11.2(b) of this title~~, may not exclude from coverage under the plan an enrollee who is unable to undergo dental treatment in an office setting or

under local anesthesia due to a documented physical, mental, or medical reason as determined by the enrollee's physician or the dentist providing the dental care. This benefit does not require an HMO to provide dental services if dental services are not otherwise scheduled or provided as part of the benefits covered by the agreement.

~~§11.510. Mandatory Offers.~~

~~Group agreements must offer the following provisions:~~
~~(1) Coverage for services and benefits on an expense incurred, service, or prepaid basis for out-patient expenses that may arise from in-vitro fertilization procedures. Benefits for in-vitro fertilization procedures must be provided to the same extent as the benefits provided for other pregnancy-related procedures under the plan. The offer to make such coverage available is required only under the conditions set out in the Insurance Code §1366.005.~~
~~(2) Hospital and medical coverage benefits for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and copayment factors, pursuant to the Insurance Code Chapter 1365.~~
~~(3) Benefits for mental and emotional illness and disorders when confined in a hospital, with corresponding alternative treatment facility benefits pursuant to the Insurance Code Chapter 1355 Subchapter C, to the extent that such benefits are not mandated as serious mental illness under §11.509(5) of this title (relating to Additional Mandatory Benefit Standards: Group Agreement Only).~~
~~(4) For small employer groups, serious mental health benefits pursuant to the Insurance Code Chapter 1355 Subchapter C.~~

(5) Agreements, including consumer choice health benefit plan agreements, providing coverage for children under 18 must define reconstructive surgery for craniofacial abnormalities as provided by Insurance Code §1367.153 (concerning Reconstructive Surgery for Craniofacial Abnormalities; Definition Required).

(6) Group agreements, including consumer choice health benefit plan agreements, must cover formulas necessary to treat phenylketonuria or a heritable disease to the same extent that the agreement provides coverage for drugs that are available only on the orders of a physician, as required by Insurance Code Chapter 1359 (concerning Formulas for Individuals With Phenylketonuria or Other Heritable Diseases).

§11.511. Optional Provisions.

~~Group, individual and conversion certificates~~ Evidences of coverage may contain optional provisions,

including, but not limited to, the following:

(1) Coordination of benefits. ~~Group plans~~Plans may contain a provision that the value of any benefits or services provided by the HMO may be coordinated with any other type of ~~group~~ insurance plan or coverage under governmental programs so no more than 100~~%~~ percent of eligible expenses incurred is paid. The coordination of benefits provision applies to the plan when an enrollee has health care coverage under more than one plan. This provision will only apply for the duration of the enrollee's coverage in a ~~group~~ plan.

(A) If benefits are covered by more than one plan, any plan or plans that do not have a coordination of benefits provision are primary.

(B) Group plans issued or renewed on or before March 25, 2014, may not coordinate benefits with any type of individual or conversion plan.

(C) ~~Requirements of~~ Group plans issued or renewed on or after March 25, 2014, may coordinate benefits with other plans subject to the requirements of Insurance Code Chapter 1203 (concerning Coordination of Benefits Provisions) and ~~§§~~Chapter 3~~.3501 - 3.3511~~, Subchapter V, of this title (relating to ~~Group~~ Coordination ~~of Benefits) relating to coordination~~ of ~~benefits by insurers should be followed by HMOs that include a coordination of benefits provision in their plan.~~ Benefits).

(2) Subrogation. ~~A~~ Plans may contain a provision that the HMO ~~receives any rights of recovery allowed by Texas law acquired by an enrollee against any person or organization for negligence or any willful act resulting in illness or injury covered by HMO benefits, but only to~~ is subrogated to and has a right to reimbursement from an individual's recovery for a personal injury for payments made or costs of benefits provided by the ~~extent of~~ HMO as a result of that injury, subject to and limited by the ~~cost to the HMO~~provisions of Civil Practice and Remedies Code Chapter 140 (concerning Contractual Subrogation Rights of ~~providing such covered services. Upon receiving such services from the HMO, the enrollee is considered to have assigned such rights~~Payors of ~~recovery to the HMO and to have agreed to give the HMO any reasonable help required to secure the recovery. The provision may include a~~

~~statement that the HMO may recover its share of attorney's fees and court costs only if the HMO aids in the collection of damages from a third party.~~

Certain Benefits), as added by Acts 2013, 83rd Leg., R.S., Ch. 180, §1 (HB 1869).

(3) Sale of substitutes to ~~Workers' Compensation Insurance.~~workers' compensation insurance. If the HMO chooses to market a product ~~which~~that provides coverage for on-the-job injuries or illness, it ~~shall~~must comply with §5.6302 of this title (relating to Sale of Substitutes to Workers' Compensation Insurance).

(4) Conversion privilege. Group agreements and certificates for an HMO may, at the HMO's option, contain a conversion privilege. If ~~the~~an HMO elects to offer a conversion privilege, it must provide that, ~~upon~~on termination of coverage, each enrollee who resides, lives, or works in the service area who has been covered under the group contract for a period of at least three months, or in the case of a court-ordered dependent, lives outside the service area~~,~~ but within the United States, has the right to convert within 31 days to a conversion agreement without presenting evidence of insurability. ~~If a basic service HMO does not offer each enrollee a conversion contract, the HMO shall provide written notice of the availability of coverage through the Texas Health Insurance Risk Pool.~~ A single service or limited service HMO ~~shall~~must offer a conversion contract without requiring evidence of insurability. Charges ~~for individuals~~ must ~~be in accordance~~comply with §11.704 of this title (relating to ~~Charges for Individuals).~~

Conversion Rates).

(5) Arbitration. ~~A~~ Plans may contain a statement of any ~~required~~ arbitration procedure. If enrollee complaints and grievances are resolved through a specified arbitration agreement, the arbitration must be conducted ~~pursuant to the Texas Arbitration Act,~~under Texas Civil Practice and Remedies Code ~~§~~Chapter 171~~.001 et seq.~~ (concerning General Arbitration).

§11.512. Optional Benefits.

An HMO may provide health services to its enrollees ~~health~~in addition to the services ~~that~~required in §11.508 of this title (relating to Basic Health Care Services and Mandatory Benefit Standards: Group, Individual and Conversion Agreements~~) does not include as basic health care~~

~~services.).~~ An HMO may limit these optional health services as to time and cost. ~~Group, individual and conversion certificates~~Evidences of coverage may contain optional benefits, including:

(1) corrective appliances and artificial aids;

(2) cosmetic surgery;

(3) ~~ambulance services;~~

~~(4)~~ care for military service-~~-~~connected disabilities for which the enrollee is legally entitled ~~for~~to services and for which facilities are reasonably available to ~~such~~the enrollee;

~~(5~~

(4) care for conditions that state or local law requires be treated in a public facility;

~~(6~~

(5) dental services, except ~~for services required for conditions affecting the temporomandibular joint and inability to undergo dental treatment as set forth in §11.509(6) and (7) of this title (relating to Additional Mandatory Benefit Standards: Group Agreement Only);~~

~~(7)~~ as otherwise required;

(6) vision care;

~~(8~~

(7) custodial or domiciliary care;

~~(9~~

(8) experimental and investigational medical, surgical, or other experimental or investigational health care procedures, unless approved as a basic health care service by the policymaking body of the HMO~~;~~

~~(10~~, provided that:

(A) a denial of a request for experimental or investigational services is an adverse determination; and

(B) an HMO must comply with Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy) if the HMO denies requested services because the HMO determines that the requested services are experimental and investigational;

(9) personal or comfort items and private rooms, unless medically necessary during inpatient
hospitalization;

~~(11) whole blood and blood plasma;~~

~~(12)~~

(10) durable medical equipment for home use (such as ~~wheel chairs~~wheelchairs, surgical beds, ~~respirators,~~ventilators, or dialysis machines);

~~(13~~

(11) infertility medical services, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and outpatient infertility drugs;

~~(14) reversal of voluntary sterilization; and~~

~~(15) prescribed drugs and medicines incident to outpatient care.~~

~~§11.513. Additional Information May Be Required.~~

~~The commissioner is authorized to require the submission of any other relevant information deemed necessary in determining whether to approve or disapprove a filing made pursuant to this section.~~

(12) reversal of voluntary sterilization;

(13) prescribed drugs and medicines incident to outpatient care; and

(14) noninsurance benefits, provided that the HMO complies with Chapter 21,

Subchapter NN, of this title (relating to Noninsurance Benefits and Features).

SUBCHAPTER G. ADVERTISING AND SALES MATERIAL

§11.602. ~~Health Maintenance Organizations~~HMOs Subject to ~~the~~ Insurance Code Chapters 541, 542, and 547, and Related Rules.

~~Health maintenance organizations~~ HMOs must comply with ~~the~~ Insurance Code Chapters 541~~,~~ (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542~~;~~ (concerning Processing and Settlement of Claims), and 547 ~~and~~(concerning False Advertising by Unauthorized Insurers) and related rules ~~promulgated by the Texas Department of Insurance, pursuant to the Insurance~~

~~Code Chapters 541, 542, and 547~~, to the extent these rules may be applied to HMOs in the same manner as insurance companies.

§11.603. Filings.

Any HMO licensed to do business in Texas ~~which~~that offers coverage to Medicare beneficiaries under the provisions of Subchapter XVIII of 42 United States Code, Health Insurance for the Aged and Disabled, ~~shall~~must file with the department a copy of each advertisement related to ~~such~~the coverage ~~which~~that is produced by the HMO or its agents and ~~which~~ is an invitation to inquire or invitation to contract as defined in §21.113 of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising) no later than 45 days ~~prior to~~before its use. Material ~~shall~~must be filed in ~~accordance~~compliance with §21.120 of this title (relating to Filing for Review). Material filed under this paragraph is not to be considered approved but may be subject to review for compliance with Texas law and consistency with other documents.

~~Subchapter~~SUBCHAPTER H. SCHEDULE OF CHARGES

§11.701. Schedule of Charges Must ~~Be~~be Filed ~~Prior to~~Before Use.

(a) No schedule of charges, formula, or method for calculating the schedule of charges~~, as defined in §11.2(b) of this title (relating to Definitions),~~ may be used until a copy of ~~such~~the formula or method for calculating the schedule of charges with supporting documentation has been filed with the commissioner, as required by §11.703 of this title (relating to Filings and Supporting Documentation~~) has been filed with the commissioner.~~
).

(b) The schedule of charges ~~shall~~must include all charges made for group, conversion, or individual coverage~~, except for any fee collected as an administrative service only fee, whereby the HMO assumes no risk.~~

~~(c) Each filing must be accompanied by the HMO reconciliation of benefits to schedule of charges form. This information may be substituted in the form of a computer printout.~~ .

§11.702. Actuarial Certification.

Each formula or method for calculating the schedule of charges must be accompanied by the certification of a qualified actuary that, based on reasonable assumptions, the formula is appropriate to produce rates that are not excessive, inadequate, or unfairly discriminatory. An actuary is considered qualified if he or she~~:~~

~~(1)~~ is a member ~~of~~in good standing of both the American Academy of Actuaries~~; or~~

~~(2) is a fellow of~~ and the Society of Actuaries.

§11.703. Filings and Supporting Documentation.

~~Each formula or method for calculating the schedule of charges must be accompanied by adequate detail including assumptions to justify that the charges produced by the formula or method are not excessive, inadequate, or unfairly discriminatory as defined in §11.706 of this title (relating to Factors To Be Considered in Determination of Reasonability of Rates).~~
~~(1) The calculations used to produce any schedule of charges as defined in §11.2(b) of this title (relating to Definitions) must be available at the HMO's office.~~
~~(2) Any changes in the assumptions in the formula or method for calculating the schedule of charges due to special characteristics of a particular group need not be filed, but justification of the variances must be retained at the HMO's office so that compliance with §11.706 of this title (relating to Factors To Be Considered in Determination of Reasonability of Rates) may be checked.~~

An HMO must submit schedule of charges information with the certificate of authority application in compliance with §11.204(11) and (12) of this title (relating to Contents). After the commissioner issues a certificate of authority, the HMO must file rates and supporting documentation before use as follows:

(1) rates for a new product:

(A) evidences of coverage to which the rates apply;

(B) for individual and small group plans, a new rate sheet including rates for each plan and each combination of rating factors used by the HMO; and

(C) actuarial memorandum:

(i) a brief description of benefits and general marketing method;

(ii) a brief description of how rates were determined, including a general description and source of each assumption used;

(iii) a list of retention components, including, but not limited to, expenses, taxes, fees, and profit expressed as a percent of premium, dollars per policy, or dollars per unit of benefit;

(iv) the target loss ratio, including a brief description of how it was calculated and all components used in its calculation;

(v) a description of the experience used in developing the HMO's rates, including the level of credibility and appropriateness of experience data, and justification for the use of proposed manual rates if the HMO's own experience is not credible;

(vi) the assumptions and support used in developing rates, including, but not limited to, adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits;

(vii) any other data used to support the proposed rate; and

(viii) an actuarial certification required by §11.702 of this title (relating to Actuarial Certification);

(2) rate adjustments for an existing product:

(A) evidences of coverage to which the rates adjustments apply;

(B) for individual and small group plans, a new rate sheet that includes rates for each plan and each combination of rating factors used by the HMO; and

(C) actuarial memorandum:

(i) a brief description of benefits and general marketing method;

(ii) the scope and reason for the rate revision;

(iii) a description of the experience used in developing the HMO's rates, including past experience, loss ratio(s) for all applicable prior experience periods, the level of credibility and appropriateness of experience data;

(iv) a brief description of how revised rates were determined, including a general description and source of each assumption used, which must also include a list of expenses, taxes, fees, and profit, expressed as a percent of premium, dollars per policy or dollars per unit of benefit, or both;

(v) the target loss ratio and description of how it was calculated;

(vi) the assumptions and support used in developing rates, including, but not limited to, adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits;

(vii) any other data used to support the proposed rate increase; and

(viii) an actuarial certification required by §11.702 of this title.

§11.704. Conversion Rates.

~~**§11.704.** Charges for Individuals.~~

(a) Charges for any individual's coverage may not be based on the individual's health status.

(b) The charge by an HMO for individual coverage ~~which~~that has been converted from group coverage ~~shall~~may not exceed 200~~%~~ percent of the ~~HMO's group community~~ rate ~~for comparable coverage. The phrase "group community rate" as used herein is~~that the ~~rate which~~individual would be charged ~~all persons in the service area if all persons were members of one group, within the parameters set out in §11.706 of this title (relating to Factors To Be Considered in Determination of Reasonability of Rates). The conversion rate is, therefore, based on the experience of all persons in the service area and not on the converting individual's characteristics~~for comparable group coverage.

~~§11.705. Enrollment Fees.~~

~~An HMO may charge a one-time enrollment fee or a reinstatement fee for lapsed contracts to offset the costs of initial enrollment or reinstatement, but said fee shall not exceed:~~
~~(1) for basic health care plans, the monthly rate attributable to administrative costs for a period of one month; or~~
~~(2) for single service health care plans, two months' premium.~~

~~§11.706. Determination of Reasonability of Rates.~~

~~(a) A rate is presumed inadequate if, after consideration of all factors including the financial support of a parent company or sponsoring organization, the rate anticipated results in lower per-member-per-month revenue than required for the HMO to reach and maintain financial break-even within three years of the commencement of operations. For HMOs that have been in operation for at least three years, any rate deficiency must be recorded in the form of a deficiency reserve liability. The deficiency reserve liability amount shall be derived from the difference between the proposed rate to be charged and the rate that would need to be charged to cover all expenses without consideration of any parental or sponsoring~~

~~organization's support. The assumptions for enrollment and expenses shall be based upon the current experience of the HMO. A deficiency reserve liability must be funded with cash or other admitted assets in an amount equal to or greater than the deficiency reserve liability. Such funding must take place prior to implementation of the proposed rates. Any HMO required to establish a deficiency reserve liability under this subsection shall provide a plan whereby the rates actually charged by the HMO would be increased over a 24-month period to a level adequate to support benefits and the expenses of the HMO. Such a plan and any deficiency reserve liability must be developed and certified annually as actuarially sound by a qualified actuary in conjunction with the actuarial certification regulation under §11.702 of this title (relating to Actuarial Certification). An HMO may apply to the commissioner for relief from the requirement to establish and fund a deficiency reserve by specifying unusual or extraordinary circumstances by which the above provisions are not appropriate. In no circumstances shall such relief result in the lowering of existing rates.~~
~~(b) The following factors shall be considered in any review of rates under the Insurance Code Chapter 1271 Subchapter F:~~
~~(1) the cost of the health care services and benefits provided by the coverage if the same coverage were provided on a private pay basis, considering community average rates for such services and benefits within the service area of the plan;~~
~~(2) the expenses of initial enrollment. This can be expressed as the one-time enrollment fee under §11.705 of this title (relating to Enrollment Fees);~~
~~(3) administrative expenses;~~
~~(4) assumed or actual utilization levels;~~
~~(5) group demographics;~~
~~(6) other factors as appropriate.~~
~~(c) In the event the commissioner considers an HMO's rates to be in potential violation of the standards set out by this section, the commissioner shall notify the HMO of the potential violation. It will be the responsibility of the HMO to demonstrate that the rates in question are not excessive, inadequate, or unfairly discriminatory using the factors reflected in subsection (b) of this section and other factors which the HMO deems pertinent.~~

~~§11.707. Subsequent Review of the Formula or Method for Calculating the Schedule of Charges.~~

~~If the formula or method for calculating the schedule of charges, or the resulting rates is to be continued beyond a one-year period, the HMO must file with the commissioner, by each anniversary of the effective date of the original filing, an actuarial statement stating that the previously filed formula or method has been consistently applied, and that the rates charged have proven and are expected to continue to be adequate, not excessive, nor unfairly discriminatory. This statement must be accompanied by reconciliation of benefits to schedule of charges form.~~

~~Subchapter~~SUBCHAPTER I. FINANCIAL REQUIREMENTS

§11.801. Accounting Guidance.

To the extent that the accounting guidance given in §7.18 of this title (relating to National Association of Insurance Commissioners Accounting Practices and Procedures Manual) does not conflict with the provisions of this chapter, an HMO must follow that guidance. In the event of a conflict

between the provisions of this chapter and §7.18 of this title, the HMO must follow the provisions of this chapter.

§11.802. Minimum Net Worth.

~~(a) On or after September 1, 1999, at the time of the initial qualifying examination, an~~ (a) An applicant for a certificate of authority to operate an HMO must have unencumbered assets ~~of the type described in subsection (b) of this section in excess of all of its liabilities equal to or greater than the required~~that satisfy the requirements of Insurance Code §843.403 (concerning Minimum Net Worth).

(b) For the purpose of calculating assets to satisfy the minimum net worth ~~established in~~requirements of Insurance Code §843.403~~.~~

~~(b) The types of assets required for an applicant to possess at the time of the qualifying examination are~~, lawful ~~money of the United States of America, bonds of this state, bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America, or bonds or other interest bearing evidences of indebtedness of any counties or municipalities of this state. Lawful~~ money of the United States of America includes deposits in an institution that is a member of the Federal Deposit Insurance Corporation. Demand deposits, savings deposits, or time deposits, of the type that are federally insured in solvent banks ~~and~~, savings and loan associations, and their branches ~~thereof~~, which are organized under the laws of the United States of America or under the laws of any state of the United States of America may not exceed the greater of:

~~(1) the amount of federal deposit insurance coverage pertaining to such deposit; or~~

~~(2) 10% of the issuing financial institution's net worth, provided that such net worth is in excess of $25 million;~~

~~(c) After the qualifying examination, the~~ (1) the amount of federal deposit insurance coverage pertaining to the deposit; or

(2) 10 percent of the issuing financial institution's equity, provided that the institution's equity is in excess of $25 million.

(c) The applicant must maintain unencumbered assets in excess of all of its liabilities by an amount equal to or greater than the minimum net worth requirement until it receives its certificate of authority~~, and thereafter,~~; then the HMO must meet the minimum net worth requirements of Insurance Code §843.403~~,~~ by maintaining unencumbered assets in excess of its liabilities by an amount equal to or

greater than the minimum net worth requirement.

~~(d) Notwithstanding subsections (b) and (c) of this section, foreign HMOs seeking admission to this state which are actively conducting business in other states, in addition to approved non-profit health corporations authorized under Insurance Code §844.005, shall be required, at a minimum, to comply with Insurance Code §843.403 at the time of the qualifying examination.~~

(d) Foreign HMOs seeking admission to this state, which are actively conducting business in other states, and approved nonprofit health corporations authorized under Insurance Code §844.005 (concerning Provision of Certain Services on Behalf of Health Maintenance Organizations), are required, at a minimum, to comply with Insurance Code §843.403.

§11.~~802~~803. Statutory Deposit Requirements.

~~(a) Statutory deposits made pursuant to Insurance Code §843.405 must consist of funds in the form of lawful money of the United States of America, bonds of this state, bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state.~~
~~(1) Certificates of deposit must be issued by a solvent, federally insured and Texas domiciled bank. However, the amount of total deposits by the HMO in the same depository bank may not exceed the greater of:~~
~~(A) the limits of federal insurance coverage pertaining to such deposits; or~~
~~(B) 10% of the issuing depository bank's net worth, provided that such net worth is in excess of $25 million.~~
~~(2) Bonds of this state, bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state must be valued at the lesser of current fair market value or amortized cost.~~
~~(b) Before the issuance of the certificate of authority, the HMO must submit funds as described in subsection (a) of this section in the amount required by Insurance Code §843.405, with four completed originals of security deposit report form number 120, one original pledge document on bank letterhead, and the applicable fees pursuant to~~ (a) Statutory deposits made under Insurance Code §843.405 (concerning Deposit with Comptroller) consisting of certificates of deposit must be issued by a solvent, federally insured bank.

(b) Before issuance of the certificate of authority, the HMO must submit proof of statutory deposits satisfying the requirements of Insurance Code §843.405 and meeting the investment requirements of §11.802 of this title (relating to Minimum Net Worth), with a completed Statutory Deposit Transaction Form, Form No. FIN407 (rev. 11/15), and Declaration of Trust Form, Form No.

FIN453 (rev. 11/15) as adopted in §13.562(b) of this title (relating to Deposit or Letter of Credit Required), as well as a safekeeping receipt showing that the security is pledged to the department, and the applicable fees under §7.1301(d) of this title (relating to Regulatory Fees) to the bond and securities officer of the department.

(c) Each HMO must annually determine the amount of statutory deposit required as specified in Insurance Code §843.405 and ~~deposit any required additional funds by March 15 in the manner set forth as follows:~~

~~(1) Any additional statutory deposit required shall be in funds as described in subsection (a) of this section and shall be accompanied by four completed originals of security deposit report form 120 and the applicable fee.~~

~~(2) If any statutory deposit is to be released, such request for release must be accompanied by four completed originals of withdrawal form number 121 and the applicable fee. If the commissioner directs such a release, the bond and securities officer of the department shall execute a release of any pledge and the funds shall be returned to the HMO.~~

~~(d) For any substitution of funds, the HMO must submit four completed originals of security deposit report form number 120, four completed originals of withdrawal form number 121, one original pledge document on bank letterhead, and the applicable fees.~~

~~(e) If the HMO wishes to request a release of all or part and/or a waiver of the statutory deposit requirements as permitted by Insurance Code~~ adjust the amount of statutory deposit by March 15 of that year.

(d) Any increases, decreases, or substitutions to the deposit funds must be in funds meeting the investment requirements of §11.802 of this title and must be accompanied by the documentation described in subsection (b) of this section.

(e) If the HMO wishes to request a waiver or release, or a waiver and a release, of all or part of the statutory deposit requirements under Insurance Code §843.405, ~~the HMO must submit a written request to the commissioner no less than 60 days prior to the March 15 due date. Such~~ then the request ~~for any release or waiver~~ must provide adequate information, including the following, to justify the ~~release:~~

relief requested:

(1) ~~Specifications~~specification of the pertinent ~~provision(s)~~provisions of the Insurance Code under which the ~~release or waiver~~relief is being requested;

(2) ~~The~~the amount of the statutory deposit for which ~~a release or waiver~~the relief is being requested;

(3) ~~If a waiver is being requested, the period of time over which the waiver is requested; (4) Supporting~~supporting documentation that justifies ~~such release or waiver~~the relief requested including:

(A) ~~Reasons~~reasons for requesting the ~~release or waiver;~~ relief;

(B) ~~Discussion as to~~ discussion of the impact of granting ~~a release and/or waiver~~the relief requested and assurance that the HMO and its enrollees will not be harmed if the ~~release or waiver~~relief is granted;

and

(C) ~~Evidence that the HMO has reported net profits for the previous 12 months; (D) Evidence that the HMO's net worth is in a positive position; (E) If~~if a request is based ~~upon~~on a guarantee:

(i) a copy of the guarantee;

(ii) a copy of the most current audited financial statements of the sponsoring organization~~;~~
, unless the sponsoring organization files financial statements with the National Association of Insurance Commissioners or the Securities Exchange Commission;

(iii) disclosure of the number of guarantees that the sponsoring organization has issued; and

(iv) disclosure of the dollar amount

of all obligations guaranteed ~~and~~, the amounts reflected as liabilities, and the amounts guaranteed that are not reflected as liabilities in the sponsoring organization's consolidated financial statements;

~~(5) If~~

(4) if the request is based on projected uncovered expenses:

(A) ~~Projections~~projections for the next calendar year ~~which includes~~ , including an income statement, a balance sheet, a cash flow statement and enrollment, ~~including~~and assumptions on which the projections are based;

(B) ~~An~~an explanation ~~as to~~of why expenses are classified as "covered"; and

(C) ~~A~~a reconciliation with explanation for any differences between submitted projections and the previous calendar year's actual experience~~.~~;

~~(6) If~~ (5) if an HMO requests a release under ~~subsections (e) or (f) of~~ Insurance Code §843.405~~:~~

(e) or (f):

(A) ~~Evidence~~evidence that the dollar amount of uncovered health care expenses are likely to continue and will not exceed the amount remaining on deposit; and

(B) ~~Explanation as to~~an explanation of the reasons for the decrease in uncovered health care expenses from that ~~which was~~ incurred during previous years~~.~~

~~(7) If~~ ;

(6) if a waiver is granted by the commissioner ~~approves~~, the ~~release or waiver,~~assets supporting the ~~HMO must submit the forms required by subsection (c)(2~~uncovered medical expenses may be invested under §11.804(3) of this ~~section.~~

title (relating to Invested Assets).

(f) ~~Whenever~~When the conditions ~~upon~~on which a waiver ~~were~~was granted change to the extent that the HMO is no longer able to qualify for the waiver, the HMO must deposit adequate funds to comply with the requirements of Insurance Code §843.405~~, within 30 days.~~

~~(g) All interest income when due on the statutory deposit funds may be paid directly to the HMO by the bank.~~ within 30 days.

(g) All interest income due on the statutory deposit funds may be paid directly to the HMO by the bank.

§11.~~803. Investments, Loans, and Other~~**804. Invested Assets.**

The admitted assets of domestic and foreign HMOs must at all times comply with the provisions of this section.

(1) Investment of minimum net worth. An HMO must have a minimum net worth as required by §11.802 of this title (relating to Minimum Net Worth).

(2) Investment of assets supporting uncovered medical expenses. An HMO must maintain statutory deposits supporting uncovered medical expenses as required by §11.803 of this title (relating to Statutory Deposit Requirements).

(3) Investments of assets in ~~an amount equivalent to its required minimum net worth in accordance with Insurance Code §843.403. Demand deposits, savings deposits or time deposits, of the type that are federally insured in solvent banks~~ excess of minimum net worth and ~~savings and loan associations and branches thereof, which are organized under the laws of the United States of America or under the laws of any state of the United States of America may not exceed the greater of:~~

~~(A) the amount of federal deposit insurance coverage pertaining to such deposit; or~~

~~(B) 10% of the issuing financial institution's net worth, provided that such net worth is in excess of $25 million;~~

~~(2) Investments to support uncovered liabilities.~~uncovered medical expenses. An HMO may invest its funds in excess of minimum net worth ~~in an amount at least equal to~~and uncovered ~~liabilities~~medical expenses only in the following:

(A) any investments allowed in ~~paragraph~~paragraphs (1) or (2) of this section;

(B) direct general obligations of any state of the United States of America for the payment of money, or obligations for the payment of money, to the extent guaranteed or insured as to

the payment of principal and interest by any state of the United States of America, provided~~:~~

~~(i) such state has the power to levy taxes for the prompt payment of the principal and~~ that:

(i) the state has the power to levy taxes for the prompt payment of the principal and interest of ~~such~~the obligations; and

(ii) ~~such~~the state ~~shall~~is not ~~be~~ in default in the payment of principal or interest on any of its direct, guaranteed, or insured general obligations at the date of ~~such~~the investment;

(C) bonds, interest-bearing warrants, or other obligations issued by authority of law by any county, city, town, school district, or other municipality or political subdivision ~~which~~that is now or hereafter may be construed or organized under the laws of any state in the United States of America and ~~which~~that is authorized to issue ~~such~~the bonds, warrants, or other obligations under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet ~~said~~the obligations or a special revenue or income to meet the principal and interest payments as they accrue ~~upon such~~on the obligations has been appropriated, pledged, or otherwise provided; and

(ii) ~~such~~the county, city, town, school district, or other municipality or political subdivision ~~shall~~is not ~~be~~ in default in the payment of principal or interest on any of its obligations at the date of ~~such~~the investment;

(D) bonds, interest-bearing warrants, or other obligations issued by authority of law by any educational institution ~~which~~that is now or hereafter may be construed or organized under the laws of any state ~~in~~of the United States of America, and ~~which~~that is authorized to issue ~~such~~the bonds and warrants under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet ~~said~~the obligations or a special revenue or income to meet the principal and interest payments as they accrue ~~upon such~~on the

obligations ~~shall have~~has been appropriated, pledged, or otherwise provided; and

(ii) ~~such~~the educational institution ~~shall~~is not ~~be~~ in default in the payment of principal or interest on any of its obligations at the date of ~~such~~the investment;

(E) investments issued by insurers or HMOs subject to the following conditions:

(i) an HMO may not make an investment under this subparagraph in any other HMO or insurer unless ~~such~~the other HMO or insurer is duly licensed to do business in its domestic state and at the time of ~~such~~the investment is in compliance with the minimum capital and surplus requirements then applicable under the provisions of that state's statutes and regulations; ~~provided,~~ however, an HMO may make an investment ~~pursuant to~~under this paragraph in another HMO ~~which~~that has not yet received its certificate of authority to conduct the business of an HMO in its domestic state or ~~which~~that does not yet possess the minimum capital and surplus required by its domestic state if ~~such~~the investment will be sufficient to give the investing HMO at least 50~~%~~ percent control in ~~such~~the other HMO~~, as the term "control" is defined in §11.2 of this title (relating to Definitions);~~

;

(ii) an HMO may not invest, except as provided in subparagraphs (F) and (G) of this paragraph, in any other HMO or insurer unless ~~such investment~~ the investments will result, within 180 days of the first investment, in the investing HMO having control in the other HMO or insurer;

~~with subsequent investments shall result within 180 days of the first investment in the investing HMO having control in such other HMO or insurer, as the term "control" is defined in §11.2 of this title;~~

(iii) ~~in no event may~~ an HMO may not invest more than 50~~%~~ percent of its net worth in excess of minimum net worth in any ~~one~~ other HMO or insurer;

(iv) ~~in no event may~~ the total investments made by an HMO in all other HMOs or insurers ~~pursuant to~~under this subparagraph may not exceed 75~~%~~ percent of the investing

HMO's net worth in excess of minimum net worth;

and

(v) the restrictions of clauses (iii) and (iv) of this subparagraph shalldo not apply if the HMO is purchasing 100% percent of the stock of another HMO for the purpose of a merger, which is anticipated to take place no later than three months from the purchase date, unless saidthe period is extended by the commissioner, and the resulting assets of the surviving HMO meet the requirements set forth in this subchapter within three months after saidthe merger, unless saidthe period of time is extended by the commissioner;

(F) bonds, debentures, bills of exchange, commercial notes, or any other bills and obligations of any corporation, incorporated under the laws of any state of the United States of America or of the United States of America, which issuing corporationthat, at the time of investment, is designated highest quality (NAIC designation 1) or high quality (NAIC designation 2) in compliance with the guidance provided by the NAIC Valuation of Securities Manual;

(G) equity interests, including common stocks

(G) equity interests, including common stocks issued by any business entity created under the laws of the United States of America or of any state of the United States, provided: that:

(i) the business entity is solvent, with a net worth of at least $1 million;

(ii) if the business entity is a dividend paying business entity, no cumulative dividends are in arrears;

(iii) an HMO shallmay not be permitted to invest in a partnership, as a general partner, except through a wholly owned subsidiary;

and

(iv) the restrictions of clauses (i) and (ii) of this subparagraph shalldo not apply if the business entity of which the HMO wishes to purchase the equity interest is, or is to be, a contracted provider of services;

(H) shares of mutual funds doing business under the Investment Company Act of 1940 (15 ~~U.S.C.~~ United States Code §80a-1, et seq.) and shares in real estate investment trusts as defined in ~~the~~ Internal Revenue Code of 1986 (26 ~~U.S.C.~~United States Code §856), provided that ~~such~~the mutual funds and real estate investment trusts be solvent with at least $1 million of net ~~worth~~assets as of the date of its latest annual, or more recent, certified audited financial statement;

(I) mortgage loans by an HMO that are secured by valid first liens on improved real estate, provided that:

~~(i) there is a title insurance policy or attorney's opinion evidencing that the borrower owns the real estate;~~

~~(ii) there is an appraisal of the real estate and its improvements and the loan does~~

(i) there is a title insurance policy or attorney's opinion showing that the borrower owns the real estate;

(ii) there is an appraisal of the real estate and its improvements and the loan does not exceed 75~~%~~ percent of ~~such~~the appraised value;

(iii) there is an executed note evidencing the loan;

(iv) there is a recorded deed of trust;

(v) the value of ~~such~~the improvements is adequately insured by a company authorized to do business in Texas or in the state in which the real estate is located~~;~~, and the insurance policy ~~must be~~is made payable to the HMO in an amount equal to at least 50~~%~~ percent of the value of ~~such~~the building, ~~provided that such~~but the insurance coverage need not exceed the outstanding balance owed to the HMO when the outstanding balance falls below 50~~%~~ percent of the value of ~~such~~the building;

and

(vi) the commissioner has the right to obtain an independent appraisal, at the HMO's expense, of real estate securing any loan;

(J) loans ~~to persons~~ secured by collateral, of a nature specified in ~~paragraph (1)~~Insurance Code §843.403 (concerning Minimum Net Worth) and §11.802 of this ~~section and subparagraphs (A) - (D) of this paragraph, but~~title (relating to Minimum Net Worth), although the amount loaned may not exceed the value of the securities held as collateral;

(K) loans, whether secured or unsecured~~,~~ and that are not in default, to medical and other health care providers under contract with the HMO for the provision of health care services~~, but in no event shall~~; however, the admitted value of any ~~such~~ loan ~~or loans~~ made under this subparagraph may not exceed the maker's ability to repay the loan ~~or loans; the maker's ability to repay the loan or loans shall be determined~~, which is calculated by ~~allowing~~ only considering assets that an HMO may hold ~~to be considered~~ toward determining any excess of assets over all liabilities of the maker; ~~liabilities of the maker;~~

(L) real estate acquired in satisfaction of debt; all ~~such~~ real property not qualifying under any other provisions of this section ~~shall~~must be sold and disposed of within five years after the HMO has acquired title ~~to same~~ unless the time for disposal is extended by the commissioner;

(M) investments in improved, income-producing real estate;

(N) additional investments ~~which~~that are not otherwise specified by this section, provided~~:~~ that:

(i) the amount of any one ~~such~~ investment ~~shall~~may not exceed 10~~%~~ percent of the net worth in excess of the HMO's minimum net worth ~~of the HMO~~plus uncovered medical expenses at the time of investment; and

(ii) the total amount of investments authorized by this paragraph ~~shall~~may not exceed the HMO's net worth in excess of its minimum net worth~~.~~

~~(3) Other~~ plus uncovered medical expenses at the time of investment.

(4) Valuation and Amortization. Except where elsewhere specifically provided, assets~~. An HMO may have assets beyond those~~ must be valued and amortized in compliance with §11.801 of

this title (relating to Accounting Guidance) as it applies to entities not required to ~~be held for~~maintain an asset valuation reserve. If no such standard applies, then the valuation must be at fair value.

(5) Evidence of ownership. A domestic HMO may demonstrate ownership of its ~~minimum net worth and uncovered liabilities which are either necessary for its operations or invested as permitted~~securities by complying with §7.86 of this title (relating to Custodied Securities).

(6) Sale of investment. Section 7.4 of this title (relating to Admissible Assets) applies to investments not specifically allowed under this subchapter. The commissioner may require any investment to be sold that would otherwise be authorized under the provisions of this section~~.~~ if the commissioner finds that the investment would cause the investing HMO to operate in a condition that is hazardous to its enrollees, creditors, or the general public.

§11.805. Other Assets.

(a) Other assets an HMO may find necessary in its operations include, but are not limited to, the following:

~~(A~~

(1) uncollected premiums or subscriptions with an adequate provision for uncollectable premiums or subscriptions;

~~(B~~

(2) advances of capitation or other fees expected to be paid for the next month to medical and other health care service providers under contract with the HMO~~;~~, provided that no termination of the contract may take place ~~prior to~~before the end of the period for which advances were paid;

~~(C~~

(3) the following ~~assets may be admitted~~items, provided that a detailed inventory is maintained with each item marked by any identifying number and the proof of cost maintained:

~~(i) Furniture~~

(A) furniture, labor-saving devices, machines, and all other office equipment used in the administration of the HMO ~~may be admitted as an asset and for such property acquired after December 31, 2000, amortized in full over a period not to exceed five years. All such property acquired prior to January 1, 2001, may be admitted and shall be amortized in full over a period not to exceed ten~~

~~years.~~

~~(ii) Furniture~~;

(B) furniture, medical equipment, and vehicles used in connection with the direct provision of health care services ~~may be admitted as an asset and for such property acquired after December 31, 2000, amortized in full over a period not to exceed five years. All such property acquired prior to January 1, 2001, may be admitted and shall be amortized in full over a period not to exceed ten years.~~

~~(iii) Electronic~~; and

(C) electronic machines, constituting a data processing system or systems and operating systems software used directly for the provision of medical services and the administration of the HMO ~~may be admitted as an asset and for such property acquired after December 31, 2000, amortized as provided by the March 2000 version of the Accounting Practices and Procedures Manual. All such property acquired prior to January 1, 2001 may be admitted and shall be amortized in full over a period not to exceed ten~~ ;

~~years;~~

~~(D~~ (4) inventories of necessary pharmaceutical and surgical supplies used directly in the treatment of medical conditions, it being the duty of the HMO to sufficiently prove the value of ~~such~~the inventories; ~~and~~

~~(E~~

(5) real estate and leasehold estates, including buildings and improvements, and leasehold improvements on rented space, for the accommodation of the HMO's current or expected business operations used in the provision or support of health care services, including space for rent to any ~~health care provider under contract with the HMO which property shall be used in the provision of health care services to members of the HMO by that provider.~~

~~(F) Claims overpayments, with the right of offset supported by a contractual agreement, that are specifically identifiable payments, may be admitted to the extent a liability to that provider exists.~~

~~(4) Valuation. Except where elsewhere specifically provided, investments, loans and assets are valued in accordance with the Purposes and Procedures of the Securities Valuation Office of the National Association of Insurance Commissioners as it applies to entities not required to maintain an asset valuation reserve. If no such standard applies, then the valuation shall be their fair value.~~

~~(5) Evidence of ownership. A domestic HMO may demonstrate ownership of its securities by complying~~

~~with §7.86 of this title (relating to Custodied Securities.)~~

~~(6) Sale of investment. Section 7.4 of this title (relating to Admissible Assets) shall apply to investments not specifically allowed under this subchapter. The commissioner may require any investment to be sold which would otherwise be authorized under the provisions of this section if the commissioner finds that such investment would cause the investing HMO to operate in a condition which is hazardous to its enrollees, creditors, or the general public.~~ physician or provider under contract with the HMO, which property will be used in the provision of health care services to members of the HMO by that physician or provider; and

(6) claims overpayments, with the right of offset supported by a contractual agreement, which are specifically identifiable payments, may be admitted to the extent a liability to that physician or provider exists.

(b) All noninvested assets of an HMO must be accounted for in compliance with §11.~~804~~801 of this title (relating to Accounting Guidance) except that the assets listed in subsection (a) of this section are admissible.

§11.806. Investment Management by Affiliate Companies.

(a) Subject to compliance with ~~the provisions of the~~ Insurance Code Chapter 843~~,~~ (concerning Health Maintenance Organizations), this chapter, and other applicable insurance laws and regulations of this state ~~that apply to HMOs, nothing in this section shall prevent~~, a domestic HMO, which is a member of ~~an HMO~~a holding company system with assets in an aggregate amount in excess of $1 billion and a tangible net worth of at least $100 million and having affiliates licensed in this state~~, from authorizing~~ may authorize an affiliated corporation ~~which~~that, if other than the ultimate ~~parent~~ holding company, is solvent with at least $10 million tangible net worth and ~~its~~whose performance and obligations under a written agreement with the HMO are guaranteed by the ultimate holding company~~,~~ to invest, hold, and administer as agent or nominee on behalf of ~~such~~the domestic HMO ~~those~~ bonds, notes, or other evidences of indebtedness ~~and repurchase agreements~~ that are authorized and permissible investments under ~~the~~ Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state that apply to HMOs, and which mature within one year of the date of acquisition ~~thereof; provided that such~~. The securities ~~are~~must be invested, held, and administered ~~pursuant to~~under a written agreement authorized by the board of directors of the HMO or an authorized committee ~~thereof~~, and ~~which is~~ submitted to the commissioner for prior approval~~, such approval to~~. Approval must be based ~~upon~~on satisfactory evidence that ~~such~~the agreement will facilitate the

operations of the domestic HMO and will not unreasonably diminish the service to or protection of the domestic HMO's enrollees within this state. (b) The agreement must:

~~The agreement must comply with the provisions of paragraphs~~ (1) ~~(8) of this section.~~

~~(1) The affiliate shall~~ specify in which office location it ~~shall~~will maintain records adequate to identify and verify the securities (or proportionate interest therein) belonging to the HMO~~organization.~~

~~(2) The affiliate shall~~; and

(2) allow the commissioner or the commissioner's designee to examine all records relating to those securities held subject to the agreement and ~~shall~~must agree to furnish these records at the principal office of the HMO within 10 business days of a request by the commissioner or any ~~one~~ of ~~his or her~~the department's commissioned examiners.

~~(3~~

(c) The HMO may authorize the affiliate to:

~~(A~~

(1) hold the securities of the HMO in bulk, in certificates issued in the name of the affiliate or its nominee, and to commingle them with securities owned by other affiliates of the affiliate;

~~(B~~

(2) provide for ~~such~~the securities to be held by a custodian, including the custodian of securities of the affiliate, or in a clearing corporation or the Federal Reserve Book Entry System as provided in this subchapter; and

~~(C~~

(3) purchase, sell, or otherwise dispose of the securities in ~~accordance~~compliance with instructions received from the HMO.

~~(4) The HMO shall report annually, if~~

(d) If required by the commissioner, the HMO must report annually to the department:

~~(A~~

(1) all investments with the affiliate ~~pursuant to~~under this section;

~~(B~~

(2) the market value of all securities held by the affiliate on behalf of the HMO as of December 31 of the year next preceding ~~(~~or other date as the commissioner may require~~);~~ and

~~(C~~

(3) the financial condition of the affiliate ~~which may include~~including, at the commissioner's discretion, balance sheets, income statements, and supporting schedules with an opinion ~~as to~~on those financial statements by an independent certified public accountant for the most recent fiscal year.

~~(5~~

(e) All of ~~such~~the investments and transactions between or among affiliates and the HMO must otherwise comply with all other applicable provisions of ~~the~~ Insurance Code ~~Chapter~~ Chapters 823 (concerning Insurance Holding Systems) and 843, and other applicable insurance laws and regulations of this state ~~that apply to HMOs.~~

~~(6.~~

(f) If the HMO or the affiliate does not comply with ~~the~~ Insurance Code ~~Chapter~~ Chapters 823 and 843 and other applicable insurance laws and regulations of this state ~~that apply to HMOs,~~ or does not comply with the written agreement governing ~~such~~the investing, holding, and administering of securities, then the commissioner's approval will be withdrawn after reasonable notice and ample opportunity to cure the noncompliance~~, and any further desire to continue such arrangement must be submitted for approval.~~

~~(7) At the instance of withdrawal of approval of the agreement, the HMO shall undertake to obtain, and the affiliated corporation shall undertake to return, those investments or funds resulting from the sale or maturity of those investments which the affiliated corporation invested, held, and~~ . If the HMO wishes to continue the arrangement, it must submit a request to the commissioner for approval.

(g) On the withdrawal of approval of the agreement, the HMO must undertake to obtain, and the affiliated corporation must undertake to return, investments or funds resulting from the sale or maturity of those investments in which the affiliated corporation invested, held, and administered on behalf of the HMO and ~~which~~the return ~~shall~~must be accomplished within 90 days unless:

~~(A~~

(1) the commissioner determines that ~~such~~the 90-day period ~~of time~~ creates a hazard to the public, in which case the commissioner may designate that the period may not exceed 30 days from the date of determination; or

~~(B~~

(2) the commissioner extends the period ~~of time with regard to~~for specific investments ~~upon~~on request by the HMO and affiliated corporation, but in no event to exceed one year from the

date of the withdrawal of approval.

~~(8~~

(h) The affiliate ~~or affiliated corporation~~ must be organized under the laws of one of the states of the United States of America or of the District of Columbia.

§11.~~805~~807. Fiduciary Responsibility.

Any director, member of a committee, officer, or any representative of a domestic HMO, who is charged with the duty of handling or investing its funds, ~~shall not intentionally:~~

~~(1) deposit or invest such funds, except in the corporate name of said HMO or in the name of nominee of said HMO as may be allowed elsewhere in this subchapter; or~~

~~(2) take or receive to his own use any fee, brokerage, or commission, on account of a loan made by or on behalf of such HMO, except reasonable interest may be received on amounts loaned to the HMO.~~ may not intentionally:

(1) deposit or invest the funds, except in the corporate name of the HMO or in the name of the nominee of the HMO as may be allowed elsewhere in this subchapter; or

(2) take or receive to his or her own use any fee, brokerage, or commission, on account of a loan made by or on behalf of the HMO, except that reasonable interest may be received on amounts loaned to the HMO.

§11.~~806~~808. Liabilities.

~~(a) Each HMO must establish and maintain records identifying and supporting each liability the HMO incurs. Each liability incurred by an HMO shall be reported on all financial statements filed with the department. A liability shall be incurred from the date a service was performed, a product was delivered, a title was transferred, or a contractual obligation entered into for an amount that is specified and unconditionally owed. Each HMO must segregate its liabilities into classification~~ (a) Each HMO must account for liabilities as provided for in §11.801 of this title (relating to Accounting Guidance), and must segregate its liabilities into classifications of "covered" or "uncovered." Agreements to loan money or to make future capital or surplus contributions do not, in themselves, cause liabilities to be covered. Any guarantee of future contributions to surplus ~~which~~that are directed and based on the payment of a debt

will allow that debt to be reflected as a covered liability. A liability, for which provision is made other than by the assets of the HMO, may qualify as a covered liability if the amount owed~~:~~ is:

(1) ~~is~~ based on a physician or provider contract with a hold-harmless clause as provided in §11.901~~(a)(1)~~ of this title (relating to Required and Prohibited Provisions);

(2) ~~is~~ subordinated in writing to the uncovered health care liabilities of the HMO; or

(3) ~~is~~ unconditionally guaranteed and the guarantee is without monetary limit, as specified in §11.~~808~~810 of this title (relating to Guarantee from a Sponsoring Organization), by a sponsoring organization ~~which~~that has a tangible net worth of at least $10 million in excess of all amounts that the sponsoring organization has guaranteed.

~~(b) Liabilities shall include, but are not limited to, the following:~~

~~(1) gross premiums received in payment for all or any part of medical and other health care services to be provided by the HMO subsequent to that financial reporting period (unearned premiums);~~

~~(2) the unpaid balance under any promissory note or other obligation evidencing amounts owed by the HMO without any adjustment for unrealized gains or losses due to an assumption of a loan or note payable at interest rates different from the prevailing rate at the time of assumption;~~

~~(3) capital leases in an amount equal to the value of the admitted assets hypothecated by the lease or the present value of the total~~

~~amounts owed under the remaining term of the lease in accordance with generally accepted accounting principles; in determining the present value of the lease payments, the rate of interest should be equivalent to the rate of interest on United States of America Treasury Notes as of December 31st of the preceding calendar year; and~~

~~(4) incurred claim liabilities, including all liabilities and expenses relating to medical and health care services provided by HMO delivery network and non-network physicians and providers.~~

~~(c) An HMO shall~~ (b) An HMO may not decrease its liabilities or establish an asset on its balance sheet for any capitated risk or other risk-sharing arrangement with a network physician or provider relating to out-of-service area or emergency care provided by any non-network physician or provider. For purposes of this subsection, non-network physician or provider means a physician or provider who

has not directly or indirectly contracted with an HMO or an HMO's network physicians or providers to provide medical or health care services to the HMO's enrollees.

§11.~~807. Dividends~~**810. Guarantee from a Sponsoring Organization.**

~~(a) Except as provided in subsection (b) of this section, dividends may be declared by an HMO at any time from any and all admitted assets in excess of all liabilities, as long as that HMO meets or exceeds its deposit, minimum net worth and risk-based capital requirements.~~
~~(b) An HMO shall give the commissioner at least 30 days' notice before the HMO shall make or pay any dividend or distribution of cash or other property (excluding pro rata distributions of any class of the HMO's own securities), whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of 10% of the HMO's net worth as of the 31st day of December next preceding, or the net gain from operations of such HMO.~~

~~§11.808. Guarantee from a Sponsoring Organization.~~

(a) The following items ~~are mandatory requirements to~~must be incorporated into a guarantee from a sponsoring organization ~~in order~~ for the HMO to report expenses and liabilities as covered~~.~~ :

(1) ~~The~~the guarantee must be approved by a board resolution of the sponsoring organization;

(2) ~~The~~the sponsoring organization must have a tangible net worth of at least $10 million for each guarantee issued;

~~(3) The sponsoring organization must agree to file audited financial statements annually with the Financial Monitoring Unit of the department within 180 days of the end of the sponsoring organization's fiscal year;~~

~~(4) The guarantee must be unconditional and may not be monetarily limited;~~

(3) the sponsoring organization must agree to file audited financial statements annually with the department's Financial Analysis Section within 180 days of the end of the sponsoring organization's fiscal year;

(4) the guarantee must be unconditional and may not be monetarily limited;

(5) ~~The~~the guarantee, at a minimum, must cover otherwise "uncovered" health care expenses and liabilities, including any present or future contingencies ~~which~~that may arise from the delivery of health care. If the HMO is ~~writing~~offering Medicaid products, all expenses and liabilities must

be covered;

(6) ~~The~~the guarantee must not be limited in duration;

(7) ~~The~~the guarantee must provide for ~~6 months~~six-months' advance notice to the department ~~prior to~~before its cancellation; and

(8) ~~The~~the guarantee must be notarized and signed by the president and another officer of the sponsoring organization.

(b) If at any time a guarantee does not comply with every requirement of this section, then the HMO will no longer qualify for ~~the following:~~ covered expenses and liabilities.

~~(1) covered expenses and liabilities; and~~

~~(2) lower net worth and statutory deposit requirements as specified in §11.1804(b) of this title (relating to Guarantees).~~

(c) If the sponsoring organization has guaranteed the payment of any debts, expenses, or contingent obligations of another person, or guaranteed the performance of any service or other obligation of another person, then the HMO must provide a ~~certified copy~~certification from the sponsoring organization of the following:

(1) the name of each person guaranteed;

(2) the type of business of that person;

and

(3) the extent of each guarantee issued, and the dollar amount of debts and contingent obligations guaranteed individually and in the aggregate.

(d) ~~In addition, the~~The HMO must also certify that the guaranteed debts are reported as liabilities or contingent liabilities of the guarantor. This certification must be submitted annually with the sponsoring organization's audited financial statements. The certified copy must be notarized and signed

by the president or chief financial officer of the sponsoring organization, with an acknowledgment of the guarantee by the HMO's president or chief financial officer ~~of the HMO.~~ .

~~§11.810. Hazardous Conditions for HMOs.~~

§11.811. Action under Insurance Code §843.157 and Insurance Code §843.461.

(a) ~~Purpose. The purpose of this section is~~In addition to ~~enumerate conditions which may indicate an HMO is in hazardous condition and which authorize~~any other actions available under the Insurance Code, the commissioner ~~of insurance to initiate an~~may take action against an HMO under ~~Insurance Code §843.461~~§843.157 (concerning Rehabilitation, Liquidation, Supervision, or ~~§843.157.~~Conservation of Health Maintenance Organizations) and Insurance Code §843.461 (concerning Enforcement Actions). In evaluating ~~any of~~ the conditions in this section, the commissioner ~~must~~will evaluate all relevant circumstances concerning the HMO's operation ~~in making an ultimate conclusion that an HMO is in hazardous condition~~. The evaluation of the information relating to these conditions is a part of the examination process. The conditions ~~enumerated~~listed in this section do not conclusively indicate that ~~an HMO is in hazardous condition.~~action must be taken. One or more of the conditions can exist in an HMO ~~which~~that is in satisfactory condition; however, one or more of these conditions has often been found in an HMO ~~which~~that was unable to perform its obligations to enrollees, creditors, or the general public, or has required the commissioner to initiate regulatory action to protect enrollees, creditors ~~and the general public.~~

~~(b) An HMO may be found to be in hazardous condition, after notice and opportunity for hearing, when the commissioner finds one or more of the following conditions to exist:~~

~~(1) an HMO's federal qualification designation and/or National Committee on Quality Assurance accreditation is revoked or discontinued;~~

~~(2) an HMO's reported claims in process exceed 12% of annualized medical and hospital expenses (12% is approximately a 45 day backlog);~~ , and the general public.

~~(~~ (b) The commissioner may take action under this section, if the commissioner finds that one or more of the conditions listed below or in §8.3 of this title (relating to Hazardous Conditions and Remedy of Hazardous Conditions) exist:

(1) an HMO's ~~parent or sponsoring organization is operating in a hazardous condition;~~

~~(4) an~~ federal qualification designation, or NCQA accreditation, or both, are revoked or discontinued;

(2) an HMO's ~~annual CPA report or actuarial opinion contains a material adverse finding or findings;~~

~~(5~~reported claims in process exceed 12 percent of annualized medical and hospital expenses (12 percent is approximately a 45-day backlog);

(3) an HMO fails to comply with ~~the~~ Insurance Code Chapter 843 ~~and~~(concerning Health Maintenance Organizations), this chapter, or other applicable insurance laws and regulations of this state ~~that apply to HMOs or Title 28, Texas Administrative Code, Chapter 11;~~

~~(6) an~~ ;

(4) an HMO has an inadequate provider network;

~~(7~~

(5) an HMO contracts with a management or administrative company on a capitated or percentage of premium basis and ~~such~~the administrative or management company refuses to submit financial statements to the HMO;

~~(8) an HMO does not file~~

(6) a ~~financial statement with the department within the time required by the Insurance Code,~~physician or ~~as requested by the department;~~

~~(9) a health care~~ provider that is under contract, directly or indirectly, with an HMO, has a pattern of balance billing;

~~(10) an HMO files financial information with the department which is false or misleading;~~

~~(11) an HMO does not amend its financial statement when requested by the department;~~

~~(12) an HMO overstates its net worth by 25% or more;~~

~~(13) an HMO relies on its parent's forgiveness of debt or frequent surplus contributions to finance its operations or to maintain its minimum net worth or risk based capital;~~ or

~~(14) an HMO does not maintain books and records sufficient to permit examiners to determine the financial condition of the HMO, examples of which include:~~
~~(A) a domestic HMO maintains books and records outside the State of Texas in violation of Insurance Code Chapter 803; or~~
~~(B) an HMO moves, or maintains, the location of the books and records necessary to conduct an examination without notifying the department of such location;~~
~~(15) an HMO's management does not have the experience, competence, or trustworthiness to operate the HMO in a safe and sound manner;~~
~~(16) an HMO's management has been found to have engaged in unlawful transactions;~~
~~(17) an HMO has a pattern of denial or nonpayment of emergency care;~~
~~(18) an HMO does not follow its policy on rating and underwriting standards appropriate to the risk;~~
~~(19) an administrative or judicial order, initiated by an insurance regulatory agency of another state, is~~

~~issued against an HMO, its parent or affiliate, or a regulatory action is initiated by another agency within the state of domicile;~~
~~(20) an HMO does not have the minimum net worth required by the Insurance Code §843.403;~~
~~(21) an HMO does not meet the requirements of §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank); or~~
~~(22) an HMO is in any condition that the commissioner finds may present a hazard to enrollees, creditors, or the general public.~~

~~Subchapter~~ (7) an HMO does not have the minimum net worth required by Insurance Code §843.403 (concerning Minimum Net Worth) and §11.802 of this title (relating to Minimum Net Worth).

(c) This section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code.

SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

§11.900. Nonprimary Care Physician ~~Specialist~~Specialists as Primary Care Physician.

(a) An HMO ~~shall~~must allow ~~enrollees~~an enrollee with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to ~~utilize~~use a nonprimary care physician specialist as a primary care physician, provided that:

(1) the enrollee makes a request for special consideration that includes ~~the following information:~~
~~(A)~~:

(A) a certification by the nonprimary care physician specialist of the medical need for the enrollee to ~~utilize~~use the nonprimary care physician specialist as a primary care physician;

(B) a statement signed by the nonprimary care physician specialist that ~~he or she~~the specialist is willing to accept responsibility for the coordination of all of the enrollee's health care needs; and

(C) the signature of the enrollee;

(2) the nonprimary care physician specialist meets the HMO's requirements for primary care physician participation, including credentialing;

(3) the HMO has ensured that the contractual obligations of the nonprimary care physician specialist are consistent with the contractual obligations of the HMO's primary care physicians; and

(4) the HMO ~~provides~~must provide the nonprimary care physician specialist with a current directory of participating specialist physicians and providers.

~~(b) HMO Action on Nonprimary Care Physician Specialist as Primary Care Physician.~~

(b) An HMO must approve or deny the request for special consideration ~~as specified in subsection (a) of this section~~ and provide written notification of the decision to the enrollee not later than 30 days after receiving the request. If the HMO denies the request ~~is denied~~, the HMO must provide the reasons for denial in the written notification ~~to the enrollee the reasons for the denial of the request.~~. An HMO must establish written criteria for determining medical need for an enrollee to ~~utilize~~use a ~~non-primary~~nonprimary care physician specialist as a primary care provider, and must include ~~such~~the criteria in the provider manual.

~~(c) Appeal of HMO Denial of Nonprimary Care Physician Specialist as Primary Care Physician. If the request for consideration specified in subsection (a) of this section is denied by the HMO, an enrollee may appeal the decision through the HMO's established complaint and appeal process.~~

(c) If the HMO denies a request for special consideration, an enrollee may appeal the decision through the HMO's established complaint and appeal process.

§11.901. Required and Prohibited Provisions.

(a) Physician and provider contracts, subcontracts, and arrangements ~~shall~~must include provisions~~:~~

~~(1)~~ regarding a hold~~-~~harmless clause as described in Insurance Code §843.361~~:~~

~~(A~~ of this title (concerning Enrollees Held Harmless).

(1) A hold-harmless clause is a provision~~, as required by Insurance Code §843.361,~~ in a physician or health care provider agreement that obligates the physician or provider to look only to the HMO and not its enrollees for payment for covered services (except as described in the evidence of coverage issued to the enrollee).

~~(B~~

(2) In ~~accordance~~compliance with Insurance Code §843.002 (concerning Definitions) relating to an "uncovered expense," if a physician or health care provider agreement contains a hold-harmless clause, then the costs of the services will not be considered uncovered health care expenses in determining amounts of deposits necessary for insolvency protection under Insurance Code §843.405~~.~~ ~~(C~~ (concerning Deposit with Comptroller).

(3) The following ~~language~~ is an example of an approvable hold-harmless clause: ~~(~~"(Physician~~/~~ or Provider) hereby agrees that in no event, including, but not limited to ~~non-payment~~nonpayment by the HMO, HMO insolvency, or breach of this agreement, ~~shall (physician/provider~~may (Physician or Provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than the HMO acting on their behalf for services provided ~~pursuant to~~under this agreement. This provision ~~shall~~does not prohibit collection of supplemental charges or copayments made in ~~accordance~~compliance with the terms of (applicable agreement) between HMO and subscriber~~/~~ or enrollee. (Physician~~/~~ or Provider) further agrees that:

~~(i~~

(A) this provision ~~shall~~will survive the termination of this agreement regardless of the cause giving rise to termination and ~~shall~~must be construed to be for the benefit of the HMO subscriber~~/~~ or enrollee; and

~~(ii~~

(B) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (~~physician/provider~~Physician or Provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause ~~shall~~will be effective on a date no earlier than 15 days after the commissioner has received written notice of ~~such proposed changes;~~

~~(2) regarding retaliation as described in Insurance Code §843.281;~~

~~(3) regarding continuity of treatment, if applicable, as described in Insurance Code §843.309 and §843.362;~~

~~(4) regarding written notification to enrollees receiving care from a physician or provider of the HMO's termination of that physician or provider in accordance with Insurance Code §843.308 and §843.309;~~

~~(5) regarding written notification of termination to a physician or provider in accordance with Insurance Code §843.306 and §843.307:~~

~~(A) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days prior to the effective date of the termination;~~ the proposed changes."

~~(B) not later than 30 days following receipt~~ (b) Physician and provider contracts, subcontracts, and arrangements must include provisions:

(1) regarding retaliation as described in Insurance Code §843.281 (concerning Retaliatory Action Prohibited);

(2) regarding continuity of ~~the~~ treatment, if applicable, as described in Insurance Code §843.309 (concerning Contracts with Physicians or Providers; Notice to Certain Enrollees of Termination of Physician or Provider Participation Plan) and §843.362 (concerning Continuity of Care; Obligation of Health Maintenance Organization);

(3) regarding written notification ~~of termination,~~to enrollees receiving care from a physician or provider ~~may request a review by the HMO's advisory review panel;~~

~~(C) within 60 days following receipt of the provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the~~of the termination of that physician or provider~~;~~

~~(6~~ in compliance with Insurance Code §843.308 (concerning Notification of Patients of Deselected Physician or Provider) and §843.309 (concerning Contracts With Physicians or Providers: Notice to Certain Enrollees of Termination of Physician or Provider Participation in a Plan);

(4) regarding posting of ~~complaints notice~~complaint notices in physician~~/~~ or provider offices as described in Insurance Code §843.283~~. A~~ (concerning Posting of Information on Complaint Process Required), provided that a representative notice that complies with this requirement may be obtained from the ~~HMO Division~~Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~;~~

~~(7~~, or the department's website at www.tdi.texas.gov;

(5) regarding indemnification of the HMO as described in Insurance Code §843.310~~;~~

~~(8~~ (concerning Contracts with Physicians or Providers; Certain Indemnity Clauses Prohibited);

(6) regarding prompt payment of claims as described in ~~the~~ Insurance Code Chapter 542, Subchapter B ~~and §1271.005~~, (concerning Prompt Payment of Claims); §1271.005 (concerning Applicability of Other Law); and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J ~~(~~, (concerning Payment of Claims to Physicians and Providers~~)~~); and Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims) with respect to ~~the~~ payment to the physician or provider for covered services ~~that are~~ rendered to enrollees;

~~(9~~

(7) regarding capitation, if applicable, as described in Insurance Code §843.315 (concerning Payment of Capitation; Assignment of Primary Care Physician or Provider) and §843.316~~;~~

~~(10~~ (concerning Alternative Capitation System);

(8) regarding selection of a primary care physician or provider, if applicable, as described in Insurance Code §843.~~315;~~

~~(11) entitling the physician or provider upon request to all information necessary to determine that the physician or provider is being compensated in accordance with the contract.~~203 (concerning Selection of Primary Care Physician or Provider); ~~A physician or provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including e-mail, computer disks, paper or access to an electronic database. Amendments, revisions or substitutions of any information provided pursuant to this paragraph must be made in accordance with subparagraph (D) of this paragraph. The HMO shall provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.~~

~~(A) This information must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider. At a minimum, the information must include:~~

~~(i) a fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM codes and modifiers:~~

~~(I) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider; or~~

~~(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that contracting physician or provider on a routine basis along with a toll-free number or electronic address through which the contracting physician or provider may request the fee schedules applicable to any covered services that the physician or provider intends to provide to an enrollee and any other information required by this paragraph, that pertains to the service for which the fee schedule is being requested if the HMO has not previously provided that information to the physician or provider;~~

~~(ii) all applicable coding methodologies;~~

~~(iii) all applicable bundling processes, which must be consistent with nationally recognized and generally accepted bundling edits and logic;~~

~~(iv) all applicable downcoding policies;~~

~~(v) a description of any other applicable policy or procedure the HMO may use that affects the payment of specific claims submitted by or on behalf of the contracting physician or provider, including recoupment;~~

~~(vi) any addenda, schedules, exhibits or policies used by the HMO in carrying out the payment of claims submitted by or on behalf of the contracting physician or provider that are necessary to provide a reasonable understanding of the information provided pursuant to this paragraph; and~~

~~(vii) the published, product name and version of any software the HMO uses to determine bundling and unbundling of claims.~~

~~(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the HMO, such as state Medicaid or federal Medicare fee schedules, the information the HMO provides shall clearly identify the source and explain the procedure by which the physician or provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.~~

~~(C) Nothing in this paragraph shall be construed to require an HMO to provide specific information that would violate any applicable copyright law or licensing agreement. However, the HMO must supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees as required by subparagraph (A) of this paragraph.~~

~~(D) No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this paragraph shall be effective as to the contracting physician or~~

~~provider, unless the HMO provides at least 90 calendar days written notice to the contracting physician or provider identifying with specificity the amendment, revision or substitution. An HMO may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.~~

~~(E) Failure to comply with this paragraph constitutes a violation of the Insurance Code Chapter 843, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs.~~

~~(F) Upon receipt of a request, the HMO must provide the information required by subparagraphs (A) - (D) of this paragraph to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.~~

~~(G) A physician or provider that receives information under this paragraph:~~

~~(i) may not use or disclose the information for any purpose other than:~~

~~(I) the physician's or provider's practice management,~~

~~(II) billing activities,~~

~~(III) other business operations, or~~

~~(IV) communications with a governmental agency involved in the regulation of health care or insurance;~~

~~(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; and~~

~~(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.~~

~~(H) A physician or provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider shall provide for reasonable advance notice to enrollees being treated by the physician or provider prior to the termination consistent with Insurance Code §843.309.~~

~~(I) The provisions of this paragraph may not be waived, voided, or nullified by contract;~~

~~(12~~ (9) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish ~~x~~X-rays and ~~nonprefabricated~~non-prefabricated orthotics covered by the evidence of coverage~~; and~~

~~(13~~ as described in Insurance Code §843.311 (concerning Contracts with Podiatrists);

(10) regarding ~~electronic health care transactions as set forth in~~the requirements of §21.3701 of this title (relating to Electronic ~~Health Care Transactions~~Claims Filing Requirements) if the contract requires electronic submission of any information described by that section~~.~~

~~(b) An HMO may require~~;

(11) requiring the preferred provider to comply with all applicable requirements of Insurance Code §1661.005 (concerning Refunds of Overpayments); and

(12) requiring a contracting physician or provider to retain in the contracting ~~physician~~physician's or provider's records updated information concerning a patient's other health benefit plan coverage.

(c) Physician and provider contracts and arrangements must include provisions entitling the physician or provider, on request, to all information necessary to determine that the physician or provider is being compensated in compliance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. ~~Upon~~The information provided must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including email, computer disks, or other electronic storage and transfer technology, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided under this paragraph must comply with paragraph (4) of this subsection. The HMO must provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(1) The information provided must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider, including at a minimum, the:

(A) fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM, ICD-10-CM, and successor codes, and modifiers:

(i) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider; or

(ii) that pertains to the range of health care services reasonably expected to be delivered under the contract by that contracting physician or provider on a routine basis, along with a toll-free number or electronic address through which the contracting physician or provider may request the fee schedules applicable to any covered services that the physician or provider intends to provide to an enrollee, and any other information required by this subsection, that pertains to the service for which the fee schedule is being requested if the HMO has not previously provided that information to the physician or provider;

(B) all applicable coding methodologies;

(C) all applicable bundling processes, which must be consistent with nationally recognized and generally accepted bundling edits and logic;

(D) all applicable downcoding policies;

(E) a description of any other applicable policy or procedure the HMO may use that affects the payment of specific claims submitted by or on behalf of the contracting physician or provider, including recoupment;

(F) any addenda, schedules, exhibits, or policies used by the HMO in carrying out the payment of claims submitted by or on behalf of the contracting physician or provider that are necessary to provide a reasonable understanding of the information provided under this subsection; and

(G) the published product name and version of any software the HMO uses to determine bundling and unbundling of claims.

(2) In the case of a reference to source information outside the control of the HMO as the basis for fee computation, such as state Medicaid or federal Medicare fee schedules, the information the HMO provides must clearly identify the source and explain the procedure by which the physician or provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(3) Nothing in this subsection may be construed to require an HMO to provide specific information that would violate any applicable copyright law or licensing agreement. However, the HMO must supply, instead of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services that are rendered to enrollees as required by paragraph (1) of this subsection.

(4) No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this subsection will be effective as to the contracting physician or provider, unless the HMO provides at least 90-calendar-days written notice to the contracting physician or provider identifying with specificity the amendment, revision, or substitution. An HMO may not make retroactive changes to claims payment procedures or any of the information required to be provided by this subsection. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this subsection, the written notice specified in this section does not supersede the requirement for mutual agreement.

(5) The HMO must provide the information required by paragraphs (1) - (4) of this subsection to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.

(6) A physician or provider receiving information under this subsection may not:

(A) use or disclose the information for any purpose other than:

(i) the physician's or provider's practice management,

(ii) billing activities,

(iii) other business operations, or

(iv) communications with a governmental agency involved in the regulation of health care or insurance;

(B) use the information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; or

(C) rely on information provided under this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(7) A physician or provider that receives information under this subsection may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider must provide for reasonable advance notice

to enrollees being treated by the physician or provider before the termination consistent with Insurance Code §843.309.

(8) The provisions of this subsection may not be waived, voided, or nullified by contract.

(d) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding written notification of termination to a physician or provider in compliance with Insurance Code §843.306 (concerning Termination of Participation; Advisory Review Panel) and §843.307 (concerning Expedited Review Process on Termination or Deselection), including provisions providing that:

(1) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days before the effective date of the termination;

(2) not later than 30 days following receipt of the written notification of termination, a physician or provider may request a review by the HMO's advisory review panel except in a case involving:

(A) imminent harm to patient health;

(B) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(C) fraud or malfeasance; and

(3) within 60 days after receipt of the physician or provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the physician or provider.

(e) On request by a participating physician or provider, an HMO ~~shall~~must include a provision in the physician's or provider's contract providing that the HMO and the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission ~~is~~ " means "a group of electronic claims submitted for processing at the same time within a Health Insurance Portability and Accountability Act (HIPAA) standard ASC X12N 837 Transaction Set and identified by a batch control number~~.~~." This subsection applies to a contract entered into or renewed on or after ~~January 1, 2006.~~ the effective date of this subsection. For a contract entered into or renewed

before the effective date of this subsection, the law and regulations in effect at the time the contract was entered or renewed, whichever is later, governs.

(f) A contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115 (concerning Contracts with Dentists).

§11.902. Prohibited Actions.

~~(a) Pursuant to Insurance Code §843.320, a contract between an HMO and~~ An HMO may not:

(1) require a physician ~~may not require the physician~~ to use a hospitalist for a hospitalized patient~~.~~

~~(b) Pursuant to the~~ by contract under Insurance Code §843.~~3045, an HMO may not~~320 (concerning Use of Hospitalist);

(2) refuse to contract with a nurse first assistant ~~as defined by the Occupations Code §301.353, as added by Acts 2005, 79th Leg. R.S., ch. 966, sec. 1, as amended,~~ to be ~~included in the HMO's~~part of a provider network or refuse to reimburse ~~the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.~~

~~(c) An HMO may not by contract or any other metho~~da nurse first assistant under Insurance Code §843.3045 (concerning Nurse First Assistant);

(3) require a physician to use the services of a nurse first assistant as defined by ~~the Occupations~~ Occupations Code §301.354 (concerning Nurse First Assistants; Assisting at Surgery by Other Nurses);

~~Code §301.353, as added by Acts 2005, 79th Leg. R.S., ch. 966, sec. 1, as amended.~~

~~(d) Pursuant to Insurance Code §843.319 (Certain Required Contracts), an HMO may not deny a contract to~~ (4) refuse to contract with a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners who joins the professional practice of a contracted physician or provider~~, satisfies the HMO's application procedures and meets the HMO's qualification and credentialing requirements for contracting.~~

~~(e) Pursuant to Insurance Code §843.312, an HMO may not refuse a request by a contracted physician and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code, to identify a physician assistant or advanced~~

~~practice nurse as a provider in the HMO's network, provided the physician assistant or advanced practice nurse meets the quality of care standards for participation in the HMO's network.~~ under Insurance Code §843.319 (concerning Certain Required Contracts);

(5) refuse a request to identify a physician assistant or advanced practice registered nurse as a provider in the HMO's network under Insurance Code §843.312 (concerning Physician Assistants and Advanced Practice Nurses);

(6) employ an optometrist or therapeutic optometrist to provide a vision care product or service, pay an optometrist or therapeutic optometrist for a service not provided, or restrict or limit an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials under Insurance Code §1451.156 (concerning Prohibited Conduct); or

(7) contract with a dentist to limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115.

§11.903. Physician or Provider Communication.

(a) An HMO may not, as a condition of a contract with a physician or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options~~;~~
, or the availability of facilities both in-network and out-of-network for the treatment of a patient's medical condition;

(2) information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient;

(3) the fact that the physician's or provider's contract with the HMO has terminated or that the physician or provider will otherwise no longer be providing medical care or health care services

under the health care plan; or

(4) the fact that, if medically necessary covered services are not available through network physicians or providers, the HMO must, ~~upon~~on the request of a network physician or provider and~~,~~ within time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow referral to a non-network physician or provider.

(b) An HMO may not in any way penalize, terminate, or refuse to compensate~~,~~ for covered services, a physician or provider for communicating with a current, prospective, or former patient, or a party designated by a patient, in any way protected by this section.

(c) An HMO may not require a physician or provider to provide a notification form stating that the physician or provider is an out-of-network provider to a current, prospective, or former patient, or a party designated by a patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

§11.904. Provision of Services Related to Immunizations and Vaccinations.

(a) ~~Pursuant to the~~In compliance with Insurance Code Chapter 1353~~,~~ (concerning Immunization or Vaccination Protocols Under Managed Care Plans), an HMO ~~shall~~may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee by a pharmacist.

~~(b) No contract between an HMO and a pharmacy or pharmacist shall prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act, (Subtitle J, Occupations Code) and rules promulgated thereunder.~~

~~Subchapter~~ (b) No contract between an HMO and a pharmacy or pharmacist may prohibit a pharmacist from administering immunizations or vaccinations if the immunizations or vaccinations are administered in compliance with the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551 - 569 (concerning Pharmacy and Pharmacists), and related rules.

SUBCHAPTER K. REQUIRED FORMS

§11.1001. Required Forms.

The following forms are to be used in conjunction with the rules adopted under this chapter. Copies of these forms may be obtained by contacting the Company Licensing and Registration ~~Division~~Office, Mail Code ~~305 2C~~103-CL, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~.~~, or from the department's website at www.tdi.texas.gov. Each HMO or other person or entity ~~shall~~must use ~~such~~the form or forms ~~as are~~ required by this title ~~and~~ as ~~are~~ appropriate to its particular activities. The forms are listed as follows:

(1) Name Application Form ~~Rev. 02/99;~~
, (rev. 03/14);

(2) Application for a Certificate of Authority to do business in the State of Texas, ~~Rev. 02/99;~~
(rev. 09/04);

(3) State of Texas Officers and Directors Page, ~~Rev.~~TDI Form FIN306, (rev. 06/~~2000;~~
10);

(4) State of Texas Biographical Affidavit, ~~Rev. 01/2002;~~
NAIC UCAA Form 11, (rev. 04/13);

(5) HMO Certification and Transmittal Form ~~Rev. 02/99;~~
, TDI Form LHL 259, (rev. 07/14);

(6) Reconciliation of Benefits to Schedule of Charges Form, ~~Rev. 04/92;~~
TDI Form LHL 654, (rev. 01/13);

(7) Statutory Deposit ~~Report~~Transaction Form, Form No. ~~120;~~FIN407 (rev.11/15); and

(8) ~~Withdrawal~~Declaration of Trust Form, Form No. ~~121.~~FIN453 (rev.11/15).

~~Subchapter~~SUBCHAPTER M. ACQUISITION ~~OF~~, CONTROL ~~OF~~, OR MERGER OF~~,~~ A DOMESTIC HMO

§11.1201.

~~**§11.1201.** Definitions.~~

~~The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.~~
~~(1) Control (including the terms "controlling," "controlled by," and "under common control with") - The possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporation office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds irrevocable proxies representing, 10% or more of the voting securities or authority of any other person. This presumption may be rebutted by a showing made in the manner provided by the Insurance Code §823.010 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect, where a person exercises directly or indirectly, either alone or pursuant to an agreement with one or more other persons, such a controlling influence over the management or policies of an authorized health maintenance organization as to make it necessary or appropriate in the public interest or for the protection of the enrollees or shareholders of the health maintenance organization that the person be deemed to control the health maintenance organization.~~
~~(2) Controlled health maintenance organization - A health maintenance organization controlled directly or indirectly by a health maintenance organization holding company.~~
~~(3) Controlled person - Any person, other than a controlled health maintenance organization, who is controlled directly or indirectly by a health maintenance organization holding company.~~
~~(4) Health maintenance organization holding company - Any person who directly or indirectly controls any health maintenance organization, except that it shall not be deemed to include: the United States, a state or any political subdivision, agency, or instrumentality thereof, or any corporation which is wholly owned directly or indirectly by one or more of the foregoing.~~
~~(5) Person - Any natural or artificial person, including, but not limited to, individuals, partnerships, associations, organizations, trusts, or corporations, but shall not include any securities broker performing no more than the usual and customary broker's function.~~
~~(6) Subsidiary - An affiliate controlled by a specified person directly or indirectly through one or more intermediaries.~~
~~(7) Voting security - Includes any security convertible into or evidencing a right to a acquire a voting security.~~

~~§11.1202. Filing Requirements.~~

~~(a) Filing requirements.~~
~~(1) No person shall:~~
~~(A) acquire in any manner any voting security of a domestic HMO if such person is, or after such acquisition would be, directly or indirectly, in control of a domestic HMO; or~~
~~(B) otherwise acquire control of or exercise any control over a domestic HMO, until and unless such person has filed with the commissioner a statement containing the information required by subsection (b) of this section and such acquisition of control has been approved by the commissioner in the manner~~

~~hereinafter prescribed. The statement filed under this subsection shall be subject to public inspection at the office of the commissioner, and a copy shall be sent by the acquiring party to the domestic HMO.~~
~~(2) For purposes of this section, a domestic HMO includes any person controlling a domestic HMO unless such person is either directly or through its affiliates primarily engaged in business other than the business of operating an HMO. A person controlling a domestic HMO shall not be considered primarily engaged in the business of operating an HMO only if that person meets each of the following tests, regardless of whether any line of noninsurance business is a primary business of the person:~~
~~(A) the assets of all HMO subsidiaries constitutes less than 20% of such person's consolidated assets;~~
~~(B) the gross revenues including investment income of all HMO subsidiaries constitute less than 20% of such person's consolidated gross revenues; and~~
~~(C) the stockholders' equity of all HMO subsidiaries constitutes less than 20% of such person's consolidated stockholders' equity.~~
~~(b) Content of statement. The statement to be filed with the commissioner hereunder shall be made under oath or affirmation and shall contain the following information:~~
~~(1) the name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in either subsection (a) or (b) of this section is to be effected (hereinafter called acquiring party), and:~~
~~(A) if such person is an individual, his principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past 10 years; and~~
~~(B) if such person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subparagraph (A) of this paragraph;~~
~~(2) the source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests;~~
~~(3) fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding three fiscal years of each such acquiring party (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement, unless such acquiring party is an individual, in which case he or she shall provide such personal financial information as required by the commissioner.~~
~~(4) any plans or proposals which each acquiring party may have to liquidate such HMO, to sell its assets, or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;~~
~~(5) the number of shares of any security referred to in subsection (a) of this section which such acquiring party proposes to acquire, the terms of the offer, request, invitation, agreement, or acquisition, and a statement as to the method by which the fairness of the proposal was achieved; and~~
~~(6) such additional information as the commissioner may require as necessary or appropriate for the protection of enrollees of the HMO or in the public interest.~~
~~(c) Supplemental information for partnerships or other groups. If the person required to file the statement referred to in subsection (a) of this section is a partnership, limited partnership, syndicate, or other group,~~

the commissioner may require that the information called for by subsection (b) of this section shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation or the person required to file the statement referred to in subsection (a) of this section is a corporation, the commissioner may require that the information called for by subsection (b) of this section shall be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than 10% of outstanding voting securities of such corporation.

(d) Filing requirement for changes in facts. If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to such HMO pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the commissioner and sent to such HMO within two business days after the person learns of such change.

§11.1203. Form Filing.

(a) General requirements.

(1) The form that is specified in §11.1204 of this title (relating to Form A (HMO)) is intended to be a guide in the preparation of the statement required by this subchapter. It is to provide notice of the information required and the location in which it will be expected to be found. In preparing any statement, the text of the form should be repeated preceding the answer. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made. The form specified in §11.1204 of this title (relating to Form A (HMO)) is also referred to in this subchapter as Form A (HMO) or as the acquisition statement.

(2) One complete, originally signed statement and two photocopies of same, including exhibits and all other papers and documents filed as a part thereof, shall be filed with the commissioner by personal delivery or by mail addressed to: Insurer Services, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(3) Statements should be prepared on paper 8 1/2 by 11 inches in size and preferably bound at the top or top left hand corner. All copies of any statement, exhibit, or financial statement shall be clear, easily readable, and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with a statement is in a foreign language, it shall be accompanied by a translation into the English language, and any monetary value shown in a foreign currency shall be converted into United States currency and the rate of exchange shall be disclosed in the submission.

(4) Every statement shall state on the face page thereof the names and addresses of all persons on whose behalf the same is made.

(b) Summaries and omissions.

(1) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the most important provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit attached to such statement. The particular page and paragraph of the exhibit to which reference is made must be specified. If two or more documents required to be attached as exhibits are substantially identical in all material respects, a copy of only one of such documents need be filed. A schedule shall be attached identifying the details in which such other document differs from the filed exhibit.

(2) By use of a reference to an exhibit, the person filing shall be deemed to have verified the accuracy of the information referred to as though it were an original statement, unless the person filing identifies such

information as being not verified.
(c) Additional information and exhibits. In addition to the information expressly required by §11.1204 of this title (relating to Form A (HMO)), there shall be added such further material information, if any, as may be necessary to avoid misleading information. The person filing may also file additional exhibits as desired. Such exhibits shall be marked as to indicate clearly the subject matters to which they refer.
(d) Amendment. Any amendment to a statement shall include on a cover page all information required for the cover page of the acquisition statement itself, as well as the phrase "Amendment No. _____ to _____" and shall indicate the date of the amendment and not the date of the original filing.
(e) Information unknown or unavailable and extension of time to furnish.
(1) Required information need only be given insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because obtaining it would involve unreasonable effort or expense, or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted, subject to the following conditions:
(A) the person filing shall give such information on the subject as he possesses or can acquire without unreasonable effort or expense, together with the sources thereof; and
(B) the person filing shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.
(2) If any required information, document, or report is not included at the time of filing, then such application will be considered incomplete in accordance with §11.301(7)(A) of this title (relating to Filing Requirements).

§11.1204. Form A (HMO).

(a) Cover page for Form A (HMO). The following shall be placed, centered, on the cover page of the Form A (HMO):
Figure: 28 TAC §11.1204(a)

Form A (HMO)

Statement Regarding the **Acquisition, Control, or Merger of**

(Name of **a Domestic** Health Maintenance Organization)**HMO.**

by

_____, Applicant

(Name of Acquiring Person)

Filed with the Texas Department of Insurance

Date:_____, _____

~~(Month/Day) (Year)~~

~~Name, title, address, and telephone number~~

~~of individual to whom notices and correspondence~~

~~concerning this statement should be addressed:~~

~~(b) HMO and method of acquisition. State the name and address of the domestic HMO to which this application relates and a brief description of how control is to be acquired.~~
~~(c) Identity and background of the applicant if not an individual.~~
~~(1) State the name and address of the applicant seeking to acquire control over the HMO.~~
~~(2) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.~~
~~(3) Furnish a chart or listing clearly identifying the interrelationships between the applicant and all affiliates of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings looking toward a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings, and the date when commenced.~~
~~(d) Identity and background of individuals associated with the applicant. State the following with respect to all persons who are directors, executive officers, or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual, in the biographical affidavit form:~~
~~(1) name and business address;~~
~~(2) present principal business activity, occupation, or employment, including position and office held and the name, principal business, and address of any corporation or other organization in which such employment is carried on;~~
~~(3) material occupations, positions, offices, or employments during the last five years, giving the starting and ending dates of each and the name, principal business, and address of any business corporation, or other organization in which each such occupation, position, office, or employment required licensing by or registration with any federal, state, or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith; and~~
~~(4) whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violation) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.~~
~~(e) Identity and background of individual applicant. Provide the following biographical data in the biographical affidavit form with respect to the applicant if he or she is an individual:~~
~~(1) name and business address;~~
~~(2) present principal business activity, occupation, or employment, including position and office held and the name, principal business, and address of any corporation or other organization in which such employment is carried on;~~

~~(3) material occupations, positions, offices, or employments during the last five years, giving the starting and ending dates of each and the name, principal business, and address of any business corporation, or other organization in which each such occupation, position, office, or employment required licensing by or registration with any federal, state, or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith; and~~

~~(4) whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.~~

~~(f) Identity and background of individuals under any proposed management contract concerning the HMO with biographical data in the biographical affidavit form. State the following with respect to all persons who are directors, executive officers, or owners of 10% or more of the voting securities of a company with which there is a proposed management contract concerning the HMO, as well as with respect to any other individuals who may be empowered under a proposed contract to manage the HMO:~~

~~(1) name and business address;~~

~~(2) present principal business activity, occupation, or employment, including position and office held and the name, principal business, and address of any corporation or other organization in which such employment is carried on;~~

~~(3) material occupations, positions, offices, or employments during the last five years, giving the starting and ending dates of each and the name, principal business, and address of any business corporation, or other organization in which each such occupation, position, office or employment required licensing by or registration with any federal, state, or municipal governmental agency, including such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith; and~~

~~(4) whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.~~

~~(g) Nature, source, and amount of consideration.~~

~~(1) Describe the nature, source, and amount of funds or other considerations used or to be used in effecting the acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding, or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes, and security arrangements relating thereto.~~

~~(2) Explain the criteria used in determining the nature and amount of such consideration.~~

~~(3) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity to remain confidential, he or she must specifically request that the identity be kept confidential. When confidentiality is requested, such identity shall be provided by a separate~~

~~instrument filed with, but not forming part of, the acquisition statement.~~

~~(4) If the consideration is to consist in whole or in part of the business and assets of the HMO or of a person controlled by the HMO, state the value thereof and how such value was derived.~~

~~(h) Future plans for HMO. Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such HMO, to sell its assets to or merge it with any person or persons, or to make any other material change in its business operations or corporate structure or management and any financial or employment guarantees given to present and contemplated management.~~

~~(i) Voting securities to be acquired. State the number of shares of the HMO's voting securities which the applicant, its affiliates, and any person listed in subsection (d) of this section plan to acquire, and the terms of the offer, request, invitation, agreement, or acquisition, and a statement as to the method by which the fairness of the proposal was derived.~~

~~(j) Financial statements and exhibits.~~

~~(1) Financial statements and exhibits shall be attached to Form A (HMO) as an appendix, but list under this subsection the financial statements and exhibits so attached.~~

~~(2) Subject to §11.1203 of this title (relating to Form Filing), the financial statements shall include the annual financial statements of the persons identified in subsection (c)(3) of this section for the preceding three fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business. Unless exempted by the commissioner, the annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant, if available, to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or other accounting principles prescribed or permitted under law. If such certificate is not available, then such financial statement shall be sworn to by the applicant as correctly reflecting its financial condition, and in such case, the commissioner at his or her discretion may require such financial statement to be certified by an independent public accountant. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the annual statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such

~~state.~~

~~(3) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the HMO and (if distributed) of additional soliciting material relating thereto.~~

~~(4) Financial projections for three years, including a balance sheet, income statement, and cash flow statement for the HMO and acquiring party. The HMO financial projections shall be on a quarterly basis. In addition, if debt is incurred by an acquiring party to fund the acquisition, such financial projections shall reflect the period of required debt service until the debt is fully liquidated.~~

~~(5) File as exhibits copies of any proposed exclusive agency contract or management contract concerning the HMO, and copies of any proposed changes to contracts of the HMO that the form of which has been previously approved by the commissioner.~~

~~(6) With regard to all affiliates of the applicant that are HMOs, file as an exhibit a detailed description of the guarantees or other financial arrangements the applicant has in connection with the operation of such affiliated HMOs.~~

~~(7) If the applicant is part of an HMO holding company, file as exhibits certified consolidated financial statements for all affiliated HMOs and consolidated pro forma balance sheets to show the effect of the change of control.~~

~~(8) In addition to the material required to be filed by this section, a person as described in §11.1202(a)(2) of this title (relating to Filing Requirements) shall file, as an exhibit, annual reports to the stockholders of the HMO and the applicant for the last two fiscal years. These reports are for review of the Texas Department of Insurance and are not part of the material required to be submitted under §11.1202(c) of this title (relating to Filing Requirements), or to be mailed to shareholders under §11.1205(c) of this title (relating to Approval by Commissioner; Hearings). The materials shall be open for public inspection at the department during the pendency of the application.~~

~~(k) Additional information.~~

~~(1) Provider contracts. If contracts the HMO has entered into with providers are not assignable at the option of the HMO under the terms thereof, file as an exhibit an agreement by each provider to assignment of the contract to the applicant, to be effective as of the date of approval by the commissioner of the change of control. In the event any provider declines to agree to assignment of the contract, file as an exhibit a list of all such providers.~~

~~(2) Authorization. If the change of control is to occur pursuant to an agreement, file as exhibits notarized statements of all parties thereto that the execution and delivery of the agreement, the consummation of the~~

~~transactions contemplated therein, and the performance by the parties of their respective obligations thereunder have been duly and validly authorized by all necessary corporate action.~~

~~(3) No conflict. File as an exhibit the opinion of legal counsel for applicant that counsel is satisfied that the change of control will not violate, conflict with, or result in a breach or acceleration of or default under:~~

~~(A) any laws, regulations, or requirements of any governmental or regulatory body applicable to the business of the HMO; or~~

~~(B) any agreement, instrument, or obligation to which the HMO is a party (including, without limitation, any contracts with an independent practice association, insurance contracts for stop-loss coverage or otherwise, and any fidelity bonds covering officers and employees of the HMO).~~

~~(l) Signature and certification. Signature and certification in the following form.~~ An HMO is subject to the requirements of Insurance Code Chapter 823 (concerning Insurance Holding Company Systems); Insurance Code Chapter 824 (concerning Merger and Consolidation of Stock Insurance Corporations); and Chapter 7, Subchapter B, of this title (relating to Insurance Holding Company Systems).

SUBCHAPTER

~~Figure: 28 TAC §11.~~~~1204(l)~~

~~Signature~~

~~Pursuant to the requirements of §11.1204(j) of the rules of the Texas Department of Insurance covering Health Maintenance Organizations, the applicant has caused this acquisition statement to be duly signed on its behalf in the City of _____ and the State of _____on the _____ day of _____, _____(year).~~

~~_____~~

~~(Name of Applicant)~~

~~(Seal)~~

~~By:~~

~~(Name)~~

(Title)

Attest:

(Signature of officer)

(Title)

Certification

The State of _____

County of _____

Before me, the undersigned authority, on this day personally appeared _____ (name of officer signing) known to me to be the _____(title) of _____ (name of applicant) who, after being placed on his oath, stated that he has read the preceding application and that the answers, exhibits, and attachments forming it are true and correct as to any factual statements contained therein.

_____

(signature of officer)

Sworn to and subscribed before me on this _____ day of _____, _____ (year) , to certify which witness my hand and seal of office.

_____

(signature of notary)

(Seal)

_____

Printed name of notary:

Notary Public in and for the State of _____

My commission expires:_____

§11.1205. Approval by Commissioner; Hearings.

(a) After notice and opportunity for hearing, if required, the commissioner shall approve any such acquisition of control referred to in §11.1202(a) or (b) of this title (relating to Filing Requirements) unless he or she finds that:
(1) after the change of control the domestic HMO referred to §11.1202(a) or (b) of this title would not be able to satisfy the requirements for the issuance of a certificate of authority to operate as an HMO as it is presently licensed to do;
(2) the effect of such acquisition of control would be substantially to lessen competition among HMOs in this state or tend to create a monopoly therein;
(3) the financial condition of any acquiring party is such as might jeopardize the financial stability of the HMO, or prejudice the interest of its enrollees or the interests of any remaining shareholders who are unaffiliated with such acquiring party;
(4) the plans or proposals which the acquiring party has to liquidate the HMO, sell its assets, or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair, prejudicial, hazardous, or unreasonable to enrollees of the HMO and not in the public interest;
(5) the competence, trustworthiness, experience, and integrity of those persons who would control the operation of the HMO are such that it would not be in the interest of enrollees of the HMO and of the public to permit the merger or other acquisition or control; or
(6) such acquisition or merger would violate any law of this or any other state or of the United States.
(b) The public hearing, if required, referred to in subsection (a) of this section shall be held within 45 days after the statement required by §11.1202(a) or (b) of this title is accepted for filing as complete in all aspects, and at least 20 days' notice thereof shall be given by the commissioner to the person filing the statement and to the domestic HMO. Not less than 10 days' notice of such public hearing shall be given by the person filing the statement to such other persons as may be designated by the commissioner. The HMO shall give prompt notice of the hearing to such persons as may be designated by the commissioner within the time and manner specified by the commissioner. All provisions of this subchapter relating to the timely notice of hearing thereon before the commissioner may be waived by the unanimous consent of all parties including the commissioner's staff. The commissioner shall make a determination within 60 days, after the conclusion of such hearing. At such hearing, the person filing the statement, the HMO, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments in connection therewith.

§11.1206. Exemptions.

(a) The commissioner by order may exempt from the provisions of this subchapter any offer, request, invitation, agreement, or acquisition which is found either:
(1) not to have been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic health maintenance organization; or
(2) otherwise not comprehended within the purposes of this subchapter.
(b) A change consisting only of the substitution of management contractors under a contract with the health maintenance organization as provided for in the Insurance Code §843.105 shall be subject to the approval of the commissioner according to the provisions of the Insurance Code §843.105 and shall be exempt from the provisions of this subchapter. No order of exemption is necessary for this purpose.

Subchapter N. HMO SOLVENCY SURVEILLANCE COMMITTEE PLAN OF OPERATION

~~§11.1301. Plan of Operation.~~

~~This plan of operation, hereinafter referred to as the plan, shall become effective upon written approval of the Texas Department of Insurance, hereinafter referred to as the department, as provided by the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs. As used in this subchapter, the committee shall be the solvency surveillance committee as provided for and defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, and the members shall be the members of the committee as provided for and defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs.~~

~~§11.1302. Solvency Survey Committee.~~

~~(a) Members. The composition of the committee shall be in accordance with the Insurance Code §843.436.~~
~~(1) The HMO members' terms shall last for three years unless otherwise appointed by the commissioner and shall be staggered with three appointments expiring each year. A member's term shall terminate if the member leaves the HMO whose characteristics were the basis for appointment. The HMO shall not automatically continue as a member.~~
~~(2) Members may serve multiple terms.~~
~~(3) A member shall serve until a successor is appointed unless such member's term is in conflict with the Insurance Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, or unless a member misses two or more consecutive meetings or engages in willful misconduct, in which case the commissioner may remove the member. The committee shall make recommendations to the commissioner and the department to fill vacancies. Members shall not receive any remuneration or emolument of office.~~
~~(4) The members shall elect a chairman, a vice chairman, a secretary-treasurer, and such other officers as they deem necessary. The term of office shall be one year or until a successor is elected and qualified. Vacancies occurring in elective office shall be filled by vote of the members.~~
~~(b) Voting. A majority of the members shall constitute a quorum for the transaction of business, and the acts of a majority of the members at a meeting at which a quorum is present shall be the acts of the committee. An affirmative vote of a majority of the total membership of the committee shall be required:~~
~~(1) to propose amendments to the plan;~~
~~(2) to approve any contract or service agreement;~~
~~(3) to levy an assessment or provide for a refund;~~
~~(4) to borrow money; or~~
~~(5) to extend funding of expenses of supervision, conservation, rehabilitation, or liquidation of an HMO as provided in Insurance Code §843.441 unless special notice of the desire to take action on this item is part of the notice of the meeting, in which case the acts of a majority of the members voting in person at a meeting at which a quorum is present shall be the acts of the committee.~~
~~(c) Meetings. On a day determined by the members, the committee shall hold a regular annual meeting. At its annual meeting, the committee may schedule additional regular meetings to be held during the period between annual meetings. Meetings shall be held at the department's offices unless the commissioner, chairman of the committee, or other officer acting on the chairman's behalf, designates some other place. At each such meeting the committee may:~~
~~(1) review the plan and submit to the department for approval any proposed amendment to the plan;~~
~~(2) review outstanding contracts or service agreements, if any, and, to the extent possible, make necessary or desirable corrections, improvements, or additions;~~

(3) consider and provide for collection of assessments for operating expenses of the committee;
(4) consider facts relevant to, and provide for, the collection of assessments as determined by the commissioner;
(5) consider any extension of funding for the expenses of supervision, conservation, rehabilitation, or liquidation of an HMO as provided in Insurance Code §843.441;
(6) review financial information relating to each HMO. Committee members shall be provided with reports regarding the financial condition of Texas licensed HMOs and regarding the financial condition, administration, and status of HMOs in supervision, conservation, rehabilitation, or liquidation at meetings. Committee members shall not reveal the condition of nor any information secured in the course of any meeting of the committee with regard to any corporation, form, or person examined by the committee;
(7) advise the commissioner on actions necessary to prevent financial impairment;
(8) receive reports and advise the commissioner regarding management of HMO impairments and insolvencies;
(9) authorize appropriate legal action to recover unpaid assessments;
(10) review, consider, and act on the powers given the committee for a special or emergency meeting as outlined in subsection (d)(1) - (3) of this section; and
(11) review, consider, and act on other matters deemed by it to be necessary and proper for the administration of the committee.
(d) Special or emergency meetings. The committee shall hold a special or emergency meeting promptly after receiving notice from the commissioner of the need for such meeting. In addition, a special meeting of the committee may be held at the request of a majority of the membership, which shall be polled by the chairman at the request of any two members seeking a special meeting. At such meetings, the committee, if appropriate, shall perform the following functions.
(1) The committee shall receive and consider the report of the commissioner regarding HMO impairments or insolvencies within the meaning of Insurance Code Articles 21.28 and 21.28-A. Such reports may include progress and developments on management of such impairments or insolvencies.
(2) In consultation with the commissioner, the committee shall consider what assessment, if any, shall be levied, decide whether any refund should be made to an HMO, and consider and decide whether any assessment for expenses of supervision, conservation, rehabilitation, or liquidation shall be extended as provided in Insurance Code §843.441. Assessments shall conform to Insurance Code §843.441. Any HMO failing to pay an assessment after 30 days' written notice that payment is due, shall be reported to the commissioner, and the committee shall consider what other action, if any, shall be taken.
(3) The committee shall take all steps permitted by law, and deemed necessary, to protect the committee's rights as pertaining to the impaired or insolvent HMO or its enrollees.
(4) In addition to the powers described in paragraphs (1) - (3) of this subsection, the committee shall have and exercise such other powers as may be reasonably necessary to implement its powers and responsibilities under the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs.
(e) Notice. Notice of meetings of the committee shall be in accordance with Chapter 551 of the Government Code.
(f) Attendance at meeting. Committee meetings shall be open to the public, but the committee may hold a closed meeting under the provisions of Subchapter D of Chapter 551, Government Code, in which only committee members, the commissioner, and persons authorized by the commissioner shall be in attendance at such meeting.

§11.1303. Operations.

~~(a) Official address. The official address of the committee shall be the address of the office of the commissioner unless otherwise designated by the committee.~~
~~(b) Record maintenance. The committee shall keep and maintain a record of the affairs and financial transactions of the committee and its agents.~~
~~(c) Custodian of accounts.~~
~~(1) The committee appoints the director of liquidation oversight as the custodian of the administrative account and as its agent for collecting assessments from HMOs. In the name of the committee, the custodian shall maintain such funds in depositories as provided by Insurance Code Article 21.28, §(2)(h). The committee may authorize the investment of some or all of these funds in other types of investments.~~
~~(2) The director of liquidation oversight shall maintain suitable account records and shall furnish the committee at each regular meeting a statement of the financial condition of the committee and a statement of income and disbursements since the last report. The director of liquidation oversight shall be entitled to reimbursement for actual expenses in performing the custodian's duties under this subsection and is authorized to hire a certified public accountant to audit the annual statement required by Insurance Code Chapters 20A and 843.~~
~~(3) Disbursement of any of the funds of the committee specifically authorized by this plan or subsequently authorized by resolution of the committee may be made~~
~~by the custodian upon receipt of a statement or voucher describing the proposed expenditure that has been approved in writing by an officer of the committee.~~
~~(d) Additional procedures. The committee shall establish any additional procedures for handling any assets of the committee as deemed appropriate.~~

~~§11.1304. Records and Reports.~~

~~(a) Written record. A written record of the proceedings of each committee meeting shall be made. The original of this record shall be retained by the commissioner with copies furnished to each member and to the department. The record shall be subject to the pertinent provisions of the law, including confidentiality laws.~~
~~(b) Annual report. Not later than May 1st of each year, the committee shall make an annual report to the commissioner. Such report shall include a financial report for the preceding calendar year in a form approved by the commissioner during the preceding calendar year.~~

~~§11.1305. Appeals.~~

~~(a) Appeal to commissioner. Any HMO or HMO agent aggrieved by an act of the committee may appeal to the committee. If such HMO or HMO agent is aggrieved by the final action or decision of the committee, or if the committee does not act on such appeal within 30 days, then the HMO or HMO agent may appeal to the commissioner within 30 days after the action or decision of the committee or the expiration of the 30-day period in which the committee failed to act on such appeal.~~
~~(b) Appeal to district court. Any HMO or HMO agent which is affected by any ruling or action of the commissioner may file a petition in the District Court of Travis County, Texas to have any ruling or action reviewed by the court pursuant to Insurance Code §§36.201 – 36.205.~~

~~§11.1306. Conformity of Statute.~~

~~Sections 843.435 - 843.441 of the Texas Insurance Code are incorporated as a part of this plan.~~

~~Subchapter~~ O. ADMINISTRATIVE PROCEDURES

§11.1401. Commissioner's Authority to Require Additional Information.

The commissioner may require additional information as needed to make any determination required by ~~the~~ Insurance Code ~~Chapters~~Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 ~~and 843,~~(concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, and other applicable insurance laws and regulations of this state ~~that apply to HMOs.~~ .

§11.1402. Notification to Physicians and Providers.

(a) ~~A health maintenance organization~~An HMO that provides coverage for health care services or medical care through one or more ~~providers or~~ physicians or providers is required by ~~the provisions of~~ Insurance Code §843.305 (concerning Annual Application Period for Physician and Providers to Contract) to provide a 20~~-~~-calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in each of the HMO's networks providing health care services or medical care under the terms and conditions established by the ~~health maintenance organization~~HMO for the provision of ~~such~~the services and the designation of ~~such providers and~~ the physicians~~.~~ and providers. Section 843.305 may not be construed to:

~~(1) require that a health maintenance organization utilize a particular type of provider or physician in its operation;~~

(1) require that an HMO use a particular type of provider or physician in its operation;

(2) require that ~~a health maintenance organization~~an HMO accept a ~~provider or~~ physician or provider of a category or type that does not meet the practice standards and qualifications established by the ~~health maintenance organization~~HMO; or

(3) require that ~~a health maintenance organization~~an HMO contract directly with ~~such providers or~~ the physicians~~.~~
or providers.

(b) An HMO ~~which is covered by~~subject to Insurance Code §843.305 must publish a notice of an application period to physicians and providers both in the public notice section of at least one major newspaper with general circulation in each of its service areas~~.~~ and on the HMO's website. The notice must be published for at least five consecutive days during the period of January 2 through January 23 of each calendar year and must include ~~this~~the caption ~~in bold type: "~~"Notice to Physicians and Providers" in bold type, the name and address of the HMO, what ~~type of services~~networks the HMO provides, and the specific dates of the 20~~-~~day period during which physicians and providers may make application to be a participating physician or provider~~.~~
in each network.

(c) ~~A health maintenance organization~~An HMO must notify a physician or provider of acceptance or ~~non-acceptance~~nonacceptance, in writing, no later than 90 days from receipt of an application for participation by that physician or provider~~.~~

~~(d) A health maintenance organization must file a copy of the published notice with the HMO Division, for information, within 15 days of publication. The filing must include the following:~~

~~(1) the name of the newspaper; and~~ in a network.

~~(2)~~ (d) An HMO must file a copy of the published notice with the department in compliance with §11.301 of this title (relating to Filing Requirements), for information, within 30 days of publication. The filing must include the following:

(1) the name of the newspaper and the beginning and ending date of the publication~~.~~;

and

(2) a copy of the website screen shots and the beginning and ending date of the publication.

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers.

~~Health Maintenance Organizations shall~~ (a) HMOs must include ~~in their next available newsletter or other general mailing to all enrollees following the effective date of this section, and shall include~~the following notice in information provided to new subscribers~~, the following notice~~:

Figure: 28 TAC §11.1403(a)

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-832-9623

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

(b) The entire notice ~~shall~~must be in at least 10-point type. If the newsletter or other mailing is in larger than 10-point type, the notice ~~shall~~must be in the same type as the rest of the newsletter or mailing. Paragraphs 1 - ~~3~~4 of the English notice and paragraphs 1 - ~~3~~4 of the Spanish notice must be in boldface type. Paragraphs 1 and 2 of the English and Spanish notices must be in capital letters. A final print of the mailing ~~shall~~must be submitted to the ~~HMO Division~~Life and Health Lines Office of the Texas Department of Insurance for filing within 30 days following distribution to enrollees.

§11.1404. Pharmacy Application and Recertification.

~~(a) An HMO may establish reasonable application and recertification fees for each licensed pharmacy that participates or applies to participate as a contract provider in an HMO delivery network.~~
~~(b) An application or recertification fee charged under this section shall be considered reasonable provided:~~
~~(1) the fee does not exceed $50 per licensed pharmacy;~~
~~(2) the fee shall be uniformly charged per application or recertification to each pharmacy holding a license issued by the Texas State Board of Pharmacy;~~

~~(3) an HMO that contracts for the pharmaceutical services of more than one licensed pharmacy under common ownership or affiliation shall charge a separate fee for each licensed pharmacy;~~

~~(4) no more than one fee per licensed pharmacy is charged by an HMO for processing an application or recertification for participation as a contracted provider under more than one group or individual contract or in more than one HMO delivery network; and~~

~~(5) no more than one fee per licensed pharmacy is charged by any HMO or insurer within the same insurance holding company system, as defined in Insurance Code §843.002, utilizing common networks.~~

~~(c) An HMO shall~~ (a) An HMO may not require any pharmacy or pharmacist participating or applying to participate as a contracted provider in an HMO delivery network~~:~~

~~(1) to provide financial statements to the HMO; and~~ to:

(1) provide financial statements to the HMO; or

(2) ~~to~~ deposit with the HMO any monies or other form of consideration, except for reasonable application and recertification fees.

~~Subchapter~~ (b) An HMO or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of, or component or mechanism related to, the claim adjudication process in violation of Insurance Code §1369.402 (concerning Certain Fees Prohibited).

SUBCHAPTER P. PROHIBITED PRACTICES

§11.1500. Discrimination Based on Health Status-Related Factors.

An HMO may not require an enrollee in a group health plan to pay a premium or contribution that is different from the premium or contribution for a similarly situated enrollee based on a health status-related factor. For purposes of this section, the term "similarly situated~~"~~" has the meaning assigned to it in 45 CFR §146.121~~, relating to prohibiting discrimination against participants~~ (concerning Prohibiting Discrimination Against Participants and ~~beneficiaries based~~Beneficiaries Based on a ~~health factor.~~Health Factor). An HMO may not establish policies or procedures that are based on health status-related factors for the eligibility of any individual to enroll under a group plan.

~~Subchapter~~SUBCHAPTER Q. OTHER REQUIREMENTS

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

(a) An HMO ~~shall~~must provide an accurate written description of health care plan terms and conditions to allow any prospective contract holder or enrollee or current contract holder or enrollee to make comparisons and informed decisions before selecting among health care plans. ~~By agreement, the~~ The HMO may deliver the ~~required~~written description of health care plan terms ~~required by this section~~and conditions electronically~~.~~
but must provide a paper copy on request.

(b) The written or electronic plan description must be filed for approval in compliance with §11.301 of this title (relating to Filing Requirements); be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements), by category~~,~~; and ~~must~~ include ~~a clear, complete and accurate description of~~ these items in the following order:

(1) a statement that the entity providing the coverage is an HMO;

(2) a toll-free number, unless exempted by statute or rule, and address for obtaining additional information, including physician and provider information;

(3) a clear, complete, and accurate description of all covered services and benefits, including a description of the options~~(~~, if any~~),~~ for prescription drug coverage, both generic and brand name~~;~~
, and if applicable, an explanation of how to access formulary information consistent with §21.3031(b) of this title (relating to Formulary Information on Issuer's Website);

(4) a clear, complete, and accurate description of emergency care services and benefits, including coverage for out-of-area emergency care services and information on access to after-hours care;

~~(5)~~

(5) a clear, complete, and accurate description of out-of-area services and benefits (if any);

(6) ~~an~~as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), statements that:

(A) a facility-based physician or other health care practitioner may not be included in the health benefit plan's physician and provider network;

(B) the facility-based physician or other health care practitioner may balance bill the enrollee for amounts not paid by the health benefit plan; and

(C) if the enrollee receives a balance bill, the enrollee should contact the HMO;

(7) a clear, complete, and accurate explanation of enrollee financial responsibility for payment of premiums, copayments, deductibles, and any other out-of-pocket expenses for noncovered or out-of-plan services, and an explanation that network physicians and providers have agreed to look only to the HMO and not to its enrollees for payment of covered services, except as set forth in this description of the plan;

~~(7)~~

(8) a clear, complete, and accurate description of any limitations or exclusions, including the existence of any drug formulary limitations;

~~(8)~~

(9) a clear, complete, and accurate description of any prior authorization requirements, including limitations or restrictions ~~thereon~~, and a summary of procedures to obtain approval for~~,~~ referrals to physicians and providers other than primary care physicians or dentists, and other review requirements, including preauthorization review, concurrent review, post service review, and post payment review, and the consequences resulting from the failure to obtain any required authorizations; ~~authorizations;~~

~~(9)~~ (10) a provision for continuity of treatment in the event of the termination of a primary care physician or dentist;

~~(10~~

(11) a clear, complete, and accurate summary of the HMO's complaint and appeal procedures ~~of the HMO~~, a statement of the availability of the independent review process, and a

statement that the HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO;

~~(11~~

(12) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, ~~updated on at least a quarterly basis. The list shall include~~with the information necessary to fully inform prospective or current enrollees about the network, including ~~names and locations~~the information required by §11.1612 of ~~physicians and providers, a statement~~this title (relating to Mandatory Disclosure Requirements), together with a link to the online directory required under §11.1612(a) of ~~limitations~~this title;

(13) a clear, complete, and accurate description of ~~accessibility and referrals to specialists~~the service area;

(14) when the HMO product includes point-of-service coverage, including ~~any limitations imposed by~~ when such coverage is provided by an insurer, or when the product is explicitly marketed with the option of purchasing point-of-service coverage, a clear, complete, and accurate explanation of the point-of-service coverage, including:

(A) an explanation of how any deductible is calculated, clearly explaining if multiple deductibles may be applied under the plan as a whole;

(B) a method to obtain a real-time estimate of the amount of reimbursement that will be paid to a non-network provider for a particular service;

(C) a clear, complete, and accurate explanation of how reimbursements of non-network point-of-service services will be determined subject to §11.2503 of this title (relating to Coverage Relating to Point-of-Service Rider Plans) for point-of-service riders or §21.2902 of this title (relating to Arrangements between Indemnity Carriers and HMOs to Provide Coverage) for dual and blended point-of-service arrangements;

(D) if point-of-service coverage is provided under a dual or blended point-of-service arrangement, a clear, complete, and accurate explanation of how the coverage will be coordinated and who the enrollee should contact for common issues, including;

(i) the identity and contact information for each entity, the HMO, the indemnity carrier, or any third party administrator (TPA) that will administer the coverages offered under the point-of-service plan;

(ii) a clear, complete, and accurate description of all duties of the HMO and other carrier to each other relating to the point-of-service plan issued under this subchapter; and

(iii) as applicable, a clear, complete, and accurate explanation of out-of-plan coverage for point-of-service coverage offered in conjunction with plans subject to Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans);

(E) a clear, complete, and accurate explanation that for an enrollee in a limited provider network, ~~and a~~ higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the HMO delivery network.

(c) An HMO may use its member handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure ~~of which physicians and providers will not accept new enrollees or participate in closed provider networks serving only certain enrollees.~~

~~(A)~~ as the written or electronic description prescribed by the commissioner and contains all the information required under this section.

(d) An HMO offering a Children's Health Insurance Program plan that files its plan description in the form of its member handbook in compliance with §11.301 of this title (relating to Filing Requirements), for information only, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook is exempt from the filing and approval requirements of subsection (b) of this section.

(e) If an HMO limits enrollees' access to health care to a limited provider network, then it ~~shall~~must provide a notice in substantially the following form to prospective and current group contract holders ~~and enrollees a notice in substantially the following form~~: "Choosing Your Physician--Now that you have chosen ~~XYZ Health Plan,~~(Name of HMO), your next choice will be deciding who will provide the majority of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP is also part of a ~~"network"~~'network' or association of health

professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer."

~~(B~~

(f) If an HMO does not limit an enrollee's selection of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or provider belongs, then it ~~shall~~must provide ~~to current or prospective enrollees~~ a notice in compliance with ~~the~~ Insurance Code Chapter 1451, Subchapter F, (concerning Access to Obstetrical or Gynecological Care) in substantially the following form to current or prospective enrollees: "ATTENTION FEMALE ENROLLEES: You have the right to select ~~an~~ and visit an obstetrician-gynecologist (OB-GYN ~~to whom you have access~~) without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

~~(C~~

(g) An HMO ~~shall~~must clearly ~~differentiate~~identify limited provider ~~networks and open~~ networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in ~~the~~each limited provider network. An HMO ~~shall~~must include an index of the alphabetical listing of all contracted physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and ~~shall~~must indicate the limited provider network(s) to which the physician or provider belongs~~,~~ and the page number where the physician or provider's name can be found.

~~(D~~

(h) An HMO ~~shall~~must provide notice to enrollees informing them to contact the HMO ~~upon~~on receipt of a bill for covered services from any physician or provider~~.~~, including a facility-based physician or other health care practitioner. The notice ~~shall~~must inform enrollees of the method(s) for contacting

the HMO for this purpose.

~~(E) An HMO that maintains an internet site shall include on its internet site the information as required in subparagraphs (A) - (D) of this paragraph.~~

~~(12) the service area.~~

~~(c) No HMO, or representatives thereof, may cause or knowingly permit the use or distribution of enrollee information which is untrue or misleading.~~

~~(d) An HMO may utilize its handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure as the written or electronic description prescribed by the commissioner and contains all the information required under subsection (b) of this section.~~

~~(e~~

(i) If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (~~e.g.,~~for example, a hospital or skilled nursing facility), the plan description must disclose that ~~upon~~on admission to the inpatient facility, a physician other than the primary care physician may direct and oversee the enrollee's care.

~~(f) An HMO that maintains an internet site shall list the information as required by subsection (b)(11) of this section and Insurance Code §843.2015 on its internet site. Such information shall be easily accessible from the home page of the site.~~

(j) An HMO that maintains a website must list the information on its website as required by subsections (b) - (g) of this section and Insurance Code §843.2015 (concerning Information Available Through Internet Site) and §1456.003 (concerning Required Disclosure: Health Benefit Plan). The information must be easily accessible from the home page of the HMO's website.

§11.1601. Enrollee Identification Cards.

(a) If an HMO issues identification (ID) cards to enrollees, the HMO ~~shall~~must issue the ID cards within 30 calendar days of receiving notice of the enrollee's selection of a primary care physician. The enrollee ID card will include, at a minimum, all necessary information to allow an enrollee to access all services under the certificate or evidence of coverage ~~which require presentation of the card.~~

~~(b) All ID cards an HMO issues shall comply with the requirements of §21.2820 of this title (relating to~~

~~Identification Cards).~~

~~(c) If an evidence of coverage provides benefits for prescription drugs, an HMO shall issue an ID card in compliance with §§21.3002 - 21.3004 of this title (relating to Definitions;~~ that require presentation of the card.

(b) All ID cards an HMO issues must comply with the requirements of Insurance Code §843.209 (concerning Identification Card) and §1693.002 (concerning Identification Card and Required Information) and §21.2820 of this title (relating to Identification Cards).

(c) If an evidence of coverage provides benefits for prescription drugs, an HMO must issue an ID card in compliance with Insurance Code §1369.153 (concerning Information Required on Identification Card) and §4151.152 (concerning Identification Cards) and §§21.3002 - 21.3004 of this title (relating to Definitions; Pharmacy Identification Cards, Standard Identification Cards, and Issuance of Standard Identification Cards).

(d) All ID cards issued by an HMO ~~shall~~must comply with the requirements of Business and Commerce Code ~~Section 35.58,~~§501.001 (concerning Certain Uses of Social Security Number Prohibited) and §501.002 (concerning Certain Uses of Social Security Number Prohibited; Remedies), which ~~restricts~~restrict the display of social security numbers on ID cards.

(e) An ID card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must display on the card or document in a location of the issuer's choice the acronym "QHP."

§11.1602. Enrollment Form and Access to Certain Information.

(a) An HMO ~~shall~~must include on its enrollment form a space in which an enrollee may indicate:

(1) ~~his or her~~ the enrollee's primary language; and

(2) whether the enrollee has a disability affecting the enrollee's ability to communicate or read.

(b) The HMO ~~shall~~must provide, at its own expense, ~~an enrollee~~a member handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the language of the major population of the HMO's enrolled population ~~pursuant to~~under Insurance Code §843.205~~.~~ (concerning Member's Handbook; Information About Complaints and Appeals). The HMO may deliver the member handbook and materials electronically but must provide a paper copy on request.

(c) If ~~an enrollee~~a member has a disability affecting the ~~enrollee's~~member's ability to communicate or read, then the HMO ~~shall~~must provide, at its own expense, ~~an enrollee~~a member handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the appropriate format, including ~~but not limited to, the following:~~

~~(1) Braille;~~

~~(2) large print, no smaller than seventeen point;~~

~~(3) audio tape;~~

~~(4) TDD access; and/or~~

~~(5) an interpreter.~~ , but not limited to:

(1) Braille;

(2) large print, no smaller than 17 point;

(3) audio tape;

(4) TDD access;

(5) an interpreter; or

(6) any combination of the above.

§11.1603. Notification of Change in Payment Arrangements.

An HMO ~~shall notify all~~must provide written notification to affected group contract holders ~~in writing~~ of a substantive change in the payment arrangement for physicians and providers within 30 days of any change in the type of payment arrangement ~~changes, e.g.,~~; for example, a change from capitation to fee for service, or from fee for service to capitation, for any type of service. The notification of the change must include a description of the changed payment arrangement ~~that has been changed~~ and a description of the new payment arrangement.

§11.1604. Requirements for Certain Contracts ~~between~~Between Primary HMOs and ANHCs and Between Primary HMOs and Provider HMOs.

A primary HMO that enters into a contract with an ANHC in which the ANHC agrees to arrange for or provide health care services~~,~~ other than medical care or services ancillary to the practice of medicine, or with a provider HMO in which the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the primary HMO as part of the primary HMO delivery network ~~shall:~~
must:

(1) submit ~~to the Texas Department of Insurance~~ a monitoring plan to the department setting out:

(A) how the primary HMO will ensure that the ANHC or provider HMO has an effective administrative system for providing timely and accurate reimbursement to all physicians and providers under contract with the ANHC or provider HMO; and

(B) how the primary HMO will ensure that all HMO functions ~~which are~~ delegated or assigned under contract with the ANHC or provider HMO are consistent with full compliance by the primary HMO with all department regulatory requirements ~~of the Texas Department of Insurance;~~
;

(2) file with the ~~Texas Department of Insurance, pursuant to §11.301(5) of this title (relating to Filing Requirements),~~ department a copy of the form of the written ~~agreement~~contract with an ANHC or provider HMO~~-~~, in accordance with §11.301(5) of this title (relating to Filing Requirements), that:

(A) requires that the ANHC or provider HMO cannot terminate the ~~agreement~~contract without 90~~-~~-days written notice;

(B) contains a hold-harmless provision that prohibits the ANHC or provider HMO and its contracted physicians and providers from billing for or attempting to collect from HMO members ~~(~~, except for authorized ~~co-payments~~copayments and deductibles~~)~~, charges for covered services under any circumstance, including the insolvency of the primary HMO, ANHC, or provider HMO;

(C) contains a provision stating that nothing in the ~~primary HMO-ANHC or primary HMO-provider HMO~~ contract ~~shall~~will be construed to in any way limit the HMO's authority or responsibility to comply with all of the department's regulatory requirements ~~of the Texas Department of Insurance;~~
;

(D) includes the ANHC's or provider HMO's acknowledgment and agreement that:

(i) the primary HMO is required to establish, operate, and maintain a health care delivery system, quality assurance system, physician and provider credentialing system, and other systems and programs meeting ~~Texas Department of Insurance and Texas Health Care Council~~department standards and is directly accountable for compliance with ~~such~~the standards;

(ii) the role of the ANHC or provider HMO in contracting with the primary HMO is limited to implementing certain systems of the primary HMO, utilizing standards approved by the primary HMO, and subject to the primary HMO's oversight and monitoring of the ANHC's or provider HMO's performance; and

(iii) the primary HMO may take necessary action to ~~assure~~ensure that all HMO systems and functions ~~which~~that are delegated or assigned under the contract with the ANHC or provider HMO are in full compliance with all department regulatory requirements ~~of the Texas Department of Insurance; ~~;

(E) requires the ANHC to make available to the primary HMO the ANHC's contracts with physicians and providers ~~so as~~ to ensure compliance with contractual requirements set

out in subparagraphs (B) and (C) of this paragraph; ~~and~~

(F) requires the ANHC to provide the primary HMO with evidence of both financial solvency and financial ability to perform, such as a certified financial audit of the ANHC conducted by an independent certified public ~~accountants, utilizing~~accountant, using generally accepted accounting and auditing principles;

and

(G) requires the ANHC or provider HMO to provide the primary HMO, on at least a monthly basis~~;~~ and in a usable form necessary for audit purposes, the data necessary for the HMO to comply with ~~the Texas Department of Insurance, and Texas Health Care Council~~department reporting requirements with respect to any services provided ~~pursuant to~~under the HMO-ANHC or HMO-provider HMO agreement, including the following data:

(i) number of primary HMO enrollees served or assigned to the ANHC or primary HMO to receive services ~~(~~, including the number added and terminated since the last reporting period~~);~~

;

(ii) form of the contracts and subcontracts between the ANHC and physicians and providers who will be providing services to enrollees of the primary HMO and any material changes to the contracts and subcontracts;

(iii) ~~co-payments~~copayments received by the ANHC or provider HMO;

(iv) summary of the amounts paid by the ANHC or provider HMO to physicians and providers;

(v) methods by which physicians and providers were paid by the ANHC or provider HMO ~~(~~, for example, capitation, fee-for-services, or other risk-sharing arrangements~~);~~

;

(vi) utilization data;

(vii) summary of the amounts paid by the ANHC or provider HMO for administrative services relating to the primary HMOs;

(viii) the time ~~period~~ that claims and debts related to claims owed by the ANHC or provider HMO have been pending;

(ix) information required for the primary HMO to be able to file claims for reinsurance, coordination of benefits, and subrogation;

(x) physician and provider ~~-~~ and enrollee satisfaction data;

(xi) complaint data;

(xii) documentation of any inquiry ~~and/~~or investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider, made by regulatory agencies, and documentation of the final resolution of ~~such an~~the inquiry ~~and/~~or investigation; and

(xiii) any other data necessary to ~~assure~~ensure proper monitoring and control of the primary HMO delivery network by the primary HMO;

(3) conduct an on-site audit of the ANHC or provider HMO ~~no less frequently than~~at least annually, or more frequently ~~upon~~on indication of material ~~non-compliance~~noncompliance, to obtain information necessary to verify compliance with all of the department's regulatory requirements ~~of the Texas Department of Insurance. Written~~, and provide written documentation of each audit ~~required by this paragraph shall be made available~~ to the ~~Texas Department of Insurance upon~~department on request; and

(4) take prompt action to correct any failure by the ANHC or provider HMO to comply with the department's regulatory requirements ~~of the Texas Department of Insurance~~ relating to any matters

delegated by the primary HMO to the ANHC or provider HMO and necessary to ensure the primary HMO's compliance with the regulatory requirements.

§11.1605. Pharmaceutical Services.

(a) ~~Should an HMO provide prescription~~Prescription drug coverage~~, such coverage shall be subject to~~ that includes copayments must do so for both generic drugs and name-brand drugs. If the negotiated or usual ~~or~~and customary cost of the drug is less than the copayment, the enrollee ~~shall~~ may only be required to pay the lower cost. The copayments may be the same, or if different, ~~shall~~must be applied as follows:

(1) if the prescription is for a generic drug, the enrollee ~~shall~~may be required to pay no more than the generic copayment;

(2) if the prescription is for a name-brand drug, the enrollee ~~shall~~may be required to pay no more than the name-brand copayment if:

(A) the prescription is written "~~Dispense~~dispense as written"; or

(B) there is no generic equivalent for the prescribed drug;

(3) if the prescription is written "product selection permitted" and the enrollee elects to receive a name-brand drug when a generic equivalent is available, then the enrollee ~~shall~~may be required to pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name-brand drug; and

(4) if the enrollee's prescription benefit requires the use of generic-equivalent drugs (required generic) and the enrollee receives a name-brand drug when a generic equivalent is available, then the enrollee may be required to pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name~~-brand drug.~~

~~(4) if the enrollee's prescription benefit requires the use of generic-equivalent drugs ("required generic")~~

~~and the enrollee receives a name brand drug when a generic equivalent is available, the enrollee shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name~~ brand drug, even when the prescription is written "dispense as written."

~~(b) Pharmacy services, if offered, shall be available and accessible within the service area for the enrolled population through pharmacies licensed by the Texas State Board of Pharmacy. The HMO shall offer such pharmacy services directly or through contracts.~~
~~(c) An HMO that provides coverage for prescription drugs under an individual or group health benefit plan, except small employer health benefit plans as defined by the Insurance Code §1501.002, shall comply with the requirements of the Insurance Code Chapter 1369 Subchapter A and §21.3010 and §21.3011 of this title (relating to Definitions; Coverage of Off-Label Drugs and Minimum Standards of Coverage for Off-Label Drug Use).~~
~~(d) An HMO that provides coverage for prescription drugs or devices under an individual or group state-mandated health benefit plan shall comply with the requirements of the Insurance Code Chapter 1369 Subchapter C (Coverage of Prescription Contraceptive Drugs and Devices and Related Services).~~
~~(e) An HMO that provides coverage for prescription drugs under a group state-mandated health benefit plan and that utilizes one or more drug formularies to specify which prescription drugs the plan will cover shall comply with the requirements of the Insurance Code Chapter 1369 Subchapter B and §§21.3020 - 21.3023 of this title (relating to Definitions; Prescription Drug Formulary, Required Disclosure of Drug Formulary, Continuation of Benefits, and Nonformulary Prescription Drugs; Adverse Determination).~~

(b) Pharmacy service must be available and accessible within the service area for the enrolled population through pharmacies licensed by the Texas State Board of Pharmacy. The HMO must offer the pharmacy services directly or through contracts.

§11.1606. Organization of an HMO.

(a) The governing body of an HMO, as described in Insurance Code §843.004~~, shall have~~ (concerning Governing Body of Health Maintenance Organization), has ultimate responsibility for the development, approval, implementation, and enforcement of administrative, operational, personnel, and patient care policies and procedures related to the HMO's operation ~~of the HMO.~~

.

(b) The HMO ~~shall~~must have a chief executive officer or operations officer who ~~shall be~~is accountable for the administration of the health plan, including:

(1) developing corporate strategy;

(2) overseeing marketing programs;

(3) overseeing medical management functions; and

(4) ensuring compliance with all applicable statutes and rules pertaining to the operations of the HMO.

(c) The HMO ~~shall~~must have a full-time clinical director who:

(1) ~~shall be currently~~is licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HMO~~. For example:~~

~~(A) a basic HMO shall have a physician;~~

~~(B) a dental HMO shall have a dentist or physician;~~

~~(C) a vision HMO shall have an optometrist or physician; and~~

~~(D) a limited services HMO shall have a physician.~~

~~(2) shall reside in the state of Texas;~~

~~(3) shall be available at all times to address complaints, clinical issues, utilization review and any quality of care issues on behalf of the HMO; ~~, for example:

(A) a basic HMO must have a physician;

(B) a dental HMO must have a dentist or physician;

(C) a vision HMO must have an optometrist or physician; and

(D) a limited services HMO must have a physician;

(2) resides in the state of Texas;

(3) is available at all times to address complaints, clinical issues, utilization review, and any quality of care issues on behalf of the HMO;

(4) ~~shall demonstrate~~demonstrates active involvement in all quality management activities; and

(5) ~~shall~~will be subject to the HMO's credentialing requirements~~, as appropriate.~~ and must be credentialed in compliance with NCQA or American Accreditation HealthCare Commission, Inc., standards.

(d) The HMO may establish one or more service areas within Texas~~. Each~~; each defined service area must:

(1) demonstrate to the department the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties ~~and zip codes~~, or any portions ~~thereof~~of counties, included in the service area;

(3) provide a complete physician and provider listing for all enrollees residing, living, or working in the service area~~;~~, as provided in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees); and

(4) maintain separate cost center accounting for each service area to facilitate the reporting of divisional operations as required for HMO financial reporting.

§11.1607. Accessibility and Availability Requirements.

(a) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network ~~which~~that is adequate and complies with Insurance Code §843.082~~.~~ (concerning Requirements for Approval of Application).

(b) There ~~shall~~must be a sufficient number of primary care physicians and specialists with hospital admitting privileges to participating facilities who are available and accessible 24 hours per day, seven days per week, within the HMO's service area to meet the health care needs of the HMO's enrollees.

(c) An HMO ~~shall~~must make general, special, and psychiatric hospital care available and accessible 24 hours per day, seven days per week, within the HMO's service area.

(d) If an HMO limits enrollees' access to a limited provider network, it must ensure that ~~such~~the limited provider network complies with ~~the provisions~~all requirements of this section.

(e) An HMO ~~shall~~must make emergency care available and accessible 24 hours per day, seven days per week, without restrictions ~~as to~~on where the services are rendered.

(f) All covered services that are offered by ~~the~~an HMO ~~shall~~must be sufficient in number and location to be readily available and accessible within the service area to all enrollees.

(g) ~~HMOs~~An HMO must arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis ~~upon~~on request and consistent with these guidelines ~~set out in paragraphs~~ :

(1) ~~(3) of this subsection:~~

~~(1) Urgent~~urgent care ~~shall~~must be available~~:~~

~~(A)~~ within 24 hours for medical ~~and~~, dental ~~conditions; and~~

~~(B) within 24 hours for~~ , and behavioral health conditions~~.~~

;

(2) ~~Routine~~routine care ~~shall~~must be available~~:~~

~~(A)~~ within:

(A) three weeks for medical conditions;

(B) ~~within~~ eight weeks for dental conditions; and

(C) ~~within~~ two weeks for behavioral health conditions.

(3) Preventive health services ~~shall~~must be available~~:~~

~~(A)~~ within:

(A) two months for a child;

(B) ~~within~~ three months for an adult; and

(C) ~~within~~ four months for dental services.

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

~~(1) 30 miles for primary care and general hospital care; and~~

~~(2) 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers.~~

~~(i) Notwithstanding subsection (h) of this section, an HMO that has a contract with the Health and Human Services Commission is not required to meet the access requirements prescribed in this section for covered services provided to participants in the CHIP Perinatal Program.~~

~~(j) If any covered health care service or a participating physician and provider is not available to an enrollee within the mileage radii specified in subsection (h)(1) and (2) of this section because physicians and providers are not located within such mileage radii, or if the HMO is unable to obtain contracts after good faith attempts, or physicians and providers meeting the minimum quality of care and credentialing requirements of the HMO are not located within the mileage radii, the HMO shall submit an access plan to the department for approval, at least 30 days before implementation in accordance with the filing requirements in §11.301 of this title (relating to Filing Requirements). The access plan shall include the following:~~

~~(1) the geographic area identified by county, city, ZIP code, mileage, or other identifying data in which services and/or physicians and providers are not available;~~

~~(2) for each geographic area identified as not having covered health care services and/or physicians or providers available, the reason or reasons that covered health care services and/or physicians and providers cannot be made available;~~

~~(3) a map, with key and scale, which identifies the areas in which such covered health care services and/or physicians and providers are not available;~~

~~(4) the HMO's plan for making covered health care services and/or physicians and providers available to enrollees in each geographic area identified;~~

~~(5) the names and addresses of the participating physicians and providers and a listing of the covered health care services to be provided through the HMO delivery network to meet the medical needs of the~~

~~enrollees covered under the HMO's plan required under paragraph (4) of this subsection;~~

~~(6) the names and address of other physicians and providers and a listing of the specialties for any other health care services or physicians and providers to be made available in the geographic area in addition to those physicians and providers participating in the HMO delivery network listed under paragraph (5) of this subsection;~~

~~(7) the procedures to be followed by the HMO to assure that primary care physicians, general hospitals, specialists, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, or single or limited health care service providers and all other mandated health care services are made available and accessible to enrollees in the geographic areas identified as being areas in which such covered health care services and/or physicians and providers are not available and accessible, and any plans of the HMO for attempting to develop an HMO delivery network through which covered health care services are available and accessible to enrollees in these geographic areas in the future; and~~

~~(8) any other information which is necessary to assess the HMO's plan.~~

~~(k) The~~

(1) 30 miles for primary care and general hospital care; and

(2) 75 miles for specialty care, special hospitals, and single health care service plan physicians or providers.

(i) Access to certain institutional providers. An HMO network providing access to more than one institutional provider in a region must make a good-faith effort to have a mix of for-profit, nonprofit, and tax-supported institutional participating providers, unless the mix is not feasible due to geographic, economic, or other operational factors. An HMO must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(j) An HMO that is unable to meet the requirements of subsections (b) - (h) of this section must file an access plan for approval with the department in compliance with §11.301 of this title (relating to Filing Requirements). The access plan must specify:

(1) the geographic area within the service area in which a sufficient number of contracted physicians and providers are not available, including a specification of the class of physician or provider;

(2) a map for each specialty, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, and providers are not available;

(3) the reason or reasons that the network does not meet the adequacy requirements specified in this section;

(4) procedures that the HMO will use to assist enrollees in obtaining medically necessary services when no network physician or provider is available, including procedures to coordinate care to hold enrollees harmless and eliminate or limit the likelihood of balance billing;

(5) a list of the physicians and providers within the relevant service area that the HMO attempted to contract with, identified by name and specialty or facility type, with:

(A) a description of how and when the HMO last contacted each physician, provider, or facility; and

(B) a description of the reason each physician, provider, or facility gave for declining to contract with the HMO;

(6) procedures detailing how out-of-network benefit claims will be handled when no physicians or providers are available, including procedures for compliance with §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers);

(7) steps the HMO will take to attempt to bring its network into compliance with this section; and

(8) a process for negotiating with a non-network physician or provider before services being rendered, when feasible.

(k) An HMO must submit an access plan that complies with subsection (j) of this section along with the annual report on network adequacy under §11.1610 of this title (relating to Annual Network Adequacy Report).

(l) Notwithstanding subsection (h) of this section, an HMO that has a contract with the Health and Human Services Commission is not required to meet the access requirements prescribed in this section for covered services provided to participants in the Children's Health Insurance Program Perinatal Program.

(m) An HMO may make arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level ~~which is~~ available within the HMO service area, such as, but not limited to, transplants~~,~~ and treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive ~~such services, unless the HMO provides the enrollee with a written explanation of the benefits and detriments of in-area~~

~~and out-of-area options.~~

~~(l) The HMO shall not be~~the services.

(n) An HMO is not required to expand services outside its service area to accommodate enrollees who live outside the service area~~,~~ but work within the service area.

~~(m~~

(o) In ~~accordance~~compliance with ~~the~~ Insurance Code Chapter 1455 (concerning Telemedicine and Telehealth), each evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or ~~a~~ telemedicine ~~medical~~ service.

§11.1610. Annual Network Adequacy Report.

(a) An HMO must file a network adequacy report with the department on or before August 15 of each year and before marketing any plan in a new service area after August 15, 2017. The network adequacy report must specify:

(1) the trade name of each HMO plan in which enrollees currently participate;

(2) the applicable service area of each plan; and

(3) whether the HMO service delivery network supporting each plan meets the requirements in §11.1607 of this title (relating to Accessibility and Availability Requirements).

(b) If applicable, the network adequacy report must include an access plan that complies with §11.1607 of this title.

(c) As part of the annual network adequacy report, the HMO must provide additional data specified in this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the HMO's plans include a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The HMO report must include the number of:

(1) claims paid for out-of-network benefits that were not based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 (concerning Emergency Care) or §1271.055 (concerning Out-of-Network Services);

(2) claims for out-of-network benefits that were based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 or §1271.055;

(3) complaints by non-network physicians and providers;

(4) complaints by network physicians and providers relating to inability to refer enrollees to network physicians or providers because network physicians or providers are not available;

(5) complaints by enrollees relating to the dollar amount of the HMO's payment for basic health care benefits;

(6) complaints by enrollees concerning balance billing;

(7) complaints by enrollees relating to the unavailability of network physicians or providers;

(8) complaints by enrollees relating to the accuracy of network physician and provider listings; and

(9) complaints by physicians and providers relating to the accuracy of network physician and provider listings.

(d) The annual network adequacy report required under this section must be submitted electronically in a format and by a method acceptable to the department. Unless and until a standardized form and method for submitting the above information is made available by the department, acceptable formats include Microsoft Word and Excel documents. Unless and until another electronic method of submission is required, the report must be submitted to the department's email address, mcqa@tdi.texas.gov, and must indicate in the subject field that the email relates to the filing of the annual network adequacy report.

(e) If the commissioner determines that the HMO's network and any access plan supporting the network are inadequate to ensure that benefits are available to all enrollees or are inadequate to ensure that all covered health care services are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions under the commissioner's authority in Insurance Code Chapter 82 (concerning Sanctions) and Insurance Code Chapter 83 (concerning Emergency Ceases and Desist Orders) to issue cease and desist orders:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and

(3) cessation of marketing entirely and withdrawal from the HMO market.

(f) This section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code.

§11.1611. Out-of-Network Claims; Non-Network Physicians and Providers.

(a) When services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee is not given the choice of a network physician or provider, the HMO must fully reimburse the non-network facility-based physician or provider at the usual and customary rate as described in subsection (e) of this section or at an agreed rate.

(b) In circumstances where an enrollee receives emergency care in a non-network facility, the HMO must fully reimburse a non-network physician or provider for emergency care services at the usual and customary rate as described in subsection (e) of this section or at an agreed rate until the enrollee can reasonably be expected to transfer to a network physician or provider.

(c) If medically necessary covered services, other than emergency care, are not available through a network physician or provider on the request of a network physician or provider, the HMO must:

(1) approve a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(2) provide for a review by a physician or provider with expertise in the same specialty as or a specialty similar to the type of health care physician or provider to whom a referral is requested under paragraph (1) of this subsection before the HMO may deny the referral.

(d) An HMO reimbursing a non-network physician or provider providing services under subsection (a), (b), or (c) of this section must ensure that the enrollee is held harmless for any amounts beyond the copayment or other out-of-pocket amounts that the enrollee would have paid had the HMO network included network physicians or providers from whom the enrollee could obtain the services.

(e) After determining that a claim from a non-network physician or provider for services provided under subsection (a), (b), or (c) of this section is payable, an HMO must issue payment to the non-network physician or provider at the usual and customary rate or at a rate agreed to by the HMO and the non-network physician or provider. If the rate was not agreed to by the physician or provider,

the HMO must provide an explanation of benefits to the enrollee that includes a statement that the HMO's payment is at least equal to the usual and customary rate for the service, that the enrollee should notify the HMO if the non-network physician or provider bills the enrollee for amounts beyond the amount paid by the HMO, of the procedures for contacting the HMO on receipt of a bill from the non-network physician or provider for amount beyond the amount paid by the HMO, and the number for the department's Consumer Protection Section for complaints regarding payment.

(f) Any methodology used by an HMO to calculate reimbursements of non-network physicians or providers for covered services not available from network physicians or providers must comply with the following:

(1) if based on usual and customary charges, then the methodology must be based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflect market rates, including geographic differences in costs;

(2) if based on claims data, then the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

(3) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than three years old; and

(4) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

§11.1612. Mandatory Disclosure Requirements.

(a) Online directory. An HMO must develop and maintain a directory of contracting physicians and health care providers, display the directory on a public Internet website maintained by the HMO, and ensure that a direct electronic link to the directory is conspicuously displayed on the electronic summary of benefits and coverage of each plan issued by the HMO. The directory must:

(1) include the name, address, and telephone number of each physician and provider;

(2) clearly indicate each health benefit plan issued by the HMO that may provide coverage for services provided by each physician or provider included in the directory;

(3) be electronically searchable by physician or health care provider name and location;

(4) be publicly accessible without the necessity or providing a password, a username, or personally identifiable information; and

(5) be reviewed on an ongoing basis and corrected or updated, if necessary, not less than once each month.

(b) Identification of limited networks and index. An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. An HMO must include an index of the alphabetical listing of all physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network(s) to which the physician or provider belongs and the page number where the physician or provider's name can be found.

(c) Notice of rights under an HMO plan required. An HMO must include the notice specified in Figure: 28 TAC §11.1612(c), in all evidences of coverage certificates, disclosures of plan terms, and member handbooks in at least a 12-point font:

Figure: 28 TAC §11.~~Subchapter~~1612(c)

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

- You may obtain a current directory of network physicians and providers at the following website: (website address to be filled out by the HMO) or by calling (to be filled out by the HMO) for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

(d) Disclosure concerning access to network physician and provider listing. An HMO must provide notice to all enrollees at least annually describing how the enrollee may access a current listing of all network physicians and providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which enrollees may obtain assistance during regular business hours to find available network physicians and providers.

(e) Disclosure concerning network information. An HMO must provide notice to all enrollees at least annually of:

(1) information that is updated at least annually regarding the following network information for each service area, or for the entire state if the plan is offered on a statewide service-area basis:

(A) the number of enrollees in the service area or region;

(B) for each physician and provider area of practice, including at a minimum internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of contracted physicians and providers, an indication of whether an active access plan under §11.1607 of this title (relating to Accessibility and Availability Requirements) applies to the services furnished by that class of physician or provider in the service area or region, and how the access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of contracted hospitals in the service area or region, an indication of whether an active access plan in compliance with §11.1607 of this title applies to hospital services in that service area or region, and how the access plan may be obtained or viewed, if applicable;

(2) information that is updated at least annually regarding whether any access plans approved under §11.1607 of this title apply to the plan and that complies with the following:

(A) if an access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the HMO's plan is not offered on a statewide service area basis, or for the entire state if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the access plan.

(f) Website disclosures. An HMO must provide information on its website regarding the HMO or health benefit plans offered by the HMO for use by current or prospective enrollees must provide a:

(1) web-based physician and provider listing for use by current and prospective enrollees; and

(2) web-based listing of the state regions, counties, or three-digit ZIP code areas within the HMO's service area(s), indicating, as appropriate, for each region, county, or ZIP code area, as applicable, that the HMO has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter.

(g) Reliance on physician and provider listing in certain cases. A claim for services rendered by a noncontracted physician or provider must be paid in the same manner as if no contracted physician or provider had been available under §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers), as applicable, if an enrollee demonstrates that:

(1) in obtaining services, the enrollee reasonably relied on a statement that a physician or provider was a contracted physician or provider as specified in:

(A) a physician and provider listing; or

(B) provider information on the HMO's website;

(2) the physician and provider listing or website information was obtained from the HMO, the HMO's website, or the website of a third party designated by the HMO to provide that information for use by its enrollees;

(3) the physician and provider listing or website information was obtained not more than 30 days before the date of services; and

(4) the physician and provider listing or website information obtained indicates that the provider is a contracted provider within the HMO's network.

(h) Additional listing-specific disclosure requirements. In all contracted physician and provider listings, including any web-based postings of information made available by the HMO to provide information to enrollees about contracted physicians and providers, the HMO must comply with the following requirements:

(1) the physician and provider information must include a method for enrollees to identify the hospitals that have contractually agreed with the HMO to facilitate the usage of contracted providers by exercising good-faith efforts to accommodate requests from enrollees to use contracted physicians and providers;

(2) the physician and provider information must indicate whether each contracted physician and provider is accepting enrollees as new patients or participates in closed provider networks serving only certain enrollees;

(3) the physician and provider information must provide an email address and a toll-free telephone number through which enrollees may notify the HMO of inaccurate information in the listing, with specific reference to:

(A) information about the physician's or provider's contract status; and

(B) whether the physician or provider is accepting new patients;

(4) the physician and provider information must provide a method by which enrollees may identify contracted facility-based physicians able to provide services at contracted facilities;

(5) the physician and provider information must include a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network;

(6) as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), the physician and provider information must give the identity of any health care facilities

within the provider network in which facility-based physicians or other health care practitioners do not participate in the health benefit plan's provider network;

(7) the provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based physician or provider, specifying the applicable provider class;

(8) the physician and provider information must be dated; and

(9) the physician and provider information must be provided in at least 10-point font.

(i) Annual enrollee notice concerning use of an access plan. An HMO operating a plan that relies on an access plan as specified in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees) and §11.1607 of this title must provide notice of this fact to each enrollee participating in the plan at issuance and at least 30 days before renewal. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available under subsection (e)(2) of this section; and

(2) information on how to obtain or view any access plan or plans the HMO uses.

(j) Disclosure of substantial decrease in the availability of certain contracted physicians. An HMO is required to provide notice as specified in this subsection of a substantial decrease in the availability of contracted facility-based physicians at a contracted facility.

(1) A decrease is substantial if:

(A) the contract between the HMO and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates, and the HMO receives notice as required under §11.901 of this title (relating to Required and Prohibited Provisions).

(2) Despite paragraph (1) of this subsection, no notice of a substantial decrease is required if:

(A) alternative contracted physicians or providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made

available to enrollees at the facility so the percentage level of contracted physicians of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available before the substantial decrease; or

(B) the HMO certifies to the department, by email to mcqa@tdi.texas.gov, that the HMO's determination that the termination of the physician contract has not caused the contracted physician service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §11.1607 of this title, as those standards apply to the applicable physician specialty.

(3) An HMO must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of contracted physicians on the portion of the HMO's website where its physician and provider listing is available to enrollees.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of physicians must be maintained on the HMO's website until the earlier of:

(A) the date on which adequate contracted physicians of the same specialty become available to enrollees at the facility at the percentage level specified in paragraph (2)(A) of this subsection;

(B) six months from the date that the HMO initially posts the notice; or

(C) the date on which the HMO provides to the department, by email to mcqa@tdi.texas.gov, the certification specified in paragraph (2)(B) of this subsection.

(5) An HMO must post notice as specified in paragraph (3) of this subsection and update its web-based contracted physician and provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an HMO receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS

§11.1702. Requirements for Issuance of Certificate of Authority to an ANHC.

(a) ~~Prior to~~Before obtaining a certificate of authority under ~~the~~ Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations), an applicant ANHC must:

(1) comply with each requirement for the issuance of a certificate of authority imposed on an HMO under ~~the~~ Insurance Code ~~Chapters~~Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 ~~and 843;~~(concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter~~;~~, and other applicable insurance laws and regulations of this state; and

(2) demonstrate by appropriate documentation that the applicant ANHC has established and maintains accreditation by~~:~~
the:

(A) ~~the National Committee on Quality Assurance~~NCQA; or

(B) ~~the~~ Joint Commission on Accreditation of Health Care Organizations~~-~~ network accreditation program.

(b) The commissioner ~~shall~~may grant a provisional certificate of authority to an applicant ANHC under ~~the~~ Insurance Code Chapter 844, if~~:~~
the:

(1) ~~the~~ applicant ANHC complies with each requirement for the issuance of a certificate of authority imposed on an HMO under ~~the~~ Insurance Code Chapters ~~1271~~843 and ~~843;~~1271, this

chapter~~;~~, and other applicable insurance laws and regulations of this state~~.~~

~~;~~

(2) ~~the~~ applicant ANHC demonstrates that it has applied for accreditation;

(3) ~~the~~ applicant ANHC is diligently pursuing accreditation as determined by the commissioner; and

(4) ~~the~~ accrediting organization has not denied the accreditation.

(c) An ANHC with a certificate of authority or a provisional certificate of authority must comply with all the appropriate requirements that an HMO must comply with under ~~the~~ Insurance Code ~~Chapters 1271~~Chapter 843 and ~~843;~~1271, this chapter~~;~~, and other applicable insurance laws and regulations of this state in order to maintain a certificate of authority.

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code~~,~~ Chapters 843 and 844, including an ANHC that contracts to arrange for or provide only medical care as defined in Insurance Code §843.002~~.~~ (concerning Definitions).

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder.

Any agent for an ANHC with a certificate of authority or a provisional certificate of authority ~~shall~~will be considered an HMO agent and ~~shall~~must comply with the applicable requirements of ~~the~~ Insurance Code Chapter 4054 (concerning Life, Accident, and Health Agents) and Chapter 19 of this title (relating to ~~Agent's~~Agents' Licensing~~), as applicable.~~).

§11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority.

An ANHC with a certificate of authority or provisional certificate of authority under Insurance Code~~,~~ Chapter 844~~,~~ (concerning Certification of Certain Nonprofit Health Corporations) and this

subchapter ~~shall be~~is subject to the same statutes and rules as an HMO and is considered an HMO for purposes of regulation and regulatory enforcement.

~~Subchapter~~SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

§11.1801. Entities Covered.

(a) As used in this subchapter, a managed care organization is an entity holding a certificate of authority to operate as an HMO under ~~the~~ Insurance Code ~~Chapters~~Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 ~~and 843~~ (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), or as an ~~approved nonprofit health corporation~~ANHC under ~~the~~ Insurance Code Chapter 844~~.~~ (concerning Certification of Certain Nonprofit Health Corporations).

(b) Any managed care organization or other entity providing the services specified in 42 United States Code §1396b(m)(2)(A) and participating in the State Medicaid Program ~~(all hereinafter referred to as an "~~or Children's Health Insurance Program (CHIP) (MCO~~")~~) must ~~first~~ comply with the requirements ~~and solvency standards set forth in this subchapter, and must not be in a hazardous financial condition as defined in~~of Insurance Code §843.~~406 of the Texas Insurance Code, §11.810~~403 (concerning Minimum Net Worth) and §7.402 of this title (relating to ~~Hazardous Conditions~~Risk-Based Capital and Surplus Requirements for Insurers and HMOs~~), or~~).

~~Chapter 8 of this title (relating to Early Warning System for Insurers in Hazardous Condition) where pertinent to managed care organizations. In addition, any MCO already subject to regulation of any kind, must be in compliance with any solvency standard and/or requirement pertinent to its regulation, as well as all applicable licensing laws and regulations.~~

~~§11.1802. Minimum Surplus or Net Worth.~~

~~(a) An MCO must possess the greater of:~~
~~(1) the statutory minimum capital and surplus (net worth) required of an MCO in accordance with the types of business that the MCO is authorized to write; or~~
~~(2) a minimum surplus or net worth equal to no less than the regulatory action level of risk based capital (150% of its authorized control level risk based capital) in accordance with the formula adopted by the commissioner pertaining to the MCO subject to the following phase-in:~~
~~(A) at December 31, 2005, the minimum net worth shall be equal to no less than 100% of the authorized~~

~~control level risk based capital,~~
~~(B) at December 31, 2006, the minimum net worth shall be equal to no less than 125% of the authorized control level risk based capital, and~~
~~(C) at December 31, 2007, the minimum net worth shall be equal to no less than 150% of the authorized control level risk based capital.~~
~~(b) If at any time the MCO discovers that it does not meet its minimum net worth requirement, the MCO shall immediately fund capital sufficient to cure the impairment.~~

~~§11.1803. Statutory Deposits.~~

~~(a) In addition to amounts already deposited in accordance with other statutory and regulatory provisions, and subject to the reduction specified in §11.1804 of this title (relating to Guarantees), an MCO must deposit with the Office of the Comptroller of Public Accounts of Texas:~~
~~(1) $400,000 if a basic service MCO;~~
~~(2) $275,000 if a limited service MCO; or~~
~~(3) $200,000 if a single service MCO.~~
~~(b) This deposit may be used to protect the interests of the enrollees of the MCO, including but not limited to the payment of the costs delineated in §11.1805(a)(2)(C) of this title (relating to Performance and Fidelity Bonds). Any deposit is subject to the procedures set forth in §11.802 of this title (relating to Statutory Deposit Requirements).~~

~~§11.1804. Guarantees.~~

~~(a) As used in this section, the phrase "certified audited financial statements" means financial statements audited by a CPA utilizing generally accepted auditing standards that attest that the financial condition of the MCO is fairly represented in accordance with generally accepted accounting principles; and the phrase "section 1115 waiver expansion program" means the Medicaid program involving children of the ages 6 - 18 years in a socio-economic level of up to 133% over the federal poverty level and who are not eligible under the regular Medicaid program.~~
~~(b) If a guarantee issued for the benefit of an MCO satisfies the conditions and requirements set forth in this section, then the additional deposit amounts specified in §11.1803(a)(1) of this title (relating to Statutory Deposits) shall be reduced to the following amounts:~~
~~Figure: 28 TAC §11.1804(b)~~

~~Additional Statutory Deposit Required~~

~~Type of HMO~~	
~~Basic Service MCO~~	~~$150,000~~
~~Limited Service MCO~~	~~$100,000~~
~~Single Service MCO~~	~~$ 75,000~~

If and only if a guarantee issued for the benefit of an MCO satisfies the conditions and requirements set forth in subsection (c)(2)(B) in this section and if the MCO participates solely in the section 1115 waiver expansion program controlled and as defined by the State Medicaid Office for Texas, and is determined by the commissioner to be such an MCO, then the $400,000 figure required by §11.1803(a)(1) of this title (relating to Statutory Deposits) is reduced to $100,000.

(c) A guarantee must:
(1) be unconditional, monetarily unlimited, cover all expenses and liabilities, and approved by the department, filed with the contracting state agency, and provide for 6 months advance notice to the department and the contracting state agency prior to its cancellation; and
(2) be executed by a sponsoring organization with:
(A) a minimum tangible worth equal to $10 million for each guarantee it has issued, and be supported by board resolutions which are properly created, certified, and filed with the department and the contracting state agency. In addition, the sponsoring organization must timely provide to the department and the contracting state agency certified audited financial statements for the most recent fiscal year, a report identifying in detail all guarantees issued or made, and notification in detail of any guarantees issued or made while a guarantee described in paragraph (1) of this subsection is in force or exists; or
(B) taxing authority over a portion of the population of Texas for the purpose of funding medical care. For the MCO to qualify for this reduction, its sponsoring organization must submit satisfactory and verifiable evidence to the Texas Health and Human Services Commission and the department that it actually has the ability to tax a portion of the population of Texas.
(d) If at any time a guarantee issued for the benefit of an MCO does not comply with every requirement of this section, then the reductions provided for in this section terminate and the amounts stated in §11.1803 of this title immediately apply to the MCO.

§11.1805. Performance and Fidelity Bonds.

(a) An MCO must provide a performance bond to the contracting state agency, and file a copy with the department, which:
(1) names the contracting state agency as the obligee;
(2) provides for the faithful performance of the MCO in accordance with the contract and all specifications related to the Medicaid Program, and covers:
(A) any expenses (including, but not limited to, administrative, personnel and legal expenses) incurred by the contracting state agency resulting from an MCO's non-performance;
(B) the additional costs for services rendered after the termination of a contract for non-performance until other arrangements for services are made; and
(C) any costs for services not paid by the MCO under its contract that ultimately may be the responsibility of the contracting state agency or State of Texas;
(3) is in an amount of at least $100,000 with no deductible; and
(4) is issued by an insurance company licensed by the department.
(b) In addition, an MCO must maintain the fidelity bonds required by and comply with Insurance Code §843.402.

§11.1806. Additional Information That May be Requested ~~From~~from an MCO Participating in Medicaid.

(a) Whenever requested by the department, ~~the~~an MCO ~~shall~~participating in Medicaid must file with the department a complete set of financial exhibits pertaining to the state Medicaid program, in the format of the Managed Care Financial Statistical Report, as may be modified or amended by the Texas Health and Human Services Commission. When a request is received, the MCO ~~shall~~must then file~~,~~ ~~on two separate occasions, an original~~ a Managed Care Financial Statistical Report reflecting the state Medicaid program operations for each contract year in the same format as the monthly Managed Care Financial Statistical Report. These reports ~~shall be in accordance~~must comply with the instructions ~~promulgated~~issued by the ~~Health and Human Services Commission.~~

~~(b) For any new or modified request to the~~ Texas Health and Human Services Commission.

~~Commission~~ (b) For any new or modified request to the Texas Health and Human Services Commission for participation in the Medicaid managed care program, all financial projections, including enrollment projections, from the effective or renewal date of a Medicaid contract that are submitted to the Texas Health and Human Services Commission ~~are~~, must also ~~required to~~ be submitted to the ~~Texas Department of Insurance.~~department. The MCO ~~shall~~must submit the same financial projections, including a cash flow statement, submitted to the Texas Health and Human Services Commission with the request to participate in the Medicaid program. This information ~~shall~~must be submitted with the application for a certificate of authority if the MCO is not already a licensed MCO. If the MCO is a licensed operation, then the financial projections must be sent with the ~~next financial statement due to the department.~~ application for service area expansion.

(c) The MCO ~~shall~~must notify the department of any similar financial or statistical reports required by other contracting state agencies and ~~shall~~must submit copies of these reports~~,~~ to the department when requested by the department~~.~~

~~(d) Information submitted pursuant to this section shall be sent to the Texas Department of Insurance, Financial Analysis & Examinations, Mail Code 303-1A, P.O. Box 149104, Austin, Texas 78714-9104~~.

~~Subchapter~~ (d) Information submitted under this section must be sent to the Financial Analysis Section, Mail Code 303-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

SUBCHAPTER T. QUALITY OF CARE

§11.1901. Quality Improvement Structure for Basic, Single Service, and Limited ~~Services~~Service HMOs.

(a) ~~A basic or~~ Basic, single service, and limited ~~services HMO shall~~service HMOs must develop and maintain an ongoing ~~quality improvement (~~QI~~)~~ program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Unless the HMO has no enrollees, the QI program ~~shall~~should include the active involvement of one or more enrollee(s) who are not employees of the HMO.

(b) The HMO governing body is ultimately responsible for the QI program. The governing body ~~shall:~~

must:

(1) appoint a quality improvement committee (QIC) that ~~shall~~must include practicing physicians and individual providers~~;~~, and may include one or more enrollee(s) from throughout the HMO's service area~~. For purposes~~, none of ~~this section, if an enrollee(s) is appointed to the committee, the enrollee(s)~~whom may ~~not~~ be ~~an employee~~employees of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet ~~no less than~~at least annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC ~~shall~~must evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians ~~and~~, individual providers, and enrollees from the service area.

(A) All committees ~~shall~~must collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

(B) All committees ~~shall~~must meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

~~(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.~~

~~(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.~~

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC must use multidisciplinary teams, when indicated, to accomplish QI program goals.

§11.1902. Quality Improvement Program for Basic, Single Service, and Limited ~~Services~~Service HMOs.

The QI program for basic, single service, and limited ~~services~~service HMOs ~~shall~~must be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO ~~shall~~must dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program ~~shall~~must include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program ~~shall~~must include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status. The work plan ~~shall~~must:

(A) include~~:~~

~~(A) Objective~~ objective and measurable goals~~;~~, planned activities to accomplish the goals~~;~~, time frames for implementation~~;~~, responsible individuals~~;~~, and evaluation methodology~~.~~

; and

(B) ~~The work plan shall~~ address each program area, including:

(i) ~~Network~~network adequacy, which includes availability and accessibility of care, including assessment of open~~/~~ and closed physician and individual provider panels;

(ii) ~~Continuity~~continuity of health care and related services;

(iii) ~~Clinical~~clinical studies;

(iv) ~~The~~the adoption and periodic updating of clinical practice guidelines or clinical care standards~~;~~, which the QI program ~~shall assure the practice guidelines:~~

must ensure:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services;

(v) ~~Enrollee~~enrollee, physician, and individual provider satisfaction;

(vi) ~~The~~the complaint and appeals process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians, and providers from effectively making complaints against the HMO;

~~(vii) Preventive health care through health promotion and outreach activities;~~

~~(viii) Claims payment processes;~~

~~(ix) Contract monitoring, including delegation oversight and compliance with filing requirements;~~

(vii) preventive health care through health promotion and outreach activities;

(viii) claims payment processes;

(ix) contract monitoring, including delegation oversight and compliance with filing requirements;

(x) ~~Utilization~~utilization review processes;

(xi) ~~Credentialing;~~ credentialing;

(xii) ~~Member~~member services; and

(xiii) ~~Pharmacy~~pharmacy services, including drug utilization.

(3) Evaluation. The QI program ~~shall~~must include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO ~~shall~~must implement a documented process for selection and retention of contracted physicians and providers. The credentialing process ~~required by this section~~ must comply with ~~the~~NCQA or American Accreditation HealthCare Commission, Inc., standards ~~promulgated by the National Committee for Quality Assurance (NCQA),~~ to the extent that those standards do not conflict with ~~other~~the laws of this state.

An HMO must have a documented process for expedited credentialing of physicians, podiatrists, and therapeutic optometrists, including a documented process for payment of claims during the expedited credentialing process, in compliance with Insurance Code Chapter 1452 (concerning Physician and Provider Credentials).

(5) Site visits for cause.

(A) The HMO ~~shall~~must have procedures for detecting deficiencies ~~subsequent to the initial~~after a site visit. When the HMO identifies new deficiencies, the HMO ~~shall~~must reevaluate the

site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO ~~shall~~may conduct the site visit to evaluate ~~the~~a complaint or other precipitating event, which may include an evaluation of any facilities or services related to ~~the~~a complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program ~~shall~~must provide for a peer review procedure for physicians and individual providers, as required ~~in~~by the Medical Practice Act, ~~Chapters 151-164,~~ Occupations Code~~.~~, Chapter 151, Subchapter A, (concerning General Provisions). The HMO ~~shall~~must designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

~~(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.~~

~~Subchapter~~ (7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of this state.

SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

§11.2101. ~~Definitions~~Community Health Maintenance Organization.

~~The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.~~ A Community Health Maintenance Organization (CHMO~~). An~~) is an entity created ~~under the authority of Section 534.101, Health and Safety Code, by~~ by one or more community centers ~~as defined by Section 534.001,~~ under Health and Safety Code~~,~~ §534.001 (concerning Establishment), and authorized by the ~~Texas Department of Insurance~~department to provide a plan for

limited health care ~~service plan~~services as defined in Insurance Code §843.002(18) (concerning Definitions).

§11.2102. General Provisions.

(a) Each CHMO must comply with all requirements for a limited health care service plan specified in this subchapter**.**

(b) Each CHMO ~~shall~~must provide coverage for work in progress and must clearly specify that the enrollee must agree to have the work completed by a participating physician or provider in the HMO delivery network, as defined under Insurance Code §843.002(15) (concerning Definitions), or as otherwise arranged by the limited service HMO.

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

(a) ~~Prior to~~Before obtaining a certificate of authority ~~under Section 534.101 of the Health and Safety Code (concerning Health Maintenance Organizations Certificate of Authority),~~ an applicant CHMO must comply with each requirement for the issuance of a certificate of authority imposed on a limited health care service plan under ~~the~~ Insurance Code ~~Chapters~~Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 ~~and 843;~~(concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter~~;~~, and other applicable insurance laws and regulations of this state.

(b) A CHMO with a certificate of authority must comply with all the appropriate requirements that a limited health care service plan must comply with under ~~the~~ Insurance Code Chapters ~~1271~~843 and ~~843;~~1271, this chapter~~;~~, and other applicable insurance laws and regulations of this state to maintain a certificate of authority. A CHMO ~~shall be~~is subject to the same statutes and rules as a limited service HMO and considered a limited service HMO for purposes of regulation and regulatory enforcement.

(c) Nothing in this subchapter ~~precludes~~prevents one or more community centers from forming a nonprofit corporation under ~~§162.001, Medical Practice Act, Chapters 151- 164,~~ Occupations Code~~,~~ §162.001 (concerning Certification by Board) to provide services on a risk-sharing or capitated basis as permitted under Insurance Code Chapter 844~~.~~
(concerning Certification of Certain Nonprofit Health Corporations).

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code §§843.051~~, 843.053, 843.073, and 843.318.~~ (concerning Applicability of Insurance and Group Hospital Service Corporation Laws), 843.053 (concerning Laws Relating to Restraint of Trade), 843.073 (concerning Certificate of Authority Requirement; Applicability to Physicians and Providers), or 843.318 (concerning Certain Contracts of Participating Physicians or Provider Not Prohibited).

§11.2104. Minimum Standards for Community Health Centers.

Each evidence of coverage providing limited mental health care services by a CHMO ~~shall~~must provide benefits as described in Chapter 11, Subchapter Y, of this ~~chapter~~title (relating to Limited Service HMOs) as minimum covered services for mental illness~~/~~ and chemical dependency.

~~Subchapter~~**SUBCHAPTER W. SINGLE SERVICE HMOS**

§11.2200. Definitions.

The following words and terms, when used in this subchapter, ~~shall~~ have the ~~following meanings,~~meaning indicated below unless the context clearly indicates otherwise~~.~~
:

(1) ADA--The American Dental Association.

(2) CDT--The current dental terminology manual developed and revised periodically by the ADA.

(3) ADA code/dental procedure description--Numerical codes and corresponding descriptions specified in the CDT to describe bona fide dental procedures.

(4) Comparable ~~Facility~~facility--The location where emergency dental services are rendered, including, but not limited to, the office of a licensed dentist, a dental clinic, hospital, freestanding emergency clinic, urgent care clinic, or other ~~such~~ facility.

(5) Emergency ~~Dental Services~~dental services--Under a single ~~health care~~ service plan providing dental care services and benefits, emergency dental services are limited to procedures administered in a ~~dentist's office, dental clinic, or other~~ comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

~~(6) Insurer--An insurance company, a group hospital service corporation operating under Chapter 842 of the Texas Insurance Code, a fraternal benefit society operating under Chapter 885 of the Code, or a stipulated premium insurance company operating under Chapter 884 of the Code.~~

(6) Insurer--An insurance company, a group hospital service corporation operating under Insurance Code Chapter 842 (concerning Group Hospital Service Corporations), a fraternal benefit society operating under Insurance Code Chapter 885 (concerning Fraternal Benefit Societies), or a stipulated premium insurance company operating under Insurance Code Chapter 884 (concerning Stipulated Premium Insurance Companies).

(7) Point-of-service group disclosure statement--A written statement containing information about dental benefits ~~which statement~~that the HMO must provide to:

(A) an employer, an association, or other private group arrangement to whom the HMO must offer a dental point-of-service plan; and

(B) any prospective enrollees in a dental point-of-~~-~~service plan, if the employer, association, or private group arrangement accepts the dental point-of-~~-~~service plan.

(8) Point-of-service plan--A plan provided through a contractual arrangement under which indemnity benefits for the cost of dental care services other than emergency care or emergency dental care are provided by an insurer in conjunction with corresponding benefits arranged or provided by an HMO that provides dental benefits and under which an enrollee may choose to obtain benefits or services under either the indemnity plan or the HMO plan in ~~accordance with specific provisions of Insurance Code §843.112.~~

~~(9) Qualified actuary--An actuary who is either:~~

~~(A) a Fellow of the Society of Actuaries, or~~

~~(B) a Member of the American Academy of Actuaries.~~ compliance with Insurance Code §843.112 (concerning Dental Point-of-Service Option).

(9) Qualified actuary--As defined in §11.702 of this title (relating to Actuarial Certification).

§11.2201. General Provisions.

(a) Each single service HMO ~~shall~~must provide uniquely described services with any corresponding copayments for each covered service and benefit and ~~shall~~must provide a single health care service plan as defined ~~under~~in Insurance Code §843.002~~(26~~ (concerning Definitions). Each single service HMO must comply with all requirements for a single health care service plan specified in this subchapter.

(b) Each single service HMO schedule of enrollee copayments ~~shall~~must specify an appropriate description of covered services and benefits, as required ~~under~~by §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), and may specify recognized procedures or other information ~~which is~~ used for the purpose of maintaining a statistical reporting system.

(c) Each single service HMO evidence of coverage ~~shall~~must include a glossary of terminology, including ~~such~~the terms used in the evidence of coverage required by §11.501 of this title (relating to ~~Forms Which Must be Approved Prior to Use). Such~~Contents of the Evidence of Coverage). The glossary

~~shall~~must be included in the information to prospective and current group contract holders and enrollees, as required ~~under~~by Insurance Code §843.201~~.~~
(concerning Disclosure of Information About Health Care Plan Terms).

(d) In the event of a conflict between the provisions of this subchapter and other provisions of this chapter, this subchapter prevails with regard to single service HMOs. It is not considered a conflict if a topic that is not addressed in this subchapter appears elsewhere in this chapter.

§11.2202. Limitations and Exclusions.

Single service HMOs are prohibited from:

(1) ~~Excluding~~excluding services required for ~~pre-existing~~preexisting conditions ~~which~~that would otherwise be covered under the plan; and

(2) ~~Establishing~~establishing waiting periods for coverage of ~~pre-existing~~preexisting conditions.

§11.2203. Minimum Standards~~, -~~ Dental Care Services and Benefits.

(a) Each single service HMO evidence of coverage ~~which~~that uses any dental procedure codes must use ~~such~~the codes as specified in the current version of the CDT~~, as defined in §11.2200 of this title (relating to Definitions).~~
and certify that the codes referenced in its evidence of coverage are as specified in the current version of the CDT.

(b) Each single service HMO evidence of coverage providing coverage for dental care services ~~shall~~must provide benefits for covered dental treatment in progress and may, if clearly disclosed, require the enrollee to have ~~such~~the treatment completed by a participating provider in the ~~Health Maintenance Organization Delivery Network~~HMO delivery network, as defined ~~under~~in Insurance Code §843.002~~(15~~ (concerning Definitions), or as otherwise arranged by the single service HMO.

(c) Each single service HMO evidence of coverage providing coverage for dental care services and benefits ~~shall offer~~must provide services for the purposes of preventing, alleviating, curing, or healing dental disease, including dental caries and periodontal disease. ~~Such~~The services may include an infection control (sterilization) fee. Single service HMOs providing coverage for dental care services ~~shall offer~~must provide coverage for the following primary and preventive services provided by a general dentist or hygienist, as applicable:

(1) office visit~~ ~~during and after regularly scheduled hours;

(2) oral evaluations;~~x~~

(3) X-rays;

(4) bitewings;

(5) panoramic film;

(6) dental prophylaxis (adult and child);

(7) topical fluoride treatment for children;

(8) dental sealants for children;

(9) amalgam fillings (one, two, three, and four or more ~~surface~~surfaces, primary and permanent~~,~~, including polishing);

(10) anterior resin fillings (one, two, three, and four or more ~~surface~~surfaces, or involving incisal angle, primary and permanent~~,~~, including polishing);

(11) simple oral extractions;

(12) surgical incision and drainage of abscess~~,~~, intraoral soft tissue; and

(13) palliative (emergency) treatment of dental pain~~.~~

, provided that the enrollee may obtain emergency treatment of dental pain in a comparable facility.

(d) Each single service HMO evidence of coverage providing coverage for dental care services and benefits may provide secondary dental care services and benefits. Each single service HMO evidence of coverage providing coverage for dental care services and benefits may include an infection control (sterilization) fee, and may provide secondary dental care services and benefits, including:

(1) posterior resin restorations, one, two, three, and four or more ~~surface~~surfaces (to include polishing);

(2) crowns and crown recementation;

(3) composite resin crowns, anterior-primary;

(4) sedative fillings;

(5) core buildup, including any pins, and pin retention;

(6) pulp cap (direct and indirect);

(7) therapeutic pulpotomy;

(8) root canal therapy, anterior, bicuspid, and molar;

(9) gingival curettage;

(10) osseous surgery;

(11) periodontal scaling and root planing;

(12) periodontal maintenance procedures;

(13) complete denture (maxillary and mandibular);

(14) partial denture (maxillary and mandibular);

(15) root removal-exposed roots;

(16) surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone ~~and/~~or section of tooth;

(17) removal of impacted tooth (soft tissue and completely bony);

(18) tooth reimplantation ~~and/~~or stabilization, or both, of accidentally evulsed or displaced tooth ~~and/~~or alveolus~~;~~, or both;

(19) alveoplasty;

(20) occlusal guard (bruxism appliance); or

(21) orthodontia.

(e) Each single service HMO providing coverage for dental care services and benefits may also offer a preventive services plan as a supplement to a basic health care service plan offered by an affiliate or another carrier, as long as a plan described in ~~section~~subsection (c) of this section has first been offered to and rejected in writing by the group contract holder. ~~Such a~~The preventive plan ~~shall~~must include~~ oral evaluations, X-rays, bitewings, panoramic film, and prophylaxis. ~~:

(1) oral evaluations;

(2) X-rays;

(3) bitewings;

(4) panoramic film; and

(5) prophylaxis.

§11.2204. Minimum Standards~~, -~~ Vision Care Services and Benefits.

(a) Each single service HMO evidence of coverage providing vision care services and benefits ~~shall~~must provide the following as covered primary and preventive vision services:

(1) comprehensive eye examination to include medical history;

(2) visual acuities, with ~~correction (distance~~ and ~~near),~~ without correction (distance and near);

(3) cover test at 20 feet and at 16 inches;

(4) versions;

(5) external examination of the eye lids, cornea, conjunctiva, pupillary reaction (neurological integrity~~)~~), and muscle function;

(6) binocular measurements for far and near;

(7) internal eye examination (ophthalmoscopy);

(8) autorefraction/refraction (far point and near point);

(9) tonometry (reasonable attempt or equivalent testing if contraindicated);

(10) retinoscopy;

(11) biomicroscopy;

(12) intraocular pressure~~-~~ glaucoma test;

(13) slit lamp examination; and

(14) urgent care ~~as defined in §11.2 of this title (relating to Definitions).~~

.

(b) A single service HMO evidence of coverage providing vision care services and benefits may provide coverage for secondary vision care services, which include ~~contact lens examination; fitting; training; follow-up visits, or eye glasses.~~ :

(1) contact lens examination;

(2) fitting;

(3) training;

(4) follow-up visits; or

(5) eye glasses.

§11.2205. Prohibited Practices.

(a) Under an individual plan, a single service HMO ~~shall~~may not limit or otherwise interfere with an enrollee's right to terminate his or her membership in the plan before the end of the enrollment year.

~~(b) A single service HMO shall not limit coverage for emergency services under a single health care service plan.~~

~~(c) A single service HMO shall not charge an emergency fee in addition to a copayment for emergency services.~~

(b) A single service HMO may not limit coverage for emergency services under a single health care service plan.

(c) A single service HMO may not charge an emergency fee in addition to a copayment for emergency services.

§11.2206. Mandatory Disclosure Statements~~,~~; Certification of Compliance.

(a) Each point-of-service group enrollment application and, if the employer, association, or private group arrangement elects to offer the point-of-service option, each enrollment form, ~~shall~~must include a disclosure statement written in a readable and understandable format that includes the following information:

(1) a statement that the dental indemnity benefits are provided through an insurer and that the dental care services are offered or arranged by the HMO;

~~(2) the name of the insurer and the name of the HMO offering the benefits; and~~

~~(3) an explanation that, in order to receive benefits:~~

~~(A) from the HMO, an enrollee must utilize only network providers, except for emergency dental~~

(2) the name of the insurer and the name of the HMO offering the benefits; and

(3) an explanation that, in order to receive benefits:

(A) under the HMO, an enrollee must use only network providers, except for emergency dental care, and pay the copayments specified in the evidence of coverage;

(B) under the indemnity plan, ~~the~~an enrollee may ~~utilize~~use any provider but ~~prior to~~before receiving reimbursement, the enrollee must meet the required deductible and is responsible for the coinsurance amount specified in the policy or certificate.

(b) Each HMO offering a point-of-service plan ~~shall~~must retain on file a certification by an HMO officer that the point-of-service plan includes dental indemnity benefits that correspond to the benefits contained in the HMO evidence of coverage. The HMO may enter into agreement with the insurer or a qualified actuary to prepare the certification, provided that the HMO retains responsibility for obtaining the certification and ~~shall~~must keep the certification in its possession.

§11.2208. ~~§11.2207. Quality Improvement Structure and Program for~~ **Single Service** ~~HMOs.~~

~~(a) A single service HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Unless the HMO has no enrollees, the QI program shall include the active involvement of one or more enrollee(s) who are not employees of the HMO.~~
~~(b) The governing body is ultimately responsible for the QI program. The governing body shall:~~
~~(1) appoint a QI committee (QIC) that shall include practicing physicians and individual providers, and may include one or more enrollee(s) from throughout the HMO's service area. For purposes of this section, if an enrollee(s) is appointed to the committee, the enrollee(s) may not be an employee of the HMO;~~
~~(2) approve the QI program;~~
~~(3) approve an annual QI plan;~~
~~(4) meet no less than annually to receive and review reports of the QIC or group of committees and take action when appropriate; and~~
~~(5) review the annual written report on the QI program.~~
~~(c) The QIC shall evaluate the overall effectiveness of the QI program.~~
~~(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual providers, and enrollees from the service area.~~
~~(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.~~
~~(B) All committees shall meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.~~
~~(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.~~
~~(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.~~

~~(d) The QI program for single service HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.~~
~~(1) Written description. The QI program shall include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.~~
~~(2) Work plan. The QI program shall include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status, as applicable. The work plan shall include:~~
~~(A) Objective and measurable goals; planned activities to accomplish the goals; time frames for implementation; responsible individuals; and evaluation methodology.~~
~~(B) The work plan shall address each program area, including:~~
~~(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;~~
~~(ii) Continuity of health care and related services, as applicable;~~
~~(iii) Clinical studies;~~
~~(iv) The adoption and use of current professionally recognized clinical practice guidelines, or, in the absence of current professionally recognized clinical practice guidelines for particular practice areas or conditions, those developed by the health plan that:~~
~~(I) are approved by participating physicians and individual providers;~~
~~(II) are communicated to physicians and individual providers; and~~
~~(III) include preventive health services.~~
~~(v) Enrollee, physician, and individual provider satisfaction;~~
~~(vi) The complaint and appeal process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians and providers from effectively making complaints against the HMO;~~
~~(vii) Preventive health care through health promotion and outreach activities:~~
~~(viii) Claims payment processes, as applicable;~~
~~(ix) Contract monitoring, including delegation oversight and compliance with filing requirements;~~
~~(x) Utilization review processes, as applicable;~~
~~(xi) Credentialing;~~
~~(xii) Member services; and;~~
~~(xiii) Pharmacy services, including drug utilization.~~
~~(3) Evaluation. The QI program shall include an annual report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.~~
~~(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers. The credentialing process required by this section must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.~~
~~(5) Site Visits for Cause.~~
~~(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.~~
~~(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.~~

~~(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.~~
~~(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.~~

~~§11.2208.~~ ~~Single Health Care Services~~ **Accessibility and Availability.**

~~(a)~~ A single ~~health care~~ service HMO that chooses to offer a particular service to an enrolled population ~~a particular service shall~~must comply with §11.1607~~(a) and (e) - (j)~~ of this title (relating to Accessibility and Availability Requirements). Any single ~~health care~~ service ~~shall~~must be ~~offered~~provided directly by the HMO or by contract.

~~(b) A sufficient number of participating single health care physicians or dentists or other individual providers with appropriate hospital or inpatient facility admitting privileges shall be available and accessible 24 hours per day, seven days per week, within the HMO's service area, to ensure availability and accessibility of care, including inpatient admissions and care, as appropriate.~~

~~(c) If a service offered by a single health care service HMO requires inpatient status for the management of a single health care condition the HMO shall provide for the appropriate inpatient facility according to the need by contracting with one or more general, or special hospitals; or home and community support services agencies for outpatient services.~~

~~Subchapter X. PROVIDER SPONSORED ORGANIZATIONS~~

~~§11.2301. Purpose and Scope.~~

~~The Social Security Act was amended by Congress in 1997 to create Medicare+Choice. Medicare+Choice recognizes and authorizes provider sponsored organizations to contract with the Health Care Financing Administration to deliver health care services to Medicare recipients in a managed care environment. The purpose of this subchapter is to provide for the licensing and regulation of these provider sponsored organizations by the department. Under state law a PSO would otherwise be a health maintenance organization (HMO). However, the Medicare+Choice program authorized a PSO to seek a waiver of state licensing from the Health Care Financing Administration if the state's solvency standards for an HMO license were more stringent than those required of a PSO under the Medicare+Choice program. This subchapter required the same solvency standards for a PSO as the Medicare+Choice program until the authority of the Health Care Financing Administration to waive the state licensing requirement expired on November 1, 2002. Otherwise the subchapter provides for the licensing of a PSO in the same manner as an HMO. After November 1, 2002, a PSO may apply for a certificate of authority under these provisions, however, the solvency provisions for HMOs must be met as a condition of~~

~~receiving a certificate of authority. By June 30, 2003, PSOs that received a certificate of authority under this subchapter before November 1, 2002, must demonstrate to the department that they are in compliance with the solvency requirements for an HMO or file a business plan with the department that demonstrates that the PSO will be in compliance with the solvency requirements for an HMO by December 31, 2006. Provider Sponsored Organizations licensed under this subchapter are only authorized to engage in the delivery of health care services pursuant to a contract with the Health Care Financing Administration related to the Medicare+Choice program.~~

~~§11.2302. Definitions.~~

~~The following words and terms, when used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.~~
~~(1) Affiliate--One health care provider, directly or indirectly, controls, is controlled by, or is under common control with the other.~~
~~(2) Capitated basis--A payment method under which a fixed per member, per month amount is paid for contracted services without regard to the type, cost or frequency of services provided.~~
~~(3) Cash equivalent--Those assets excluding accounts receivables, which can be exchanged on an equivalent basis as cash, or converted into cash within 90 days from their presentation for exchange.~~
~~(4) Control--An individual, group of individuals,~~
~~or entity has the power, directly or indirectly, to direct or influence significantly the actions or policies of an organization or institution.~~
~~(5) Current ratio--Total current assets divided by total current liabilities.~~
~~(6) Deferred acquisition costs--Those costs incurred in starting or purchasing a business. These costs are capitalized as intangible assets and carried on the balance sheet as deferred charges since they benefit the business for periods after the period in which the costs were incurred.~~
~~(7) Department--Texas Department of Insurance.~~
~~(8) Engaged in the delivery of health care services--~~
~~(A) For an individual, that the individual directly furnishes health care services; or~~
~~(B) For an entity, that the entity is organized and operated primarily for the purpose of furnishing health care services directly or through its provider members or entities.~~
~~(9) Generally accepted accounting principles--Broad rules adopted by the accounting profession as guides in measuring, recording, and reporting the financial affairs and activities of a business to its owners, creditors and other interested parties.~~
~~(10) Guarantor--An entity that:~~
~~(A) has been approved by the department under §11.2310 of this title (relating to Guarantees) as meeting the requirements to be a guarantor; and~~
~~(B) obligates its resources to a PSO to enable the PSO to meet the solvency requirements required to contract with the Health Care Financing Administration as a Medicare+Choice organization.~~
~~(11) Health care delivery assets--Any tangible assets that are part of a PSO's operation, including hospitals and other medical facilities and their ancillary equipment, and such property as may be reasonably required for the PSO's principal office or for such other purposes as the PSO may need for transacting its business.~~
~~(12) Health care provider--~~
~~(A) Any individual who is engaged in the delivery of health care services in this state and is licensed or certified by the state to engage in that activity in this state; and~~
~~(B) Any entity that is engaged in the delivery of health care services in this state and is licensed or certified to deliver those services if such licensing or certification is required by state law or regulation.~~
~~(13) Insolvency--A condition where the liabilities of the debtor exceed the fair valuation of its assets.~~

(14) Medicare+Choice--A Medicare program that expands the health care options available to Medicare beneficiaries.
(15) Net worth--The excess of total assets over total liabilities, excluding fully subordinated debt or subordinated liabilities.
(16) PSO--Provider Sponsored Organization. A PSO is a public or private entity that is established or organized, and controlled and operated, by a health care provider, or a group of affiliated health care providers to provide health care solely to Medicare enrollees pursuant to a contract with the Health Care Financing Administration and which provider(s) share substantial financial risk and have at least a majority financial interest in the entity.
(17) Qualified actuary--A member in good standing of the American Academy of Actuaries or a person recognized by the Academy as qualified for membership, or a person who has otherwise demonstrated competency in the field of actuarial determination and is satisfactory to the department.
(18) Statutory accounting practices--Those accounting principles or practices prescribed or permitted by the domiciliary state insurance department in the state that the PSO operates.
(19) Subordinated debt--An obligation that is owed by an organization, that the creditor of the obligation, by law, agreement, or otherwise, has a lower repayment rank in the hierarchy of creditors than another creditor. The creditor would be entitled to repayment only after all higher ranking creditors' claims have been satisfied. A debt is fully subordinated if it has a lower repayment rank than all other classes of creditors.
(20) Subordinated liability--Claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all other creditors.
(21) Uncovered expenditures--Those expenditures for health care services that are the obligation of an organization, for which an enrollee may also be liable in the event of the organization's insolvency and for which no alternative arrangements have been made that are acceptable to the department. They include expenditures for health care services for which the organization is at risk, such as out-of-area services, referral services and hospital services. However, they do not include expenditures for services when a provider has agreed not to bill the enrollee.

§11.2303. Application for Certificate of Authority.

(a) Any health care provider may apply to the commissioner for and obtain a certificate of authority to establish and operate a PSO for the purpose of providing health care to Medicare enrollees in accordance with this subchapter.
(b) Prior to obtaining a certificate of authority under the Insurance Code Chapter 843, an applicant PSO must comply with each requirement for the issuance of a certificate of authority imposed on an HMO under the Insurance Code Chapters 1271 and 843, 28 Texas Administrative Code Chapter 11, and other applicable insurance laws and regulations of this state except where preempted by federal law.
(c) An applicant for a certificate of authority for a PSO shall complete and file with the department the application form for a health maintenance organization adopted by reference under §11.1001 of this title (relating to Required Forms) and the Financial Plan required by §11.2304 of this title (relating to Financial Plan Requirement).

§11.2304. Financial Plan Requirement.

(a) General rule. At the time of application under §11.2303 of this title (relating to Application for Certificate of Authority), an applicant must submit a financial plan acceptable to the department.
(b) Content of plan. A financial plan must include:
(1) A detailed marketing plan;

~~(2) Statements of revenue and expense on an accrual basis;~~
~~(3) Statements of sources and uses of funds;~~
~~(4) Balance sheets;~~
~~(5) Detailed justifications and assumptions in support of the financial plan including, where appropriate, certification of reserves and actuarial liabilities by a qualified health maintenance organization actuary; and~~
~~(6) If applicable, statements of the availability of financial resources to meet projected losses.~~
~~(c) Period covered by the plan. A financial plan must:~~
~~(1) Cover the first 12 months after the estimated effective date of a PSO's Medicare+Choice contract; or~~
~~(2) If the PSO is projecting losses, cover 12 months beyond the end of the period for which losses are projected.~~
~~(d) Funding for projected losses. Except for the use of guarantees, letters of credit, and other means as provided in §11.2310 of this title (relating to Guarantees), an organization must have the resources for meeting projected losses on its balance sheet in cash or a form that is convertible to cash in a timely manner, in accordance with the PSO's financial plan.~~
~~(e) Guarantees and projected losses. Guarantees will be an acceptable resource to fund projected losses, provided that a PSO:~~
~~(1) meets the department's requirements for guarantors and guarantee documents as specified in §11.2310 of this title; and~~
~~(2) obtains from the guarantor cash or cash equivalents to fund the projected losses timely, as follows:~~
~~(A) prior to the effective date of a PSO's Medicare+Choice contract, the amount of the projected losses for the first two quarters;~~
~~(B) during the first quarter and prior to the beginning of the second quarter of a PSO's Medicare+Choice contract, the amount of projected losses through the end of the third quarter; and~~
~~(C) during the second quarter and prior to the beginning of the third quarter of a PSO's Medicare+Choice contract, the amount of projected losses through the end of the fourth quarter.~~
~~(3) If the guarantor complies with the requirements in paragraph (2) of this section, the PSO, in the third quarter, may notify the department of its intent to reduce the period of advance funding of projected losses. The department will notify the PSO within 60 days of receiving the PSO's request if the requested reduction in the period of advance funding will not be accepted.~~
~~(4) If the guarantee requirements in paragraph (2) of this subsection are not met, the department may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. The department retains discretion to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.~~
~~(f) Letters of credit. Letters of credit are an acceptable resource to fund projected losses, provided they are irrevocable, unconditional, and satisfactory to the department. They must be capable of being promptly paid upon presentation of a sight draft under the letters of credit without further reference to any other agreement, document, or entity.~~
~~(g) Other means. If satisfactory to the department, and for periods beginning one year after the effective date of a PSO's Medicare+Choice contract, a PSO may use the following to fund projected losses:~~
~~(1) lines of credit from regulated financial institutions;~~
~~(2) legally binding agreements for capital contributions; or~~
~~(3) legally binding agreements of a similar quality and reliability as permitted in paragraphs (1) and (2) of this subsection.~~
~~(h) Application of guarantees, letters of credit or other means of funding projected losses.~~
~~Notwithstanding any other provision of this section, a PSO may use guarantees, letters of credit and,~~

beginning one year after the effective date of a PSO's Medicare+Choice contract, other means of funding projected losses, but only in a combination or sequence that the department considers appropriate.

§11.2305. Issuance of Certificate of Authority.

The commissioner of insurance may issue a certificate of authority for the purpose of providing health care to Medicare enrollees only to a PSO that meets each requirement for the issuance of a certificate of authority as a health maintenance organization imposed by the Insurance Code, Chapter 843, provided, a PSO that received a certificate of authority before November 1, 2002 does not have to comply with Sections 843.405 and 843.408, Insurance Code until December 31, 2006 under the provisions of §11.2306 of this title (relating to Solvency Standards).

§11.2306. Solvency Standards.

(a) A PSO or the legal entity of which the PSO is a component that received a certificate of authority under §11.2305 of this title (relating to Issuance of Certificate of Authority) before November 1, 2002 must have a fiscally sound operation that meets the requirements of §11.2307-11.2310 of this title (relating to Provider Sponsored Organizations).
(b) By June 30, 2003, a PSO described in subsection (a) of this section must:
(1) demonstrate that it complies with §§11.801-11.810 of this title (relating to Financial Requirements); or
(2) file a business plan with the department that contains quarterly projected pro forma financial statements that demonstrates that the PSO will be in compliance with the requirements of §§11.801-11.810 of this title by December 31, 2006.
(c) A PSO or the legal entity of which the PSO is a component that receives a certificate of authority after November 1, 2002, must have a fiscally sound operation that meets the requirements of §§11.801-11.810 of this title as a condition of receiving the certificate of authority.

§11.2307. Minimum Net Worth Amount.

(a) Prior to the issuance of a certificate of authority, a PSO must have a minimum net worth amount, as determined under subsection (d) of this section, of:
(1) at least $1,500,000, except as provided in paragraph (2) of this subsection.
(2) no less than $1 million based on evidence from the organization's financial plan under §11.2304 of this title (relating to Financial Plan Requirement) demonstrating to the department's satisfaction that the organization has available to it an administrative infrastructure that the department considers appropriate to reduce, control or eliminate start-up administrative costs.
(b) After the effective date of a PSO's certificate of authority, a PSO must maintain a minimum net worth amount equal to the greater of:
(1) one million dollars;
(2) two percent of annual premium revenues as reported on the most recent annual financial statement filed with the department for up to and including the first $150 million of annual premiums and 1% of annual premium revenues on premiums in excess of $150 million;
(3) an amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with the department; or
(4) using the most recent annual financial statement filed with the department, an amount equal to the sum of:
(A) eight percent of annual health care expenditures paid on a non-capitated basis to non-affiliated

providers; and
(B) four percent of annual health care expenditures paid on a capitated basis to non-affiliated providers plus annual health care expenditures paid on a non-capitated basis to affiliated providers.
(c) Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth requirement under subsections (a) and (b)(4) of this section.
(d) The minimum net worth amount shall be calculated as follows:
(1) Cash requirement. A PSO must maintain the following in cash or cash equivalents:
(A) At the time of application for a certificate of authority, the PSO must maintain at least $750,000 of the minimum net worth amount in cash or cash equivalents.
(B) After the effective date of a PSO's certificate of authority, a PSO must maintain the greater of $750,000 or 40% of the minimum net worth amount in cash or cash equivalents.
(2) Intangible Assets. A PSO may include intangible assets, the value of which is based on Generally Accepted Accounting Principles, in the minimum net worth amount calculation subject to the following limitations:
(A) At the time of application:
(i) Up to 20% of the minimum net worth amount, provided at least $1 million of the minimum net worth amount is met through cash or cash equivalents; or
(ii) Up to 10% of the minimum net worth amount, if less than $1 million of the minimum net worth amount is met through cash or cash equivalents, or if the department has used its discretion under subsection (a)(2) of this section.
(B) From the effective date of the PSO's certificate of authority:
(i) Up to 20% of the minimum net worth amount if the greater of $1 million or 67% of the minimum net worth amount is met by cash or cash equivalents; or
(ii) Up to 10% of the minimum net worth amount if the greater of $1 million or 67% of the minimum net worth amount is not met by cash or cash equivalents.
(3) Health care delivery assets. Subject to this section, a PSO may apply 100% of the Generally Accepted Accounting Principles depreciated value of health care delivery assets to satisfy the minimum net worth amount.
(4) Other assets. A PSO may apply other assets not used in the delivery of health care provided that those assets are valued according to Statutory Accounting Practices as defined by the department.
(5) Subordinated debts and subordinated liabilities. Fully subordinated debt and subordinated liabilities are excluded from the minimum net worth amount calculation.
(6) Deferred acquisition costs. Deferred acquisition costs are excluded from the calculation of the minimum net worth amount.

§11.2308. Liquidity.

(a) A PSO must have sufficient cash flow to meet its financial obligations as they become due and payable.
(b) To determine whether the PSO meets the requirement in subsection (a) of this section, the department will examine the following:
(1) The PSO's timeliness in meeting current obligations;
(2) The extent to which the PSO's current ratio of assets to liabilities is maintained at 1:1 including whether there is a declining trend in the current ratio over time; and
(3) The availability of outside financial resources to the PSO.
(c) If the department determines that a PSO fails to meet the requirement in subsection (b)(1) of this section, the department will require the PSO to initiate corrective action and pay all overdue obligations.
(d) If the department determines that a PSO fails to meet the requirement of subsection (b)(2) of this

section, the department will require the PSO to initiate corrective action to:
(1) change the distribution of its assets;
(2) reduce its liabilities; or
(3) make alternative arrangements to secure additional funding to restore the PSO's current ratio to 1:1.
(e) If the department determines that a PSO fails to meet the requirement of subsection (b)(3) of this section, the department will require the PSO to obtain funding from alternative financial resources.

§11.2309. Deposits.

(a) Insolvency deposit.
(1) At the time of application, an organization must deposit $100,000 in cash or securities (or any combination thereof) into an account in a manner that is acceptable to the department.
(2) The deposit must be restricted to use in the event of insolvency to help assure continuation of services or pay costs associated with receivership or liquidation.
(3) At the time of the PSO's application for a certificate of authority, and, thereafter, upon the department's request, a PSO must provide the department with proof of the insolvency deposit, such proof to be in a form that the department considers appropriate.
(b) Uncovered expenditures deposit.
(1) If at any time uncovered expenditures exceed 10% of a PSO's total health care expenditures, then the PSO must place an uncovered expenditures deposit into an account with any organization or trustee that is acceptable to the department.
(2) The deposit must at all times have a fair market value of an amount that is 120% of the PSO's outstanding liability for uncovered expenditures for enrollees, including incurred, but not reported, claims.
(3) The deposit must be calculated as of the first day of each month required and maintained for the remainder of each month required.
(4) If a PSO is not otherwise required to file a quarterly report, it must file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.
(5) The deposit required under this section is restricted and in trust for the department's use to protect the interests of the PSO's Medicare enrollees and to pay the costs associated with administering the insolvency. It may be used only as provided under this section.
(c) Deposit as asset. A PSO may use the deposits required under subsections (a) and (b) of this section to satisfy the PSO's minimum net worth amount required under §11.2307(a) and (b) of this title (relating to Minimum Net Worth Amount).
(d) Income. All income from the deposits or trust accounts required under subsections (a) and (b) of this section are considered assets of the PSO. Upon the department's approval, the income from the deposits may be withdrawn.
(e) Withdrawal. On prior written approval from the department, a PSO that has made a deposit under subsection (a) or (b) of this section may withdraw that deposit or any part thereof if:
(1) a substitute deposit of cash or securities of equal amount and value is made;
(2) the fair market value exceeds the amount of the required deposit; or
(3) the required deposit under subsections (a) or (b) of this section is reduced or eliminated.

§11.2310. Guarantees.

(a) General policy. A PSO, or the legal entity of which the PSO is a component, may apply to the department to use the financial resources of a guarantor for the purpose of meeting the requirements in §11.2304 of this title (relating to Financial Plan Requirement). The department has the discretion to

~~approve or deny approval of the use of a guarantor.~~
~~(b) Request to use a guarantor. To apply to use the financial resources of a guarantor, a PSO must submit to the department the material described in paragraphs (1) (2) of this subsection:~~
~~(1) Documentation that the guarantor meets the requirements for a guarantor under subsection (c) of this section; and~~
~~(2) The guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the guarantor's balance sheets, profit and loss statements, and cash flow statements.~~
~~(c) Requirements for guarantor. To serve as a guarantor, an organization must meet the following requirements:~~
~~(1) Be a legal entity authorized to conduct business within a state of the United States.~~
~~(2) Not be under federal or state bankruptcy or rehabilitation proceedings.~~
~~(3) Have a net worth (not including other guarantees, intangibles and restricted reserves) equal to three times the amount of the PSO guarantee.~~
~~(4) If the guarantor is regulated by a state insurance commissioner, or other state official with authority for risk-bearing entities, it must meet the net worth requirement in paragraph (3) of this subsection with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.~~
~~(5) If the guarantor is not regulated by a state insurance commissioner or other similar state official, it must meet the net worth requirement in paragraph (3) of this subsection with all guarantees and all investments in and loans to organizations covered by a guarantee and to related parties (subsidiaries and affiliates) excluded from its assets.~~
~~(d) Guarantee document. If the guarantee request is approved, a PSO must submit to the department a written guarantee document signed by an appropriate authority of the guarantor. The guarantee document must contain the following provisions:~~
~~(1) State the financial obligation covered by the guarantee;~~
~~(2) Agree to unconditionally fulfill the financial obligation covered by the guarantee;~~
~~(3) Agree not to subordinate the guarantee to any other claim on the resources of the guarantor;~~
~~(4) Declare that the guarantor must act on a timely basis, in any case not more than five business days, to satisfy the financial obligation covered by the guarantee; and~~
~~(5) Meet other conditions as the department may establish from time to time.~~
~~(e) Reporting requirement. A PSO must submit to the department the current internal financial statements and annual audited financial statements of the guarantor according to the schedule, manner, and form that the department requests.~~
~~(f) Modification, substitution, and termination of a guarantee. A PSO cannot modify, substitute or terminate a guarantee unless the PSO:~~
~~(1) requests the department's approval at least 90 days before the proposed effective date of the modification, substitution, or termination;~~
~~(2) demonstrates to the department's satisfaction that the modification, substitution, or termination will not result in insolvency of the PSO; and~~
~~(3) demonstrates how the PSO will meet the requirements of this section.~~
~~(g) Nullification. If at any time the guarantor or the guarantee ceases to meet the requirements of this section, the department will notify the PSO that it ceases to recognize the guarantee document. In the event of this nullification, a PSO must:~~
~~(1) meet the applicable requirements of this section within 15 business days; and~~
~~(2) if required by the department, meet a portion of the applicable requirements in less than the time period granted in paragraph (1) of this subsection.~~

~~§11.2311. Dissolution; Liquidation; Rehabilitation.~~

~~Any dissolution, liquidation, rehabilitation, supervision or conservation of an entity licensed under this subchapter shall be handled as provided in Insurance Code Articles 21.28 and 21.28-A and §§843.463 and 843.407.~~

~~§11.2312. Reports.~~

~~Each PSO shall annually, on or before the 1st day of March, file an annual statement, in the form adopted by the Commissioner, with the department. Each PSO shall file other reports with the department as required from time to time.~~

~~§11.2313. Examinations.~~

~~The commissioner may make an examination concerning the quality of health care services and of the affairs of a PSO as often as the commissioner deems necessary, but not less frequently than once every three years.~~

~~§11.2314. Suspension or Revocation of Certificate of Authority.~~

~~The commissioner, after notice and opportunity for hearing, may suspend or revoke any certificate of authority issued to a PSO, if the commissioner finds that the PSO is insolvent or that any of the conditions described in Insurance Code §843.461 exist.~~

~~§11.2315. Application of Other Insurance Laws.~~

~~Subject to the provisions of this subchapter, the holder of a certificate of authority issued under this subchapter has all the powers granted to and duties imposed on a health maintenance organization under the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, and is subject to regulation and regulatory enforcement under these laws in the same manner as a health maintenance organization.~~

~~Subchapter~~SUBCHAPTER Y. LIMITED SERVICE HMOS

§11.2401. Definitions.

The following words and terms, when used in this subchapter, ~~shall~~ have the ~~following meanings,~~meaning indicated below unless the context clearly indicates otherwise~~.~~

~~:~~

(1) Acute ~~Day Treatment~~day treatment--Program-based services focused on the short-term, acute treatment of individuals who require multi-disciplinary treatment ~~in order~~ to obtain maximum control of psychiatric symptoms. Services are provided in a highly structured and safe

environment with constant supervision. Contacts with staff are frequent, activities and services constantly available, and developmental and social supports encouraged and facilitated. Staff receive specialized training in crisis management. Activities are goal oriented, focusing on improving peer interaction, appropriate social behavior, and stress tolerance.

(2) Assessment--The clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental, or other information from the individual and family seeking services to determine~~,~~ level of need (including urgency) and specific treatment needs (including the preferences of the individual seeking services).

(3) Case ~~Management~~management--Case management activities are provided to assist individuals in gaining access to medical, social, educational, and other appropriate services that will help them achieve a quality of life and community participation acceptable to each individual. The role of ~~persons~~individuals who provide case management activities is to support and assist the person in achieving goals.

(4) Crisis ~~Hotline~~hotline--A continuously available, staffed telephone service providing information, support, and referrals to callers 24 hours per day, seven days per week.

(5) Crisis ~~Respite--Those services~~respite--Services provided for temporary, short term, periodic relief to individuals or their primary caregivers during a crisis. Program-based respite services involve temporary residential placement outside the usual living situation. Community-based respite services involve introducing respite staff into the usual living situation or providing a place for the individual to go during the day or other services considered to provide respite.

(6) Crisis services—Services~~--Services,~~ including crisis hotline, crisis intervention, and crisis respite.

(7) Intensive outpatient service--An organized ~~non-residential~~nonresidential service providing structured group and individual therapy, educational services, and life~~--~~skills training ~~which~~

~~is~~for less than 24 hours per day.

(8) Medication administration--A service provided to an individual by a licensed nurse ~~(~~or other appropriately trained and certified person under the supervision of a physician or registered nurse as provided by state law~~)~~ to ensure the direct application of a medication to the body of the individual by any means including handing the individual a single dose of medication to be taken orally.

(9) Medication monitoring--A service provided to an individual ~~and/or~~, family member, or other collateral by a licensed nurse ~~(~~or other appropriately trained and certified person under the supervision of a physician or registered nurse as provided by state law~~)~~ for the purpose of assessment of medication actions, target symptoms, side effects and adverse effects, potential toxicity, and the impact of medication for the individual and family in ~~accordance~~compliance with the plan of care.

(10) Medication training--A service to an individual ~~and/or~~, family member, or other collateral by a licensed nurse ~~(~~or other appropriately trained professional or paraprofessional as provided by state law~~)~~ for the purpose of teaching the knowledge and skills needed by the individual~~/~~, family~~/~~ member, or other collateral in the proper administration and monitoring of prescribed medication in ~~accordance~~compliance with the individual's plan of care.

(11) Medication-related services--Services, including medication administration, medication monitoring, medication training, and pharmacological management.

(12) Partial hospitalization--The provision of treatment for mental health care or chemical dependency for individuals who require care or support or both in a hospital or chemical dependency treatment center but who do not require 24-hour supervision.

(13) Pharmacological management--Service provided to an individual, family member, or collateral by a physician or other appropriately trained and certified professional as provided by state law for the purpose of determining symptom remission and the medication regimen needed to initiate

~~and/~~or maintain an individual's plan of care.

(14) Screening--Gathering triage information necessary to determine a need for in-depth assessment. This information is collected through interview, in person or by phone, with the individual, family member, or collateral as part of the admission~~/~~ or intake process or as necessary.

(15) Treatment planning--Activities for the purpose of medically necessary, prioritized, comprehensive, collaborative, and measurable treatment that reflects the needs and wishes of the individual and builds ~~upon~~on the strengths of the individual.

§11.2402. General Provisions.

(a) A limited service HMO must develop and maintain an ongoing quality improvement structure and program that complies with Chapter 11, Subchapter T, of this title (relating to Quality of Care).

(b) Each limited service HMO ~~shall~~must provide uniquely~~-~~ described services with any corresponding copayments for each covered service and benefit, and ~~shall~~ provide a limited health care service plan as defined ~~under~~in Insurance Code §843.002~~.~~ (concerning Definitions). Each limited service HMO must comply with all requirements for a limited health care service plan specified in this subchapter.

~~(b~~

(c) Each limited service HMO schedule of enrollee copayments ~~shall~~must specify an appropriate description of covered services and benefits, as required ~~under~~by §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), and may specify recognized procedure codes or other information used for maintaining a statistical reporting system.

~~(c~~

(d) Each limited service HMO evidence of coverage ~~shall~~must include a glossary of ~~terminology~~terms, including ~~such~~the terms used in the evidence of coverage required by §11.501 of this title (relating to ~~Forms Which Must be Approved Prior to Use). Such~~Contents of the Evidence of Coverage). The glossary ~~shall~~must be included in the information to prospective and current group

contract holders and enrollees, as required ~~under~~by Insurance Code §843.201~~.~~

~~(d) In the event of a conflict between the provisions of this subchapter and other provisions of Chapter 11 of this title (relating to~~ (concerning Disclosure of Information about Health ~~Maintenance Organizations), this subchapter prevails with regard to limited service HMOs. It is not considered a conflict if a topic that is not addressed in this subchapter appears elsewhere in Chapter 11 of this title.~~ Care Plan Terms).

§11.2403. ~~Limitations and Exclusions~~**Prohibited Practices.**

~~Limited~~A limited service ~~HMOs are prohibited from:~~

HMO may not:

(1) ~~Excluding~~exclude services required for ~~pre-existing~~preexisting conditions which would otherwise be covered under the plan;

(2) ~~Establishing~~establish waiting periods for coverage of ~~pre-existing~~preexisting conditions; ~~and~~

(3) ~~Imposing~~impose a lifetime coverage maximum for any covered service or benefit~~.~~ ;

~~§11.2404. Prohibited Practices.~~

~~(a) A limited service HMO shall not~~ (4) limit or otherwise interfere with an enrollee's right to terminate his or her membership in the plan before the end of the enrollment year~~.~~

~~(b) A limited service HMO shall not~~;

(5) limit coverage for emergency services under a limited health care service plan~~.~~

~~(c) A limited service HMO shall not~~;

(6) charge an emergency fee in addition to a copayment for emergency services~~.~~

~~(d) A limited service HMO shall not~~; or

(7) count medication~~-~~related services and services provided by telephone toward the annual outpatient visit total for either serious or ~~non-serious~~nonserious mental illness.

§11.2405. Minimum Standards~~, -~~ Mental Health and Chemical Dependency Services and Benefits.

~~(a)~~ Each limited service HMO evidence of coverage providing coverage for mental health~~/~~ and chemical dependency services and benefits ~~shall~~must:

(1) cover, in ~~accord~~compliance with the limited service HMO's standards of medical necessity, court~~-~~-ordered mental health~~/~~ and chemical dependency treatment and may, if clearly disclosed, require the enrollee to have ~~such~~the treatment completed by a participating physician or provider in the ~~Health Maintenance Organization Delivery Network~~HMO delivery network, as defined ~~under~~in Insurance Code §843.002~~,~~ (concerning Definitions), or as otherwise arranged by the limited service HMO~~.~~;

~~(b) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall~~ (2) comply with Chapter 21, Subchapter P, of this title (relating to Mental Health Parity)

(3) provide primary mental health~~/~~ and chemical dependency services and benefits, including:

~~(1) For~~

(A) for treatment of serious mental illness ~~(~~, as defined in ~~the~~ Insurance Code Chapter 1355 ~~Subchapter A~~, Subchapter A, (concerning Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses and Other Disorders), up to 45 inpatient days per year~~,~~ and up to 60 outpatient visits per year, which include assessment~~/~~ or screening, treatment planning, and crisis services~~.~~

~~(2) For~~;

(B) for treatment of ~~non-serious~~nonserious mental illness, up to 30 inpatient days per year~~,~~ and up to 30 outpatient visits per year, which include screening and assessment~~/screening~~, treatment planning, and crisis services~~.~~

~~(3) Treatment~~;

(C) treatment of chemical dependency in ~~accord~~compliance with the levels of care and clinical criteria specified in ~~§§~~Chapter 3~~.8001, et seq.~~, Subchapter HH, of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers~~).~~); and

~~(4) Any~~ (D) any other services necessary and appropriate to treat mental health~~/~~ and chemical dependency services or required by the Insurance Code, Health and Safety Code, and other

applicable laws and regulations of this ~~State.~~

~~(c) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall~~state; and

(4) demonstrate the capacity to provide, and may provide, secondary intensive rehabilitative, and community support services for mental illness~~/~~ and chemical dependency, including, but not limited to, case management, partial hospitalization, residential, acute day treatment, intensive outpatient~~, ACT~~ service, Assertive Community Treatment teams, and habilitative~~/~~ or rehabilitative services for pervasive developmental disorders.

§11.2406. Minimum Standards~~, –~~ Long ~~-~~Term Care Services and Benefits.

Each limited service HMO evidence of coverage providing long-term care services and benefits ~~shall~~must comply with ~~the~~ Insurance Code Chapter 1651 (concerning Long-Term Care Benefit Plans) and ~~§§~~Chapter 3~~.3801, et seq.~~, Subchapter Y, of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy).

~~Subchapter~~**SUBCHAPTER Z. POINT-OF-SERVICE RIDERS**

§11.2501. Definitions.

The following words and terms, when used in this subchapter, ~~shall~~ have the ~~following~~ meaning~~,~~ indicated below unless the context indicates otherwise~~.~~

:

(1) Coinsurance--An amount in addition to the premium and copayments due from an enrollee who accesses out-of-plan covered benefits, for which the enrollee is not reimbursed.

~~(2) Corresponding benefits--Benefits provided under a point-of-service (POS) rider or the indemnity portion of a point-of-service (POS) plan, as defined in the Insurance Code §1273.001 and §843.108, that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a POS~~

~~plan.~~

~~(3) Cost containment requirements--Provisions in a POS rider requiring a specific action, such as the provision of specified information to the HMO,~~ (2) Corresponding benefits--Benefits provided under a point-of-service rider or the indemnity portion of a point-of-service plan, as defined in Insurance Code §843.108 (concerning Point-of-Service Rider) and §1273.001 (concerning Definitions), that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a point-of-service plan.

(3) Cost containment requirements--Provisions in a point-of-service rider requiring a specific action that must be taken by an enrollee or by a physician or ~~a~~ provider on behalf of the enrollee, such as the provision of specified information to the HMO, to avoid the imposition of a specified penalty on the coverage provided under the rider for proposed service or treatment.

(4) Coverage--Any benefits available to an enrollee through an indemnity contract or rider, any services available to an enrollee under an evidence of coverage, or combination of the benefits and services available to an enrollee under a ~~POS~~point-of-service plan.

(5) Health plan products--Any health care plan issued by an HMO ~~pursuant to~~under the Insurance Code or a rule adopted by the commissioner.

(6) In-plan covered services--Health care services, benefits, and supplies to which an enrollee is entitled under the evidence of coverage issued by an HMO, including emergency services, approved out-of-network services, and other authorized referrals.

(7) ~~Non-participating~~Nonparticipating physicians and providers--Physicians and providers ~~that~~who are not part of an HMO delivery network.

(8) Out-of-plan covered benefits--All covered health care services, benefits, and supplies that are not in-plan covered services. Out-of-plan covered benefits include health care services, benefits, and supplies obtained from participating physicians and providers under circumstances in which the

enrollee fails to comply with the HMO's requirements for obtaining in-plan covered services.

(9) Participating physicians and providers--Physicians and providers that are part of an HMO delivery network.

~~(10) Point-of-service blended contract plan (POS blended contract plan)--A POS plan evidenced by a single contract, policy, certificate or evidence of coverage that provides a combination of indemnity benefits for which an indemnity carrier is at risk and services that are provided by an HMO under a POS plan.~~

~~(11) Point-of-service dual contracts plan (POS dual contracts plan)--A POS plan providing a combination of indemnity benefits and HMO services through separate contracts, one being the contract, policy or certificate offered by an indemnity carrier for which the indemnity carrier is at risk and the other being the evidence of coverage offered by the HMO.~~

(10) Point-of-service blended contract plan--A point-of-service plan evidenced by a single contract, policy, certificate, or evidence of coverage that provides a combination of indemnity benefits for which an indemnity carrier is at risk and services that are provided by an HMO under a point-of-service plan.

(11) Point-of-service dual contracts plan--A point-of-service plan providing a combination of indemnity benefits and HMO services through separate contracts, one being the contract, policy, or certificate offered by an indemnity carrier for which the indemnity carrier is at risk and the other being the evidence of coverage offered by the HMO.

(12) Point-of-service rider ~~(POS rider)---~~A rider issued by an HMO that meets the solvency requirements of §11.2502 of this title (relating to Issuance of Point-of-~~service~~Service Riders) and that provides coverage for out-of-plan services, including services, benefits, and supplies obtained from participating physicians or providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining approval for in-plan covered services.

~~(13) Point-of-service rider plan (POS rider plan)--A POS plan provided by an HMO pursuant to this subchapter under an evidence of coverage that includes a POS rider.~~

(13) Point-of-service rider plan--A point-of-service plan provided by an HMO in compliance with this subchapter under an evidence of coverage that includes a point-of-service rider.

§11.2502. Issuance of Point-of-Service Riders.

~~An HMO may issue a POS rider plan only if the HMO meets all of the applicable requirements set forth in this section.~~
~~(1) Solvency of HMOs Issuing Point-of-service Rider Plans.~~
~~(A) For HMOs that have been licensed for at least one calendar year, the HMO shall maintain a net worth of at least the sum of:~~
~~(i) the greater of:~~
~~(I) the minimum net worth required by the Code for that HMO; or~~
~~(II) 100% of the authorized control level of risk-based capital as set forth in §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank); and~~
~~(ii) twenty-five percent of total gross point-of-service premium revenue reported in the preceding calendar year.~~
~~(B) For HMOs that have been licensed for less than one calendar year, the HMO shall maintain a net worth of at least the sum of:~~
~~(i) the minimum net worth required by the Code for that HMO; and~~
~~(ii) fifty percent of the yearly average of the two-year annual premium gross point-of-service premium revenue as projected in its application for a certificate of authority.~~
~~(C) Assets of the HMO shall be of a sufficient amount to cover reserve liabilities for the POS riders and shall be limited to those allowable assets listed under §11.803(1) of this title (relating to Investments, Loans and Other Assets).~~
~~(D) Reserves held by an HMO for POS riders shall be calculated in accordance with Chapter 3, Subchapter GG of this title (relating to Minimum Reserve Standards for Individual and Group Accident and Health Insurance).~~
~~(E) An HMO that has issued a POS rider plan under this section and whose net worth or assets subsequently fall below the requirements of subparagraphs (A), (B) or (C) of this paragraph shall cease issuing additional new POS rider plans to groups or individuals, except as provided in paragraphs (4) and (5) of this section, until it comes into compliance with the requirements of this paragraph.~~
~~(2) Limitations on POS Rider Expenses. An HMO's POS rider expenses must not exceed 10% of medical and hospital expenses on an annual basis for all health plan products sold by the HMO.~~
~~(A) An HMO may issue a POS rider plan under this section only if the total medical and hospital expenses incurred by the HMO for the preceding four calendar quarters for all POS riders issued by the HMO under this section do not exceed 10% of the annual medical and hospital expenses incurred by the HMO for all health plan products sold during the preceding four calendar quarters.~~
~~(B) An HMO that has issued any POS rider plans under this subchapter is responsible for compiling, maintaining, and reporting to the department the total medical and hospital expenses incurred by the HMO on an annual basis for all POS riders as well as the total medical and hospital expenses incurred by the HMO on an annual basis for all health plan products sold to ensure that the HMO is in compliance with the requirements of this subchapter.~~
~~(C) An HMO that has issued any POS rider plans under this subchapter and whose total medical and hospital expenses incurred for the preceding four calendar quarters for all POS riders issued under this subchapter has exceeded 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the preceding four calendar quarters shall:~~
~~(i) immediately cease issuance of additional new POS rider plans to groups or individuals, except as provided in paragraphs (4) and (5) of this section;~~
~~(ii) offer all subsequent new POS plans through POS blended contracts or POS dual contracts in accordance with Chapter 21, Subchapter U of this title (relating to Arrangements between Indemnity Carriers and HMOs for Point-of-service Coverage); and~~

~~(iii) not issue any additional new POS rider plans until it has either:~~
~~(I) established to the satisfaction of the commissioner that:~~
~~(-a-) its total medical and hospital expenses incurred for the preceding four calendar quarters for all POS riders issued under this section have not exceeded 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the preceding four calendar quarters; and~~
~~(-b-) its total medical and hospital expenses incurred for all POS riders issued under this section for the next four calendar quarters will not exceed 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the next four calendar quarters; or~~
~~(II) become an indemnity carrier licensed under the Code.~~
~~(D) Notwithstanding subparagraph (C)(iii) of this subsection, an HMO that has issued POS riders for which the HMO's annual medical and hospital expenses incurred by the HMO for the POS riders have exceeded 10% of the HMO's total annual medical and hospital expenses incurred by the HMO for all health plan products that can establish, to the satisfaction of the commissioner, that its total medical and hospital expenses incurred on an annual basis for all POS riders issued under this section will not exceed 10% of the total annual medical and hospital expenses incurred by the HMO for all health plan products for the following one year period, may offer new POS rider plans under this section during that following year.~~
~~(3) Renewability and discontinuance of POS rider plans.~~
~~(A) POS rider plans issued under this subchapter are guaranteed renewable if the plan is:~~
~~(i) a small employer plan, pursuant to the Insurance Code §1501.108;~~
~~(ii) a large employer plan, pursuant to the Insurance Code §1501.108;~~
~~(iii) an individual plan, pursuant to §11.506(3)(D) of this chapter (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate); or~~
~~(iv) an association plan, pursuant to §21.2704 of this title (relating to Mandatory Guaranteed Renewability Provisions for Health Benefit Plans Issued to Members of an Association or Bona Fide Association).~~
~~(B) An HMO that discontinues a POS rider plan must comply with all laws and rules applicable to that plan.~~
~~(C) An HMO that discontinues existing POS rider plans in order to bring the HMO into compliance with the 10% cap:~~
~~(i) shall offer, if the discontinued plan is issued to:~~
~~(I) a small employer group, to each employer, the option to purchase other small employer coverage offered by the small employer carrier at the time of the discontinuation, pursuant to the Insurance Code §1501.109(d);~~
~~(II) a large employer group, to each employer, the option to purchase any other large employer coverage offered by the large employer carrier at the time of the discontinuation, pursuant to the Insurance Code §1501.109(d);~~
~~(III) an individual, the option to purchase to each enrollee any other individual basic health care coverage offered by the HMO pursuant to §11.506(3)(D)(v) of this title;~~
~~(IV) an association, the option to purchase any other health benefit plan being offered by the HMO pursuant to §21.2704(d)(1)(B) of this title.~~
~~(ii) shall not issue any additional new POS rider plans:~~
~~(I) for at least one calendar year after the date on which it last discontinued any of its existing POS rider business and then only if it can establish to the satisfaction of the commissioner that:~~
~~(-a-) its total medical and hospital expenses incurred for the preceding four calendar quarters for all POS riders issued under this subchapter will not have exceeded 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the preceding four calendar quarters; and~~

~~(b) its total medical and hospital expenses incurred for all POS riders issued under this subchapter for the next four calendar quarters will not exceed 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the next four calendar quarters; or~~
~~(II) until it has become licensed as an indemnity carrier under the Code.~~
~~(4) An HMO that ceases to issue a POS rider plan in order to comply with the 10% cap required under paragraph (2) of this section shall continue to offer the plan to each new member of a group to which the POS rider plan has been issued unless and until the HMO divests itself of the group's business by discontinuing the plan as set forth in paragraph (3) of this section.~~
~~(5) An HMO that ceases to issue a POS rider plan in order to comply with the 10% cap required under paragraph (2) of this section must continue to offer the plan to each new individual entitled to coverage under an existing individual plan for which a POS rider has been issued unless and until the HMO divests itself of the individual plan by discontinuing the plan as set forth in paragraph (3) of this section.~~

(a) Financial requirements. An HMO that issues a point-of-service rider is subject to the requirements of Insurance Code §843.403 (concerning Minimum Net Worth) and §7.402 of this title (relating to Risk-Based Capital and Surplus Requirements for Insurers and HMOs).

(b) Termination, cancellation, and renewability. An HMO must comply with all state and federal laws and rules applicable to termination, cancellation, and renewability of a point-of-service rider plan.

§11.2503. Coverage Relating to ~~POS~~Point-of-Service Rider Plans.

(a) An HMO may not consider an in-plan covered service to be a benefit provided under the ~~POS~~point-of-service rider.

(b) An HMO ~~shall~~may not require an enrollee to use either the ~~POS~~ point-of-service rider benefits or in-plan covered services first.

(c) An HMO that includes limited provider networks:

(1) ~~shall~~may not limit the access, under the ~~POS~~point-of-service rider, of an enrollee whose in-plan covered services are restricted to the limited provider network, to either ~~to~~ participating physicians and providers or ~~to non-participating~~nonparticipating physicians and providers;

(2) ~~shall~~may not impose cost-sharing arrangements for an enrollee whose in-plan covered services are restricted to a limited provider network, and who, through the ~~POS~~point-of-service rider

, accesses a participating physician or provider outside the limited provider network, that differ from the cost-sharing arrangements for in-plan covered services obtained by the enrollee from a physician or provider in the limited provider network;

and

(3) may provide for cost-sharing arrangements for benefits obtained from ~~non-participating~~nonparticipating physicians and providers that are different from the cost sharing arrangements for in-plan covered services, provided that coinsurance required under a ~~POS~~point-of-service rider ~~shall~~must never exceed 50~~%~~ percent of the total amount to be covered.

(d) An HMO that issues or offers to issue a ~~POS~~point-of-service rider plan is subject, to the same extent as the HMO is subject in issuing any other health plan product, to all applicable provisions of ~~the~~ Insurance Code Chapters ~~843,~~ 541~~,~~ (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542~~,~~ (concerning Processing and Settlement of Claims), 543~~,~~ (concerning Prohibited Practices Related to Policy or Certificate of Membership), 544~~, and~~ (concerning Prohibited Discrimination), 547~~.~~
(concerning False Advertising by Unauthorized Insurers), 843 (concerning Health Maintenance Organizations), and 1273 (concerning Point-Of-Service Plans).

(e) A ~~POS~~point-of-service rider plan offered under this subchapter must contain:

(1) a ~~POS~~point-of-service rider that:

(A) ~~shall contain~~includes coverage that corresponds to all in-plan covered services provided in the evidence of coverage as well as coverage that is provided to an enrollee as part of the enrollee's in-plan coverage through separate riders attached to the evidence of coverage;

(B) may include benefits in addition to in-plan covered services;

(C) may limit or exclude coverage for benefits that do not correspond to in-plan covered services;

(D) ~~shall~~may not limit coverage for benefits that correspond to in-plan covered services except as provided in subparagraphs (E), (F~~)~~), and (G) of this paragraph;

(E) may include reasonable out-of-pocket limits and annual and lifetime benefit allowances ~~which~~that differ from limits or allowances on in-plan covered services provided under other riders attached to the evidence of coverage so long as the allowances and limits comply with applicable federal and state laws;

~~(F) may provide for cost-sharing arrangements that are different from the cost-sharing arrangements for in-plan covered services, provided that coinsurance required under a POS rider shall never exceed 50% of the total amount to be covered;~~

~~(G) may be reduced by benefits obtained as in-plan covered services;~~

(F) may provide for cost-sharing arrangements that are different from the cost-sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50 percent of the total amount to be covered;

(G) may be reduced by benefits obtained as in-plan covered services;

(H) ~~shall~~may not reduce or limit in-plan covered services in any way by coverage for benefits obtained by an enrollee under the ~~POS~~point-of-service rider;

(I) if applicable, ~~shall~~must disclose:

(i) how the ~~POS~~point-of-service rider cost-sharing arrangements differ from those in the evidence of coverage~~,~~;

(ii) any reduction of benefits as set forth in subparagraph (G) of this paragraph~~,~~;

(iii) any deductible that must be met by the enrollee under the ~~POS~~point-of-service rider~~,~~; and

(iv) whether copayments made for in-plan covered services apply toward the ~~POS~~point-of-service rider deductible;

(J) ~~shall~~must provide coverage for services obtained without the HMO's authorization from a participating physician or provider~~. However,~~, but the enrollee must comply with

any precertification requirements as set forth in subparagraph (L) of this paragraph that are applicable to the ~~POS~~point-of-service rider;

(K) ~~shall~~must include a description of how an enrollee may access out-of-plan covered benefits under the ~~POS~~point-of-service rider, including coverage contained in other riders attached to the evidence of coverage;

(L) ~~shall~~must disclose all precertification requirements for coverage under the ~~POS~~point-of-service rider including any penalties for failure to comply with any precertification or cost containment provisions, provided that ~~any such~~the penalties ~~shall~~will not reduce benefits more than 50~~%~~ percent in the aggregate;

(M) if it is issued to a group, ~~shall~~must contain provisions that comply with ~~the~~ Insurance Code Chapter 1251, Subchapter C~~;~~, (concerning Partnership for Long-Term Care Program); and

(N) if it is issued to an individual, ~~shall~~must contain provisions that comply with ~~the~~ Insurance Code §§1201.211 - 1201.217~~.~~ (concerning Policy Provision: Notice of Claim, Policy Provision: Claim Forms, Policy Provision: Proof of Loss, Policy Provision: Time of Payment of Claims, Policy Provision: Payment of Claims, Policy Provision: Physical Examinations and Autopsy, Policy Provision: Legal Actions);

(2) an evidence of coverage that includes a description and reference to the ~~POS~~point-of-service rider sufficient to notify a prospective or current enrollee that the plan provides the option of accessing participating physicians and providers as well as ~~non-participating~~nonparticipating physicians and providers for out-of-plan covered benefits, and that accessing these benefits through the ~~POS~~point-of-service rider may involve greater costs than accessing corresponding in-plan covered services; and

(3) a side-by-side summary of the schedule of the corresponding coverage for services, benefits, and supplies available under the ~~POS~~point-of-service rider and services, benefits, and supplies available in the evidence of coverage that together constitute the ~~POS~~point-of-service rider plan.

~~Subchapter~~SUBCHAPTER AA. DELEGATED ENTITIES

§11.2601. General Provisions.

(a) ~~Purpose. The purpose of this subchapter is to set forth the requirements that must be met by any HMO that delegates any function as described in the Insurance Code Chapters 843 and 1272, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs. These requirements are designed to ensure that a~~A delegating HMO~~:~~ must:

(1) ~~identifies~~identify all responsibilities relating to the function being delegated;

(2) ~~creates~~create an agreement that enables the HMO and department to monitor both the delegated entity's financial solvency and performance or subsequent delegation of all delegated functions; and

(3) ~~retains~~retain ultimate responsibility for ensuring that all delegated functions are performed in ~~accordance~~compliance with applicable statutes and rules.

(b) ~~Severability. Where any terms~~This subchapter applies to all contracts entered into or ~~sections of this subchapter are determined by a court of competent jurisdiction to be inconsistent with the Insurance Code Chapters 843 and 1272 and applicable insurance laws of this state related to health maintenance organization regulation, as identified by this subchapter, the Insurance Code Chapters 843 and 1272 and applicable insurance laws of this state that apply to HMOs will apply and the remaining terms and provisions of this subchapter shall continue in effect.~~

~~(c) Applicability to Group Model HMO.~~renewed on and after the effective date of these rules.

(c) This subchapter does not apply to a group model HMO, as defined ~~by~~in Insurance Code §843.111~~.~~ (concerning Group Model Health Maintenance Organizations).

§11.2602. Definitions.

The following words and terms, when used in this subchapter, ~~shall~~ have the following

meanings, unless the context clearly indicates otherwise.

(1) Delegated entity--An entity, other than an HMO authorized to do business under ~~the~~ Insurance Code ~~Chapters~~Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 ~~and~~(concerning to Delegation of Certain Functions by Health Maintenance Organization) and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the HMO any function regulated by ~~the~~ Insurance Code ~~Chapters~~Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to physicians and providers not employed by the group is less than 20 percent of the total collected revenue of the group calculated on a calendar~~-~~-year basis.

(2) Delegated network--Any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by ~~Section 551.003,~~ Occupations Code~~.~~ §551.003 (concerning Definitions). The term does not include a delegated entity that shares risk for a category of services with an HMO.

(3) Delegated third party--A third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility to perform any function regulated by ~~the~~ Insurance Code ~~Chapters~~Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by ~~the~~ Insurance Code

~~Chapters~~Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state ~~that apply to HMOs.~~

.

(4) Health care--Any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, ~~or~~ dental care, ~~or~~ hospitalization, or incident to the furnishing of ~~such~~the services, care~~,~~ or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

§11.2603. Requirements for Delegation by HMOs.

(a) Any delegation of any function ~~pursuant to the~~under Insurance Code ~~Chapters~~Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 ~~and~~(concerning Delegation of Certain Functions by Health Maintenance Organization), and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~ by an HMO ~~shall~~must comply with this subchapter.

(b) Oversight by the department does not relieve ~~the~~an HMO of responsibility for monitoring and oversight of its delegated entities.

(c) ~~Prior to~~Before entering into, renewing, or amending a delegation agreement, an HMO ~~shall~~must make a reasonable effort to evaluate the delegated entity's current and prospective ability to perform the functions to be delegated, including, but not limited to, the solvency and financial operations of the delegated entity and the projected financial effects of the agreement ~~upon~~on the delegated entity.

(d) An HMO that delegates functions to a delegated entity must have a written contingency plan to resume any and all delegated functions, including, as applicable:

~~(1) quality of care;~~

~~(2) continuity of care, including a plan for transferring enrollees to new providers in the event of termination of the delegation agreement; and~~

~~(3) processing, adjudication and payment of claims.~~

~~(c) The department may require an HMO to immediately terminate any delegation agreement to ensure that the HMO is in compliance with the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs.~~

(1) quality of care;

(2) continuity of care, including a plan for transferring enrollees to new physicians and providers in the event of termination of the delegation agreement; and

(3) processing, adjudication, and payment of claims.

(e) The department may require an HMO to immediately terminate any delegation agreement to ensure that the HMO is in compliance with Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state.

(f) ~~The~~An HMO retains ultimate responsibility for any and all functions delegated.

(g) A delegated entity's failure to comply with applicable statutes or rules constitutes a violation of ~~the~~ Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~ by the delegating HMO.

(h) An HMO is responsible for monitoring each delegated entity with which it contracts to ensure compliance with all applicable statutes and rules, as well as for solvency.

(i) An HMO ~~shall~~must report to the department, within a reasonable time, all penalties assessed against a delegated entity under the provisions of the delegation agreement.

~~(j) If an HMO cannot ensure~~

(j) If an HMO cannot ensure that a delegated entity is performing all delegated functions in ~~accordance~~compliance with all applicable statutes, rules, or an order issued by the department ~~pursuant to~~under this subchapter, the HMO ~~shall~~must resume all delegated functions from the delegated entity.

(k) If a license is required for any function delegated by an HMO, the HMO must ensure that the delegated entity or third party performing the function has a current appropriate license.

(l) ~~Upon~~On termination of a delegation agreement by either party, the HMO ~~shall~~must notify the department.

§11.2604. Delegation Agreements - General Requirements and Information to be Provided to HMO.

(a) An HMO that delegates ~~to a delegated entity~~ any function required by ~~the~~ Insurance Code ~~Chapters~~Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 ~~and~~(concerning Delegation of Certain Functions by Health Maintenance Organization), and other applicable insurance laws and regulations of this state ~~that apply~~ to ~~HMOs shall~~a delegated entity must execute a written agreement with that delegated entity.

(b) Written agreements ~~shall~~must include ~~the following:~~
:

(1) a provision that the delegated entity and any delegated third parties must agree to comply with all statutes and rules applicable to the functions being delegated by the HMO;

~~(2) a provision that the HMO shall monitor the acts of the delegated entity through a monitoring plan. The monitoring plan shall be set forth in the delegation agreement, and must contain, at a minimum:~~

(2) a provision that the HMO will monitor the acts of the delegated entity through a monitoring plan, which must be set forth in the delegation agreement, and contain, at a minimum:

(A) provisions for the review of the delegated entity's solvency status and financial operations~~. This shall include~~, including, at a minimum, review of the delegated entity's financial statements, consisting of at least a balance sheet, income statement, and statement of cash flows for the current and preceding year;

(B) provisions for the review of the delegated entity's compliance with the terms of the delegation agreement as well as with all applicable statutes and rules affecting the functions delegated by the HMO under the delegation agreement;

(C) a description of the delegated entity's financial practices in sufficient detail that will ensure that the delegated entity tracks and timely reports to the HMO liabilities including incurred but not reported obligations;

~~reported obligations;~~

(D) a method by which the delegated entity ~~shall~~must report monthly a summary of the total amount paid by the delegated entity to physicians and providers under the delegation agreement; and

(E) a monthly log, maintained by the delegated entity, of oral and written complaints from physicians, providers, and enrollees regarding any delay in payment of claims or nonpayment of claims pertaining to the delegated function, including the status of each complaint;

~~(3) a statement that the HMO shall utilize the monitoring plan on an ongoing basis. Compliance with this requirement shall be documented by the HMO maintaining, at a minimum:~~

~~(A) periodic signed statements from the~~

(3) a statement that the HMO will use the monitoring plan on an ongoing basis; compliance with this requirement must be documented by the HMO maintaining, at a minimum:

(A) periodic signed statements from the individual identified by the HMO in paragraph (23) of this subsection that the HMO has reviewed the information required in the monitoring plan; and

(B) periodic signed statements from the chief financial officer of the HMO acknowledging that the most recent financial statements of the delegated entity have been reviewed~~.~~ ;

(4) a provision establishing the penalties to be paid by the delegated entity for failure to provide information required by this subchapter;

(5) a provision requiring quarterly assessment and payment of penalties under the agreement, if applicable;

(6) a provision that the agreement cannot be terminated without cause by the delegated entity or the HMO without written notice provided to the other party and the department before the 90th day preceding the termination date, provided that the commissioner may order the HMO to terminate the agreement under §11.2608 of this ~~subchapter~~title (relating to Department May Order Corrective Action);

(7) a provision that requires the delegated entity, and any entity or physician or provider with which it has contracted to perform a function of the HMO, to hold harmless an enrollee under any circumstance, including the insolvency of the HMO or delegated entity, for payments for covered services other than copayments and deductibles authorized under the evidence of coverage;

(8) a provision that the delegation agreement may not be construed to limit in any way the HMO's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(9) a provision that any failure by the delegated entity to comply with applicable statutes and rules or monitoring standards ~~shall allow~~permits the HMO to terminate delegation of any or all delegated functions;

(10) a provision that the delegated entity must permit the commissioner to examine at any time any information the department reasonably considers is relevant to:

(A) the financial solvency of the delegated entity; or

(B) the ability of the delegated entity to meet the entity's responsibilities in connection with any function delegated to the entity by the HMO;

(11) a provision that the delegated entity, in contracting with a delegated third party directly or through a third party, ~~shall~~will require the delegated third party to comply with the requirements of paragraph (10) of this subsection;

(12) a provision that the delegated entity ~~shall~~must provide the license number of any delegated third party performing any function that requires a license as a third party administrator under ~~the~~ Insurance Code Chapter 4151~~,~~ (concerning Third-Party Administrators), or a license as a utilization review agent under ~~the~~ Insurance Code ~~Article 21.58A,~~Chapter 4201 (concerning Utilization Review Agents), or that requires any other license under the Insurance Code or another insurance law of this state;

~~(13) if utilization review is delegated, a provision stating that:~~

(13) if utilization review is delegated, a provision stating that:

(A) enrollees will receive notification at the time of enrollment identifying the entity that will be performing utilization review;

(B) the delegated entity or delegated third party performing utilization review ~~shall~~must do so in ~~accordance~~compliance with ~~Texas~~ Insurance Code ~~Art. 21.58A~~Chapter 4201 and related rules; and

(C) utilization review decisions made by the delegated entity or a delegated third party ~~shall~~must be forwarded to the HMO on a monthly basis;

(14) a provision that any agreement in which the delegated entity directly or indirectly delegates to a delegated third party any function delegated to the delegated entity by the HMO ~~pursuant to the~~under Insurance Code ~~Chapters~~Chapter 843 and Insurance Code Chapter 1272 and other applicable insurance laws and regulations of this state, including any handling of funds, must be in writing;

~~of this state that apply to HMOs, including any handling of funds, shall be in writing;~~

(15) a provision that ~~upon~~on any subsequent delegation of a function by a delegated entity to a delegated third party, the executed updated agreements ~~shall~~must be filed with the department and enrollees ~~shall~~must be notified of the change of any party performing a function for which notification of an enrollee is required by this chapter or ~~the~~ Insurance Code ~~Chapters~~Chapter 843 and Insurance Code Chapter 1272 and other applicable insurance laws and regulations of this state ~~that apply to HMOs;~~

;

(16) an acknowledgment and agreement by the delegated entity that the HMO is not ~~precluded~~prevented from requiring that the delegated entity provide any and all evidence requested by the HMO or the department relating to the delegated entity's or delegated third party's financial viability;

~~relating to the delegated entity's or delegated third party's financial viability;~~

(17) a provision acknowledging that any delegated third party with which the delegated entity subcontracts will be limited to performing only those functions set forth and delegated in the agreement, using standards approved by the HMO and that are in compliance with applicable statutes and rules;

(18) a provision that any delegated third party is subject to the HMO's oversight and monitoring of the delegated entity's performance and financial condition under the delegation agreement;

(19) a provision that requires the delegated entity to make available to the HMO samples of each type of contract the delegated entity executes or has executed with physicians and providers to ensure compliance with the contractual requirements described by paragraphs (6) and (7) of this subsection, except that the agreement may not require that the delegated entity make available to the HMO contractual provisions relating to financial arrangements with the delegated entity's physicians and providers;

(20) a provision that requires the delegated entity to provide information to the HMO on a quarterly basis and in a format determined by the HMO to permit an audit of the delegated entity and to ensure compliance with the department's reporting requirements with respect to any functions delegated by the HMO to the delegated entity and to ensure that the delegated entity remains solvent to perform the delegated functions, including:

~~(A) a summary:~~

(A) a summary:

(i) describing any payment methods, including capitation or fee for services, that the delegated entity uses to pay its physicians and providers and any other third party performing a function delegated by the HMO; and

(ii) of the breakdown of the percentage of physicians and providers and any other third party paid by each payment method listed in clause (i) of this subparagraph;

(B) the period ~~of time~~ that claims and any other obligations for health care filed with the delegated entity, under this and any other delegation agreements to which the delegated entity is a party, have been pending but remain unpaid, divided into categories of 0 to 45 days, 46 to 90 days, and 91 or more days. The summary ~~shall~~must include aggregate information for all delegation agreements entered into by the delegated entity and information for the specific delegation agreement entered into between the parties;

(C) the aggregate dollar amount of claims and other obligations for health care owed by the delegated entity to any physician or provider, including estimates for incurred but not reported obligations;

(D) information that the HMO requires in order to file claims for reinsurance, coordination of benefits, and subrogation; and

(E) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under ~~Subchapter A, Chapter 160,~~ Occupations Code, Chapter 160, Subchapter A, (concerning Requirements Relating to Medical Peer Review), that relates to:

(i) any regulatory agency's inquiry or investigation of the delegated entity or of an individual physician or provider with whom the delegated entity contracts that relates to an enrollee of the HMO; and

(ii) the final resolution of any regulatory agency's inquiry or investigation;

(21) a provision relating to enrollee complaints that requires the delegated entity to ensure that ~~upon~~on receipt of a complaint, as defined in ~~the~~ Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~, a copy of the complaint ~~shall~~must be sent to the HMO within two business days, except that in a case in which a complaint involves emergency care, as
defined in ~~the~~ Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~, the delegated entity ~~shall~~must forward the complaint immediately to the HMO, ~~and~~ provided that nothing in this paragraph prohibits the delegated entity from attempting to resolve a complaint

;

(22) a provision that the HMO, the delegated entity, and any delegated third party ~~shall~~must comply with the provisions of Chapter 22 of this title~~;~~
(relating to Privacy);

(23) a provision identifying an officer of the HMO as the representative of the HMO for all matters related to the delegation agreement; and

(24) a provision identifying which party to the agreement ~~shall~~will bear the expense of compliance with each requirement set forth in this subsection, including the cost of any examinations performed ~~pursuant to~~under this subchapter.

§11.2605. Delegation Agreements - Information to be Provided by HMO to Delegated Entity.

(a) An HMO ~~shall~~must provide to each delegated entity with which the HMO has a delegation agreement, at least monthly unless otherwise stated in the agreement and provided in standard electronic format agreed to by the parties, the following information:

(1) the name and either the date of birth or social security number of each enrollee of the HMO who is eligible or assigned to receive health care from the delegated entity, including the enrollees added and terminated since the previous reporting period;

(2) the age, sex, evidence of coverage, and any riders to that evidence of coverage, and, if applicable, the name of the employer, for the enrollees of the HMO who are eligible or assigned to

receive health care from the delegated entity;

(3) a summary of the number and amount of claims paid by the HMO on behalf of the delegated entity during the previous reporting period. However,; provided that an HMO is not precludedprevented from providing, upononrequest, additional nonproprietary information regarding suchthe claims, if the HMO pays any claims for the delegated entity;

(4) a summary of the number and amount of pharmacy prescriptions paid for each enrollee for which the delegated entity has taken partial risk during the previous reporting period, provided that an HMO is not precludedprevented from providing, upononrequest, additional nonproprietary information regarding suchthe claims, if the HMO pays any claims for the delegated entity;

(5) information that is needed by the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation; and

(6) patient complaint data that relates to the delegated entity.

(b) An HMO shallmust provide to each delegated entity with which the HMO has a delegation agreement the following information, as applicable, provided in standard electronic format agreed to by the parties at least quarterly unless otherwise stated in the agreement:

(1) detailed risk-pool data, reported quarterly and on settlement, sufficient to allow the delegated entity to adequately monitor its position in the risk pool; and

(2) the percent of premium attributable to hospital or facility costs, if hospital or facility costs impact
the delegated entity's costs and, if there are changes in hospital or facility contracts with the HMO, the projected impact of those changes on the percent of premium attributable to hospital and facility costs within 30 days of suchthe changes.

§11.2606. Reporting Requirements.

(a) ~~Upon~~On receipt of a financial statement indicating that a delegated entity or delegated third party has an amount of total liabilities greater than its total assets, the HMO ~~shall~~must immediately forward a copy of the financial statement to the department.

(b) An HMO that becomes aware of any information, including the information described in subsection (a) of this section, that suggests or indicates that the delegated entity or delegated third party is not operating in ~~accordance~~compliance with its written agreement or is operating in a condition that may render the continuance of its business hazardous to the enrollees, ~~shall~~must immediately:

~~(1) notify the delegated entity in writing of those findings; and~~

(1) notify the delegated entity in writing of those findings; and

(2) request, in writing, a written explanation with supporting documentation of:

(A) the delegated entity's or delegated third party's apparent noncompliance with the written agreement; or

(B) the existence of the condition that apparently renders the continuance of the delegated entity's or delegated third party's business hazardous to the enrollees.

(c) A delegated entity ~~shall~~must respond in writing to a request from an HMO under subsection (b) of this section not later than the 30th day after the date the request is received. The response ~~shall~~must include a corrective action plan.

(d) A copy of all written communications required by subsections (b) and (c) of this section ~~shall~~must be sent to the department simultaneously with transmission to the HMO or delegated entity or delegated third party.

(e) The HMO ~~shall~~must cooperate with the delegated entity to correct any failure by the delegated entity to comply with the applicable statutes and rules relating to any matters:

(1) delegated to the delegated entity by the HMO; or

(2) necessary for the HMO to ensure compliance with statutory or regulatory requirements.

§11.2607. Examinations of Delegated Entities.

(a) On receipt of complaints, a notice under §11.2606 of this title (relating to Reporting Requirements), or as otherwise permitted under the ~~Texas~~ Insurance Code or related rules~~ adopted thereunder~~, the department may examine any matter relating to the financial solvency of the delegated entity or delegated third party or the delegated entity's ability to meet its responsibilities under the delegation agreement.

(b) The department may request documents, perform on-site examinations, and require any other action of the delegated entity and any delegated third party that the department determines necessary to perform an examination under this section.

(c) A delegated entity's failure to comply with a request under subsection (b) of this section may result in~~:~~

either or both:

(1) notification to the HMO that the delegated entity is subject to penalties ~~pursuant to~~under the delegation agreement;

or

(2) entry of an order by the commissioner to resume or redelegate any functions delegated to the delegated entity or terminate the agreement in its entirety.

_____(d) The department ~~shall~~will issue a report to the delegated entity and HMO ~~upon~~on completion of the department's examination. The report ~~shall~~will detail the results of the examination and any corrective actions necessary by the delegated entity ~~and/~~or ~~the~~ HMO.

_____(e) The delegated entity and the HMO ~~shall~~must respond to the department's report and submit a corrective action plan to the department not later than the 30th day after the date of receipt of the department's report.

§11.2608. Department May Order Corrective Action.

_____(a) The department may require at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

_____(1) relates to any matters delegated by the HMO to the delegated entity;

_____(2) is necessary to ensure the HMO's compliance with statutory and regulatory requirements; or

_____(3) relates to the financial solvency and operations of the delegated entity.

_____(b) The commissioner ~~shall~~may order the HMO to take any action the commissioner determines is necessary to ensure that the HMO maintains compliance with the Insurance Code ~~Chapter 1272~~, this chapter, and other applicable insurance laws and regulations of this state ~~that apply to HMOs~~, including but not limited to:

_____(1) resumption of any or all functions delegated to the delegated entity, including claims processing, adjudication, and payments for health care previously rendered to enrollees of the HMO;

(2) temporarily or permanently ceasing assignment of new enrollees to the delegated entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive health care; or

(4) termination of the HMO's delegation agreement with the delegated entity.

§11.2609. Reserve Requirements for Delegated Networks.

In addition to any other requirements set forth in this subchapter, ~~HMOs~~an HMO that ~~contract~~contracts with a delegated ~~networks shall~~network must ensure that the delegated network complies with ~~the~~ Insurance Code Chapter 1272, Subchapter D~~.~~, (concerning Reserve Requirements). The HMO's agreement with the delegated network ~~shall~~must include a provision:

(1) that records related to the requirements of ~~the~~ Insurance Code Chapter 1272, Subchapter D ~~shall~~, must be accessible at all times to the HMO;

(2) requiring all financial records and related information necessary to show the delegated network's compliance with the requirements of ~~the~~ Insurance Code Chapter 1272, Subchapter D;

(3) making the records described in paragraph (1) of this section available to the department ~~upon~~on request; and

(4) that records be kept providing evidence that the HMO has adequately monitored the delegated network for compliance with the requirements of ~~the~~ Insurance Code Chapter 1272, Subchapter D.

§11.2610. Penalties for ~~Non-Compliance~~Noncompliance.

(a) Failure of any party to any agreement under this subchapter to comply with any requirement of this subchapter may result in an order from the commissioner that the HMO must terminate the delegation agreement and~~/or~~ resume or redelegate any or all delegated functions as well as the imposition of penalties provided under the ~~Texas~~ Insurance Code and ~~applicable~~related rules~~ adopted thereunder.~~

.

(b) Any action by an HMO relating to a delegation agreement that does not comply with this subchapter or takes place ~~pursuant to~~under a provision of a delegation agreement not in compliance with this subchapter constitutes a violation under this subchapter.

§11.2611. Filing of Delegation Agreements.

(a) An HMO ~~shall~~must file the written executed agreement described in this subchapter and any subsequently executed amendments to the agreement with the department ~~not later than the 30th day after the date the agreement or amendment is executed.~~
~~(b) The copy of the executed agreement shall be filed for information in accordance with~~as required under §11.301 of ~~subchapter D of~~ this title (relating to Filing Requirements).

(b) Every agreement must include as an attachment a completed Delegated Entity Data form, form SN014, (rev. 02/16).

(c) Every agreement ~~shall~~must include, as an attachment, a table of contents that allows the department to track the agreement's compliance with the requirements of ~~§§§~~11.2604 of this title (relating to Delegation Agreements - General Requirements and Information to be Provided to HMO) and §11.2605 of this title (relating to Delegation Agreements - Information to be Provided by HMO to Delegated Entity~~) of this subchapter.~~
~~(d) Upon notification from the department of a deficiency in a delegation agreement or filing required under this subchapter, the HMO shall respond within ten business days with a proposed correction for the defect.~~).

~~§11.2612. Applicability.~~

~~This subchapter applies to all contracts entered into or renewed on and after the effective date of these rules.~~

(d) On notification from the department of a deficiency in a delegation agreement or filing required under this subchapter, the HMO must respond within 10 business days with a proposed correction for the defect.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____.

_____

Norma Garcia
General Counsel
Texas Department of Insurance

The commissioner adopts the repeal of Chapter 11, 28 TAC §§11.1 - 11.2612 and new Chapter 11, 28 TAC §§11.1 - 11.2612.

_____

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO._____