CHAPTER 21. TRADE PRACTICES

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28 TAC §21.3802

SUBCHAPTER GG. HEALTH CARE QUALITY ASSURANCE PRESUMED COMPLIANCE
28 TAC §21.4105

INTRODUCTION. The Texas Department of Insurance (TDI) proposes amending 28 TAC §§21.2 - 21.4, 21.6, 21.102, 21.104, 21.120, 21.203 - 21.205, 21.301, 21.403, 21.408, 21.701, 21.703 21.704, 21.705, 21.901, 21.1004 - 21.1007, 21.1101, 21.1110, 21.2001, 21.2006, 21.2010, 21.2011, 21.2202, 21.2204, 21.2212, 21.2501, 21.2601, 21.2604, 21.2606, 21.2702, 21.2819, 21.2902, 21.3201, 21.3302, 21.3303, 21.3305, 21.3701, 21.3802, and 21.4105 concerning deceptive and unfair trade practices.

EXPLANATION. The proposed amendments (1) change instances of the obsolete "State Board of Insurance" to "Department of Insurance," (2) replace obsolete statutory references to Insurance Code articles that have changed because of codification, (3) update websites and addresses, (4) correct punctuation and grammatical errors, and (5) make nonsubstantive language and usage changes to adhere to current agency style (e.g., capitalizing "Commissioner" and changing "shall" to other context-appropriate words).

The proposed amendments to the sections are described in the following paragraphs, organized by subchapter.

Subchapter A. Unfair Competition and Unfair Practices of Insurers, and Misrepresentation of Policies. Amendments are proposed to §§21.2, 21.3, and 21.6 to update obsolete statutory references. Additional amendments are proposed to §21.3 and §21.4 to update obsolete references to the State Board of Insurance.

Additional amendments include: "shall" is replaced with "may" in §21.3; superfluous "or" instances are removed in §21.4; and in §21.6, "shall" is replaced with "will."

Subchapter B. Advertising, Certain Trade Practices, and Solicitation. Amendments are proposed to §§21.102, 21.104, and 21.120 to remove obsolete references to "viatical." An amendment is proposed to §21.120 to update an obsolete mailing address. Amendments are proposed to §21.120 to change "shall" to "must," change "division" to "title," and update a regulatory reference.

Subchapter C. Unfair Claims Settlement Practices. Amendments are proposed to §21.203 and §21.205 to update obsolete statutory references. Amendments are proposed to §21.204 to correct a typo in a citation to §21.203 and update obsolete references to the State Board of Insurance.

Additional amendments to §21.203 include replacing "shall" with "may" or "will," as appropriate; capitalization of "Commissioner of Insurance"; addition of missing periods; deletions of "the"; and changes to syntax for proper grammar. In §21.204, additional

amendments include replacing "shall" with "must," replacing "such" with "the" in two places, and replacing "of" with "by." In §21.205, an additional amendment includes replacing "shall" with "must."

Subchapter D. Statistical Agents. Amendments are proposed to §21.301 to update obsolete statutory references. Amendments also include deleting "shall" or replacing it with "will" and "must," as appropriate; capitalizing "Commissioner"; inserting the word "following"; and inserting a comma and a colon where needed.

Subchapter E. Unfair Discrimination Based on Sex or Marital Status. Amendments are proposed to §21.403 to update obsolete references to "the board," to remove obsolete references to "non-profit legal service corporations," delete unnecessary uses of the word "shall" and revise text as appropriate to reflect removal of "shall," and correct punctuation. Amendments are proposed to §§21.403 and 21.408 to update obsolete statutory references.

Subchapter H. Unfair Discrimination. Amendments are proposed to §§21.701, 21.703, and 21.705 to update obsolete statutory references. Amendments are proposed in §21.704 to update an obsolete mailing address and to replace "shall" with "may." Additional amendments in §21.703 include replacing "mental retardation" with "intellectual disability" to conform with the Diagnostic and Statistical Manual of Mental Disorders and to conform with changes to the Health and Safety and Insurance Codes; replacing "handicap or partial handicap" with "disability or partial disability" to conform with changes to Insurance Code §544.002.

Subchapter I. Prohibited Agent Practices. Amendments are proposed to §21.901 to update obsolete statutory references. Additional amendments include adding and deleting commas; deleting one instance of "shall" and replacing another instance with "will"; and replacing "shall be" with "are," "pursuant" with "according"; and "article" with "chapter."

Subchapter J. Prohibited Trade Practices. Amendments are proposed to §§21.1004 - 21.1007 to update obsolete statutory references. Additional amendments include adding a hyphen in §21.1004; deleting an unnecessary comma and replacing "shall" with "may" and "shall be" with "is" in §21.1005, as appropriate; and making the word "To" lowercase in the heading of §1.006 and replacing "shall" with "does" in §21.1006.

An amendment to §21.1004 updates a section title. An amendment to §21.1007 removes an unnecessary and obsolete mailing address.

In addition, amendments delete §21.1004(f) and (g) because subsection (f) is no longer effective, and subsection (g) is no longer relevant. Subsection (g) contains an expiration clause for subsection (f), providing for the section to expire on January 1, 2008. An amendment also deletes §21.1004(d) because the provision provides an out-of-date effective date for the section.

Subchapter K. Certification of Creditable Coverage. Amendments are proposed to §21.1101 to update obsolete statutory references and an amendment is proposed to §21.1110 to remove an unnecessary and obsolete mailing address. Additional amendments include adding a comma, hyphens, punctuating "USC" to make it "U.S.C.," capitalizing "Commissioner of Insurance." The defined term "risk pool" is removed from §21.1101 because the term is not used in the subchapter, and the paragraphs that follow it are renumbered as appropriate.

Subchapter L. Medical Child Support, Unfair Practices. Amendments are proposed to §§21.2001, 21.2006, 21.2010, and 21.2011 to update obsolete statutory references and delete the words "shall" and "shall be" or replace it with "must," "will," or "are," as appropriate. Additional amendments in §21.2001 include replacing dashes with double hyphens, and adding punctuation to "USC" to make it "U.S.C.." An additional amendment in §21.2010 removes an unnecessary and obsolete mailing address.

Additional amendments in §21.2011 include deleting "will subject" and replacing with "subjects" and replacing "application" with "applicable."

Subchapter M. Mandatory Benefit Notice Requirements. Amendments are proposed to §21.2106 to remove an unnecessary and obsolete mailing address.

Subchapter N. Life Insurance Illustrations. Amendments are proposed to §§21.2202, 21.2204, and 21.2212 to update obsolete statutory references. Additional amendments to §21.2202 include changing the capitalization of "subchapter" and "Commissioner." Additional amendments to §21.2204 include changing the capitalization of "subchapter" and "Commissioner," deleting two instances of an unnecessary "shall," and changes to syntax. Additional amendments to §21.2212 include changing "subsection" to "subchapter," and deleting an unnecessary "shall."

Subchapter Q. Complaint Records to be Maintained. Amendments are proposed to §21.2501 to update obsolete statutory references and eliminating unnecessary uses of "the."

Subchapter R. Diabetes. Amendments to §§21.2601, 21.2604, and 21.2606 to update obsolete statutory references. Additional amendments to §21.2601 include changing a colon to a period, eliminating unnecessary uses of "shall," capitalizing "Commissioner," revising references to current statutes for consistency with current agency style, and adding punctuation to "USC" to change it to "U.S.C." Additional amendments to §21.2604 include replacing "shall" with "must," adding hyphens and commas where grammatically appropriate, changing numbers rendered in words to numerals, replacing "on-going" with "ongoing," and eliminating unnecessary use of "services." Additional amendments to §21.2606 include replacing "shall" with "must" or "should" as appropriate and updating the title of the Commissioner of Public Health.

Subchapter S. Association Plans. Amendments are proposed to §21.2702 to update obsolete statutory references. Additional amendments include changing a colon

to a period, capitalizing "Commissioner," eliminating unnecessary uses of "shall," and adding commas and hyphens where appropriate.

Subchapter T. Submission of Clean Claims. Amendments are proposed to §21.2819 to revise a reference to an Administrative Code section and to remove an unnecessary and obsolete mailing address.

Subchapter U. Arrangements Between Indemnity Carriers and HMOs for Point-of-Service Coverage. Amendments are proposed to §21.2901 and §21.2902 to update obsolete statutory references. Additional amendments in §21.2901 include eliminating an unnecessary "shall" and adding commas where grammatically appropriate. Additional amendments in §21.2902 include replacing "shall" with "must," "will," "do," or "may" as appropriate; replacing "pursuant" with "according;" adding the word "by;" and updating the heading of a subchapter in a reference to the Administrative Code.

Subchapter X. Evaluation of Network Physicians and Providers. Amendments are proposed to §21.3201 to update obsolete statutory references and an out-of-date website address. Additional amendments include changing the capitalization of "Applicability," changing a colon to a period, eliminating an unnecessary "shall," replacing "shall" with "must," and removing text addressing ways to request the Texas Standardized Credentialing Application via mail or over the phone.

Subchapter Y. Unfair Discrimination in Compensation for Women's Health Care. Amendments are proposed to §§21.3302, 21.3303, and 21.3305 to update obsolete statutory references. Additional amendments include replacing a colon with a period and eliminating an unnecessary "shall" in §21.3302 and replacing "shall" with "must," "than" with "from," and "if" with "whether" in §21.3305.

Subchapter CC. Electronic Health Care Transactions. Amendments are proposed to §21.3701 to update obsolete statutory references and to update a mailing address. Additional amendments include correcting a citation to a section in the

Administrative Code, replacing "shall" with "must" or "will," as appropriate; replacing "ten" with "10;" and replacing "Department of Insurance" with "department." Amendments are also proposed to update the titles of department staff, which have changed due to internal reorganizations.

Subchapter DD. Eligibility Statements. Amendments are proposed to §21.3802 to update obsolete statutory references and eliminate an unnecessary "shall."

Subchapter GG. Health Care Quality Assurance Presumed Compliance. Amendments are proposed to §21.4105 to update obsolete website references and an obsolete mailing address. Additional amendments include adding the word "as," making the word "department" possessive, replacing "shall" with "will," and eliminating an unnecessary use of the word "internet."

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Justin Beam, chief clerk, Office of the Chief Clerk, General Counsel Division, has determined that during each year of the first five years the proposed new amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of the proposed amendments. The proposed amendments are limited to updating statutory citations to reflect the recodification of the Insurance Code, updating website addresses, removing obsolete addresses and state agency names, correcting typographical and grammatical errors, and other nonsubstantive changes. Because the proposed amendments make no substantive changes, they neither add to or decrease state revenues or expenditures nor change any requirements placed on local governments.

Mr. Beam does not anticipate any measurable effect on local employment or the local economy as a result of this proposal because the proposed amendments do not make any substantive changes.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Mr. Beam expects that administering the proposed amendments will have the public benefit of ensuring that TDI's rules are accurate and transparent by reflecting the updated Insurance Code references and the correct agency name, contact information, and website address for TDI.

Mr. Beam expects that the proposed amendments will not increase the cost of compliance for stakeholders because they do not impose substantive changes.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities because the amendments make only nonsubstantive changes. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a cost on regulated persons, thus no additional rulemakings are required under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed amendments:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

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

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on July 19, 2021. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The request for public hearing must be separate from any comments and received by the department no later than 5:00 p.m., central time, on July 19, 2021. If TDI holds a public hearing, TDI will consider comments presented at the hearing.

SUBCHAPTER A. UNFAIR COMPETITION AND UNFAIR PRACTICES OF INSURERS, AND MISREPRESENTATION OF POLICIES

28 TAC §§21.2, 21.3, 21.4, and 21.6

STATUTORY AUTHORITY. TDI proposes amendments to §§21.2, 21.3, 21.4, and 21.6 under Insurance Code §§463.006, 541.401, 543.001, and 36.001.

Insurance Code §463.006 provides that the Commissioner adopt rules necessary to carry out and supplement the Texas Life and Health Insurance Guaranty Association Act.

Insurance Code §541.401 provides that the Commissioner may adopt and enforce rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

Insurance Code §543.001 provides that the Commissioner may adopt and enforce rules as provided by Chapter 541, Subchapter I, to ensure life insurance companies do not circulate statements that misrepresent the terms, benefits, or dividends received on a life insurance policy or certificate.

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

CROSS-REFERENCE TO STATUTE. Section 21.2 implements Insurance Code Chapter 541 and Insurance Code §543.001. Section 21.3 implements Insurance Code §541.003. Section 21.4 implements Insurance Code §541.061. Section 21.6 implements Insurance Code §463.451.

TEXT.

§21.2. Interpretations.

The meanings given to the provisions, terms, and words of this regulation are not to be limited to the common law meaning, which may have been given thereto, but are

to be interpreted to accomplish the purpose of these sections in accordance with the provisions of [~~the~~] Insurance Code Chapter 541 and Insurance Code §543.001[~~, Article 21.21, §13~~].

§21.3. Unfair Trade Practices Prohibited.

(a) Misrepresentation of insurance policies, unfair competition, and unfair practices by insurers, agents, and other connected persons are prohibited by Insurance Code Chapter 541 and Insurance Code §543.001 [~~Article 21.20 and Article 21.21~~] or by other provisions of the Insurance Code and this chapter [~~by these sections of the Texas State Board of Insurance~~]. No person may [~~shall~~] engage in this state in any trade practice that is a misrepresentation of an insurance policy, that is an unfair method of competition, or that is an unfair or deceptive act or practice as defined by the provisions of the Insurance Code or as defined by these sections and other rules and regulations [~~of the State Board of Insurance~~] authorized by the Insurance Code.

(b) Irrespective of the fact that the improper trade practice is not defined in any other section of these rules and regulations, no person may [~~shall~~] engage in this state in any trade practice which is determined pursuant by law to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

§21.4. Misrepresentation Defined; Standards for Determining Misrepresentation.

The term misrepresentation, or the prohibited conduct, act, or practice that constitutes misrepresentation by a person subject to the provisions of these sections, is defined as any one of the following acts or omissions:

(1) any untrue statement of a material fact; [~~or~~]

(2) any omission to state a material fact necessary to make the statements made (considered in the light of the circumstances under which they are made) not misleading; [~~or~~]

(3) the making of any statement in such manner or order as to mislead a reasonably prudent person to a false conclusion of a material fact; [~~or~~]

(4) (No change.)

(5) any failure to disclose any matter required by law to be disclosed, including failure to make disclosures in accordance with the provisions of these sections and other applicable rules [~~of the State Board of Insurance~~].

§21.6. Prohibition against the Use of Guaranty Fund Protection in the Sale of Insurance.

The use in any manner of the protection afforded by the Life and Health Insurance Guaranty Association Act [~~Life, Accident, Health, and Hospital Service Insurance Guaranty Act~~] (the Act) by any person in the sale of any product included within the scope of the Act ([~~the~~] Insurance Code[~~,~~] Chapter 463 [~~Article 21.28-D~~]) will [~~shall~~] constitute unfair competition and unfair practices under [~~the~~] Insurance Code[~~,~~] Chapter 541 [~~Article 21.21,~~] and will [~~shall~~] be subject to the provisions thereof.

SUBCHAPTER B. ADVERTISING, CERTAIN TRADE PRACTICES, AND SOLICITATION 28 TAC §§21.102, 21.104, and 21.120

STATUTORY AUTHORITY. TDI proposes amendments to §§21.102, 21.104, and 21.120 under Insurance Code §562.106 and §36.001.

Insurance Code §562.106 provides that if the Commissioner reasonably believes that a program operator or marketer may not be operating in compliance with Chapter 562, the Commissioner by order may require the program operator or marketer to submit

to the Commissioner any advertisement, solicitation, or marketing materials or other document requested by the Commissioner.

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

CROSS-REFERENCE TO STATUTE. Sections 21.102 and 21.104 implement Insurance Code, Chapter 541, Subchapter B-1. Sections 21.102, 21.104, and 21.120 implement Insurance Code §562.052.

TEXT.

§21.102. Scope.

For the purpose of this division:

(1) (No change.)

(2) (No change.)

(3) "Policy" includes any policy, plan, certificate, contract, evidence of coverage, agreement, statement of coverage, cover note, certificate of policy, rider or endorsement which provides, limits, or controls insurance for any kind of loss or expense or because of the continuation, impairment, or discontinuance of human life or annuity benefits issued by an insurer, [~~viatical or~~] life settlement contracts, premium finance agreements, or any other product offered by an insurer and regulated by the Department.

(4) "Insurer" includes any individual, partnership, corporation, organization, or person issuing evidence of coverage or insurance, or any other entity acting as an insurer to which this division can be made legally applicable including, as applicable, Health Maintenance Organizations, and all insurance companies doing the business of insurance in this state such as capital stock companies, mutual companies, title insurance

companies, fraternal benefits societies, local mutual aid associations, local mutual burial associations, statewide mutual assessment companies, county mutual and farm mutual insurance companies, Lloyds' plan companies, reciprocal or interinsurance exchanges, stipulated premium insurance companies, and group hospital service companies and, as can be made appropriate, premium finance companies, and [~~viatical and~~] life settlement providers.

(5) "Agent" includes each agent, solicitor, counselor, and soliciting representative of an insurer and, as can be made appropriate, [~~viatical and~~] life settlement brokers and provider representatives.

(6) - (8) (No change.)

§21.104. Requirement of Identification of Policy or Insurer.

(a) - (c) (No change.)

(d) All advertisements, other than institutional, shall explicitly and conspicuously disclose that the product concerned is property, life or other insurance, an annuity, HMO coverage, a [~~viatical or~~] life settlement contract, or a prepaid legal services contract, on the basis that each of these products are classified or addressed by statute or rule or as the products are filed with the department. It is sufficient for an insurer to use the term "PPO plan" in advertisements when referring to a preferred provider benefit plan offered under Insurance Code Chapter 1301.

(e) - (i) (No change.)

§21.120. Filing for Review.

(a) Any advertisement required to be submitted or submitted voluntarily by an insurer licensed to do business in Texas must [~~shall~~] be accompanied by a transmittal letter addressed to the [~~Advertising Unit,~~] Texas Department of Insurance, Life and Health

Lines, MC-LH-LHL[~~333 Guadalupe, Mail Code 111-2A, Austin, Texas 78701, or~~] P.O. Box 12030[~~149104~~], Austin, Texas 78711-2030 [~~78714-9104~~]. The transmittal letter must [~~shall~~] contain the following information:

(1) - (5) (No change.)

(6) an attachment explaining all variable material; the variable material must [~~shall~~] be identified with brackets on the advertisement(s).

(b) All advertisements must [~~shall~~] be submitted in duplicate.

(c) (No change.)

(d) An advertisement subject to requirements regarding filing of the advertisement with the department for review under the Insurance Code or Texas Administrative Code, Title 28, and that is the same as or substantially similar to an advertisement previously reviewed and accepted by the department, is not required to be filed for review. For the purposes of this subsection, "substantially similar" means the new advertisement does not introduce any substantive content not previously reviewed, nor does it eliminate any content satisfying required disclosures or that would render the advertisement noncompliant with §21.112 of this title [~~division~~] (relating to General Prohibition). A person or entity wishing to introduce a "substantially similar" advertisement must file a signed written statement with the department at the address identified in subsection (a) of this section. Such statement must identify or illustrate the changes to be introduced, and list the previously reviewed and accepted form(s) in which those changes would appear, including the form number(s) and the department's filing number(s) under which those forms were previously reviewed and accepted.

(e) The following rules require that advertisements be filed with the department for review at or prior to use:

(1) §3.1744 [~~§3.1707~~] of this title (relating to Advertising, Sales and Solicitation Materials; Filing Prior to Use), regarding [~~viatical and~~] life settlement contracts;

(2) - (4) (No change.)

SUBCHAPTER C. UNFAIR CLAIMS SETTLEMENT PRACTICES
28 TAC §§21.203, 21.204, and 21.205

STATUTORY AUTHORITY. TDI proposes amendments to §§21.203, 21.204, and 21.205 under Insurance Code Chapter 542.014 and §36.001.

Insurance Code Chapter 542.014 provides that the Commissioner may adopt rules necessary to implement the Unfair Claim Settlement Practices Act.

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

CROSS-REFERENCE TO STATUTE. Section 21.203 implements Insurance Code §542.003. Section 21.204 implements Insurance Code §542.006. Section 21.205 implements Insurance Code §542.007.

TEXT.

§21.203. Unfair Claim Settlement Practices.

No insurer may [~~shall~~] engage in unfair claim settlement practices. Unfair claim settlement practices means committing or performing any of the following:

(1) (No change.)

(2) failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, provided that "pertinent communications" will [~~shall~~] exclude written communications that are direct responses to specific inquiries made by the insurer after initial report of a claim. An acknowledgment within 15 business days is presumed to be reasonably prompt;

(3) - (5) (No change.)

(6) failure of any insurer to maintain, in substantial compliance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions), a complete record of all complaints, as that term is defined in §21.202(4) of this title (relating to Definitions), which it has received during the preceding three years or since the date of its most recent financial examination by the Commissioner of Insurance [~~commissioner of insurance~~], whichever time is shorter. For purposes of this section, "substantial compliance" has the meaning set out in §21.2503 of this title (relating to Compliance Standard);

(7) (No change.)

(8) not attempting in good faith to promptly settle [~~promptly~~] claims where liability has become reasonably clear under one portion of the policy in order to influence settlement under other portions of the policy coverage. (This provision does not apply to those situations where payment under one portion of coverage constitutes evidence of liability under another portion of coverage.);

(9) failing to promptly provide [~~promptly~~] to a policyholder a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

(10) - (12) (No change.)

(13) undertaking to enforce a full and final release from a policyholder when, in fact, only a partial payment has been made. (This provision will [~~shall~~] not prevent or have application to the compromise settlement of doubtful or disputed claims.);

(14) - (16) (No change.)

(17) with respect to the Texas personal auto policy, delaying or refusing [~~to delay or refuse~~] settlement of a claim solely because there is other insurance of a different type available to satisfy partially or entirely the loss forming the basis of that claim. The

claimant who has a right to recover from either or both insurers is entitled to choose under which coverage and in what order payment is to be made;

(18) a violation of [~~the~~] Insurance Code Chapter 542[~~, Article 21.55,~~] by an insurer subject to its provisions; or

(19) (No change.)

§21.204. Special Claim Reports and Statistical Plan.

If the department finds [~~it should be found by the Texas Department of Insurance~~] based on complaint or complaints of unfair claim settlement practices as described in §21.203 of this title (relating to Unfair Claim [~~Claims~~] Settlement Practices), that an insurer should be subjected to closer supervision with respect to such practices, it may require the [~~such~~] insurer to file a report at such periodic intervals as the department deems necessary. The [~~Such~~] periodical reports must [~~shall~~] contain the following information:

(1) - (2) (No change.)

(3) the total number of written claims settled, including the original amount filed for by the insured, the settled amount, and the classification by [~~of~~] line of insurance of each individual settled claim, for the past 12-month period or from the date of the insurer's last periodic report, whichever time is shorter;

(4) (No change.)

(5) the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. Such periodic reports must [~~shall~~] be filed with the department [~~State Board of Insurance and the commissioner of insurance~~].

§21.205. Minimum Standard of Performance.

All insurers must [~~shall~~] maintain their affairs so that no unfair claims settlement practices are committed and the minimum standard of performance for all insurers (as that term is used in [~~the~~] Insurance Code Chapter 542, Subchapter A[~~, Article 21.21-2~~]) is to comply with the provisions of §21.203 of this title (relating to Unfair Claims Settlement Practices).

SUBCHAPTER D. STATISTICAL AGENTS
28 TAC §21.301

STATUTORY AUTHORITY. TDI proposes amendments to §21.301 under Insurance Code §§38.207and 36.001.

Insurance Code §38.207 provides that the Commissioner may adopt rules necessary to accomplish the purposes of Chapter 38, Subchapter E.

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

CROSS-REFERENCE TO STATUTE. Section 21.301 implements Insurance Code Chapter 38, Subchapter E.

TEXT.

§21.301. Performance Standards for Designated Statistical Agent.

(a) Definitions. The following words and terms when used in this section [~~shall~~] have the following meanings unless the context clearly indicates otherwise.

(1) - (3) (No change.)

(4) Designated statistical agent--An organization duly designated by or contracted with the Commissioner [~~commissioner~~] to gather insurance data from insurers according to a statistical plan.

(5) Statistical plan--A document promulgated by the Commissioner [~~commissioner~~] that specifies the information to be reported, the insurers who must report the information, and the procedures and format for the information to be reported to the designated statistical agent.

(b) Each designated statistical agent must [~~shall~~] comply with the agreed upon standards of performance.

(c) If, after notice and the opportunity for a hearing, the Commissioner [~~commissioner~~] determines that a designated statistical agent has failed to comply with the agreed upon standards of performance, the Commissioner [~~commissioner~~] may impose sanctions against the designated statistical agent under [~~the Texas~~] Insurance Code Chapter 82 [~~Annotated, Article 1.10 §7~~], including but not limited to an administrative monetary penalty under [~~Texas~~] Insurance Code Chapter 84 [~~Annotated, Article 1.10E~~].

(d) In determining the amount of the administrative monetary penalty, the Commissioner will [~~commissioner shall~~] consider the following factors described in this subsection.

(1) - (7) (No change.)

(8) Any other consideration that the Commissioner [~~commissioner~~] may deem appropriate.

(e) - (f) (No change.)

SUBCHAPTER E. UNFAIR DISCRIMINATION BASED ON SEX OR MARITAL STATUS
28 TAC §21.403 and §21.408

STATUTORY AUTHORITY. TDI proposes amendments to §§21.403 and 21.408 under Insurance Code §541.401 and §36.001.

Insurance Code §541.401 provides that the Commissioner may adopt and enforce rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

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

CROSS-REFERENCE TO STATUTE. Sections 21.403 and 21.408 implement Insurance Code §544.002.

TEXT.

§21.403. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings unless the context clearly indicates otherwise.

(1) Insurer--Includes [~~Shall include~~], but is not be limited to, all life, health, and accident companies;[,] capital stock companies;[,] mutual assessment life insurance companies;[,] statewide mutual assessment corporations;[,] county mutual insurance companies;[,] local mutual aid associations;[,] farm mutual insurance companies;[,] mutual or natural premium life or casualty insurance companies;[,] general casualty companies;[,] Mexican casualty companies;[,] Lloyds, reciprocal, or inter-insurance exchanges;[,] nonprofit hospital, medical, or dental service corporations including, but not limited to, companies subject to the Insurance Code Chapter 842 [~~chapter 20~~], as amended;[,]

stipulated premium insurance companies;[,] fidelity, guaranty, and surety companies;[,] title insurance companies;[,] health maintenance organizations;[,] [~~non-profit legal service corporations;~~] and all other organizations, corporations, or persons engaged in the business of insurance, whether or not named previously; provided, however, these sections do [~~shall~~] not apply to any society, company, or other insurer whose activities are by statute exempt from the regulation of the department [~~board~~] and which are entitled by statute to an exemption certificate from the department [~~board~~] in evidence of their exempt status; nor to fraternal benefit societies.

(2) Policy--Includes [~~Shall include~~] any insurance policy, plan, certificate or subscriber agreement, statement of coverage, binder, rider, endorsement, or application, if attached, offered by any person or entity engaged in the business of insurance or board-regulated prepaid services in this state.

§21.408. Amendments.

The subject matters covered by this subchapter [~~these sections~~] treat only a portion of the subject matters contemplated by [~~the~~] Insurance Code Chapter 541[~~, Article 21.21,~~] and are not exhaustive on this subject; therefore, these sections remain open for corrections and future additions as the needs may arise or procedures require.

SUBCHAPTER H. UNFAIR DISCRIMINATION
28 TAC §§21.701, 21.703, and 21.704

STATUTORY AUTHORITY. TDI proposes amendments to §§21.701, 21.703 21.704, and 21.705 under Insurance Code §541.401 and §36.001. TDI proposes amendments to §21.705 under Insurance Code §545.003.

Insurance Code §541.401 provides that the Commissioner may adopt and enforce rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade

practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

Insurance Code §545.003 provides that the Commissioner may adopt rules to be followed for an HIV-related test requested or required by an issuer.

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

CROSS-REFERENCE TO STATUTE. Section 21.701 implements Insurance Code §541.001. Section 21.703 implements Insurance Code §544.002. Section 21.704 implements Insurance Code Chapter 545. Section 21.705 implements Insurance Code §545.052.

TEXT.

§21.701. Purpose.

The purpose of these sections is to identify specific acts or practices which are prohibited by [~~the~~] Insurance Code §541.057[~~, Article 21.21, §4(7)~~] and [~~the~~]§544.002 [~~, Article 21.21-3~~].

§21.703. Definitions Concerning Discrimination.

For the purpose of §21.702 of this title (relating to Unfairly Discriminatory Acts or Practices) and to effectuate the objectives of [~~the~~] Insurance Code §544.002[~~, Article 21.21-3~~], the definitions specified in this section are applicable. The words "physical or mental impairment" include, but are not limited to, any psychological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following bodily systems: neurological, musculoskeletal, special sense organs, respiratory and speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin,

and endocrine system or any mental or physiological disorder such as intellectual disability [~~mental retardation~~], organic brain syndrome, emotional or mental illness, and specific learning disabilities. As used in [~~the~~] Insurance Code §544.002 [,] [~~Article 21.21-3~~], the words "disability or partial disability" [~~"handicap or partial handicap"~~] mean a physical or mental impairment which substantially limits one or more of the person's major life activities.

§21.704. Unfair Discrimination.

(a) General propositions.

(1) No inquiry in an application for health or life insurance coverage, or in an investigation conducted by or on behalf of an insurer in connection with an application for such coverage, may [~~shall~~] be directed toward determining the proposed insured's sexual orientation.

(2) (No change.)

(3) Insurers may [~~shall~~] not direct, require, or request insurance support organizations to investigate, directly or indirectly, the sexual orientation of a proposed insured or a beneficiary.

(b) Medical/lifestyle applications, questions, and underwriting standards.

(1) No question may [~~shall~~] be used which is designed to establish the sexual orientation of the proposed insured.

(2)-(6) (No change.)

(7) No adverse underwriting decision may [~~shall~~] be made because medical records or a report from any other source shows that the proposed insured has demonstrated acquired immune deficiency syndrome-related concerns by seeking counseling from health care professionals. This paragraph does not apply to a proposed insured seeking or having sought treatment.

(8) Whenever a proposed insured is requested to take an HIV-related test in connection with an application for insurance, the use of such a test must be revealed to the proposed insured or to any other person legally authorized to consent to such a test, and his or her written authorization obtained. The form of such authorization must be printed on a separate piece of paper and must contain the specific language in the form, entitled Notice and Consent for HIV-Related Testing, which the Texas Department of Insurance has adopted and incorporated herein by reference, effective January 7, 1997. This form is published by the Texas Department of Insurance and copies of this form are available from and on file at the offices of the [~~Life/Health Group, Mail Code 106-1E, of the~~] Texas Department of Insurance, Life and Health Lines, MC-LH-LHL [~~at 333 Guadalupe~~], P.O. Box 12030 [~~149104~~], Austin, Texas 78711-2030[~~78714-9104~~]. Other information may be included so long as it is not misleading or violative of any applicable law or rule. Testing may be required only on a nondiscriminatory basis. No adverse underwriting decision shall be made on the basis of such a positive HIV-related test unless the established test protocol as provided by §21.705 of this title (relating to Nondiscriminatory Testing for Human Immunodeficiency Virus) has been followed.

(9) (No change.)

(10) The result of an HIV-related test is [~~shall be~~] confidential.

(A) - (B) (No change.)

(C) Written notice of a positive HIV-related test result must [~~shall~~] be provided by the insurer to either:

(i) - (ii) (No change.)

[~~(c) Effective date. This section becomes effective February 1, 1988, except for paragraphs (8) and (9) of subsection (b) of this section, which become effective January 7, 1997.~~]

(c)[~~(d)~~] Severability. If any provision of this section or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of the provisions of this section which can be given effect without the invalid provisions or application. To this end, all provisions of this subchapter are declared to be severable.

§21.705. Nondiscriminatory Testing for Human Immunodeficiency Virus

A proposed insured for life or health and accident insurance, or for coverage by a company licensed under [~~the~~] Insurance Code[~~,~~] Chapter 842 [~~20~~], or with a licensed health maintenance organization may be required to be tested for the presence of the human immunodeficiency virus (HIV). Requiring such testing is not unfair discrimination provided:

(1) – (3) (No change.)

SUBCHAPTER I. PROHIBITED AGENT PRACTICES
28 TAC §21.901

STATUTORY AUTHORITY. TDI proposes amendments to §21.901 under Insurance Code §541.401 and §36.001.

Insurance Code §541.401 provides that the Commissioner may adopt rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

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

CROSS-REFERENCE TO STATUTE. Section 21.901 implements Insurance Code §543.001.

TEXT.

§21.901. Prohibition Against Solicitation or Acceptance of Power of Attorney.

(a) - (c) (No change.)

(d) Premium finance company provisions. The provisions of this section will [~~shall~~] not prohibit any person subject to the provisions of this section from accepting applications for premium financing on premium financing agreement forms that include a power of attorney in favor of the premium financing company for purposes of canceling a financed insurance contract, so long as the power-of-attorney provisions comply with statutory provisions of [~~the~~] Insurance Code[~~,~~] Chapter 651 [~~24~~], concerning the financing of insurance premiums.

(e) Declaration of unfair practice. The failure to comply with the provisions of this section [~~shall~~] constitute unfair competition and unfair practices according [~~pursuant~~] to [~~the~~] Insurance Code Chapter 541[~~, Article 21.2,~~] and are [~~shall be~~] subject to the provisions of that chapter [~~article~~].

SUBCHAPTER J. PROHIBITED TRADE PRACTICES
28 TAC §§21.1004, 21.1005, 21.1006

STATUTORY AUTHORITY. TDI proposes amendments to §§21.1004 — 21.1007 under Insurance Code §§541.401, 544.304, 544.354, and 36.001.

Insurance Code §541.401 provides that the Commissioner may adopt rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

Insurance Codes §§544.304 provides that the Commissioner adopt rules necessary to implement Insurance Code Chapter 544, Subchapter G.

Insurance Code §544.354 provides that the Commissioner adopt rules necessary to accomplish the purpose of Insurance Code Chapter 544, Subchapter G.

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

CROSS-REFERENCE TO STATUTE. Section 21.1004 implements Insurance Code §551.107. Section 21.1005 implements Insurance Code Chapter 541. Section 21.1006 and §21.1007 implement Insurance Code §§541.001, 541.003, and 541.401.

TEXT.

§21.1004. Restrictions on Certain Claims in Residential Property Insurance and Transition Plan Requirement.

(a) - (b) (No change.)

(c) Premium consequence prohibited. An insurer may not assign any premium consequence through a premium surcharge or claims-free program based on filed claims occurring on or after September 1, 2005, in whole or in part, due to:

(1) - (2) (No change.)

(3) a claim that an insurer is prohibited from using under Insurance Code [~~Article 5.35-4 §3 (recodified as~~] §544.353[~~, HB 2018 79th Legislature, Regular Session)~~].

(d) Claims-free programs. Claims-free programs must be based on sound actuarial principles. Actuarial support as specified in §5.9332 of this title (relating to Categories of Supporting Information [~~Filing Requirements~~]) must be filed with the department in the event such program is introduced or changed.

(e) (No change.)

[~~(f) Transition plan required. If an insurer introduces a new method or changes an existing method of considering, utilizing, reviewing, or otherwise evaluating a policyholder's claim experience, including a tier classification, which results in an increase of 10% or more in premium for any policyholder, a transition plan is required and must be filed with the department. The transition plan shall:~~]

[~~(1) be reasonable and promote market and rate stability;~~]

[~~(2) take into consideration any changes other than claims history that may impact overall rates and premiums; and~~]

[~~(3) moderate or otherwise mitigate overall rate and premium increases for individual policyholders over one or several renewal periods.~~]

[~~(g) Expiration clause. Subsection (f) of this section expires January 1, 2008.~~]

§21.1005. Prohibition of Underwriting Guidelines Based on the Purchase of Types or Amounts of Coverage in Excess of Minimum Limits Liability Coverage.

(a) Prohibition. Effective September 1, 1995, an insurer or agent may [~~shall~~] not use an underwriting guideline for private passenger automobile insurance based, in whole or in part, on whether an insured or applicant purchases types or amounts of coverage in excess of the minimum automobile liability coverage required to show proof of financial responsibility under the Motor Vehicle Safety Responsibility Act, Transportation Code, Chapter 601 [~~Texas Safety Responsibility Law, Texas Civil Statutes, Article 6701h~~]. The failure to comply with this section constitutes an unfair trade practice in the business of insurance in violation of [~~the~~] Insurance Code Chapter 541[~~, Article 21.21~~], and is [~~shall be~~] subject to the provisions thereof.

(b) - (c) (No change.)

§21.1006. Prohibition Against Declining to [~~To~~] Write Residential Property Insurance Based on the Age or Value of the Property.

(a) (No change.)

(b) An insurer may not decline to write residential property insurance based on the age of the property sought to be insured. This provision does not prohibit an insurer from declining to write coverage based on physical conditions of the property, including wiring, heating, air conditioning, plumbing, and roofing. This provision does [~~shall~~] not prohibit the Texas Windstorm Insurance Association from requiring, in accordance with the provisions of Chapter 2210 [~~Article 21.49~~] of the Insurance Code, different building code standards to qualify for coverage based on the date that the structure was constructed, repaired, or additions were made.

(c) (No change.)

[~~(d) This rule takes effect September 1, 1997.~~]

§21.1007. Restrictions on Using Guidelines Based on a Water Damage Claim, Previous Mold Damage, or a Mold Damage Claim

(a) - (c) (No change.)

(d) This subsection contains provisions related to underwriting and rating based on a previous appliance-related claim.

(1) - (6) (No change.)

(7) Water damage repair certificate form (PC327 WDR-1). An inspector must use the water damage repair certificate form (PC327 WDR-1) found on TDI's website at www.tdi.texas.gov [~~, or by requesting the form from the Property and Casualty Lines Office, MC 104-PC, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104~~]. TDI adopts by reference the water damage repair certificate form (PC327 WDR1) that an inspector must use, subject to the provisions of this subchapter and Insurance

Code Chapter 544. Persons using the form should confirm that they are using the most recent online version before giving a copy to the property owner.

(8) TDI has information about inspectors who may have the knowledge and experience in water damage remediation to inspect and certify the proper remediation of an appliance-related claim. A list of inspectors can be obtained from TDI's website or by requesting it from the TDI Property and Casualty Lines Office.

(e) - (f) (No change.)

SUBCHAPTER K. CERTIFICATION OF CREDITABLE COVERAGE
28 TAC §21.1101 and §21.1110

STATUTORY AUTHORITY. TDI proposes amendments to §21.1101 and §21.1110 under Insurance Code §§845.004, 846.005, and 36.001.

Insurance Code §845.004 provides that the Commissioner adopt rules necessary to implement Insurance Code Chapter 845, Subchapter A — D.

Insurance Code §846.005 provides that the Commissioner may adopt rules necessary to augment and implement Insurance Code Chapter 846.

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

CROSS-REFERENCE TO STATUTE. Section 21.1101 implements Insurance Code §1205.002 and §1205.004. Section 21.1110 implements Insurance Code §1205.002 and §1357.056.

TEXT.

§21.1101. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) - (3) (No change.)

(4) Commissioner--The Commissioner [~~commissioner~~] of Insurance [~~insurance of the State of Texas~~].

(5) Creditable coverage--

(A) An individual's coverage is creditable if the coverage is provided under:

(i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. [~~USC~~] Section 1001 et seq.);

(ii) - (iii) (No change.)

(iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. [~~USC~~] Section 1395c et seq.);

(v) Title XIX of the Social Security Act (42 U.S.C. [~~USC~~] Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. [~~USC~~] Section 1396s);

(vi) Chapter 55 of Title 10, United States Code (10 U.S.C. [~~USC~~] Section 1071 et seq.);

(vii) - (viii) (No change.)

(ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. [~~USC~~] Section 8901 et seq.);

(x) (No change.)

(xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. [~~USC~~] Section 2504(e)); and

(xii) (No change.)

(B) Creditable coverage does not include:

(i) - (v) (No change.)

(vi) credit-only insurance;

(vii) - (viii) (No change.)

(ix) if offered separately, coverage that provides limited-scope dental or vision benefits;

(x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(xi) - (xiii) (No change.)

(xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. [~~USC~~] Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. [~~USC~~] Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

(6) Health benefit plan--A plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) (No change.)

(ii) a group hospital service corporation operating under Insurance Code[~~,~~] Chapter 842 [~~20~~];

(iii) a fraternal benefit society operating under Insurance Code[,] Chapter 885 [~~10~~];

(iv) a stipulated premium insurance company operating under Insurance Code[,] Chapter 884 [~~22~~]; or

(v) (No change.)

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. [~~USC~~] Section 1001 et seq.), a plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. [~~USC~~] Section 1002), and operating under Insurance Code Chapter 846 [~~, Article 3.95-1 et seq.~~]; or

(ii) (No change.)

(C) a plan issued by any other entity not licensed under the Insurance Code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis.

(7) (No change.)

(8) HMO--Any person governed by the Texas Health Maintenance Organization Act, Insurance Code[,] Chapter 843 [~~20A~~], including:

(A) a person defined as a health maintenance organization under Insurance Code §843.002 [~~Section 2 of the Texas Health Maintenance Organization Act~~];

(B) an approved nonprofit health corporation that is certified under Occupations Code Chapter 162 [~~Section 5.01(a), Medical Practice Act, Article 4495b, Texas Civil Statutes~~], and that holds a certificate of authority issued by the Commissioner [~~commissioner~~] under Insurance Code Chapter 844 [~~, Article 21.52F~~];

(C) a statewide rural health care system under Insurance Code §845.052 and §845.054 [~~, Article 20C.05~~]; or

(D) a nonprofit corporation created and operated by a community center under Chapter 534, Subchapter C, Health and Safety Code.

(9) Issuer of a health benefit plan—An insurance company,[;] a group hospital service corporation operating under Insurance Code[,] Chapter 842, [~~20;~~] a fraternal benefit society operating under Insurance Code[,] Chapter 885, [~~10;~~] a stipulated premium insurance company operating under Insurance Code[,] Chapter 884, [~~22;~~] a Lloyd's plan operating under Insurance Code[,] Chapter 941, [~~18;~~] a reciprocal or interinsurance exchange operating under Insurance Code[,] Chapter 942, [~~19;~~] or an HMO that issues a health benefit plan.

(10) - (12) (No change.)

(13) Qualified beneficiary--As defined in Section 4980B(g)(1) of the Internal Revenue Code (26 U.S.C. [~~USC~~] Section 4980B(g)(1)).

[~~(14) Risk pool--The Texas Health Insurance Risk Pool established under Insurance Code, Article 3.77, or other similar arrangements in other states.~~]

(14)[~~(15)~~] Short-term limited duration insurance—Health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective.

(15)[~~(16)~~] Waiting period--A period of time established by an employer that must pass before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits. If an employee or dependent enrolls as a late enrollee, any period before such late enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

§21.1110. Form CCC.

(a) Form CCC relating to Insurance Code §1205.002 and §1357.056 [~~, Article 21.52G~~] for certification and disclosure of coverage under a health benefit plan is included in subsection (b) of this section in its entirety and has been filed with the Office of the Secretary of State. [~~The figure can be obtained from the Texas Department of Insurance Life /Health Group, MC 106-1As, P.O. Box 149104, Austin, Texas 78711-2030~~].

(b) (No change.)

SUBCHAPTER L. MEDICAL CHILD SUPPORT, UNFAIR PRACTICES
28 TAC §§21.2001, 21.2006, 21.2010, and 21.2011

STATUTORY AUTHORITY. TDI proposes amendments to §§21.2001, 21.2006, 21.2010, and 21.2011 under Insurance Code §§541.401, 846.005, 1301.007, 1355.258, 1504.002, 1701.060, and 36.001.

Insurance Code §541.401 provides that the Commissioner may adopt rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

Insurance Code §846.005 provides that the Commissioner may adopt rules necessary to augment and implement Insurance Code Chapter 846.

Insurance Code §1301.007 provides that the Commissioner adopt rules necessary to implement Insurance Code Chapter 1301.

Insurance Code §1355.258 provides that the Commissioner adopt rules necessary to implement Insurance Code Chapter 1355, Subchapter F.

Insurance Code §1504.002 provides that the Commissioner adopt rules necessary to implement Insurance Code Chapter 1504, including rules that define acts that constitute unfair or deceptive practices under Insurance Code Chapter 541, Subchapter I.

Insurance Code §1701.060 provides that the Commissioner may adopt rules necessary to implement the purposes of Insurance Code Chapter 1701.

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

CROSS-REFERENCE TO STATUTE. Section 21.2001 implements Insurance Code §1504.002. Section 21.2006 implements Insurance Code §1504.002 and §1504.054. Section 21.2010 implements Insurance Code §1504.052. Section 21.2011 implements Insurance Code §1504.002 and §1504.003.

TEXT.

§21.2001. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) Actuarial assumptions--[—]The value of a parameter, or other choice, having an impact on an estimate of a future cost or other actuarial item under evaluation.

(2) Actuarially equivalent--[—]Producing equal actuarial present value, determined as of a given date with each value based on the same set of actuarial assumptions.

(3) Actuarial present value--[—]The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of actuarial assumptions.

(4) Child--[—]

(A) – (B) (No change.)

(5) Child support agency--[—]As defined in [the] Family Code[,] §101.004.

(6) Custodial parent--[—]

(A) - (B) (No change.)

(7) Health insurer--[—]Any insurance company, stipulated premium company, fraternal benefit society, group hospital service corporation, or HMO that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(8) Insurer--[—]

(A) (No change.)

(B) a governmental entity subject to:

(i) Insurance Code, Articles 3.51-1, [3.51-2,] 3.51-4, or 3.51-5 [or 3.51-5A]; or

(ii) [Section 1, Chapter 123, Acts of the 60th Legislature, 1967 (the] Insurance Code Chapter 1578 [, Article 3.51-3]); Local Government Code, Chapter 177; or Insurance Code §1355.151 or §1364.101;

(C) a multiple employer welfare arrangement, as that term is defined by [the] Insurance Code §§846.001, 846.002, 846.202, and 846.251 [, Article 3.95-1]; or

(D) a health insurer that issues coverage for a group health plan, as defined by the Employee Retirement Income Security Act of 1974, §607(1) (29 U.S.C. [USC]§1167).

(9) Medical assistance--[—]Medical assistance under the state Medicaid program.

(10) Medical support order--[—]A court or administrative judgment, decree, or order whether temporary, final, or subject to modification for the benefit of a child that provides for health coverage of the child.

(11) Policy--[—]Includes an individual, blanket, or franchise insurance agreement or contract, a certificate issued under a group policy, a group hospital service contract, or evidence of coverage issued by a health maintenance organization.

(12) Qualified actuary--[—]An actuary who is either:

(A) - (B) (No change.)

§21.2006. Notice of Availability of Continuation or Conversion Coverage.

(a) For the purpose of providing notification to the custodial parent under Insurance Codes §1504.054 [~~Article 3.96-5~~] and §21.2008 of this title (relating to Information Provided by an Insurer), the custodial parent must [~~shall~~] notify the insurer of any change of address. If no such change of address is submitted by the custodial parent to the insurer, then the insurer must [~~shall~~] comply with the provisions of Insurance Code §1504.054 [~~Article 3.96-5~~] and §21.2008 of this title (relating to Information Provided by an Insurer) regarding notification to the custodial parent if such notice is sent to the last known address of the custodial parent.

(b) The insurer must [~~shall~~] enroll or continue enrollment of the child on application of a parent of the child, a child support agency, or the child over 18 years of age.

§21.2010. Prohibition on Service Area Restrictions.

(a) With respect to a child who lives outside the insurer's service area but inside the United States whose coverage under the policy is required by a medical support order, an insurer must [~~shall~~] either:

(1) - (2) (No change.)

(b) If the policy contains preferred provider provisions for the purposes of offering a network of preferred providers as defined in [~~the~~] Insurance Code Chapter 1301 [~~Article 3.70-3C~~], and the insurer does not provide coverage under subsection (a)(2) of this section, reimbursement for services for a child who is the subject of a medical support order and lives outside the insurer's service area must [~~shall~~] be provided at the preferred provider level of benefits.

(c) If the insurer provides coverage under subsection (a)(2), the coverage must [~~shall~~] include benefits identical to, greater than, or comparable to those provided to other dependent children covered by the policy under which coverage is required by a medical support order.

(d) If the coverage is provided under subsection (a)(2) of this section, the insurer must [~~shall~~] submit a certification to the Texas Department of Insurance. The certification must [~~shall~~] be filed with the Texas Department of Insurance, Life and Health Division by email to MCQA@tdi.texas.gov [~~Life/Health/HMO Intake Unit, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104 Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701~~], signed by an officer of the insurer and include:

(1) - (2) (No change.)

(3) the name of the HMO or indemnity carrier with which the insurer has contracted to provide coverage to children who are the subject of a medical support order and a statement, if applicable, that the HMO or indemnity carrier has filed the applicable forms providing the coverage as required by Insurance Code Chapter 1701, and Insurance Code §1504.002 and §1504.052 [~~Articles 3.42 and 3.96-8~~] or §11.301 of this title (relating to Filing Requirements [~~for HMOs~~]);

(4) (No change.)

(5) if the coverage is not identical, the certification must [~~shall~~] also be signed by a qualified actuary or an officer of the insurer who attests that the coverage

provided is at least actuarially equivalent to or greater than the coverage provided to other dependent children under the policy under which coverage is required by a medical support order. The determination of actuarial equivalence of the coverages must [~~shall~~] take into account plan design (e.g., copayments, coinsurance, deductibles, etc.) and scope of benefits. The certification must [~~shall~~] identify any other variables considered in the analysis relating to the actuarial equivalence of the coverages.

§21.2011. Unfair or Deceptive Practices.

(a) A violation of §21.2002 of this title (relating to Prohibition Against Denial of Enrollment), §21.2003 of this title (relating to Requirements Concerning Adopted Children or Children Placed for Adoption), §21.2004 of this title (relating to Enrollment of Child Who Is the Subject of a Medical Support Order), §21.2005 of this title (relating to Prohibition on Cancellation or Nonrenewal), §21.2009 of this title (relating to Submission and Payment of Claims), and §21.2010 of this title (relating to Prohibition on Service Area Restrictions) are [~~shall be~~] considered an unfair or deceptive practice and will [~~shall~~] subject the insurer to the penalties provided in [~~the~~] Insurance Code Chapter 541 [~~, Article 21.21~~] and other applicable [~~application~~] provisions of the Insurance Code.

(b) A violation of §21.2006 of this title (relating to Notice of Availability of Continuation of Conversion Coverage), §21.2007 of this title (relating to Assignment of Medical Support Rights to State Agency), and §21.2008 of this title (relating to Information Provided by an Insurer) subjects [~~shall subject~~] the insurer to the penalties provided in [~~the~~] Insurance Code Chapter 82 [~~, Article 1.10, §7~~] and other applicable provisions of the Insurance Code.

SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS
28 TAC §21.2106

STATUTORY AUTHORITY. TDI proposes §21.2106 under Insurance Code §§1370.004, 1251.008, 843.151, and 36.001.

Insurance Code §1370.004 provides that health benefit plan issuers must provide written notice of coverage required under Insurance Code Chapter 1370 to each woman 18 year of age or older enrolled in the plan in accordance with rules adopted by the Commissioner.

Insurance Code §1251.008 provides that the Commissioner may adopt rules necessary to administer Insurance Code Chapter 1251.

Insurance Code §843.151 provides that the Commissioner may adopt rules as necessary and proper to implement Insurance Code Chapter 1271.

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

CROSS-REFERENCE TO STATUTE. Section 21.2106 implements Insurance Code §1370.004. Section 21.2106 implements Insurance Code §§1357.056, 1362.004, 1363.004, 1366.058, and 1357.006.

TEXT.

§21.2106. Forms.

(a) The forms identified in §21.2103 of this title (relating to Mandatory Benefit Notices) are included in subsection (b) of this section in their entirety. The forms can be obtained from the [~~Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or from the~~] TDI website, www.tdi.texas.gov.

(b) (No change.)

SUBCHAPTER N. LIFE INSURANCE ILLUSTRATIONS
28 TAC §§21.2202, 21.2204, and 21.2212

STATUTORY AUTHORITY. TDI proposes amendments to §§21.2202, 21.2204, and 21.2212 under Insurance Code §§541.401, 543.001, and 36.001.

Insurance Code §541.401 provides that the Commissioner may adopt rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

Insurance Code §543.001 provides that the Commissioner may adopt rules as provided by Chapter 541, Subchapter I, to ensure life insurance companies do not circulate statements that misrepresent the terms, benefits, or dividends received on a life insurance policy or certificate.

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

CROSS-REFERENCE TO STATUTE. Section 21.2202 implements Insurance Code §543.001. Section 21.2204 implements Insurance Code §541.401. Section 21.2212 implements Insurance Code §§543.001, 541.051, 541.052, and 541.057.

TEXT.

§21.2202. Authority.

This subchapter [~~Subchapter~~] is issued based upon the authority granted the Commissioner [~~commissioner~~] under [~~the~~] Insurance Code §543.001; Chapter 541, Subchapter J; and §36.001 [~~, Article 21.21 §13 and Article 1.03A~~].

§21.2204. Definitions.

For the purposes of this subchapter [~~Subchapter~~], the following terms [~~in this section shall~~] have the following meanings [~~placed opposite them~~] unless the explicit wording of a section or portion of a section directs [~~shall~~] otherwise [~~direct~~].

(1) - (8) (No change.)

(9) Illustration--a presentation or depiction used in the solicitation or sale of a life insurance policy that includes non-guaranteed elements of a policy of life insurance over a period of years and includes but is not limited to the three types defined in subparagraphs (A) - (C) of this paragraph.

(A) (No change.)

(B) Supplemental illustration--an illustration furnished in addition to a basic illustration that meets the applicable requirements of this subchapter [~~Subchapter~~], and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

(C) (No change.)

(10) - (11) (No change.)

(12) Insurer--a life insurance company as defined by [~~the~~] Insurance Code §841.001 and §982.001 [~~, Article 3.01 §(1)~~]; a fraternal benefit society as defined by [~~the~~] Insurance Code §885.051 and §885.052 [~~, Article 10.01 §§(a) and (b)~~]; a Mutual Life Insurance Company as defined by [~~the~~] Insurance Code Chapter 882 [~~, Article 11.01~~]; or a Stipulated Premium Insurance Company as defined by [~~the~~] Insurance Code Chapter 884 [~~, Article 22.01~~].

(13) Lapse-supported illustration--an illustration of a policy form failing the test of self-supporting as defined in this subchapter [~~Subchapter~~], under a modified

persistency rate assumption using persistency rates underlying the disciplined current scale for the first five years and 100% policy persistency thereafter.

(14) Minimum assumed expenses--the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from:

(A) - (B) (No change.)

(C) a generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the National Association of Insurance Commissioners or by the Commissioner [~~commissioner~~]. Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

(15) - (21) (No change.)

§21.2212. Penalties.

Any violation of this subchapter [~~subsection~~] [~~shall~~] constitute a misrepresentation of the terms of an issued and unissued policy in violation of [~~the~~] Insurance Code[~~,~~] Chapter 541, Subchapter B, [~~Article 21.21 §4(1) and (2)~~] and to be a misrepresentation of the terms, benefits, and advantages of a policy within the meaning of [~~the~~] Insurance Code §543.001 [~~, Article 21.20~~]. Violations of this subchapter [~~subsection shall~~] subject the insurer and agent to the penalties provided in [~~the~~] Insurance Code Chapter 541 [~~, Article 21.21~~] and other applicable provisions of the Insurance Code.

SUBCHAPTER Q. COMPLAINT RECORDS TO BE MAINTAINED
28 TAC §21.2501

STATUTORY AUTHORITY. TDI proposes §21.2501 under Insurance Code §541.401 and §36.001.

Insurance Code §541.401 provides that the Commissioner may adopt and enforce rules necessary to accomplish the purpose of Chapter 541, which is to regulate trade practices in the business of insurance by defining or determining trade practices that are unfair methods of competition or deceptive acts or practices and prohibiting them.

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

CROSS-REFERENCE TO STATUTE. Section 21.2501 implements Insurance Code §542.005.

TEXT.

§21.2501. Applicability and Purpose.

This subchapter applies to all insurers as defined in §21.2502 of this title (relating to Definitions). The purpose of this subchapter is to prescribe the minimum information required to be maintained in the complaint record of an insurer, to provide a recommended format for the maintenance of such a record by insurers, and to require presentation of such information at the time of examination of insurers or upon other request for complaint record information by the department. Complaint record maintenance provisions of this subchapter apply to all complaints of an insurer not specifically excepted by this subchapter, including complaints relating to the claims settlement practices of an insurer.

(1) This subchapter does not apply to complaints received and maintained by Health Maintenance Organizations. [~~The~~] Insurance Code Chapter 843, Subchapter G [~~, Article 20A.12~~], as amended, as well as §11.205 of this title (relating to Additional Documents to be [~~To Be~~] Available for Review [~~During Examinations~~]), expressly and specifically provide for complaint record maintenance by HMOs.

(2) This subchapter does not apply to the complaints received by an insurer in its capacity as a utilization review agent. Complaint record maintenance and reporting for such complaints are addressed in §19.1705[~~19.1716~~] of this title (relating to Complaints and Information).

SUBCHAPTER R. DIABETES
28 TAC §21.2601, 21.2604, and 21.2606

STATUTORY AUTHORITY. TDI proposes amendments to §§21.2601, 21.2604, and 21.2606 under Insurance Code §1358.057 and §36.001.

Insurance Code §1358.057 provides that the Commissioner adopt rules necessary to implement Insurance Code Chapter 1358, Subchapter B.

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

CROSS-REFERENCE TO STATUTE. Sections 21.2601 and 21.2604 implement Insurance Code §1358.004. Section 21.2606 implements Insurance Code §1358.055.

TEXT.

§21.2601. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.[:]

(1) - (2) (No change.)

(3) Diabetes--Diabetes mellitus. A chronic disorder of glucose metabolism that can be characterized by an elevated blood glucose level. The terms "diabetes" and "diabetes mellitus" are synonymous.

(4) Diabetes equipment--The term "diabetes equipment" includes items defined in Insurance Code §1358.051 and §1358.056, [~~Article 21.53 G §§1(1) and 5~~] and §21.2605 of this title (relating to Diabetes Equipment and Supplies).

(5) Diabetes supplies--The term "diabetes supplies" includes items defined in Insurance Code §1358.051 and §1358.056 [~~Article 21.53 G §§1(2) and 5~~], and §21.2605 of this title.

(6) (No change.)

(7) Health benefit plan--A health benefit plan, for purposes of this subchapter, means:

(A) a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(i) an individual, group, blanket, or franchise insurance policy or insurance agreement;[,] a group hospital service contract;[,] or an individual or group evidence of coverage that is offered by:

(I) (No change.)

(II) a group hospital service corporation operating under [~~Chapter 20 of the Texas~~] Insurance Code Chapter 842;

(III) a fraternal benefit society operating under [~~Chapter 10 of the Texas~~] Insurance Code Chapter 885;

(IV) a stipulated premium insurance company operating under [~~Chapter 22 of the~~] Insurance Code Chapter 884;

(V) a reciprocal exchange operating under [~~Chapter 19 of the~~] Texas Insurance Code Chapter 942; or

(VI) a health maintenance organization (HMO) operating under Insurance Code Chapter 843 [~~the Texas Health Maintenance Organization Act (Chapter 20A, Texas Insurance Code)~~];

(ii) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. [~~USC~~] §1002), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by §3, Employee Retirement Income Security Act of 1974 (29 U.S.C. [~~USC~~] §1002) that holds a certificate of authority under Insurance Code Chapter 846 [~~Article 3.95-2~~]; or

(iii) notwithstanding [~~§172.014,~~] Local Government Code §172.014, or any other law, health and accident coverage provided by a risk pool created under [~~Chapter 172,~~] Local Government Code Chapter 172.

(B) A plan offered by an approved nonprofit health corporation that is certified under Texas Occupation Code §162.001(b)[~~§5.01(a), Medical Practice Act~~], and that holds a certificate of authority issued by the Commissioner [~~commissioner~~] under Insurance Code Chapter 844 [~~Article 21.52F~~].

(C) A health benefit plan is not:

(i) (No change.)

(ii) a small employer plan written under [~~Chapter 26 of the~~] Insurance Code Chapter 1501;

(iii) a Medicare supplemental policy as defined by §1882(g)(1), Social Security Act (42 U.S.C. [~~USC~~] §1395 ss);

(iv) a plan that is designed to supplement benefits provided under a program established by the Department of Defense pursuant to Chapter 55 of Title 10, United States Code (10 U.S.C. §[~~USC Section~~]1071 et seq.);

(v) - (vi) (No change.)

(vii) a long-term care policy, including a nursing home fixed indemnity policy, unless the Commissioner [~~commissioner~~] determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by subparagraph (A) of this paragraph.

(8) (No change.)

(9) Nutrition counseling--As defined in [~~§701.002 of the Texas~~] Occupations Code §701.002.

(10) - (11) (No change.)

§21.2604. Minimum Standards for Benefits for Persons with Diabetes, Requirement for Periodic Assessment of Physician and Organizational Compliance.

(a) Health benefit plans provided by HMOs must [~~shall~~] provide coverage for the services in paragraphs (1) through (7) of this subsection and must [~~shall~~] contract with providers that agree to comply with the minimum practice standards outlined in subsection (b) of this section. Services to be covered include:

(1) (No change.)

(2) immunizations required by Insurance Code Chapter 1367, Subchapter B [~~Article 21.53F~~], Coverage for Childhood Immunizations;

(3) - (7) (No change.)

(b) HMOs must [~~shall~~] contract with providers who, at a minimum, provide care that complies with subsection (a) of this section that includes:

(1) for all insureds:

(A) - (C) (No change.)

(D) annually the following:

(i) - (iv) (No change.)

(v) for insureds under 18 [~~eighteen~~] years of age, a referral for a retinal camera examination to be performed by an ophthalmologist or therapeutic optometrist.

(2) For treatment of an insured 65 [~~sixty-five~~] years of age and over or an insured with complications affecting two or more body systems:

(A) - (B) (No change.)

(3) (No change.)

(4) For insureds with Type 1 Diabetes:

(A) - (B) (No change.)

(C) ongoing [~~on-going~~] management, which includes quarterly office visits, at which evaluation includes:

(i) - (x) (No change.)

(xi) results of home glucose self-monitoring;

(xii) - (xvi) (No change.)

(xvii) reevaluation of short- and long-term self-management goals;

(xviii) - (xix) (No change.)

(xx) counseling for high-risk behaviors; and

(xxi) for insureds under 18 [~~eighteen~~] years of age, growth assessment.

(c) Health plans provided by HMOs must [~~shall~~] periodically assess physician and organizational compliance with the minimum practice standards contained in subsection (b) of this section.

(d) Health benefit plans provided by entities other than HMOs must [~~shall~~] provide coverage at a minimum for:

(1) (No change.)

(2) immunizations required by Insurance Code Chapter 1367, Subchapter B [~~Article 21.53F~~], Coverage for Childhood Immunizations;

(3) - (7) (No change.)

§21.2606. Diabetes Self-Management Training.

(a) A health benefit plan must [~~shall~~] provide diabetes self-management training or coverage for diabetes self-management training for which a physician or practitioner has written an order, including a written order of a practitioner practicing under protocols jointly developed with a physician, to each insured or the caretaker of the insured in accordance with the standards contained in Insurance Code §1358.054 [~~Article 21.53G, Sec. 4(b) and (c)~~].

(b) A person may not provide a component of diabetes self-management training under subsection (a) of this section unless the subject matter of the component is within the scope of the person's [~~person's~~] practice and the person meets the education requirements as determined by the person's [~~person's~~] licensing agency in consultation with the Commissioner [~~commissioner~~] of Public Health [~~health~~].

(c) Self-management training should [~~shall~~] include the development of an individualized management plan that is created for and in collaboration with the insured and that meets the requirements of the minimum standards for benefits in accordance with §21.2604 of this title (relating to Minimum Standards for Benefits for Persons with Diabetes).

(d) Nutrition counseling and instructions on the proper use of diabetes equipment and supplies must [~~shall~~] be provided or covered as part of the training.

(e) Diabetes self-management training must [~~shall~~] be provided, or coverage for diabetes self-management training must [~~shall~~] be provided to an insured or a caretaker, upon the following occurrences relating to an insured, provided that any training involving the administration of medications must comply with the applicable delegation rules from the appropriate licensing agency:

(1) - (3) (No change.)

(f) An HMO must [~~shall~~] provide oversight of its diabetes self-management training program on an ongoing basis to ensure compliance with this section.

(g) Health benefit plans provided by entities other than HMOs must [~~shall~~] disclose in the plan how to access providers or benefits described in subsection (a) of this section.

SUBCHAPTER S. ASSOCIATION PLANS
28 TAC §21.2702

STATUTORY AUTHORITY. TDI proposes amendments to §21.2702 under Insurance Code §§843.151, 1115.005, 1251.0008, and 36.001.

Insurance Code §843.151 provides that the Commissioner may adopt rules necessary to implement Insurance Code Chapter 843.

Insurance Code §1115.005 provides that the Commissioner may adopt reasonable rules to accomplish and enforce the purpose of Chapter 1115.

Insurance Code §1251.008 provides that the Commissioner may adopt rules necessary to administer Insurance Code Chapter 1251.

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

CROSS-REFERENCE TO STATUTE. Section 21.2702 implements Insurance Code §§1108.002, 1115.001, 1131.060(a) and (b), 1251.004, 1251.052(a) and (b), 1251.054 and 1251.108.

TEXT.

§21.2702. Definitions.

The following words and terms when used in this subchapter [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.[~~:~~]

(1) (No change.)

(2) Bona Fide Association--An association that, in addition to meeting the requirements of an association in paragraphs (1)(A) and (C) of this subsection:

(A) (No change.)

(B) does not condition membership in the association on any health-status-related factor relating to an individual (including the individual eligible for membership or a dependent of the individual eligible for membership, if dependent coverage is offered);

(C) makes coverage under a health benefit plan offered through the association available to all members, regardless of any health-status-related factor relating to the members (or dependents eligible for coverage through a member, if dependent coverage is offered); and

(D) (No change.)

(3) - (5) (No change.)

(6) HMO--A health maintenance organization as defined in [~~the~~] Insurance Code §843.002 [~~Article 20A.02(n)~~].

(7) Health benefit plan--A group insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or

evidence of coverage issued by a health carrier that provides benefits for health care benefits or services. The term does not include the following plans of coverage:

(A) (No change.)

(B) Only if the benefits are provided under a separate policy or contract of insurance or evidence of coverage:

(i) - (vi) coverage for a specified disease or illness;

(vii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known [~~know~~] as CHAMPUS supplemental programs);

(viii) - (ix) (No change.)

(8) Health carrier--Any entity authorized under the Texas Insurance Code or another insurance law of this state that provides health benefit plans in this state, including an insurance company; a group hospital service corporation operating under Insurance Code[~~,~~] Chapter 842 [~~20~~]; a stipulated premium insurance company operating under Insurance Code[~~,~~] Chapter 884 [~~22~~]; an approved nonprofit health corporation that is certified under Occupations Code Chapter 162 [~~Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes)~~] and that holds a certificate of authority issued by the Commissioner [~~commissioner~~] under Insurance Code Chapter 844 [~~, Article 21.52F~~], or an HMO.

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

(A) - (F) (No change.)

(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 [~~Article 21.21-5~~]; or

(H) (No change.)

(10) (No change.)

SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS
28 TAC §21.2819

STATUTORY AUTHORITY. TDI proposes amendments to §21.2819 under Insurance Code §§843.336, 1301.007 and 36.001.

Insurance Code §843.336 provides that the Commissioner may adopt rules that specify the information that must be entered on the claim form for a claim to be a clean claim.

Insurance Code §1301.007 provides that the Commissioner may adopt rules necessary to implement Chapter 1301 relating to preferred provider benefit plans, including the prompt payment of claims.

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

CROSS-REFERENCE TO STATUTE. Section 21.2819 implements Insurance Code §843.337 and §1301.102.

TEXT.

§21.2819. Catastrophic Event.

(a) (No change.)

(b) Within 10 days after the entity returns to normal business operations, the entity must send a certification of the catastrophic event to the [~~Life /Health and HMO Intake Team,~~] Texas Department of Insurance by email to promptpay@tdi.texas.gov. [~~P.O. Box149104, Mail Code 106-1E, Austin, Texas 78714-9104.~~] The certification must:

(1) - (3) (No change.)

(c) (No change.)

SUBCHAPTER U. ARRANGEMENTS BETWEEN INDEMNITY CARRIERS AND HMOS FOR POINT-OF-SERVICE COVERAGE
28 TAC §21.2901 and 21.2902

STATUTORY AUTHORITY. TDI proposes amendments to §21.2901 and §21.2902 under Insurance Code §§843.151, 1201.006, 1251.008, 1273.005, 1301.007, 1701.060, 4201.003, and 36.001.

Insurance Code §843.151 provides that the Commissioner may adopt rules necessary to implement Insurance Code Chapters 843; 1452, Subchapter A; 1507, Subchapter B; 222; 251; and 258 as applicable to health maintenance organizations; and Insurance Code Chapters 1271 and 1272.

Insurance Code §1201.006 provides that the Commissioner may adopt rules necessary to implement the purposes and provisions of Insurance Code Chapter 1201.

Insurance Code §1251.008 provides that the Commissioner may adopt rules necessary to administer Insurance Code Chapter 1251.

Insurance Code §1273.005 provides that the Commissioner may adopt rules to implement Chapter 1273, Subchapter A.

Insurance Code §1301.007 provides that the Commissioner adopt rules necessary to implement Insurance Code Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1701.060 provides that the Commissioner may adopt rules necessary to implement the purpose of Insurance Code Chapter 1701.

Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement Chapter 4201.

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

CROSS-REFERENCE TO STATUTE. Section 21.2901 implements Insurance Code §843.337. Section 21.2902 implements Insurance Code §§843.106, 843.107, and 843.108.

TEXT.

§21.2901. Definitions.

The following words and terms, when used in this subchapter [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) Corresponding benefits--Benefits provided under the indemnity portion of a point-of-service (POS) plan, as defined in Insurance Code §1273.001 and §843.108 [~~Articles 3.64(a)(4) and 20A.02(bb)of the Code~~], that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a point-of-service plan.

(2) - (11) (No change.)

TEXT.

§21.2902. Arrangements between Indemnity Carriers and HMOs to Provide Coverage.

(a) Written agreement between the HMO and the indemnity carrier. A POS plan offered under this subchapter must be evidenced by a written agreement between the HMO and indemnity carrier that must be filed with the department as a plan document and must [~~shall~~] provide the following:

(1) the identity of each entity, including the HMO, the indemnity carrier, or any third-party administrator (TPA) that will administer the coverages offered under the POS plan;

(2) - (3) (No change.)

(4) the HMO's network of providers and, if the POS indemnity coverage includes preferred provider benefits, as allowed by Insurance Code Chapter 1301 [~~Article 3.70-3C of the Code~~] and applicable rules, the indemnity carrier's list of preferred providers, which may [~~shall~~] not be identical; and[~~;~~]

(5) the respective premium rates for the POS HMO coverage and for the POS indemnity coverage must [~~shall~~] be derived separately by the HMO and the indemnity carrier and must [~~shall~~] be separately identified in each POS plan contract; however, the agreement may provide that for a POS plan offered by the entities under this subchapter:

(A) - (B) (No change.)

(C) the entity delegated to collect the premium will [~~shall~~] then disburse the appropriate premium to the other party or parties;

(6) - (7) (No change.)

(8) neither entity may [~~shall~~] use the other to perform functions or duties that are its own responsibility by law or rule, including but not limited to[~~,~~] making all reports and filings required by law or rule;

(9) the entities may delegate those functions or duties permitted by law or rule to be delegated to another party to perform, including but not limited to contracting with providers, administering claims, and conducting grievance procedures, provided that the delegating entity remains [~~shall remain~~] responsible for ensuring that all delegated functions are [~~shall be~~] conducted in compliance with all applicable laws and rules;

(10) the agreement between the indemnity carrier and the HMO may not be canceled or terminated until the coverage for each enrollee in a POS plan issued by both

the indemnity carrier and HMO is terminated or canceled according [~~pursuant~~] to the provisions of this subchapter; and

(11) (No change.)

(b) Basic requirements. In addition to complying with all of the requirements listed in subsection (a) of this section, a contract creating a POS blended contract plan and contracts that together create a POS dual contracts plan must provide the following:

(1) enrollees may [~~shall~~] not be required to first use either the POS indemnity coverage or POS HMO coverage;

(2) if the premiums necessary to maintain both the POS HMO coverage and the POS indemnity coverage are not paid, both coverages will [~~shall~~] be cancelled simultaneously, and any premium the enrollee has remitted to maintain coverage will [~~shall~~] be returned to the enrollee;

(3) (No change.)

(4) corresponding coverage for a POS plan must include the following:

(A) all mandatory benefit offers required by the Insurance Code that are accepted or rejected by the purchaser must also be accepted or rejected in the same manner with respect to both the POS HMO and the POS indemnity coverage;

(B) - (C) (No change.)

(5) if medically necessary covered services, benefits, and supplies are not available through the HMO's participating physicians or providers, the HMO is not relieved of its obligation to provide out-of-network services under Insurance Code Chapter 1271 [~~Article 20A.09 of the Code~~] on the basis that the same services are available to an enrollee through POS indemnity coverage; and

(6) (No change.)

(c) POS blended contracts. Contracts for POS blended contract plans must:

(1) - (5) (No change.)

(6) disclose all coinsurance required for POS indemnity coverage, which must [~~shall~~] never exceed 50% of the total amount to be covered;

(7) (No change.)

(8) disclose all precertification requirements for POS indemnity coverage under the plan including any penalties for failing to comply with any precertification or cost containment provisions, provided that any such penalties do [~~shall~~] not reduce benefits by more than 50% in the aggregate;

(9) disclose how the enrollee may complain about a denial of coverage and appeal an adverse determination rendered concerning the coverage under the POS plan and disclose any rights the enrollee may have to an independent review of an adverse determination under Insurance Code Chapter 4201 [~~Article 21.58A of the Code~~];

(10) POS indemnity coverage issued to a group must [~~shall~~] contain provisions that comply with Insurance Code §§1251.111 - 1251.116 [~~Article 3.51-6 Sec. (1)(d)(2)(vii) - (xiii) of the Code~~]; and

(11) POS indemnity coverage issued to an individual must [~~shall~~] contain provisions that comply with Insurance Code §§1201.111 - 1201.217 [~~Article 3.70-3(A)(5) - (11) of the Code~~].

(d) POS dual contracts. Contracts comprising a POS dual contract plan must comply with the following:

(1) The contract issued by the indemnity carrier must [~~shall~~] comply with all applicable requirements for indemnity carriers and must [~~shall~~]:

(A) - (B) (No change.)

(C) disclose all applicable copayments and coinsurance, which must [~~shall~~] never exceed 50% of the total amount to be covered;

(D) (No change.)

(E) disclose all precertification requirements for POS indemnity coverage under the plan, including any penalties for failing to comply with any precertification or cost containment provisions, provided that any such penalties must [~~shall~~] not reduce benefits more than 50% in the aggregate;

(F) disclose how the enrollee may complain about a denial of coverage and appeal an adverse determination rendered concerning the coverage under the POS indemnity coverage and disclose any rights the enrollee may have to an independent review of an adverse determination under Insurance Code Chapter 4201 [~~Article 21.58A of the Code~~], if applicable;

(G) POS indemnity coverage issued to a group must [~~, shall~~] contain provisions that comply with Insurance Code §§1251.111 - 1251.116 [~~Article 3.51-6 Sec (1)(d)(2)(vii) - (xiii) of the Code~~];

(H) POS indemnity coverage issued to an individual must [~~shall~~] contain provisions that comply with Insurance Code §§1201.111 - 1201.217 [~~Article 3.70-3(A)(5) - (11) of the Code~~].

(2) The contract issued by the HMO must [~~shall~~] comply with all requirements for an HMO evidence of coverage and must [~~shall~~]:

(A) - (C) (No change.)

(e) Filings. All plan documents for a POS plan offered under this subchapter must [~~shall~~] be submitted to the department [~~Filings Intake Division~~] in accordance with:

(1) Insurance Code Chapter 1271 [~~Article 20A.09 of the Code~~] and Chapter 11 of this title (relating to Health Maintenance Organizations), including the filing fee requirements; and

(2) Insurance Code Chapter 1701 [~~Article 3.4 of the Code~~] and Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings [~~Filing of Policy Forms, Riders, Amendments,~~

~~Endorsements for Life, Accident, and Health Insurance and Annuities~~]), including the filing fee requirements.

SUBCHAPTER X. EVALUATION OF NETWORK PHYSICIANS AND PROVIDERS. 28 TAC §21.3201

STATUTORY AUTHORITY. TDI proposes amendments to §21.3201 under Insurance Code §1452.052 and §36.001.

Insurance Code §1452.052 provides that the Commissioner adopt a standardized verification of credentials form for physicians, advanced practice nurses, and physician assistants.

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

CROSS-REFERENCE TO STATUTE. Section 21.3201 implements Insurance Code §1452.051 and §1452.052.

TEXT.

§21.3201. Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses, and Physician Assistants.

(a) Purpose and applicability [~~Applicability~~]. The purpose of this section is to identify the standardized credentialing application form required by [~~the~~] Insurance Code §1452.052 [~~Article 21.58D~~]. Hospitals, health maintenance organizations, preferred provider benefit plans, and preferred provider organizations are required to use this form for credentialing and recredentialing of physicians, advanced practice nurses, and physician assistants.

(b) Definitions. The following words and terms when used in this section [~~shall~~] have the following meanings.[~~:~~]

(1) - (3) (No change.)

(4) Health maintenance organization--A health maintenance organization as that term is defined by [~~the~~] Insurance Code §843.002(14).

(5) Hospital--A licensed public or private institution as defined by Health and Safety Code Chapter 241[~~, Health and Safety Code,~~] and any hospital owned or operated by state government.

(6) (No change.)

(7) Physician assistant--A person who holds a license issued under Occupations Code Chapter 204[~~, Occupations Code~~].

(8) Preferred provider benefit plan--A plan issued by an insurer under [~~the~~] Insurance Code Chapter 1301 [~~Article 3.70-3C~~].

(9) Preferred provider organization--An organization contracting with an insurer issuing a preferred provider benefit plan under [~~the~~] Insurance Code Chapter 1301 [~~Article 3.70-3C,~~] for the purpose of providing a network of preferred providers.

(10) (No change.)

(c) Texas Standardized Credentialing Application. The Texas Standardized Credentialing Application must [~~shall~~] be used by all hospitals, health maintenance organizations, preferred provider benefit plan insurers, and preferred provider organizations for credentialing and recredentialing of physicians, advanced practice nurses, and physician assistants.

(d) (No change.)

(e) Availability. This form may be obtained on the department's [~~Department's~~] website [~~Web site~~] at www.tdi.texas.gov [~~www.tdi.state.tx.us or from the Texas Department of Insurance, Quality Assurance Section, HMO Division, Mail Code 103-6A, P.O. Box~~

~~149104, Austin, Texas 78714-9104; or by calling 1-800-599-SHOP (1476); in Austin, 305-7211~~]. Reproduction of this form without any changes is allowed.

(f) (No change.)

SUBCHAPTER Y. UNFAIR DISCRIMINATION IN COMPENSATION FOR WOMEN'S HEALTH CARE
28 TAC §§21.3302, 21.3303, and 21.3305

STATUTORY AUTHORITY. TDI proposes amendments to §§21.3302, 21.3303, and 21.3305 under Senate Bill 8, 77th Legislature (2001) (SB 8) and §36.001.

The enacting language of SB 8, which enacted the article that was codified as Insurance Code Chapter 1454 effective April 1, 2005, provides that the department may adopt rules necessary to implement the act.

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

CROSS-REFERENCE TO STATUTE. Section 21.3302 implements Insurance Code Chapter 1454. Section 21.3303 implements Insurance Code §1454.002. Section 21.3305 implements Insurance Code §§1454.106, 1454.107, and 1454.108.

TEXT.

§21.3302. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.[:]

(1) Issuer--Those entities that offer a health benefit plan as identified in Insurance Code §1454.002 [~~Article 21.53N §2(1-8)~~].

(2) - (3) (No change.)

§21.3303. Applicability.

This subchapter applies to issuers that provide coverage for reproductive health or reproductive oncology services for women and applies to health benefit plans as described in Insurance Code §1454.002 [~~Article 21.53N §2~~] that are delivered, issued for delivery, or renewed on or after January 1, 2002.

§21.3305. Complaints.

(a) A complaint against an issuer filed with the Texas Department of Insurance for alleged violations of Insurance Code §1454.051 [~~Article 21.53N §3~~] must [~~shall~~] include:

(1) a description of the alleged violation under Insurance Code §1454.051 [~~Article 21.53N~~];

(2) (No change.)

(3) the physician's or provider's name, if different from [~~than~~] the complainant;

(4) - (6) (No change.)

(b) Within 10 days of receipt of a complaint, the department will determine whether [~~if~~] all the information in subsection (a) of this section has been received.

(c) If all the information identified in subsection (a) of this section is included in the complaint:

(1) - (2) (No change.)

(3) the 120-day time period in Insurance Code §1454.107 [~~Article 21.53N §4(c)~~] will commence.

(d) (No change.)

(e) If the department believes that the information received by the department under subsection (a) of this section substantiates the alleged unfair discrimination in compensation as contemplated in Insurance Code Chapter 1454 [~~Article 21.53N of the Insurance Code~~] and this subchapter, action will be taken in accordance with Insurance Code Chapter 1454, Subchapter C [~~Article 21.53N §4 of the Insurance Code~~].

SUBCHAPTER CC. ELECTRONIC HEALTH CARE TRANSACTIONS
28 TAC §21.3701

STATUTORY AUTHORITY. TDI proposes §21.3701 under Insurance Code §1213.006 and §36.001.

Insurance Code §1213.006 provides that the Commissioner may adopt rules necessary to implement the requirements for electronic health care transactions found in Chapter 1213.

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

CROSS-REFERENCE TO STATUTE. Section 21.3701 implements Insurance Code Chapter 1213.

TEXT.

§21.3701. Electronic Claims Filing Requirements.

(a) The purpose of this section is to implement Insurance Code Chapter 1213 [~~Article 21.52Z of the Insurance Code~~]. This section applies to a contract between an issuer of a health benefit plan and a health care professional or health care facility (hereinafter referred to as "physicians or providers").

(b) Consistent with Insurance Code Chapter 1213 [~~Article 21.52Z~~] and this section, the issuer of a health benefit plan may, by contract, require physicians and providers to electronically submit the following:

(1) - (3) (No change.)

(c) (No change.)

(d) A contract between the issuer of a health benefit plan and a physician or provider that requires electronic submission of any information described in subsection (b) of this section must [~~shall~~] include a provision stating that in the event of a systems failure[,] or a catastrophic event as defined in §21.2802 [~~§21.2803~~] of this title (relating to Definitions)[,] that substantially interferes with the business operations of the physician or provider, the physician or provider may submit non-electronic claims in accordance with the requirements in this subchapter and for the number of calendar days during which substantial interference with business operations occurs as of the date of the catastrophic event or systems failure. A physician or provider must [~~shall~~] provide written notice of the physician's or provider's intent to submit non-electronic claims to the issuer of the health benefit plan within five calendar days of the catastrophic event or systems failure.

(e) A contract between the issuer of a health benefit plan and a physician or provider that requires electronic submission of the information described in subsection (b) of this section must [~~shall~~] include a provision allowing for a waiver of the electronic submission requirements in any of the following circumstances:

(1) (No change.)

(2) The operation of small physician and provider practices. This exception applies to those physicians and providers with fewer than 10 [~~ten~~] full-time-equivalent employees, consistent with 42 C.F.R. §424.32(d)(1)(viii).

(3) - (4) (No change.)

(f) (No change.)

(g) Upon receipt of a request for a waiver from a physician or provider, the issuer of a health benefit plan must [~~shall~~], within 14 calendar days, issue or deny a waiver.

(h) A waiver or denial of a waiver must be issued in writing to the requesting physician or provider. A written waiver must [~~shall~~] contain any restrictions, conditions, or limitations related to the waiver. A written denial of a request for a waiver or the issuance of a qualified or conditional waiver must [~~shall~~] include the reason for the denial or any restrictions, conditions, or limitations, and notice of the physician's or provider's right to appeal the determination to the department [~~Texas Department of Insurance~~].

(i) A physician or provider that is denied a waiver of the electronic submission requirements[,] or granted a waiver with restrictions, conditions, or limitations, may, within 14 calendar days of receipt, appeal the waiver determination. The request for appeal and accompanying documentation must [~~shall~~] be sent to the Director of MCQA [~~Deputy Commissioner, HMO Division~~], MC-LH-MCQA, P.O. Box 12030 [~~149104~~], Austin, Texas 78711-2030 [~~78714-9104~~] and to the issuer of the health benefit plan. The information must [~~shall~~] include:

(1) - (4) (No change.)

(j) Upon receipt of notice of a request for appeal under this section, an issuer of a health benefit plan must [~~shall~~], within 14 calendar days, submit to the department [~~Deputy Commissioner of the HMO Division~~] and to the physician or provider:

(1) (No change.)

(2) any additional information necessary for the determination of the appeal.

(k) The department [~~Deputy Commissioner of the HMO Division~~] may request additional information from either party and may request the parties to appear at a hearing. Either party may choose to attend a hearing conducted at the department or participate in a hearing via telephone.

(l) Upon receipt of all information required by subsections (i) and (j) of this section, the Director of Managed Care Quality Assurance will [~~Deputy Commissioner of the HMO Division shall~~] issue a determination within 14 calendar days of the later of the receipt of all necessary information or the conclusion of the hearing.

(m) Either party may request a hearing before the Deputy Commissioner of Life and Health [~~Senior Associate Commissioner of the Life, Health and Licensing Program~~] for reconsideration of the Director of the Managed Care Quality Assurance Office's [~~Deputy Commissioner of the HMO Division's~~] determination. Either party may choose to attend a hearing conducted at the department or participate in a hearing via telephone. A request for reconsideration must be received by the Chief Clerk [~~Senior Associate Commissioner~~] at MC-GC-CCO, P.O. Box 12030 [~~149104~~], Austin, Texas 78711-2030 [~~78714-9104~~] within 14 calendar days of receiving notice of the appeal determination.

(n) - (p) (No change.)

SUBCHAPTER DD. ELIGIBILITY STATEMENTS
28 TAC §21.3802

STATUTORY AUTHORITY. TDI proposes §21.3802 under Insurance Code §1274.004 and §36.001.

Insurance Code §1274.004 provides that the Commissioner adopt rules necessary to implement Chapter 1274.

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

CROSS-REFERENCE TO STATUTE. Section 21.3802 implements Insurance Code §1274.001.

TEXT.

§21.3802. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings unless the context clearly indicates otherwise.

(1) - (5) (No change.)

(6) Physician--

(A) (No change.)

(B) a professional association organized under the Texas Professional Association Law [~~Act~~] (Business Organizations Code Chapters 301 and 302 [~~Article 1528f, Vernon's Texas Civil Statutes~~]);

(C) (No change.)

(D) a medical school or medical and dental unit, as defined or described by Education Code §§61.003, 61.501, or 74.601[~~, Education Code~~], that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(E) (No change.)

(7) (No change.)

SUBCHAPTER GG. HEALTH CARE QUALITY ASSURANCE PRESUMED COMPLIANCE 28 TAC §21.4105

STATUTORY AUTHORITY. TDI proposes §21.4105 under Insurance Code §847.007 and §36.001.

Insurance Code §847.007 provides that the Commissioner may by rule determine the application of compliance with national accreditation requirements by a delegated entity, delegated third party, or utilization review agent to compliance by the health

benefit plan issuer that contracts with the delegated entity, delegated third party, or agent.

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

CROSS-REFERENCE TO STATUTE. Section 21.4105 implements Insurance Code §847.005.

TEXT.

§21.4105. Department Monitoring and Analysis of National Accreditation Organization Standards.

(a) Analysis of standards. The department will compare statutory and regulatory requirements of the department for health benefit plan issuers with the standards of national accreditation organizations. The standards of national accreditation organizations that are the same as, substantially similar to, or more stringent than the department's statutory and regulatory requirements will be identified and used to determine the presumption of compliance of health benefit plan issuers.

(b) Monitoring schedule. The department will [~~shall~~], at least annually, monitor and analyze updates and amendments made to accreditation standards by national accreditation organizations to ensure that those standards remain the same as, substantially similar to, or more stringent than the statutory and regulatory requirements of the department.

(c) Posting of standards. The department will post a table on its [~~internet~~] website that contains a summary of its comparison of national accreditation organization standards with the statutory and regulatory requirements of the department and indicates

which portions of the examination process the department will presume compliance for accredited entities. The presumed compliance table listing the summary of the comparison of national accreditation standards and department statutory and regulatory requirements may be obtained from:

(1) the department's [~~Department's internet~~] website at[~~:~~] www.tdi.texas.gov [~~www.tdi.state.tx.us~~]; or

(2) the Financial Regulation [~~Health and WC Network Certification and QA~~] Division, MC-FRD [~~Mail Code 103-6A~~], Texas Department of Insurance, P.O. Box 12030 [~~149104~~], Austin, Texas 78711-2030 [~~78714-9104~~].

(d) Updates to standards. The department will update the table of standards posted on its [~~internet~~] website on at least an annual basis, as necessary, to reflect changes made to national accreditation organization standards.

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

Issued in Austin, Texas, on June 4, 2021.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance