CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS
REPEAL OF

SUBCHAPTER A. GENERAL PROVISIONS
28 TAC §11.1, §11.2

SUBCHAPTER B. NAME APPLICATION PROCEDURE
28 TAC §§11.101 - 11.109

SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY
28 TAC §§11.201 - 11.207

SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO SUBSEQUENT TO ISSUANCE OF CERTIFICATE OF AUTHORITY
28 TAC §§11.301 - 11.303

SUBCHAPTER F. EVIDENCE OF COVERAGE
28 TAC §§11.501 - 11.513

SUBCHAPTER G. ADVERTISING AND SALES MATERIAL
28 TAC §11.602, §11.603

SUBCHAPTER H. SCHEDULE OF CHARGES
28 TAC §§11.701 - 11.707

SUBCHAPTER I. FINANCIAL REQUIREMENTS
28 TAC §§11.801 - 11.810

SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS
28 TAC §§11.900 - 11.904

SUBCHAPTER K. REQUIRED FORMS
28 TAC §11.1001

SUBCHAPTER M. ACQUISITION OF, CONTROL OF, OR MERGER OF, A DOMESTIC HMO
28 TAC §§11.1201 - 11.1206

SUBCHAPTER N. HMO SOLVENCY SURVEILLANCE COMMITTEE PLAN OF OPERATION
28 TAC §§11.1301 - 11.1306

SUBCHAPTER O. ADMINISTRATIVE PROCEDURES
28 TAC §§11.1401 - 11.1404

SUBCHAPTER P. PROHIBITED PRACTICES
28 TAC §11.1500

SUBCHAPTER Q. OTHER REQUIREMENTS
28 TAC §§11.1600 - 11.1607

SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS
28 TAC §§11.1702 - 11.1704

SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID
28 TAC §§11.1801 - 11.1806

SUBCHAPTER T. QUALITY OF CARE
28 TAC §§11.1901, 11.1902

SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS
28 TAC §§11.2101 - 11.2104

SUBCHAPTER W. SINGLE SERVICE HMOS
28 TAC §§11.2200 - 11.2208

SUBCHAPTER X. PROVIDER SPONSORED ORGANIZATIONS
28 TAC §§11.2301 - 11.2315

SUBCHAPTER Y. LIMITED SERVICE HMOS
28 TAC §§11.2401 - 11.2406

SUBCHAPTER Z. POINT-OF-SERVICE RIDERS
28 TAC §§11.2501 - 11.2503

SUBCHAPTER AA. DELEGATED ENTITIES
28 TAC §§11.2601 - 11.2612

ADOPTION OF

SUBCHAPTER A. GENERAL PROVISIONS
28 TAC §11.1, §11.2

SUBCHAPTER B. NAME APPLICATION PROCEDURE
28 TAC §§11.101, 11.102, 11.104 - 11.109

SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY
28 TAC §§11.201 - 11.207

SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO AFTER ISSUANCE OF CERTIFICATE OF AUTHORITY

28 TAC §§11.301 - 11.303

SUBCHAPTER F. EVIDENCE OF COVERAGE
28 TAC §§11.501 - 11.509, 11.511, 11.512

SUBCHAPTER G. ADVERTISING AND SALES MATERIAL
28 TAC §11.602, §11.603

SUBCHAPTER H. SCHEDULE OF CHARGES
28 TAC §§11.701 - 11.704

SUBCHAPTER I. FINANCIAL REQUIREMENTS
28 TAC §§11.801 - 11.808, 11.810, 11.811

SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS
28 TAC §§11.900 - 11.904

SUBCHAPTER K. REQUIRED FORMS
28 TAC §11.1001

SUBCHAPTER M. ACQUISITION OF, CONTROL OF, OR MERGER OF, A DOMESTIC HMO
28 TAC §§11.1201

SUBCHAPTER O. ADMINISTRATIVE PROCEDURES
28 TAC §§11.1401 - 11.1404

SUBCHAPTER P. PROHIBITED PRACTICES
28 TAC §11.1500

SUBCHAPTER Q. OTHER REQUIREMENTS
28 TAC §§11.1600 - 11.1607, 11.1610 - 11.1612

SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS
28 TAC §§11.1702 - 11.1704

SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM
28 TAC §11.1801, §11.1806

SUBCHAPTER T. QUALITY OF CARE
28 TAC §11.1901, §11.1902

SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS
28 TAC §§11.2102 - 11.2104

SUBCHAPTER W. SINGLE SERVICE HMOS
28 TAC §§11.2200 - 11.2206, 11.2208

SUBCHAPTER Y. LIMITED SERVICE HMOS
28 TAC §§11.2401 - 11.2403, 11.2405, 11.2406

SUBCHAPTER Z. POINT-OF-SERVICE RIDERS
28 TAC §§11.2501 - 11.2503

SUBCHAPTER AA. DELEGATED ENTITIES
28 TAC §§11.2601 - 11.2611

INTRODUCTION. The commissioner of insurance adopts the repeal of Title 28 TAC, Chapter 11, §§11.1 - 11.2612, relating to Health Maintenance Organizations. The commissioner also adopts a new Title 28 TAC, Chapter 11, §§11.1 - 11.2612, relating to Health Maintenance Organizations, to replace the existing chapter. The repeal is adopted without changes to the proposed text published in the October 7, 2016, issue of the *Texas Register* (41 TexReg 7810 - 7908). The department adopts the new sections with and without changes to the proposed text published in the October 7, 2016, issue of the *Texas Register* (41 TexReg 7810 - 7908). The adoption of the repeal and new sections is effective August 1, 2017.

The department adopts §§11.102 - 11.109, 11.201 - 11.203, 11.205 - 11.207, 11.302, 11.303, 11.501 - 11.505, 11.507, 11.511, 11.602, 11.603, 11.701 - 11.704, 11.801 - 11.805, 11.807, 11.808, 11.810, 11.811, 11.900, 11.904, 11.1201, 11.1401, 11.1403, 11.1404, 11.1500, 11.1602 - 11.1606, 11.1702 - 11.1704, 11.1801, 11.1806, 11.1902, 11.2101 - 11.2104, 11.2200 - 11.2206, 11.2208, 11.2401 - 11.2403, 11.2405, 11.2406, 11.2502 - 11.2503, and 11.2601 - 11.2611 without changes to the proposed text.

The department adopts §§11.1, 11.2, 11.101, 11.204, 11.301, 11.506, 11.508, 11.509, 11.512, 11.806, 11.901 - 11.903, 11.1001, 11.1402, 11.1600, 11.1601, 11.1607, 11.1610 – 11.1612, 11.1901, and 11.2501 with nonsubstantive changes from the text as proposed. The department revised §§11.1, 11.2, 11.506, 11.508, 11.509, 11.512, 11.806, 11.901, 11.902, 11.1402, 11.1600, 11.1601, 11.1607, 11.1610 - 11.1612, and 11.1901 in response to public comments.

SUMMARY OF CHANGES. The department made changes to the following sections:

Section 11.1. The department added subsection (c) to address the effective date of August 1, 2017, for the new chapter.

Section 11.2. The department changed the term "advanced practice nurses" to "advanced practice registered nurses" in §11.2(b)(21) to be consistent with statutory definitions. The department also changed "specialty hospitals" to "special hospitals" in §11.2(b)(23)(C) and §11.2(b)(47) to be consistent with statutory definitions. In addition, the department replaced the words "A licensed establishment" in §11.2(b)(47) with the words "An establishment, licensed under Health and Safety Code Chapter 241 (concerning Hospitals)."

Section 11.101. The department added a comma to correct a punctuation error.

Section 11.204. The department changed §11.204(5)(C) to refer to the requirements of 28 TAC Chapter 1, (relating to General Administration) rather than list persons who must be fingerprinted. The department corrected the capitalization in a reference to an Insurance Code section in §11.204(7)(B).

Section 11.301. The department revised §11.301(4) to clarify the department's intent that after issuance of a certificate of authority, an HMO needs to file a written request to implement or modify, and receive approval for, only the items listed in the subsection. The department also corrected the capitalization in a reference to an Administrative Code section in §11.301(1)(E) of the section and removed a superfluous comma in paragraph (4)(b)(i).

Section 11.506. The department declined to adopt the proposed requirement in §11.506(b)(1)(D) for an HMO to provide on its face page the notices required by §11.1610 and §11016.11 because it may be impractical for some HMOs. The department revised §11.506(b)(2)(B) to refer to "§11.1611" rather than "section 11.1611." The department revised 11.506(b)(2)(B) to clarify that in-network deductibles may apply only in consumer choice plans, and that out-of-network deductibles are permitted except with regard to emergency situations or other circumstances where the enrollee is unable to access an in-network provider. The department moved the phrase "unless otherwise prohibited by law" to the beginning of §11.506(b)(3)(A) for clarity. To correct a typographical error, the department inserted parentheses in §11.506(b)(12)(B) in a reference to another subparagraph in subsection (b)(12).

Section 11.508. The department revised §11.508(a) to correct a typographical error in a citation referencing §11.506 so that it correctly refers to subsection (b), and it revised §11.508(a)(2) to use the term "private duty nursing" as a more accurate term than "special duty nursing." The department also revised §11.508(d) to refer to Chapter 1507 rather than 28 TAC §§21.3515 - 21.3518 because those sections have been proposed for repeal and a reference to the chapter is more appropriate. The

department revised the first sentence of §11.508(e) to insert the words "HMO, physician, or provider" between the words "an" and "to" so that the beginning of the subsection reads "Nothing in this title requires an HMO, physician, or provider to …" This clarifies the subsection by inserting words from the repealed section that the department intended to include in the proposal, but which were inadvertently left out.

Section 11.509. The department revised §11.509(3) to add the word "coverage" to the language requiring individual and group agreements to comply with the benefit, offer, and notice requirements of Insurance Code Title 8, Subtitle E. The department revised §11.509(6) to correct a typographical error in the capitalization of words in the reference to the title of Insurance Code Chapter 1359.

Section 11.512. The department revised §11.512(10) to use the term "ventilators" rather than "respirators" because the former is the term most commonly used in coverage agreements.

Section 11.806. The department changed the word "may" to "must" at the beginning of §11.806(b) so that the section remains consistent with the intent of the current section.

Section 11.901. In §11.901(b)(4) the department added a comma to correct a punctuation error. The department made grammatical and typographical corrections to §11.901(b)(7) and (9) to correct references to the titles of statutes. The department changed the phrase "regarding electronic health care transactions as set forth in §21.3701 of this title" in §11.901(b)(10) to "regarding the requirements of §21.3701 of this title." This clarifies that the section requires the inclusion of all requirements of 28 TAC §21.3701 in physician and provider contracts, subcontracts, and arrangements, and not just those regarding authorization and eligibility transactions. The word "subcontracts" is removed from the first sentence of §11.901(c) because a contracting physician or provider can provide the required information to subcontractors.

Section 11.902. The department changed the term "advanced practice nurse" to "advanced practice registered nurse" in §11.902(5) to be consistent with statutory definitions.

Section 11.903. The department changed the word "many" to "may" in §11.903(c) to correct a typographical error.

Section 11.1001. The department added a comma to correct a punctuation error.

Section 11.1402. The department changed the first sentence of §11.1402(b) to require a notice of an application period to be published both in the public notice section of at least one major newspaper with general circulation in each of its service areas and on the HMO's website. The phrases

"if published in the newspaper" and "if published on the HMO's website" are eliminated from §11.1402(d) because requiring both forms of publication removes the need for the conditional phrasing.

Section 11.1600. The department inserted the words "together with a link to the online directory required under §11.1612(a) of this title" at the end of §11.1600(b)(12) to aid in making comparisons and informed decisions regarding health plans.

Section 11.1601. The department corrected a typographical error and changed an incorrect citation to Insurance Code §1693.003 in §11.1601(b) to be to Insurance Code §1693.002 instead.

Section 11.1607. The department revised the language of §11.1607(d) to be closer to the previous language, and to read "[i]f an HMO limits enrollees' access to a limited provider network, it must ensure that the limited provider network complies with all requirements of this section." This change makes it clear that the responsibility for compliance, and penalties for noncompliance, remains on the HMO. The department changed the term "specialty hospitals" to "special hospitals" in §11.1607(h)(2) to be consistent with statutory definitions.

Section 11.1610. The department changed the filing date for network adequacy reports from October 1 to August 15 to allow time between the required filing and the federal open enrollment period. The October 1, 2017, start date for the filing requirement before marketing any plan in a new service area is eliminated, resulting in that requirement being effective when the rule is effective. An unnecessary space was eliminated in §11.1610(c)(1) in the phrase "§1271.055 (concerning Out-of-Network Services)."

Section 11.1611. The department revised references to subsection (g) in §11.1611(a) and (b) to refer instead to subsection (e). This corrects a typographical error and addresses the deletion of proposed subsection (d). The words "contracted" and "health care" have been removed from subsection (c) as redundant and mistaken, respectively. The department did not adopt subsection (d) as proposed, and it redesignated the remaining subsections as necessary to reflect this change. The word "contracted" has been replaced with "network" in the redesignated subsection (d) for consistency, and the department also revised the subsection to include a necessary reference to subsection (c). References to proposed subsection (d) were removed from the redesignated subsections (d) and (e).

Section 11.1612. The department changed several provider references to refer to both physicians and providers for clarity. The department added the phrase "if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the

service" to the end of the notice required by §11.1612(c) to clarify a requirement relating to detrimental reliance. The department agrees with commenters that reference to an out-of-network deductible is inconsistent with §11.506(b)(2)(B) and §11.1611(d) as redesignated, and has revised the notice in subsection (c) to correct this error. The department did not adopt paragraphs (1)(B), (2), and (3) of subsection (h) as possibly being of less value than information required by the rest of the proposed section when considered in the context of an HMO plan where the consumer has protections from balance billing, and redesignated the remaining paragraphs of the subsection. The department changed the word "insurer" to "HMO" in subsection (i) to correct a clerical error. The department did not adopt subsection (k) because the proposed subsection may not have sufficient utility to justify its cost. The department declined to adopt proposed subsection (l) because it was dependent on proposed subsection (k).

Section 11.1901. The department changed the word "must" to "should" in the second sentence of subsection (a) because of the difficulty faced by some HMOs, especially those with low commercial enrollment, in convincing enrollees to participate in quality improvement programs.

Section 11.2501. The department made a nonsubstantive grammatical change to move the phrase "such as the provision of specified information to the HMO" to another location within paragraph (3).

REASONED JUSTIFICATION. The repeal and new sections are necessary to implement changes required by HB 1485 and HB 2017, 79th Legislature, Regular Session (2005); HB 1594, HB 1847, HB 1919, and SB 1731, 80th Legislature, Regular Session (2007); HB 389, HB 451, HB 806, HB 1290, HB 1357, HB 2000, HB 4290, SB 39, and SB 1771, 81st Legislature, Regular Session (2009); HB 438, HB 1405, HB 1951, HB 2292, SB 7, SB 554, and SB 1431, 82nd Legislature, Regular Session (2011); SB 365 and SB 632, 83rd Legislature, Regular Session (2013); and HB 574, HB 1514, HB 1624, SB 94, SB 332, SB 481, and SB 684, 84th Legislature, Regular Session (2015).

New Chapter 11 provides clarified rule requirements for industry and consumers; reduces the costs of reporting, compliance, and oversight for regulated entities; provides clear direction for examination requirements; and corrects numbering, codification changes, references to statutes and rules, and grammatical errors identified during the review of the repealed chapter. The new chapter

does not include definitions from the repealed chapter for terms that are not used in the rules, and does not include references to advisory committees that are no longer statutorily required.

Differences included in the chapter bring the HMO rules into alignment with the recently adopted holding company rules in 28 TAC Chapter 7, Subchapter B, and allow for modernization of filing processes, including the use of electronic formats. Other differences more closely align the handling of access plans, out-of-network claims, and disclosure requirements with those in the preferred and exclusive provider plans rules at 28 TAC §§3.3704 - 3.3711.

The department reviewed all sections of the repealed Chapter 11 to assess whether the reasons for initially adopting the sections continue to exist, in accordance with the Texas Government Code §2001.039. The department determined that in most, but not all, cases, the reasons for initially adopting the sections continue to exist. In those cases, the commissioner incorporated the provisions of those sections into the new chapter. Following its review, the department determined that the original reasons for adopting §§11.510, 11.706, 11.707, 11.1202 - 11.1206, 11.1301 - 11.1306, 11.2207, 11.2301 - 11.2315, and 11.2404 no longer exist, so the commissioner did not include the provisions of those sections in the new chapter.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received written comments from six commenters, one of whom also made oral comments. Commenters in support of the proposal with changes were: the Center for Public Policy Priorities; the Coalition for Nurses in Advanced Practice; the Office of Public Insurance Counsel; SHA, LLC d/b/a FirstCare Health Plans; the Texas Association of Health Plans; and the Texas Medical Association.

Comment on Effective Date - §11.1.

One commenter suggested that the proposed rules should apply to HMO plans issued or renewed on or after January 1, 2018. The commenter said that rates and forms for HMO plans to be issued or renewed in 2017 have already been finalized, so it would not be feasible to implement most of the rule proposed rule changes during 2017.

Agency Response to Comment on Effective Date - §11.1.

The department recognizes the difficulties imposed by rate and form preparation, but also sees the need to standardize regulations as soon as reasonably practicable. The department also appreciates the need to begin network adequacy reporting in the near future so that network adequacy may be more easily assessed. Balancing these factors, the department adopts the new Chapter 11, §§11.1 - 11.2612 and the repeal of the old chapter with the effective date of August 1, 2017. This will ensure that network adequacy reports are filed this year, but not affect the majority of plans issued or renewed in 2017.

Comment on §11.1.

One commenter noted that the statement in repealed §11.1(3)—that a violation of the lawful rules or orders of the commissioner is a violation of the Insurance Code and other applicable insurance laws of this state—is true even if not explicitly stated in the rules, and suggested that the department reinstate the language in proposed §11.1 for the purposes of clarity.

Agency Response to Comment on §11.1.

The department agrees that the statement is true even if not stated in the rules. However, the department concludes that putting the statement in the rules adds text that is not essential and declines to reinstate the language.

Comment on §11.2(b)(21).

One commenter suggested changing the term "advanced practice nurses" to "advanced practice registered nurses" to be consistent with Occupations Code §301.152, as amended in 2013.

Agency Response to Comment on §11.2(b)(21).

The department agrees to make the change to be consistent with the definition in Occupations Code §301.152.

Comment on §11.2(b)(23)(C) and §11.2(b)(47).

One commenter suggested changing the term "specialty hospitals" to "special hospitals" in §11.2(b)(23)(C) and §11.2(b)(47) to be consistent with the definition in the Texas Hospital Licensing Law at Health and Safety Code §241.003(7). The commenter also suggested replacing the phrase "A licensed

establishment" with "An establishment, licensed under Health and Safety Code Chapter 241 (concerning Hospitals)."

Agency Response to Comment on §11.2(b)(23)(C) and §11.2(b)(47).

The department agrees to make the changes to be consistent with Health and Safety Code §241.003(7) and to adopt the reference to Health and Safety Code Chapter 241 for clarity.

Comment on §11.202.

One commenter supported provisions in the new section to provide for electronic filing in this and other sections.

Agency Response to Comment on §11.202.

The department appreciates the supportive comment.

Comment on §11.204(5)(B).

One commenter noted that TDI did not include in new Chapter 11 the provision in repealed §11.204 requiring any relationship between the HMO and any affiliate or other organization in which a shareholder with 10 percent or more interest also has an interest to be clearly identified in an application for a certificate of authority. The commenter suggested that the department reinstate that provision.

Agency Response to Comment on §11.204(5)(B).

The prohibition referenced by the commenter is in Insurance Code Chapter 823. Putting the statement in the rules adds text that is not essential. The department declines to make the change.

Comment on §11.204(5)(C).

One commenter supported requiring submission of a complete set of fingerprints for each director, officer, and executive of an applicant for a certificate of authority. Another commenter suggested that filing fingerprints for each executive that is not a director or officer is unnecessary and unduly burdensome, and recommended that this requirement not be included or, alternatively, that it be limited to certain identified positions.

Agency Response to Comment on §11.204(5)(C).

The department appreciates the supportive comment. The department has a legitimate interest in investigating fitness for holding a license, authorization, certification, permit, or registration, or a person's fitness to have the ability to control licensed, registered, permitted, certificate holding, and authorized entities such as HMOs. The proposed fingerprint requirement is consistent with Chapter 53 of the Occupations Code and 28 TAC Chapter 1. The department is making an effort to standardize requirements across licensing and permitting areas in 28 TAC Chapter 1, and changes the proposed subparagraph to refer to the requirements of 28 TAC Chapter 1, (relating to General Administration) . This has the effect of continuing to require fingerprints from officers, directors, and controlling shareholders of HMOs. The department will continue to monitor its need for fingerprints and may modify the requirements in a future rulemaking.

Comment on §11.204(18).

One commenter recommended that HMOs applying for a certificate of authority not be required to include their written plan descriptions in the application.

Agency Response to Comment on §11.204(18).

The department believes that the written plan description is an important item for staff to consider when evaluating the application, and declines to make the suggested change.

Comment on §11.204(19)(B).

One commenter noted that proposed §11.204(19)(B) is much more specific than the version in the repealed section in describing what needs to be furnished in the application, and the commenter strongly supported the department's proposed additions.

Agency Response to Comment on §11.204(19)(B).

The department appreciates the supportive comment.

Comment on §11.204(27).

One commenter recommended that the department not require that copies of complaint and appeal procedures and template letters, in addition to the complaint log, be included within the application for a certificate of authority.

Agency Response to Comment on §11.204(27).

The department believes that requiring this information will speed up the process of evaluating the application and will increase the reliability of that evaluation. The department declines to make the suggested change.

Comment on §11.204(28).

One commenter recommended that "documentation of claim systems and procedures that demonstrates the HMO's ability to pay claims timely and comply with applicable claim payment statutes and rules" not be required to be included in the application, but remain as additional documents to be available for review. The commenter noted that "documentation of claims systems and procedures" is vague and overly broad.

Agency Response to Comment on §11.204(28).

The department believes that the phrasing in question is sufficiently precise, and that it can, in the event of any misunderstanding, be resolved by the department requesting further information. The department also believes that requiring this information will speed up the process of evaluating the application and increase the reliability of that evaluation. The department declines to make the suggested change.

Comment on §11.301.

One commenter supported the provisions in this and other sections that provide for electronic filing.

Agency Response to Comment on §11.301.

The department appreciates the supportive comment.

Comment on §11.301(4).

One commenter recommended that the department not implement additional new approval requirements and suggested that it maintain the informational filing requirements in the repealed section for several items. The commenter said that the department has the ability to review and take appropriate action on documents filed for information. The commenter said that an approval process unnecessarily restricts and delays an HMO's ability to implement needed changes to forms and

processes. The commenter argued that because most forms are already approved by the department and because forms and rates must also be filed with CMS, adding additional review and approval time to the filing schedule would unduly delay the process of making health plans available in the market—particularly in the case of an approval requirement for the written plan description and schedule of benefits. These requirements for approval include:

(1) in paragraph (4)(A), the written plan description and any material change in the HMO's emergency care procedures;

(2) in paragraph (4)(B), any material change in network configuration, and a resulting access plan; and

(3) in paragraph (4)(C), affiliated management agreements and the form of all contracts or subcontracts between affiliated physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees described in §11.204(14)(B), including any amendments; any change in the physical address of the books and records described in §11.205; any insurance contracts or amendments, guarantees, or other protection against insolvency, including the stop-loss or reinsurance agreements, if changing the carrier or description of coverage, between the HMO and affiliates, as described in §11.204(16); and modifications to any type of affiliate compensation arrangements, such as fee-for-service, risk sharing, or capitated risk arrangements, including any financial incentives for physicians and providers.

Agency Response to Comment on §11.301(4).

The department believes that having this information speeds up the process of evaluating the application and increases the reliability of that evaluation. The department also notes that the information requested is important to determine compliance with statutes and rules; increases the transparency of regulation; has positive effects on consumer education about benefits, rights, and responsibilities; and will improve the regulation of network adequacy. The written plan description and other information required by §11.301(4)(A), (B), and (C) are important items to consider when evaluating the application. The department declines to make the suggested changes.

Comment on §11.301(4)(C).

One commenter asked that the department clarify the application of the requirements in §11.301(4)(C) to file for approval the form of all contracts or subcontracts between affiliated physician

and provider groups, with the individual members of the groups and modifications to any type of affiliate compensation arrangements. The commenter also requested the meanings of the terms "affiliated physician and provider groups" and "affiliate compensation arrangements."

Agency Response to Comment on §11.301(4)(C).

The requirements apply to "affiliate" relationships, which are covered under Insurance Code Chapter 823 (concerning Insurance Holding Company Systems) and 28 TAC Chapter 7. Section 7.202 defines "affiliate" as "a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified," and provides that "[i]f the controlling person includes a member of the immediate family of a person, any other person that is an affiliate of the family member is deemed to be an affiliate of the controlling person." That definition covers the department's meaning in the language in question. The department declines to make the suggested change.

Comment on §11.302.

One commenter recommended that the department simplify the process and reduce the amount of information required for service area expansions and reductions (particularly reductions), and consider allowing network access plan filings be combined for affiliated HMOs and insurers using the same network.

Agency Response to Comment on §11.302.

The department believes that the information required for service area expansions and reductions is necessary to evaluate them. The department needs to have separate access plan filings for each network used by each reporting entity in order to tell if each network meets the applicable criteria. Combining filings would make this determination more difficult and less reliable. The department declines to make the suggested change.

Comment on §11.501.

One commenter recommended not adding the schedule of benefits to the list of forms that are part of the evidence of coverage and must be filed for approval.

Agency Response to Comment on §11.501.

This information is required to be part of the evidence of coverage in both the repealed and new §11.506, and must therefore be approved under the repealed and new §11.502. Changing §11.501 would not alter this requirement, and the department declines to make the suggested change.

Comment on §11.504.

One commenter objected to the provision stating that an evidence of coverage form may be disapproved if it is contrary to the law "or policy of this state" as being vague and contrary to the rulemaking requirements of the Administrative Procedures Act, which includes in the definition of "rule" in Government Code §2001.003: "a state agency statement of general applicability that ... implements, interprets, or prescribes law or policy."

Agency Response to Comment on §11.504.

The language commented on was in the repealed §11.504, and the department incorporated it without changing it. Nothing in the language is contrary to the rulemaking requirements of the Administrative Procedures Act. The department declines to make the suggested change.

Comment on §11.506(b)(1).

One commenter recommended that the notices specified by §11.1610 (relating to Annual Network Adequacy Report) and §11.1611 (relating to Out-of-Network Claims; Non-Network Physicians and Providers) not be required to be on the face page, due to a lack of space on that particular page.

Agency Response to Comment on §11.506(b)(1).

The department agrees that the inclusion of this information would create a space issue on the face page, and has not adopted proposed §11.506(b)(1)(D).

Comments on §11.506(b)(2)(B).

One commenter suggested that §11.506(b)(2)(B) should clearly state that HMOs cannot charge deductibles for an out-of-network service involving emergency care or for out-of-network services not available in the HMO's network. The commenter contended that an express prohibition on an HMO charging a deductible is imperative with regard to out-of-network claims covered by §11.1611 in order to give full effect to §11.1611(e). When combined with §11.1611(d), allowing a plan to charge a

deductible for out-of-network services addressed by §11.1611 would place the double burden on a patient of being responsible for paying his or her deductible and being solely responsible for any balance bill. This would place undue pressure on the enrollee to accept one of the facilitated referrals, even if the enrollee and his or her physician do not believe it is medically appropriate to do so.

Another commenter said that the Insurance Code provides no statutory authority for allowing deductibles only in cases involving emergency care, services that are not available in the HMO's delivery network, services performed out of the HMO's service area, or for services performed by a physician or provider who is not in the HMO's delivery network. The commenter noted that requiring an HMO benefit plan to be considered and labeled as a "consumer choice" plan in order to include a deductible creates significant consequences for the individual market in light of the federal Affordable Care Act and department rules that require the offer of a non "consumer choice" plan in the same “category” and using the same sources and methods of distribution.

Agency Response to Comments on §11.506(b)(2)(B).

With regard to the first and second commenter, the department revised §11.506(b)(2)(B) to clarify the state of the law - that in-network deductibles may apply only in consumer choice plans, and that out-of-network deductibles are permitted except with regard to emergency services or other circumstances where the enrollee is unable to access an in-network provider.

With regard to the second commenter, Insurance Code §843.982(3) generally requires an HMO to protect enrollees against these items "except to the extent of reasonable requirements for copayments." But Insurance Code Chapter 1507, Subchapter B allows for them in consumer choice plans. Because the statutory language prevents the department from permitting deductibles, it is irrelevant that this may have consequences in the individual market under federal law. Nevertheless, the department has looked at the individual plans being marketed on the federal exchanges and has observed that a number of carriers have been able to market plans without deductibles.

The department declines to make the suggested changes.

Comment on §11.506(b)(2)(C).

One commenter contended that telling an enrollee to contact the HMO if he or she receives a balance bill without telling the enrollee for what purpose is not very helpful. Instead, the commenter proposed telling a patient that he or she should contact the HMO if they receive a balance bill "because

the HMO may be responsible for making an additional payment to the non-network physician or provider in order to hold the enrollee harmless."

Agency Response to Comment on §11.506(b)(2)(C).

The department believes that the proposed language is sufficient to generally advise enrollees what they need to do about balance billing, and declines to make the suggested change.

Comment on §11.506(b)(3).

One commenter recommended against eliminating clauses (v) and (vi), arguing that while use of these provisions is extremely rare, it is necessary on occasion. The commenter recommended that the provisions be included in the rules in as they appeared in the repealed rules or with appropriate notice and process requirements.

Agency Response to Comment on §11.506(b)(3).

These are not valid reasons under Insurance Code §1271.307 or 42 USC §300gg-2 to terminate coverage, and the department is changing the proposed section to conform to existing law. The department declines to make the suggested changes.

Comment on §11.506(b)(3)(A).

One commenter proposed moving "unless otherwise prohibited by law" to the front of the subparagraph to make clear that the phrase modifies the first part of the rule allowing an HMO to cancel coverage.

Agency Response to Comment on §11.506(b)(3)(A).

The department agrees that this adds clarity, and agrees to make the suggested change.

Comment on §11.506(b)(5).

One commenter proposed more specific references to the complaint and appeal procedures in the paragraph, such as notice of adverse determination by a utilization review agent and review by an independent review organization under Insurance Code §4201.401.

Agency Response to Comment on §11.506(b)(5).

The complaint and appeal procedures are already included in the "internal adverse determination appeal and independent review procedures." Those procedures are already set out in Insurance Code Chapters 843, 4201, and 4202. The department declines to make the suggested change.

Comment on §11.506(b)(9)(F)(i).

One commenter recommended that a statement be added to the clause that non-emergent services are subject to applicable rules, authorization requirements, and reimbursement of a standard physician clinic.

Agency Response to Comment on §11.506(b)(9)(F)(i).

The language in question deals with emergency services, not non-emergent services. It requires a "description of how to obtain services in emergency situations" and defines "comparable facility." This language does not appear to require any statement regarding non-emergent services, and adding the suggested language does not add clarity. The department declines to make the suggested change.

Comment on §11.508(a)(1)(J).

One commenter recommended against expanding to include emergency transport as a part of emergency services. The commenter stated that this change would negate the ability of HMOs to negotiate fair prices with ambulance and air ambulance providers and protect enrollees from exorbitant balance bills. The commenter also stated that the vast majority of these provider types elect to remain out-of-network with all HMOs and insurers, leaving HMOs with little to no recourse for any type of negotiation after the services have been rendered.

Agency Response to Comment on §11.508(a)(1)(J).

The department anticipates that emergency transport is currently already covered by all applicable plans, and, as a result, this provision should have little or no economic impact. The department finds that consumers have a reasonable expectation that emergency transport will be covered, and this expectation is based, to some extent, on the fact that emergency transport has historically been a covered service. While the department appreciates that there are practical difficulties in resolving differences about what amounts can or should be charged, the proposed language should mitigate and not exacerbate those difficulties. Between the consumer and the HMO, which is required

to cover emergency care by Insurance Code §1271.155, the department believes that the HMO is in the better position to negotiate resolution of out of network emergency transport claims. The department declines to make the suggested change, but will continue to monitor the situation and reserves the right to make changes as necessary.

Comment on §11.508(a)(2).

One commenter suggested using the term "private duty nursing" rather than "special duty nursing" because "special duty nursing" is not a recognized medical term and is not assigned a billable CPT code; although a code has been assigned for "private duty nursing."

Agency Response to Comment on §11.508(a)(2).

The department agrees with the logic of the comment, and agrees to make the suggested change.

Comment on §11.509(3).

One commenter suggested adding the word "coverage" to the language requiring individual and group agreements to comply with the Insurance Code's benefit, offer, and notice requirements under Title 8, Subtitle E, because Subtitle E also addresses coverage for certain illnesses and procedures.

Agency Response to Comment on §11.509(3).

The department agrees with the logic of the comment, and agrees to make the suggested change.

Comment on §11.512(10).

One commenter suggested using the term "ventilators" rather than "respirators" because the former is the term used in most, if not all, coverage agreements.

Agency Response to Comment on §11.512(10).

The department agrees with the logic of the comment, and agrees to make the suggested change.

Comment on §11.703.

One commenter recommended that the proposed new actuarial memorandum requirements for rate filings (including a description and source of each actuarial assumption; a listing of retention components; the target loss ratio; a description of the experience used in developing the initial rates; and, for rate adjustments, the actual experience supporting the revised rates) not be adopted. The commenter said that extensive new requirements are likely to unreasonably hinder and delay making new products available in the market and making necessary rate adjustments. The commenter said that HMOs are already required to file extensive information with CMS in support of new and revised rates and follow specific notice requirements of rate changes.

Agency Response to Comment on §11.703.

The section is meant to include the information necessary to evaluate actuarial memoranda. Rather than delay products, the section should speed up the evaluation of actuarial memoranda by clarifying what supporting documentation is required by rule at the start of the process, instead of the department requesting additional information before filings can be processed. The department declines to make the suggested change.

Comment on §11.803.

One commenter suggested requiring evidence of financial stability as part of any HMO's request to alter its statutory deposit requirements.

Agency Response to Comment on §11.803.

This information is already available from required financial statement filings. The department sees no benefit from requiring another filing of the same information, and declines to make the suggested change.

Comments on §11.804(3)(N)(i).

Two commenters recommended against the proposed text of this clause (the "basket clause"), limiting each investment to no more than 10 percent of net worth in excess of minimum net worth "plus uncovered medical expenses." The commenters stated that the addition of uncovered medical expenses

would be a significant departure for the basket clause and could add a significant and unnecessary burden for some HMOs.

Agency Response to Comments on §11.804(3)(N)(i).

Current investments are grandfathered, and their treatment will not be changed by the section. The purpose of the section is to ensure that sufficient provision has been made to safeguard the availability of funds so that uncovered expenses can be taken care of. The department declines to make the suggested change.

Comment on §11.804(3)(N)(ii).

One commenter noted that "uncovered medical expense" is an income statement item added to the minimum net worth, a balance sheet item. The commenter recommended slightly revising the proposed section to refer to "accrued uncovered medical expense payables" or "accrued uncovered medical expense liability."

Agency Response to Comment on §11.804(3)(N)(ii).

The department believes that the wording is sufficiently clear, and declines to make the suggested change.

Comment on §11.806(b).

One commenter suggested that the rule should require, rather than permit, an HMO to: (1) specify where it maintains records adequate to identify and verify the securities belonging to the HMO; and (2) allow the insurance commissioner or designee to examine all records relating to those records, and furnish those records at the principal office of the HMO within 10 business days of a request by the commissioner or designee. The commenter noted that repealed §11.804 does this.

Agency Response to Comment on §11.806(b).

The department notes that the intent of the subsection is to continue to require HMOs to produce records. The department agrees to change the proposed wording from "may" to "must" at the beginning of the subsection to be consistent with the intent of the repealed section.

Comment on §11.808(a).

One commenter noted that the subsection removes the requirement that an HMO establish and maintain records identifying and supporting each liability it incurs, and replaces it with a requirement that an HMO account for liabilities as provided in §11.801. The commenter noted that proposed §11.801 requires an HMO to follow the National Association of Insurance Commissioners (NAIC) Accounting and Procedures Manual to the extent it does not conflict with the department's HMO rules. The commenter asked whether the NAIC standards also require the aforementioned recordkeeping by HMOs. If they do not contain the same recordkeeping requirements, then the commenter said they oppose the deletion of the record keeping requirement and recommended that the department reinstate the requirement in the rules.

Agency Response to Comment on §11.808(a).

Section 11.801 provides that, to the extent that the accounting guidance given in 28 TAC §7.18 does not conflict with the provisions of Chapter 11, an HMO must follow that guidance. In the event of a conflict between the provisions of Chapter 11 and §7.18, the HMO must follow the provisions of Chapter 11. Section 7.18 provides that Texas statutes; department rules; and directives, instructions, and orders of the commissioner preempt the NAIC manual. The department believes that the recordkeeping requirements of the NAIC Accounting and Procedures Manual require the records in question, as do Insurance Code Chapters 843 and 401. The department determines that the manual, rules, and statutes adequately address the commenter's concerns, and declines to make the suggested change.

Comment on §11.810.

One commenter suggested revising §11.810(b)(2) to provide that if a guarantee did not comply with every requirement of §11.810, the HMO would no longer qualify for the lower net worth and statutory deposit requirements as specified in current §11.1804(b), or for covered expenses and liabilities.

Agency Response to Comment on §11.810.

The guarantees referred to in the section relate to an HMO's ability to report expenses and liabilities as covered. In that context, should a guarantee not comply with the requirements of the section, it makes sense to not allow the expense or liability to be reported as covered. This would not imply an effect on net worth beyond the loss of the "covered" designation. In addition, the majority of

existing Subchapter S (§§11.1802(b) and 11.1803 - 11.1805) are deleted because the material is now regulated under Insurance Code Chapter 823 (concerning Insurance Holding Company Systems) and 28 TAC Chapter 7, so a reference to §11.1804 would not be appropriate. The department declines to make the suggested change.

Comment on §11.811.

One commenter suggested that the heading of the section is obscure and that the department should keep the heading of the repealed section to help interested parties find the relevant regulatory provisions.

Agency Response to Comment on §11.811.

The repealed section's heading is "Hazardous Conditions for HMOs." The term "hazardous condition" has specific connotations in Insurance Code Chapters 83, 406, 443, 822, 823, and 843, while §11.811 deals with actions under two specific sections, allowing action in situations beyond those implied by the term "hazardous condition." The department believes that it is more informative and less confusing to refer to those sections (Action Under Insurance Code §843.157 and Insurance Code §843.461) than to use a term that may convey an inaccurately restrictive view of the contents of the section. The department declines to make the suggested change.

Comment on §11.811(a).

One commenter suggested retaining the use of "hazardous condition(s)" instead of using "relevant circumstances concerning the HMO's operation," and indications that "action must be taken" throughout the section.

Agency Response to Comment on §11.811(a).

The section deals with actions under two specific sections, allowing action in situations beyond those implied by the term "hazardous condition." In that situation, the department believes that the use of less specific but more accurate terms, instead of "hazardous condition," is necessary. The department declines to make the suggested change.

Comments on §11.811(b).

One commenter noted that the list of items that might trigger action against an HMO by the department under the repealed section was shortened in the proposal, and encouraged the department to retain two items that constitute a "hazardous condition" under the repealed rules. The commenter specifically suggested retaining §§11.810(b)(17) (HMO pattern of denial or nonpayment of emergency care) and (19) (administrative or judicial order initiated by an insurance regulatory agency of another state, is issued against an HMO, its parent or affiliate, or a regulatory action is initiated by another agency within the state of domicile) from the repealed section. The commenter also questioned the use of the word "indirectly" in subsection (b)(6), asking if the language applies to subcontracts in an out-of-network scenario, and stating that in that case the commenter opposed the use of the word.

A second commenter suggested that some of the conditions listed in 28 TAC §8.3 are inappropriate to apply to an overall assessment of the financial condition of an HMO. In particular, the commenter argued that §8.3(a)(6), "an insurer's unassigned surplus has a deficit which is in excess of 20 percent of surplus," is inappropriate for application to HMOs due to the nature of HMOs' business operations and manner by which HMOs have been allowed to operate over the past 40 years. The commenter recommended that the department not add the conditions listed in 28 TAC §8.3 to those putting an HMO in a potentially hazardous condition for which the department can take action. The commenter stated that §8.3 has several ratio tests that are more restrictive than those currently used for HMOs, particularly the surplus ratio test of 4:1, which may be difficult for HMOs to meet. The commenter also suggested that such provisions may not be enforceable under 42 USC §300e-10, which invalidates a state's attempt to apply insurance company solvency and capital requirements to HMOs if it prevents an HMO from doing business because "that State by law, regulation, or otherwise … requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency."

Agency Response to Comments on §11.811(b).

Repealed subsections (b)(17) and (19) are covered by 28 TAC §8.3(36) and (39), and so do not need to be included in the new subsection. The use of the word "indirectly" in subsection (b)(6) refers to third parties under contract with an HMO, and would not apply to out-of-network situations.

With regard to the second comment, the department notes the difficulty caused by reliance on the "hazardous condition" language. The rule provides that the commissioner may—not will—take

action under Insurance Code §843.157 or §843.461 if conditions listed in §11.811 or §8.3 exist. This implies that the commissioner's decision to act or not act is fact-specific. That does not amount to preventing an HMO from doing business and does not violate 42 USC §300e-10. The 4:1 ratio test mentioned by the commenter is in the NAIC standards, and appears to apply to life insurers. It should not be an issue in the context of HMOs.

The department declines to make the suggested changes.

Comment on §11.901.

One commenter noted that the term "arrangement" has been in the existing HMO rules for years, and stated that it assumed that its use in §11.901(a) - (d) means an express "agreement." The commenter stated that if the department intended a different meaning, the commenter opposed the application of hold-harmless provisions being extended in that fashion.

Agency Response to Comment on §11.901.

The department agrees that the term "arrangement" has been in use for years, and notes that in the context of the section, it is meant to cover agreements with physicians and providers. The department is not attempting here to extend "hold harmless" provisions beyond that point, or to preclude out-of-network physicians and providers from balance billing.

Comment on §11.901(a)(3).

One commenter suggested language to allow in-network physicians to collect out-of-pocket amounts like the amount of a deductible or in-network coinsurance directly from an enrollee if the HMO may charge enrollees for those amounts.

Agency Response to Comment on §11.901(a)(3).

Insurance Code §843.982(3) generally requires an HMO to protect enrollees against out-of-pocket amounts "except to the extent of reasonable requirements for copayments." However, Chapter 1507, Subchapter B allows for them in consumer choice plans. Because of the differences between the different plans, the department believes that the current “supplemental charges or copayments” is appropriate. The department declines to make the suggested change.

Comment on §11.901(b)(10).

One commenter suggested replacing the phrase "electronic health care transactions" in §11.901(b)(10) with the phrase "electronic health care requirements" to make it clear that the section requires the inclusion of all requirements of 28 TAC §21.3701 in physician and provider contracts, subcontracts, and arrangements, not just those regarding authorization and eligibility transactions.

Agency Response to Comment on §11.901(b)(10).

The department agrees that this was its intent, and agrees to make the suggested change by replacing the phrase "regarding electronic health care transactions as set forth in §21.3701 of this title" with "regarding the requirements of §21.3701 of this title."

Comment on §11.901(b)(11).

One commenter encouraged the department to remove the requirement that contracts and arrangements between HMOs and physicians and providers include an express provision "requiring the preferred provider to comply with all applicable requirements of Insurance Code §1661.005 (concerning Refunds of Overpayments)." If the department retains the language of the proposed rule, this commenter encouraged the department to require language requiring HMOs to comply with Insurance Code §843.350 as well.

Agency Response to Comment on §11.901(b)(11).

HMOs are required to comply with Insurance Code §843.350 even if that requirement is not restated in §11.901, while TDI has no direct authority to enforce §1661.005. Thus, including §1661.005 in the required contract provisions is necessary, but including §843.350 is not. The department declines to make the suggested change.

Comment on §11.901(b)(12).

One commenter encouraged the department to retain the repealed language giving an HMO discretion to require a contracting physician or provider to retain updated information concerning a

patient's other health benefit plan coverage rather than mandating that HMOs impose such a requirement.

Agency Response to Comment on §11.901(b)(12).

The department notes that this information is already available, and providing for its retention helps ensure that up-to-date information is available for purposes of prompt payment, coordination of benefits, and other matters. The department declines to make the proposed change.

Comment on §11.901(c).

One commenter encouraged the department to retain the language from the repealed section specifying that failure to comply with §11.901(c)(4) constitutes a violation of Insurance Code Chapter 843, Chapter 11, and applicable insurance laws and regulations of this state that apply to HMOs. The commenter stated that it was important that physicians and HMOs should be aware that noncompliance carries penalties.

Agency Response to Comment on §11.901(c).

The statement about violations is true even if not stated in the rules, and in this case including the statement would add text that is not essential. The department declines to make the suggested change.

Comment on §11.901(c).

One commenter recommended not expanding the requirement that HMO provider contracts be required to include provisions entitling the physician or provider (on request) to "all information necessary to determine that the physician or provider is being compensated in compliance with the contract" to apply to subcontracts and "arrangements." The commenter noted that the term "arrangements" is not defined. The commenter maintained that subcontracting physicians and providers should rely upon the contracting physicians or providers to provide the information.

Agency Response to Comment on §11.901(c).

As noted in response to the previous comment on §11.901, the term "arrangement" has been in use for years, and in the context of this section, it is meant to cover agreements with physicians and providers. The department agrees that it will generally be more practical for physicians and providers to

provide the required information to their subcontractors, rather than requiring the HMO to do so. The department agrees to strike the word "subcontracts" from the first sentence of §11.901(c).

Comment on §11.901(c)(7).

One commenter recommended that the department amend the paragraph to clarify that a physician or provider who receives requested reimbursement calculation information under the proposed section may terminate the contract on or before the 30th day after receiving the information (without penalty or discrimination in participation in other health care products or plans) only if the termination is based on the newly received information. The commenter said that providers have taken advantage of this "loophole" to avoid agreed termination notice provisions in provider contracts.

Agency Response to Comment on §11.901(c)(7).

While the department appreciates the commenter's concerns, the department has not observed this behavior in the past. The department declines to make the suggested change, but will monitor this issue and may address it in the future should the need arise.

Comment on §11.902(5).

One commenter suggested that the term "advanced practice nurses" be changed to "advanced practice registered nurses" to be consistent with Texas Occupations Code §301.152, as amended in 2013.

Agency Response to Comment on §11.902(5).

The department agrees to make the change to be consistent with the definition in Occupations Code §301.152.

Comment on §11.903.

One commenter suggested that the department include a provision that prohibits an HMO from terminating participation of a physician or provider solely because the physician or provider informs an enrollee about the full range of physicians and providers available to the enrollee, including out-of-network providers. The commenter noted that Insurance Code §843.306(f) contains the prohibition, but neither the current nor proposed sections include it. The commenter suggested that the section should

include this language to ensure the public and regulated community are made more fully aware of its scope and application.

Agency Response to Comment on §11.903.

The department agrees that Insurance Code §843.306(f) contains the prohibition, and notes that the prohibition is effective whether or not the rules repeat it. The department believes that in this case, repeating the prohibition would add bulk to the rules without significantly making the public and regulated community more aware of the statutory prohibition. The department declines to make the suggested change.

Comments on §11.1402(b).

One commenter supported the proposed change to allow website publishing rather than newspaper notices.

A second commenter encouraged the department to require HMOs to publish the notice of an application period to physicians and providers both by newspaper and on the HMO's website, noting that publication on the HMO's website is not even minimal public outreach. That commenter urged that the publication be for a minimum of 10 days rather than five days, and supported requiring that the notice be filed with the department.

Agency Response to Comments on §11.1402(b).

The department agrees that the newspaper publication requirement should be continued in addition to the required website publication, in order to effectively reach out to physicians and providers who want to contract with HMOs, especially given the small effort and expense required for the latter, and the department agrees to make that suggested change. The department believes that the five-day publication requirement is sufficient. The department declines to make the suggested change to the duration of publication.

Comment on §11.1402(d).

One commenter supported the extended filing period for notices required by the new section, but recommended that HMOs not be required to file the notices; instead making the notices available to the department. Another commenter urged that the filings continue, and urged eliminating the phrases "if published in the newspaper" and "if published on the HMO's website."

Agency Response to Comment on §11.1402(d).

The department believes it is appropriate to continue to require positive proof of publication, and declines to change that requirement. The department agrees to eliminate the phrases "if published in the newspaper" and "if published on the HMO's website" in §11.1402(d), because requiring both forms of publication removes the need for the conditional phrasing.

Comment on §11.1600.

One commenter encouraged the department to retain the repealed section's prohibition against the use or distribution of enrollee information that is untrue or misleading, both to inform the public and to clarify the department's oversight authority.

Agency Response to Comment on §11.1600.

Insurance Code §843.204 contains the prohibition requested by the commenter, which is effective whether or not the rules repeat it. The department believes that repeating the prohibition would add bulk to the rules without significantly making the public and regulated community more aware of the statutory prohibition. The department declines to make the suggested change.

Comments on §11.1600(b).

One commenter recommended that the department not implement additional new approval requirements and maintain the repealed informational filing requirements for written descriptions of plan terms and conditions. The commenter said that the department has the ability to review and take appropriate action on documents filed for information, and an approval process unnecessarily restricts and delays an HMO's ability to implement needed changes to forms and processes. The commenter recommended that the department not implement the additional new approval requirements. The commenter argued that because most forms are already approved by the department and forms and rates must also be filed with CMS, adding additional review and approval time to the filing schedule will unduly delay the process of making health plans available in the market; particularly in the case of an approval requirement for the written plan description and schedule of benefits.

The items of concern to the commenter include:

(1) in (4)(A), the written plan description and any material change in the HMO's emergency care procedures;

(2) in (4)(B), any material change in network configuration, and any resulting access plan; and

(3) in (4)(C),

(a) affiliated management agreements and the form of all contracts or subcontracts between affiliated physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees described in §11.204(14)(B), including any amendments;

(b) any change in the physical address of the books and records described in §11.205;

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

(d) modifications to any type of affiliate compensation arrangements, such as fee-for-service, risk sharing, or capitated risk arrangements, including any financial incentives for physicians and providers.

A second commenter strongly supported requiring HMOs to file a plan description for approval by the commissioner.

Agency Response to Comments on §11.1600(b).

The department appreciates the support for the proposed language.

The department believes that having the information mentioned by the first commenter will speed up the process of evaluating an application and increase the reliability of that evaluation. The department also notes that the information requested is important to determine compliance with statutes and rules; increases the transparency of regulation; has positive effects on consumer education about benefits, rights, and responsibilities; and will improve the regulation of network adequacy. The written plan description and other information required by §11.301(4)(A), (B), and (C) are important items to consider when evaluating the application. The department declines to make the suggested changes.

Comment on §11.1600(b)(2).

One commenter suggested that the department require that HMOs include a link in a plan description to the directory of contracting physicians and health care providers.

Agency Response to Comment on §11.1600(b)(2).

The department agrees that a link should be required to aid in making comparisons and informed decisions regarding health plans. The department agrees to make the suggested change by inserting the words "together with a link to the online directory required under §11.1612(a) of this title" at the end of §11.1600(b)(12), which seems a more appropriate place to put this requirement.

Comment on §11.1600(b)(6)(C).

One commenter encouraged the department to require that an HMO's plan description provide that the enrollee should contact the HMO if he or she receives a balance bill, explain the purpose of that contact, and state that the HMO may be responsible for making an additional payment to the non-network physician or provider in order to hold the enrollee harmless.

Agency Response to Comment on §11.1600(b)(6)(C).

The department believes that the language is sufficient to generally advise enrollees about balance billing in the context of the required disclosures concerning health benefit plans, and it declines to make the suggested change.

Comment on §11.1601(b).

One commenter encouraged the department to replace an incorrect reference to Insurance Code §1693.003 in the proposed section with a reference to Insurance Code §1693.002.

Agency Response to Comment on §11.1601(b).

The department agrees that the citation is incorrect, and has changed the reference to Insurance Code §1693.002.

Comment on §11.1606.

One commenter requested confirmation that the requirement that clinical directors be full-time employees allows individual physician directors to perform some duties for affiliated HMOs and insurers.

Agency Response to Comment on §11.1606.

The section requires an HMO to "have a full-time clinical director." This does not imply that one person could be a full-time clinical director for multiple entities.

Comment on §11.1607(a) - (c).

One commenter supported the department's proposal to adopt §11.1607(a) - (c) with language largely unaltered from what was in the repealed section.

Agency Response to Comment on §11.1607(a) - (c).

The department appreciates the supportive comment.

Comment on §11.1607(d).

One commenter encouraged the department to retain the language of repealed §11.1607(d) instead of the new language in order to impose the compliance duty on the HMO and to subject the HMO to penalties for non-compliance. The commenter stated that the language "the limited provider network must comply with all requirements under this section" may place the compliance duty on an entity other than the HMO.

Agency Response to Comment on §11.1607(d).

The department did not intend to alter the responsibility for compliance. The department agrees to modify the language to be closer to the original language, and to read "[i]f an HMO limits enrollees' access to a limited provider network, it must ensure that the limited provider network complies with all requirements of this section" to make it clear that responsibility for compliance and penalties for noncompliance remains on the HMO.

Comment on §11.1607(e).

One commenter supported the department's proposal to leave the subsection largely unaltered from the version in the repealed section.

Agency Response to Comment on §11.1607(e).

The department appreciates the supportive comment.

Comment on §11.1607(f).

One commenter supported the department's proposed language and said that it would strongly oppose any weakening of this provision, as it is an important basic network adequacy requirement.

Agency Response to Comment on §11.1607(f).

The department appreciates the supportive comment.

Comments on §11.1607(g).

One commenter supported the new language and said that it would strongly oppose any weakening of this provision as it is an important basic network adequacy requirement.

A second commenter suggested aligning the subsection with the U.S. Department of Health & Human Services' proposal for Medicaid managed care organization appointment wait times and mileage standards.

A third commenter supported the department's decision to not expand the network adequacy mileage requirement in §11.1607(h) to ensure in-network access to local providers. This commenter instead encouraged the department to reduce the existing mileage requirements so that HMO network adequacy is measured by distances of not greater than 15 miles in non-rural areas and 30 miles in rural areas for primary care and general hospital care. This commenter also encouraged the department to reduce the distance applicable to specialty care, special hospitals and single healthcare service plan physicians and providers to 45 miles, rather than 75 miles.

Agency Response to Comments on §11.1607(g).

The department appreciates the supportive comments. There is a developing framework on the federal side that has not yet been tested, and the standards in the adopted rules are adequate and the same as in the NAIC Model. The department prefers at this point to continue with the Texas framework that is clearly understood, but will continue to monitor the situation. The department declines to make the suggested changes.

Comment on §11.1607(h)(2).

One commenter suggested that the term "specialty hospitals" be changed to "special hospitals" to track the definition in the Texas Hospital Licensing Law at Health and Safety Code §241.003(7), which defines a hospital to include "a general hospital and a special hospital."

Agency Response to Comment on §11.1607(h)(2).

The department agrees to make the suggested change to be consistent with Health and Safety Code §241.003(7).

Comment on §11.1607(j).

One commenter encouraged the department to develop "an explicit set of criteria to enable a waiver analysis and approval" if §11.1607(j) is intended "to act as an extended waiver from the application of the network adequacy requirements."

The commenter encouraged the department to retain the three bases for approval of an access plan from the repealed rule in order to limit the "acceptable reasons for HMO failure to satisfy the network adequacy standards."

The commenter encouraged the department to require an "HMO to file, along with the access plan, the contact information (i.e., phone number, email and mailing address) of the list of physicians and providers within the relevant service area that the HMO attempted to contract with so that [the department] can vet the accuracy of the HMO plan's representations regarding the necessity of an access plan."

The commenter suggested that the HMO should be required to identify by name" the particular staff person of the physician or providers, if any, to whom the HMO reached out for contract negotiations (as well as that person's contact information)."

The commenter encouraged the department to require the "estimate of total claims cost savings per year that the HMO anticipates will result from using an access plan instead of contracting with physicians or providers located within the service area, and its impact on premium," which the department included in the informal working draft originally shared with the public.

Agency Response to Comment on §11.1607(j).

An access plan is an HMO's plan, subject to the department's approval, to ensure that the HMO's enrollees have access to all the medically necessary care from physicians and providers needed to ensure a network's adequacy when certain types of contracted physicians or providers do not meet the objective standards established in §11.1607(b) - (h). An access plan is not a waiver of those standards and does not relieve an HMO from providing medically necessary care to enrollees. In fact, there are limited circumstances under which a filed access plan can be considered by the department for approval. Those limited circumstances are:

(1) when there are no available providers within the service area;

(2) when there are no providers in the area that meet the minimum quality of care and credentialing requirements of the HMO; or

(3) when the available providers within the service area have refused to contract with the HMO.

An access plan must disclose the information required in §11.1607(j) for the department to determine whether the network meets the objective adequacy standards without an access plan for one of the reasons listed above. The department cannot approve an incomplete access plan or one that does not demonstrate the required circumstances.

The access plan requirements in Chapter 11 have been in place since 1998 without change and recognize that, in a geographic area the size of Texas, all required physicians and providers may not be located throughout the state, and physicians and providers are independent contractors who are not mandated to contract with HMOs.

Similarly, the statute and rules for Preferred Provider Benefit Plan (PPBP) and Exclusive Provider Benefit Plan (EPBP) products require access plans so that enrollees have access to medically necessary care and to ensure network adequacy. For those products, the access plan, accompanied by a waiver request, must be filed with and approved by the department in accordance with the process contained in the PPBP and EPBP rules authorized by Insurance Code §1301.0055(3) and set out in 28 TAC §3.3707.

The rulemaking authority in Insurance Code §843.102(c) provides the statutory authority for access plans for HMOs. The adopted language increases the documentation necessary for an access plan to include a list of the physicians and providers within the relevant service area with whom the HMO attempted to contract, identified by name and specialty or facility type with:

(1) a description of how and when the HMO last contacted each physician, provider, or facility; and

(2) a description of the reason each physician, provider, or facility gave for declining to contract with the HMO.

The access plan requirements have been increased in the new sections to add the additional elements noted above, which serve to increase and not weaken the access plan review process.

If an HMO has a material change in the network configuration, and that material change results in the HMO's inability to comply with the network adequacy standards set forth in §11.1607(b) - (h), the HMO must file an access plan in compliance with §11.301(4)(B)(i) and (ii).

It is not clear to the department that including the suggested language "HMO should be required to identify by name the particular staff person of the physician or providers, if any, to whom the HMO reached out for contract negotiations (as well as that person's contact information)" would be useful at this time. It would also be an additional requirement not contemplated in the formal proposal, and therefore no parties would have an opportunity to comment on it.

An HMO must provide all covered services and the services must be accessible and available so that travel distances from any point in its service area are no greater than 30 miles for primary care and general hospital care, or 75 miles for specialty care, special hospitals, and single healthcare services plan physicians or providers. Emergency care and urgent care must be available at all times. Enrollees with routine medical conditions must be able to access care within three weeks. Enrollees with routine behavioral health conditions must be able to access care within two weeks. Preventative services for children must be available within two months, and preventative health services for adults must be available within three months.

Currently, as with PPBP and EPBP plans, if an HMO does not meet this criteria, it can reduce its service area, or it may submit an access plan to demonstrate how it will provide care to enrollees in the event there is a lack of contracted providers available to ensure that enrollees have access to all the medically necessary care to ensure the plan's network adequacy. The department can only approve an access plan if an HMO demonstrates that it meets network adequacy standards; therefore, an HMO with an approved access plan is not subject to additional enforcement actions for things addressed under the access plan. If an HMO refuses to reduce its service area or to submit an access plan, the department would, and does, take enforcement action.

The access plan is a required filing and is subject to requirements for HMO form filings that include a 30-day date by which the filing is deemed approved. However, no HMO access plan has defaulted to approved status under this provision.

The language that required "an estimate of total claims cost savings per year that the HMO anticipates will result from using an access plan instead of contracting with physicians or providers located within the service area, and its impact on premium" was not included in the formal proposal because there would be no impact on premium for HMOs since all HMOs have closed networks. The PPBP and EPBP rules have this language because there might be an impact on premium if more claims

were from out-of-network providers. The plan's cost would go down and, in theory, the enrollee's costs would also go down. That has not happened.

The department declines to make the suggested changes.

Comments on §11.1607(j)(4).

One commenter suggested that reducing or eliminating member balance billing might cause certain providers to opt out of network participation because there will be no incentive for them to contract. The commenter stated that this provider disincentive will negatively impact network adequacy and cause higher premiums or out-of-pocket expenses on individual or group renewal.

A second commenter objected to the inclusion of a "hold harmless" requirement, suggesting that if the rules mandate that an HMO hold a member harmless, non-network providers will likely refuse to accept the usual and customary rate or agree to any amount less than their full billed charges, which would virtually eliminate the HMO's ability to negotiate an agreed amount as provided for in Insurance Code §1271.055 and §1271.155.

A third commenter objected to "hold harmless" language, stating that the Insurance Code provides no statutory authority for a requirement that an HMO must hold enrollees harmless from balance billing.

Agency Response to Comments on §11.1607(j)(4).

With regard to the first two commenters, the department is not convinced that reducing or eliminating balance billing will cause providers to opt out of network participation, and believes they will have an incentive to participate in networks because of the benefits of network contracts, such as prompt pay requirements. Additionally, the alternative would be to leave consumers unprotected from balance bills through no fault of their own – situations where network providers were not available and emergency situations. Such protection is why health coverage is purchased. Finally, since existing statutory provisions and longstanding department practice require HMOs to hold their enrollees harmless for these charges, the impact of the section on actual practice should be minimal.

With regard to the third commenter, the department maintains that its long-standing interpretation of an HMO's obligation to an enrollee based on Insurance Code §1271.055, coupled with the Legislature's knowledge of this interpretation for at least a decade and lack of action to change the interpretation, supports the language in the rule. If an HMO is unable to contract with a sufficient

network of providers, it may reduce its service area in order to avoid the "hold harmless" requirement. If it declines to reduce its service area, the department does not believe that the enrollee in a closed network product should bear any burden associated with the HMO's failure to contract for necessary services.

The department declines to make the suggested changes.

Comment on §11.1607(k).

One commenter supported the requirement that an HMO must submit an access plan along with the annual network adequacy report.

Agency Response to Comment on §11.1607(k).

The department appreciates the supportive comment.

Comment on §11.1607(m).

One commenter supported provisions allowing an HMO to make arrangements with physicians or providers outside the HMO's service area to provide enrollees access to a higher level of care or specialty than the enrollee would otherwise receive within the service area.

Agency Response to Comment on §11.1607(m).

The department appreciates the supportive comment.

Comments on §11.1610.

One commenter suggested that the current preferred provider benefit plan network adequacy reporting system is ineffective, and suggested that the department delay implementation of this system with respect to HMOs until it is able to reform the preferred provider benefit plan side to create a process that requires insurer compliance and provides information that is accessible and usable by the public.

A second commenter encouraged the department to require HMOs to file an annual network adequacy report and supported §11.1610 with modifications.

A third commenter supported the requirement for HMOs to file an annual network adequacy report.

A fourth commenter recommended not adopting an annual network filing for HMOs, noting that networks are reviewed during the triennial examination process and during any service area expansion or reduction filings. The commenter also requested that the department consider allowing network access plan filings be combined for affiliated HMOs and insurers using the same network.

Agency Response to Comments on §11.1610.

The department declines to make the change suggested by the first commenter. The network adequacy reporting system is far from ineffective, and the department has seen significant changes in behavior from rule changes, resulting in a higher level of compliance. There is a clear need to act now rather than wait, since inaction will delay gains in network access.

The department appreciates the second and third commenters' supportive comments, and it addresses the second commenter's suggested modifications in response to comments on §11.1610(a), (c), and (d).

The department declines to make the changes suggested by the fourth commenter. Triennial examinations are not frequent enough to enable the department to assess compliance with the continuous requirement for network adequacy. Each network needs to stand on its own. If reporting across affiliated insurers and HMOs is combined, there would be no way to determine whether a particular HMO's network meets the applicable criteria.

Comments on §11.1610(a).

One commenter contended that a filing date on or before October of each year is too late in the year for the department to make an assessment of the adequacy of a plan's networks before the federal open enrollment period, which begins on November 1. The commenter noted that in the informal HMO rule proposal, the department proposed for the deadline to be on or before August 1 of each year. The commenter advocated a filing window of August 1 – August 15 of each year. The commenter strongly supported the requirement for a plan to file a network adequacy report before marketing any plan in a new service area. The commenter recommended that the department strike the language specifying an October 1, 2017, start date for that requirement. The commenter was concerned that the October 1, 2017, date would create a gap in which an HMO could market a plan in a new service area between the effective date of the new HMO rules and October 1, 2017, without filing a network adequacy report in advance, thereby escaping effective oversight by the department. The commenter suggested that the

department would not have access to the very basic network demographic information contained in the annual network adequacy report.

Another commenter suggested that annual report filings be due on April 1 each year, if they are required at all.

Agency Response to Comments on §11.1610(a).

The department appreciates the support for the requirement for a plan to file a network adequacy report prior to marketing any plan in a new service area.

The department agrees that an October due date for annual filings is too late, and an April 1 due date is too early. The department changes the due date for filings to August 15 of each year. By requiring filings on August 15, the department can more efficiently utilize resources, spread the workload across the year, and ensure filings are reviewed in a more timely fashion.

The department agrees that a gap between the effective date of the proposed rules and October 1, 2017, would be inadvisable. The department agrees to eliminate the October 1, 2017, start date for the filing requirement before marketing any plan in a new service, resulting in that requirement becoming effective when the rule does.

Comment on §11.1610(b).

One commenter strongly supported proposed §11.1607(b), without modification, which requires the network adequacy report to include an access plan, if applicable, that complies with the requirements of the title.

Agency Response to Comment on §11.1610(b).

The department appreciates the supportive comment.

Comment on §11.1610(c).

One commenter recommended that the reporting period in §11.1610(c) be for the preceding 12 months rather than the preceding calendar year, noting that if the filing date is late in the year (for example, in October), the data submitted to the department will be of limited utility because of the age of the data. The commenter supported the department's move toward reporting the information under the proposed subsection based on geographic regions within the service area. The commenter sought clarification from the department about what out-of-network benefits §11.1610(c)(1) would cover and

why it was necessary. The commenter suggested limiting §11.1610(c)(3) to complaints by non-network physicians and providers concerning payment for out-of-network services, adding a category for complaints by enrollees concerning the same matter, adding a category for complaints about the referral facilitation process, and adding a catchall report of other complaints about other network adequacy requirements.

Agency Response to Comment on §11.1610(c).

The department appreciates the supportive comments. The reporting of data on an annual basis best meets the department's needs to review and compare network data and allows time for HMOs to compile and report the data. The data specified in §11.1610(c)(1) would cover any out-of-network benefits not reported under §11.1610(c)(2), such as those based on enrollee choice or Point-of-Service options, and will aid the department in assessing the extent of network availability. The subsection requires the reporting of data that will satisfy the department's current need for information. The department is not convinced that expanding the data collection would be helpful at this time, and will continue to monitor the situation and assess the utility of the data being collected. The department declines to make the suggested changes.

Comment on §11.1610(d).

One commenter recommended that the department promptly develop a standard form and format for the annual network adequacy report, rather than developing such a form later.

Agency Response to Comment on §11.1610(d).

The department appreciates the suggestion, but is still evaluating its data requirements and is not yet ready to adopt a standardized reporting form. The department will continue to work on this matter, but declines to make the suggested change at this point.

Comment on §11.1610(e).

One commenter stated that it supported the department's authority to order an HMO that is failing to meet regulatory standards to reduce its service area, cease marketing in parts of the state, and cease marketing entirely and withdraw from the HMO market. The commenter was concerned that the language in subsection (e) only permits the department to issue a cease and desist order if both the network and any access plan supporting the network fail to meet the applicable criteria. The commenter

urged the importance of only sparingly allowing the use of access plans if the department moves forward with this language. The commenter also stated that if an HMO fails to comply with the terms of its access plan, it should be subject to all available sanctions.

Agency Response to Comment on §11.1610(e).

The department appreciates the supportive comment. The department will only approve an access plan if no provider is available or none will contract. Further, the orders available under the subsection would, by definition, only come into play if both a network and any supporting access plan fail to meet the applicable criteria. If this is not the case, services should be available, and no cease and desist order would be necessary. The department further notes that subsection (f) expressly provides that the section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code. The department declines to change the subsection.

Comments on §11.1611.

One commenter stated that while it did not oppose, in theory, the department's desire to clarify requirements applicable to HMOs for proper payment of certain out-of-network claims, the commenter was concerned that the framework offered by the department: (1) may create some confusion for HMO enrollees who need to understand their HMO's responsibility to hold them harmless; (2) lacks an express clarifying statement that the payment issued in accordance with a methodology specified in subsection (g) does not automatically discharge an HMO's obligation to hold an enrollee harmless; and (3) in some instances allows HMOs to avoid their statutory obligation to hold HMO enrollees harmless. The commenter suggested a number of changes to deal with its expressed concerns. The commenter also submitted objections to another commenter's possible suggestions that the department apply mediation to out-of-network claims involving HMOs.

A second commenter said that the department's proposed rules will hopefully help limit the number of HMO enrollees who have to file a complaint to benefit from existing protections or who pay balance bills a plan should cover.

A third commenter recommended that the section track the statutory provisions in Insurance Code §1271.055 and §1271.155, and that the section should not expand application of statutory requirements.

Agency Response to Comments on §11.1611.

The department appreciates the supportive comment. The department does not believe that the changes suggested by the first commenter are necessary, and it believes that the proposed language adequately addresses the issue. The department does not believe that the rule expands the application of statutory requirements. With regard to suggestions that the department apply mediation to out-of-network claims involving HMOs, the department notes that the section does not contain such a provision, and that this is an issue that might be more appropriately raised before the Legislature because TDI does not generally regulate providers and there is currently no statutory requirement for a provider to participate in mediation in the HMO context. The department does not believe that the section expands the application of statutory requirements, and declines to make the suggested changes.

Comments on §11.1611(a).

One commenter encouraged the department to clarify an HMO's obligation to compensate a non-network physician or provider under circumstances that suggest the enrollee did not actively choose a non-network option, and suggested that the subsection should require an HMO to fully reimburse physicians and providers other than facility-based ones. The commenter suggested that the department strike the qualifying language "as described in subsection (g)" from the subsection so that HMOs would not inappropriately believe they had satisfied their obligations merely by complying with subsection (g).

A second commenter generally supported the subsection, but expressed concern that more explicit instructions should be provided to consumers about their obligations regarding payment and their ability to contact their HMO about balance bills.

Agency Response to Comments on §11.1611(a).

The department appreciates the supportive comment. The department does not believe that the changes suggested by the first commenter are necessary, and believes that the proposed language adequately addresses the commenter's concerns.

The reference in the proposal to subsection (g) is a typographical error. The reference should instead have been to subsection (f), which deals with the amount of payment. Subsection (g), by contrast, describes the methodology used to calculate reimbursements, and should not confuse HMOs about the amount of reimbursement required. As adopted, the subsection is corrected to refer to

subsection (e) instead of subsection (g). Proposed subsection (f) has been redesignated as subsection (e) in this adoption order because proposed subsection (d) was not adopted and the remaining subsections in the section have been redesignated as appropriate. The department believes that subsection (e) is sufficiently clear, and is not inclined at this point to require more explicit instructions to consumers. The department will continue to monitor compliance and complaints to ensure that the subsection is followed as intended. The department declines to make the suggested changes.

Comment on §11.1611(b).

One commenter strongly supported the inclusion of the word "fully" in the subsection, stating that it believes that this continues the department's long-standing policy, of which the Legislature has had notice for at least the past decade. The commenter strongly encouraged the department to remove the "in a non-network facility" language, which it believes limits the application of the subsection more than Insurance Code §1271.155 and lacks statutory authority. The commenter suggested the deletion of the language "until the enrollee can be reasonably expected to transfer to a network physician" as limiting an HMO's responsibility more than permitted by Insurance Code §1271.155. The commenter suggested that the department strike the qualifying language "as described in subsection (g)" from the subsection so that HMOs would not believe they had satisfied their obligations merely by complying with subsection (g).

Agency Response to Comment on §11.1611(b).

The department appreciates the supportive comment. The department notes that the language in the subsection is intended to cover emergency care received at a non-network facility, while care received at a network facility would be covered by subsection (a). The combination of the two subsections satisfies the requirements of Insurance Code §1271.155. The language in the subsection regarding transfer complies with Insurance Code §1271.155, because the definitions of "emergency care" in Insurance Code §843.002(7) and §1201.060 involve the onset of conditions of such severity, including severe pain, and that the absence of immediate medical care could reasonably be expected to result in: (1) placing the individual's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of a bodily organ or part. These definitions would no longer apply at the point where an enrollee can reasonably be expected to transfer to a network physician or provider.

The reference in the proposal to subsection (g) is a typographical error. The reference should instead have been to subsection (f), which deals with the amount of payment. Subsection (g), by contrast, describes the methodology used to calculate reimbursements, and should not confuse HMOs about the amount of reimbursement required. As adopted, the subsection is corrected to refer to subsection (e) instead of subsection (g). Proposed subsection (f) has been redesignated as subsection (e) in this adoption order because proposed subsection (d) is being deleted and the remaining subsections in the section are redesignated as appropriate. The department declines to make the suggested changes.

Comments on §11.1611(c).

One commenter generally supported the subsection, but recommended changes that it said would more closely track the language of Insurance Code §1271.055 and not lower the level of review. The commenter suggested removing the words "contracted" as redundant and "health care" as unintentional. The commenter also suggested shortening the time to approve referral to a non-network physician or provider from five days to three days after receipt of reasonably requested documentation, providing for a review conducted by a specialist of the same license and same or similar specialty, and inserting a requirement specifying the reimbursement of the non-network physician or provider.

A second commenter suggested that subsection (c)(2) be revised to provide for a review by "a health care provider (or their representative) with expertise in the same or a similar specialty," stating that this would enable HMOs to reach out to network providers to determine if they can meet the needs of the member, and that a requirement to use board-certified specialists for each review is prohibitively expensive.

Agency Response to Comment on §11.1611(c).

The department appreciates the supportive comment.

The department has determined that the remainder of the language sufficiently tracks Insurance Code §1271.055 and Chapter 4201, both of which cover the review contemplated in the subsection. The department believes that a five-business-day time limit for referral is reasonable and is limited by the "within the time appropriate to the circumstances … but in no event to exceed" language in the subsection. The department does not see the utility of including additional language in the subsection regarding a review governed by Insurance Code Chapter 4201. The department does not believe it

necessary to again include a requirement specifying the reimbursement of the non-network physician or provider in the subsection. The department agrees to remove the words "contracted" as redundant and "health care" as redundant and mistaken, respectively, but declines to make the remainder of the suggested changes.

With regard to the second commenter's suggestion, the department believes that the subsection already embodies enough flexibility and does not require the use of board-certified specialists for each review. The department declines to make the changes suggested by the second commenter.

Comments on Proposed §11.1611(d).

One commenter opposed the subsection for reasons of public policy and as being a new exemption from the provisions of Insurance Code §1271.055(b)(2), and recommended changes to it providing for referrals to physicians only, concerning the application of subsections (c) and (e) – (h) of the section, and requiring payment at the usual and customary billed charge.

A second commenter stated that the subsection was a provision that does not work for preferred or exclusive provider benefit plans and should not be adopted for HMOs. The second commenter stated that it was not aware of the process contemplated by the subsection ever taking place with PPO or EPO plans, and thought that it was an unrealistic scenario. The commenter stated that HMOs may be able to negotiate a single case agreement with one non-network provider for a referral, but that it is not feasible to do so with three.

A third commenter suggested that requiring plans who facilitate a referral to a non-network provider to give the referring provider at least three names of non-network preferred physicians or providers could significantly delay the referral and access to needed care.

Agency Response to Comment on Proposed §11.1611(d).

The department agrees to strike subsection (d) from the section as unadvisable at this time, and revises and redesignates the remaining subsections to reflect this change.

Comments on Proposed §11.1611(e).

One commenter encouraged the department to revise the language to ensure that the HMO's "hold harmless" responsibility applies in proposed subsection (e) even where an enrollee goes outside

the HMO's referral. The commenter suggested that the language require an HMO to hold an enrollee harmless rather than to “ensure” an enrollee is held harmless to clarify that the requirement is on the HMO alone, and not the physician. The commenter also suggested that the department use the word "network" rather than "contracted" for consistency inside the section.

A second commenter suggested, as it did in relation to §11.1607(j)(4), that a "hold harmless" provision might cause certain providers to opt out of network participation as there will be no incentive for them to contract, and this provider disincentive would negatively impact network adequacy and cause higher premiums or out-of-pocket expenses on individual or group renewal.

A third commenter strongly supported the "hold harmless" language in proposed §11.1611(e), noting that the Legislature has not acted since 2005 to change the department's long-standing interpretation of the HMO Act as protecting consumers from balance billing when out-of-network care is unavoidable. The commenter suggested that making the department's long-standing interpretation explicit in the rule would not make it harder for HMOs to contract with hospital-based physicians or other providers because they already understand the department's interpretation.

A fourth commenter objected to the inclusion of a "hold harmless" requirement for the reasons it advanced in objecting to one in §11.1607(j), claiming the requirement lacks statutory authority.

Agency Response to Comments on Proposed §11.1611(e).

The department concludes that the first change suggested by the first commenter is unnecessary because of the elimination of proposed subsection (d) from the adopted text, and declines to make that suggested change. The department believes that the subsection as written will result in enrollees being held harmless, and declines to make the second requested change. The department agrees to strike the word "contracted" and substitute "network" for consistency.

With regard to the second commenter, the department is not convinced that reducing or eliminating balance billing will cause providers to opt out of network participation, and believes they will have an incentive to participate in networks because of the benefits of network contracts, such as prompt pay requirements. Additionally, the alternative would be to leave consumers unprotected from balance bills through no fault of their own – situations where network providers were not available and emergency situations. Such protection is why health coverage is purchased. Finally, since existing statutory provisions and longstanding department practice require HMOs to hold their enrollees

harmless for these charges, the impact of the section on actual practice should be minimal. The department declines to make the change requested by the second commenter.

The department appreciates the third commenter's support for the proposed subsection and agrees that the department's interpretation of an HMO's obligations to an enrollee based on Insurance Code §1271.055, coupled with the Legislature's knowledge of this interpretation for at least a decade and lack of action to change the interpretation, supports the language. For the same reasons, the department declines to make the change suggested by the fourth commenter.

The subsection is redesignated as subsection (d) because of the elimination of the proposed subsection (d) from the adopted text, and a reference to subsection (d) is removed from it.

Comments on Proposed §11.1611(f).

One commenter suggested amending the subsection to require that an explanation of benefits provided by an HMO to an enrollee after the HMO pays a non-network physician or provider for services provided under subsection (a), (b), (c), or proposed (d) inform the enrollee that the enrollee is not required to pay the provider any amount beyond their copayments, coinsurance, and deductible amounts.

A second commenter encouraged the department to fully inform enrollees of the respective responsibilities of the HMO and the enrollee with regard to payment for out-of-network services received under the statutory exceptions in the proposed subsection.

A third commenter recommended that the department adopt specific and clear language that can be used by HMOs on Explanations of Benefits (EOBs) when the plan initially pays an amount that has not been agreed to in advance in order to satisfy the requirements of the subsection.

A fourth commenter recommended that the rule track the language of Insurance Code §1271.155 rather than stating that an HMO must issue payment "to the non-network physician or provider" at the usual and customary rate or at a rate agreed to by the HMO and the non-network physician or provider.

Agency Response to Comments on Proposed §11.1611(f).

The department believes that the subsection is sufficiently clear, and is not inclined at this point to follow the suggestions of the first three commenters to require more explicit instructions to consumers or to change the requirements for explanations of benefits. The department will continue to

monitor compliance and complaints to ensure that the subsection is functioning as intended. The department concludes that the change suggested by the fourth commenter does not add clarity to the subsection, which complies with the statute. Additionally, the payment and notice requirements of this section track the same requirements, based on the same statutory language, found in §3.3725, for exclusive provider benefit plans. The department declines to make the suggested changes.

The subsection is redesignated as subsection (e) because of the elimination of proposed subsection (d) in the adopted text, and a reference to subsection (d) is removed from the redesignated subsection.

Comment on Proposed §11.1611(g).

One commenter requested that the department clarify that the language in the subsection applies to both emergency care and covered services not available from network physicians. The commenter asked that the department amend the subsection to clarify that the "usual and customary rate" to which the rule is referring is the "usual and customary charge." The commenter suggested that the department strike the language relating to claims data. The commenter also suggested that, should the department retain the language in the proposed subsection relating to claims data, the department make it clear that claims data must be based on billed charges. The commenter requested clarification that the language in the proposed subsection is not intended to satisfy the "hold harmless" requirement or allow HMOs to circumvent it, and stated that it opposed the language and that if the language was so intended, it suggested changes stating that subsection (g) applies to both emergency care and covered services not available from non-network physicians and stating that the usual and customary rate is the same as the usual and customary charge,.

Agency Response to Comment on Proposed §11.1611(g).

The language in the subsection applies to covered services not available from network physicians or providers, including in cases of emergency. The department believes that the language relating to claims data may be a useful way for HMOs to produce evidence of a usual and customary rate, and declines to change that language. The language regarding claims data refers to "usual and customary billed charges" and clearly anticipates that the data be based on charges actually billed, not some other measure. The proposed subsection describes the methodology used to calculate reimbursements, and it should not confuse HMOs about the amount of reimbursement required. The

HMO statutes, like the exclusive provider benefit plan provision in Insurance Code §1301.0052 and §1301.0053, reference a usual and customary rate, not a usual and customary charge. This section, like the section in the preferred and exclusive provider benefit plan rules, §3.3725, requires payment at the usual and customary rate. An HMO's statutory "hold harmless" obligation, which has been enforced by the department for many years, is not adversely affected by the proposed subsection, and the department does not believe that additional language regarding this obligation is needed at this point. The department declines to make the suggested changes.

The subsection is redesignated as subsection (f) because of the elimination of proposed subsection (d) from the adopted text.

Comment on §11.1612(a).

One commenter generally supported the subsection, but suggested adding the specialty of the physician to the list of information required to be provided and shortening the time frames for updating the directory to two to five business days after the occurrence of certain events.

Agency Response to Comment on §11.1612(a).

The department appreciates the supportive comment. The department believes that it will be useful, at least initially, to have consistency between the HMO rules and the preferred and exclusive provider benefit plan rules. The section provides that directories must be updated not less than once each month, consistent with Insurance Code §1451.505. The department declines to make the suggested changes at this time.

Comments on §11.1612(c).

One commenter suggested revising the subsection to point out that the HMO must hold the enrollee harmless in certain situations, and that the HMO must tell the enrollee to contact it if the enrollee receives a balance bill in those situations or if the enrollee relied on inaccurate directory information. The commenter also suggested that the department, if it has not done so already, should implement a complaint response system that is able to identify and expedite network adequacy complaints so consumers will be able to resolve the issue and access care as quickly as possible.

A second commenter generally supported the subsection, with changes. The commenter recommended adding all physician and provider listings, including any web-based physician and

provider listings, to the list of locations that must contain the notice for use by current and prospective enrollees. The commenter recommended that the department add "physician" to each reference regarding providers to make it clear that physicians are included in the notice. The commenter also recommended that the department delete the "in most cases" language from the notice if the department deletes the "loss of hold harmless" exception from §11.1611(d)(3).

The second commenter said that the subsection states that the enrollee may be responsible for paying "any applicable … out-of-network deductible." The commenter stated that it understands that the language is qualified by "any applicable;" thus, it may or may not apply. The commenter said that it appreciated that, if the department is going to permit the HMO to charge a deductible on the out-of-network services when an enrollee seeks emergency care or a network provider is unavailable, the recognition that the non-network physician has a right to collect that payment from the enrollee. The commenter noted that if the department prohibits a plan from charging the enrollee an out-of-network deductible in §11.506(b)(2)(B) for emergency care and services when a network physician is not available, then one would think that the out-of-network deductible amount language should be stricken. The commenter asked what would be the applicable coinsurance in this instance.

The second commenter recommended modifications to the notice bullet regarding provider directories to track the language from the notice provision when a network physician is not available, since the rules contemplate the same remedies. The commenter noted that its concerns with the deductible and coinsurance language extend to this language as well.

The second commenter recommended that the department adopt two new paragraphs at the end of the mandatory notice explaining to enrollees their rights and remedies when relying on materially inaccurate physician or provider listings, as well as steps to take to avail themselves of those rights. The commenter contended that the addition of this language to the HMO mandatory disclosure notice would make the detrimental reliance provision in subsection (g) much more meaningful to consumers.

A third commenter supported the language in the notice required by §11.1612(c) that indicates that HMOs must generally ensure enrollees pay only cost sharing if they received out-of-network services involuntarily.

Agency Response to Comment on §11.1612(c).

An HMO's statutory "hold harmless" obligation is not adversely affected by the subsection, and the department does not believe that additional language regarding this obligation is needed at this point. The department declines to make the changes suggested by the first commenter at this time. The department has already implemented a complaint response system that is able to identify and expedite network adequacy complaints so consumers will be able to resolve the issue and access care as quickly as possible.

With regard to the second commenter, the department believes that adding the notice to all physician and provider listings is likely to be confusing and unhelpful. The department declines to make the suggested change. The department agrees to change provider and physician references in the proposed subsection to refer to both physicians and providers for clarity. The department declines to change the "in most cases" language because there may be situations where a "hold harmless" duty does not apply. The department declines to change the "any applicable" language with regard to deductibles because there may be cases involving the Consumer Choice statute or rules where the language is necessary. However, the department agrees that the reference to an out-of-network deductible is inconsistent with §11.506(b)(2)(B) and §11.1611(d) as redesignated, and has revised the notice to correct this error. The department agrees that it would be useful to add language to the notice that the department believes encapsulates the commenter's concerns about reliance, and proof of reliance, on current and materially inaccurate directory information. But the department believes it would be simpler and more effective to add "if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service" to the end of the notice required by the proposed subsection.

The department appreciates the third commenter's supportive comment.

Comment on §11.1612(d).

One commenter supported the subsection's requirement that HMOs provide notice to all enrollees at least annually describing how the enrollee may access a current listing of all network physicians and providers on a cost-free basis. The commenter also recommended that the department amend §11.1612 to require a nonelectronic copy of the directory to be updated not less than once each month.

Agency Response to Comment on §11.1612(d).

The department appreciates the supportive comment. The department notes that monthly updates to a nonelectronic copy of the directory are already required by Insurance Code §§843.201, 843.2015, and 1451.505, and that requirement does not need to be repeated here. The department declines to make the suggested change.

Comments on §11.1612(e).

One commenter urged the department to incorporate what it described as the very basic, yet necessary, critical and vital consumer protections contained in the subsection into the HMO rules.

A second commenter suggested that the disclosure requirement in the subsection would potentially confuse enrollees and cause unnecessary concerns. The commenter opposed requiring plans to submit reporting to enrollees at least once a year, suggesting that an online directory gives members up-to-date direct information on available providers, and the commenter said that proposed language in subsection (a) speaks to required information that will better assist enrollees in identifying providers that can provide the services needed. The commenter also noted that §11.1610, relating to Annual Network Adequacy Report, requires plans to submit an annual adequacy report to demonstrate the plan is meeting minimum adequacy standards.

A third commenter strongly supported the subsection.

A fourth commenter recommended that the proposed subsection not be adopted because it would provide little or no value with disproportionate burden and cost.

Agency Response to Comments on §11.1612(e).

The department appreciates the supportive comments.

The department does not believe that the subsection's disclosure requirements would confuse enrollees and cause unnecessary concerns or that yearly disclosure is inappropriate. The department sees this as an issue of the transparency that is necessary to enable enrollees to make intelligent choices about their coverage and their care, and notes that not all of the information required is found in online directories. The value of the information is well in excess of any cost to provide it. The department declines to make the changes suggested by the second and fourth commenters.

Comment on §11.1612(f).

One commenter strongly supported the subsection as a vital consumer protection measure.

Agency Response to Comment on §11.1612(f).

The department appreciates the supportive comment.

Comments on §11.1612(g).

Two commenters supported the subsection.

Agency Response to Comments on §11.1612(g).

The department appreciates the supportive comment.

Comments on §11.1612(h).

Two commenters supported the subsection.

A third commenter recommended not adopting the subsection because it would provide little or no value with disproportionate burden and cost. The commenter objected in particular to additional listing-specific disclosure requirements, particularly proposed paragraphs (1)(B), (2), (3), (4), (8), (9), and (10), which it maintains are overly burdensome.

Agency Response to Comments on §11.1612(h).

The department appreciates the supportive comments.

The department does not believe that the disclosure requirements in the subsection are overly burdensome. The department sees this as an issue of the transparency that is necessary to enable enrollees to make intelligent choices about their coverage and their care, and notes that not all of the information required is found in online directories. The value of the information is, in most cases, well in excess of any cost to provide it. However, the department agrees to not adopt proposed paragraphs (1)(B), (2), and (3) as possibly having less value than information required by the rest of the proposed section when considered in the context of an HMO plan where the consumer has protections from balance billing. As adopted, subparagraph (1) is rewritten to incorporate (1)(A). The remaining paragraphs of the subsection are redesignated as appropriate. The department declines to make the remaining changes suggested by the third commenter.

Comment on §11.1612(i).

One commenter strongly supported the subsection, but urged the department to require the provision of either a copy of the access plan itself or information on how to immediately access an electronic version. The commenter also suggested changing the word "insurer" to "HMO."

Agency Response to Comment on §11.1612(i).

The department appreciates the supportive comment. The department does not agree that changing the information required would result in significant consumer protections, and declines to make that change. The department agrees to correct the error and change the word "insurer" to "HMO."

Comments on §11.1612(j).

One commenter supported the subsection.

A second commenter supported the subsection, but urged that the phrase "or providers" be deleted from subparagraph (J)(2)(a), because it would allow an HMO to circumvent the notice requirements if alternative contracted providers of the same specialty as the physician group that terminates its contract were made available to enrollees. The commenter stated that this is not an appropriate substitute for physicians of that specialty and would entirely defeat the purpose of the provision. The commenter also recommended that the section be further amended to require an HMO to not only post notice on its website and update its web-based contracted provider listings on substantial decreases of facility-based providers, but also to notify the department at the same time. The commenter contended that this notification would aid the department in monitoring HMO compliance with the provisions of this subsection and would help with network adequacy in general.

Agency Response to Comments on §11.1612(j).

The department appreciates the supportive comments.

The department does not believe that Insurance Code Chapter 4201 would permit the kind of substitution suggested by the commenter, or that the subsection circumvents that chapter. The point of the required updates is to advise enrollees, and the department does not believe that additional notification to the department is necessary, although the department will continue to monitor the situation. The department declines to make the suggested changes.

Comments on Proposed §11.1612(k).

Two commenters supported the proposed subsection.

A third commenter recommended not adopting the proposed subsection because it provides little or no value with disproportionate burden and cost. The commenter noted that the status of a network can change on any day after coverage documents are issued, rendering the AHCN designation untimely, inaccurate, and unbeneficial. The commenter said that if there is a gap in a network based on a lack of a licensed hospital within an area, such a designation would be misleading.

Agency Response to Comment on Proposed §11.1612(k).

The department appreciates the supportive comments, but also agrees that the proposed subsection may not have sufficient utility for consumers in the context of an HMO plan with strict network adequacy requirements and protections from balance billing by out of network providers to justify its cost, and agrees to not adopt it.

Comment on Proposed §11.1612(l).

One commenter supported the subsection.

A second commenter supported the subsection with amendments to correct a citation and decrease the time a plan may remain noncompliant.

Agency Response to Comment on Proposed §11.1612(l).

The department appreciates the supportive comment, but has not adopted it because it was dependent on subsection (k), which has not been adopted.

Comment on §11.1806.

One commenter encouraged the department to clarify whether the section also applies to Managed Care Organizations (MCOs) participating in the Children's Health Insurance Program (CHIP) or explicitly state that the section does not apply to those MCOs.

Agency Response to Comment on §11.1806.

Since it contains no exemption, the section applies to MCOs participating in CHIP.

Comment on Subchapter T, §11.1901 and §11.1902.

One commenter noted that Insurance Code §843.102(d) requires only "quality assurance program minutes" be made available to the commissioner, and encouraged the department to require the availability of an HMO's annual Quality Improvement (QI) plan required under §11.1901(b)(3); minutes from meetings under §11.1901(b)(4); annual written report under §11.1902(3); minutes and findings from meetings under §11.1901(c)(1)(B); the written QI program description under §11.1902(1); the annual QI work plan under §11.1902(2), to the extent that it is a distinct plan from the "annual QI plan" under §11.1901(b)(3); and the credentialing, site visit, and peer review procedures required under §11.1902(4), (5), and (6).

Agency Response to Comment on Subchapter T, §11.1901 and §11.1902.

The items are confidential under Insurance Code §843.102, and the department declines to make the suggested changes.

Comment on §11.1901.

One commenter recommended that the department not require a QI program to include "the active involvement of one or more enrollee(s) who are not employees of the HMO," because HMOs, especially those with low commercial enrollment, often find it very difficult to convince enrollees to participate in the QI program.

Agency Response to Comment on §11.1901.

The commenter's concerns represent a common problem, and the department agrees to change the word "must" to "should" at the end of subsection (a) so that it is not an absolute requirement.

Comment on Subchapter AA, §§11.2601 - 11.2611.

One commenter asked that the department confirm and clarify that the provisions of this subchapter apply only to delegated entities as defined in the Insurance Code.

Agency Response to Comment on Subchapter AA, §§11.2601 - 11.2611.

The subchapter applies to delegated entities as defined in the Insurance Code and to entities bound by the provisions of Insurance Code Chapter 1272.

Chapter 11. Health Maintenance Organizations

28 TAC §§11.1 - 11.2612

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER A

28 TAC §11.1 and §11.2

STATUTORY AUTHORITY. The commissioner adopts the repeals under Health and Safety Code §62.054; Insurance Code §§36.001, 38.001, 401.056, 404.005, 423.004, 423.104, 441.005, 541.401, 823.002, 823.012, 843.009(f), 843.051(g), 843.076, 843.080(a) and (b), 843.082, 843.102, 843.112, 843.151, 843.154, 843. 002, 843.2015, 843.251(b), 843.404, 843.406(b), 844.004, 1271.004(a) and (d), 1271.151, 1271.152, 1271.306(c), 1271.307(c), 1272.001, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055, 1367.105, 1367.154, 1367.207, 1368.007, 1369.0543, 1369.057, 1451.254, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1467.001, 1467.003, 1501.002, 1501.010, 1507.002, 1507.009, 1507.059, 4201.002, 4201.003, and 4201.057(d); and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a

hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section, and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §823.002 provides definitions for terms used in Insurance Code Chapter 823.

Insurance Code §823.012 provides, in relevant part, that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.009(f) provides that the commissioner adopt rules, consistent with the section, relating to applications under the section and consideration of those applications that the commissioner considers advisable.

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the

commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system, and administer matters relating to the complaint system.

Insurance Code §843.404 provides that the commissioner may adopt rules, or by rule establish guidelines, requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMO's investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §1271.004(a) defines "Individual Health Care Plan."

Insurance Code §1271.004(d) provides that the commissioner may adopt rules necessary to implement §1271.004 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital; and provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.057 provides that the commissioner may adopt rules necessary to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1467.001 provides definitions for use in Insurance Code Chapter 1467, including a definition of "facility-based physician."

Insurance Code §1467.003 provides that the commissioner, the Texas Medical Board, and the chief administrative law judge adopt rules necessary to implement their respective powers and duties under Chapter 1467.

Insurance Code §1501.002 provides definitions for terms used in Insurance Code Chapter 1501.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to: (1) implement Chapter 1501; and (2) meet the minimum requirements of federal law, including regulations.

Insurance Code §1507.002 provides definitions for terms used in Insurance Code Chapter 1507.

Insurance Code §1507.009 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter A.

Insurance Code §1507.059 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter B.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

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

Insurance Code §4201.057(d) provides that the commissioner adopt rules for appropriate verification and enforcement of compliance with §4201.057(c).

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

TEXT.

SUBCHAPTER A. GENERAL PROVISIONS

§11.1. Purpose.

§11.2. Definitions.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER B

28 TAC §§11.101 - 11.109

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §§32.041, 36.001, 38.001, 541.059, 541.401, 843.071, 843.076, 843.078, 843.080(a), 843.083, 843.151, and 843.154.

Insurance Code §32.041 provides that the department must furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §843.071 provides: (a) that a person may not organize or operate an HMO in this state, or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with an HMO, without obtaining a certificate of authority under Chapter 843; and (b) that

a person may not use "health maintenance organization" or "HMO" in the course of operation unless the person: (1) complies with Chapter 843 and: (A) §1367.053; (B) Chapter 1452, Subchapter A; (C) Chapter 1507, Subchapter B; (D) Chapters 222, 251, and 258, as applicable to an HMO; and (E) Chapters 1271 and 1272; and (2) holds a certificate of authority under Chapter 843.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

TEXT.

SUBCHAPTER B. NAME APPLICATION PROCEDURE.

§11.101. How To Obtain Forms.

§11.102. Information Required.

§11.104. Criteria.

§11.105. Use of the Term "HMO," Service Mark, Trademarks, d/b/a.

§11.106. Time Limits; Extension Requirements.

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

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

§11.109. Situations in Which Name Applications Will Cease.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER C

28 TAC §§11.201 - 11.207

STATUTORY AUTHORITY. The commissioner adopts the repeals under Health and Safety Code §62.054; Insurance Code §§32.041; 36.001; 38.001; 401.056; 801.056; 802.056; 803.003; 804.102; 843.002; 843.006; 843.076; 843.078; 843.079; 843.080(a) and (b); 843.082; 843.083; 843.102; 843.105; 843.151; 843.154; 843.201; 843.205; 843.251(a), (b), and (c); 843.361; 843.402, 843.404; 1271.155; 1271.251; 1272.052; 4201.152; 4201.153; 4201.154; and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §801.056 provides that the department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

Insurance Code §803.003 provides, in relevant part, for a domestic company to locate its principal offices and any part of its books, records, and accounts outside this state if the company has given notice to the commissioner and the commissioner has not disapproved the notice before the 31st day after the date on which the company has given notice and the company meets the requirements of Chapter 803.

Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and

maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.006 provides that, in general, each application, filing, and report required under Insurance Code Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapter 222, 251, or 258, as applicable to an HMO; or Chapter 1271 or 1272 is a public document.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable quality of care standards that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements for language and for providing access to enrollees who have disabilities that affect their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.402 provides for an HMO to maintain in force in its own name a fidelity bond on its officers and employees in an amount of at least $100,000 or another amount prescribed by the commissioner, prescribes the form of the bond, and provides for the substitution of a cash deposit with the comptroller in lieu of a bond.

Insurance Code §843.404 provides that the commissioner may adopt rules, or by rule establish guidelines, requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMO's investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce

charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated; and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §4201.152 provides that a utilization review agent must conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

Insurance Code §4201.153 provides that a utilization review agent must use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. The section provides requirements for utilization review determinations and screening criteria. The section further provides for the use of screening criteria and for the referral of a denial of requested treatment to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Insurance Code §4201.154 provides that a utilization review agent's written screening criteria and review procedures be made available for review and inspection to determine appropriateness and compliance as considered necessary by the commissioner and copying as necessary for the commissioner to accomplish the commissioner's duties under the Insurance Code.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

TEXT.

SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY.

§11.201. Filing Fee.

§11.202. Binding, Indexing, and Numbering Requirements.

§11.203. Revisions during Review Process.

§11.204. Contents.

§11.205. Documents To Be Available for Qualifying Examinations.

§11.206. Review of Application.

§11.207. Withdrawal of an Application.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER D.

28 TAC §§11.301 - 11.303

STATUTORY AUTHORITY. The commissioner adopts the repeals under Health and Safety Code §62.054; Insurance Code Chapter 843, Subchapter J; and Insurance Code §§32.041; 36.001; 38.001; 401.051; 401.052; 401.054; 401.056; 404.005; 423.004; 802.056; 803.003; 804.102; 843.076; 843.078; 843.079; 843.080(a) and (b); 843.082; 843.101; 843.102; 843.103; 843.105; 843.151; 843.154; 843.156; 843.201; 843.205; 843.251(a), (b), and (c); 1271.102; 1271.155; 1271.251; 1271.306(c); 1271.307(c); 1272.052; 1272.064; 1272.103; 1272.255; 1353.002; 1358.057; 1362.005; 1363.005; 1364.004; 1367.055; 1367.105; 1367.154; 1367.207; and 1369.0541.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 843, Subchapter J, provides for various matters relating to the payment of claims by HMOs to physicians and providers, including clean claims, the timing of claims and submission of claims, deadlines for action on claims, claim auditing, verification, coordination of payment, and payment for emergency care payments, and provides that the commissioner may

examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §32.041 provides that the department must furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.051 provides, in relevant part, for the department or an examiner appointed by the department to visit a carrier to examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the laws of this state that affect the conduct of the carrier's business.

Insurance Code §401.052 provides, in relevant part, for the department to visit and examine a carrier as frequently as the department considers necessary.

Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer

might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section, and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

Insurance Code §803.003 provides, in relevant part, for a domestic company to locate its principal offices and any part of its books, records, and accounts outside this state if the company has given notice to the commissioner and the commissioner has not disapproved the notice before the 31st day after the date on which the company has given notice and the company meets the requirements of Chapter 803.

Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or

documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.101 provides, in relevant part, that an HMO may provide or arrange for medical care services only through: (1) other HMOs; or (2) physicians or groups of physicians who have independent contracts with the HMOs. The section also provides that HMOs may provide or arrange for health care services only through: (1) other HMOs; (2) providers or groups of providers who are under contract with or are employed by the HMO; or (3) additional HMOs or physicians or providers who have contracted for health care services with: (A) the other HMOs; (B) physicians with whom the HMO has contracted; or (C) providers who are under contract with or are employed by the HMO. The section also provides that an HMO may provide or authorize the following in a manner approved by the commissioner: (1) emergency care; (2) services by referral; and (3) services provided outside the service area.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.103 provides, in relevant part, that an HMO may: (1) purchase, lease, construct, renovate, operate, or maintain hospitals or medical facilities and ancillary equipment and other property reasonably required for the principal office of the HMO or for another purpose necessary in engaging in the business of the HMO; and (2) make loans to a medical group, under an independent contract with the group to further its program, or corporations under its control, to acquire or construct medical facilities and hospitals, or to further a program providing health care services to enrollees. The section provides that if the exercise of a power granted under subsection (a) involves an affiliate, as described by §823.003, the HMO must file notice and adequate supporting information with the commissioner for approval before exercising that power. The section provides that the commissioner

disapprove the exercise of a power described by subsection (a) that would in the commissioner's opinion: (1) substantially and adversely affect the financial soundness of the HMO and endanger its ability to meet its obligations; or (2) impair the interests of the public or the HMO's enrollees or creditors in this state. The section provides for the commissioner to disapprove the exercise of a power within 31 days after notice is filed, with a 30 day extension.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to

an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and that if the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The section also provides for the extension of the period of time for approval or disapproval and for a hearing on the disapproval of a form.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula

or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

TEXT.

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

§11.301. Filing Requirements.

§11.302. Service Area Expansion or Reduction Applications.

§11.303. Examination.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER F
28 TAC §§11.501 - 11.513

STATUTORY AUTHORITY. The commissioner adopts the repeals under Civil Practice and Remedies Code Chapters 140 and 171; Insurance Code Title 8, Subtitle E; Insurance Code Chapter 4201, Subchapters H and I; and Insurance Code §§32.041, 36.001, 521.102, 541.059, 541.401, 542.057, 843.151, 843.154, 843.201, 843.2071, 1201.062, 1203.002, 1203.003, 1203.052, 1203.053, 1203.054, 1271.005, 1271.006, 1271.051, 1271.101, 1271.102, 1271.103, 1271.104, 1271.151, 1271.152, 1271.153, 1271.154, 1271.155,

1271.201, 1271.251, 1271.253,1271.304, 1271.306, 1271.307, 1354.002, 1356.005, 1358.054, 1358.055, 1358.056, 1358.057, 1359.003, 1362.003, 1362.004, 1362.005, 1363.003, 1363.004, 1363.005, 1364.004, 1367.053, 1367.054, 1367.055, 1367.105, 1367.153, 1367.154, 1367.207, 1369.054, 1369.0541, 1369.0542, 1369.0543, 1369.0544; 1369.055, 1369.056, 1369.057, 1451.254, 1451.255, 1451.256, 1451.257, 1451.258, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1503.003, 4201.002, and 4201.003.

Civil Practice and Remedies Code Chapter 140 provides for subrogation rights for the issuer of a plan that provides benefits under which the policy or plan issuer may be obligated to make payments or provide medical or surgical benefits to or on behalf of a covered individual as a result of a personal injury to the individual caused by the tortious conduct of a third party.

Civil Practice and Remedies Code Chapter 171 provides for arbitration agreements.

Insurance Code Title 8, Subtitle E, provides for benefits payable under health coverages.

Insurance Code Chapter 4201, Subchapter H, provides for the appeal of adverse determinations.

Insurance Code Chapter 4201, Subchapter I, provides for the independent review of adverse determinations.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §1201.062 provides that an individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide certain coverage for children and grandchildren.

Insurance Code §1203.002 places restrictions on coordination of benefits provisions in evidences of coverage.

Insurance Code §1203.003 provides that a provision of an insurance policy that violates §1203.003 is void.

Insurance Code §1203.052 allows the coordination of dental benefits between primary and secondary insurers.

Insurance Code §1203.053 prohibits certain dental coordination of benefits provisions.

Insurance Code §1203.054 provides that a provision of an insurance policy that violates §1203.053 is void.

Insurance Code §1271.005 provides that: (a) Chapters 1368 and 1652 apply to an HMO other than an HMO that offers only a single health care service plan; (b) Chapter 1355, Subchapter B, applies to an HMO providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that: (1) Chapter 1355, Subchapter B, does not conflict with Chapter 1271, Chapter 843, Subchapter A; Chapter 1452, or Chapter 1507, Subchapter B; and (2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the service area of the HMO and is subject to inspection and review as required by Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; or rules adopted under Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; (c) an HMO must comply with Chapter 542, Subchapter B, with respect to prompt payment to an enrollee; (d) notwithstanding any other law, Chapter 1355, Subchapter C, applies to a group contract issued by an HMO; and (e) notwithstanding any other law, §1201.062 applies to an evidence of coverage issued by an HMO.

Insurance Code §1271.006 provides for a limiting age of 25 for children and grandchildren and for benefits to an enrollee's dependent grandchild who is living with and in the household of the enrollee.

Insurance Code §1271.051 provides that: (a) an evidence of coverage that is a contract must contain a clear and complete statement of the information required by §§1271.052, 1271.053, and 1271.054; and (b) an evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by §§1271.052, 1271.053, and 1271.054.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance

or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and the commissioner does not disapprove the form before the 31st day after the date the form is filed, the form is considered approved. Section 1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.103 provides that: (a) after notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the commissioner; and (b) if the commissioner withdraws approval of a form under the section, the form may not be issued until it is approved.

Insurance Code §1271.104 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Chapter 1271, Subchapter C.

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.153 provides basic health care services provided under an evidence of coverage include periodic health evaluations for each adult enrollee, and that the section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Insurance Code §1271.154 provides, in relevant part, that an HMO must ensure that each health care plan provided by the HMO includes well-child care from birth.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271, Subchapter F.

Insurance Code §1271.304 provides constraints on the termination of group continued coverage.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

Insurance Code §1271.307 provides that an individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee, an HMO may decline to renew an individual health care plan or conversion contract only under specified conditions, and the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1354.002 provides that if a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits

for Alzheimer's disease the proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies.

Insurance Code §1356.005 provides that a health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer, and contains conditions regarding that coverage.

Insurance Code §1358.054 provides that: (a) a health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for: (1) diabetes equipment; (2) diabetes supplies; and (3) diabetes self-management training in accordance with the requirements of §1358.055; and (b) a health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under §1358.054. The section also provides that the amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

Insurance Code §1358.055 contains conditions governing the provision of diabetes self-management training.

Insurance Code §1358.056 provides that a health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1359.003 provides that: (a) a group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease; and (b) the group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.

Insurance Code §1362.003 provides that: (a) a health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer; (b) that

coverage required under the section includes at a minimum: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male who: (A) is at least 50 years of age and is asymptomatic; or (B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Insurance Code §1362.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1362; and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to administer Chapter 1362.

Insurance Code §1363.003 provides that: (a) a health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer; and (b) provides for minimum coverage required under the section.

Insurance Code §1363.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1363, and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to administer Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to administer Chapter 1364.

Insurance Code §1367.053 provides that a health benefit plan that provides coverage for a family member of an insured or enrollee must provide for each covered child from birth through the date of the child's sixth birthday coverage for certain immunizations, and defines "covered child" for the purposes of the section.

Insurance Code §1367.054 provides that coverage required under §1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement, and that this does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.153 provides that a health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1369.054 provides for notice and disclosure of certain information to enrollees and other individuals by an issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan.

Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

Insurance Code §1369.0542 provides that a health benefit plan issuer must display on a public Internet website maintained by the issuer formulary information as required by the commissioner by rule, requires a direct electronic link to the formulary information to be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the health benefit plan issuer's Internet website, and provides that the information must be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.0544 provides that a health benefit plan issuer may make the information described by 1369.0543(d)(1) available to enrollees, prospective enrollees, and others through a toll-free telephone number that operates at least during normal business hours.

Insurance Code §1369.055 provides that an issuer of a health benefit plan that covers prescription drugs must offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. The section also provides that this does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is: (1) covered under the health benefit plan; and (2) medically appropriate for the enrollee.

Insurance Code §1369.056 provides that the refusal of a health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of §4201.002 if: (1) the drug is not included in a drug formulary used by the health benefit plan; and (2) the enrollee's physician has determined that the drug is medically necessary. The section also provides that the enrollee may appeal the adverse determination under Chapter 4201, Subchapters H and I.

Insurance Code §1369.057 provides that the commissioner may adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1451.255 provides that a health benefit plan must permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist. The section provides that a health benefit plan may limit an enrollee's self-referral to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee, and makes other provisions concerning the selection of a physician to provide such care.

Insurance Code §1451.256 provides, in relevant part, that a health benefit plan must permit an enrollee who selects an obstetrician or gynecologist under §1451.255 to have direct access to the health care services of that selected physician without a referral from the enrollee's primary care physician or

prior authorization or precertification from the plan issuer. The section provides that a health benefit plan may not impose a copayment or deductible for direct access to health care services as required by the section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

Insurance Code §1451.257 provides that a health benefit plan must include in the classification of persons authorized to provide medical services under the plan a sufficient number of properly credentialed obstetricians and gynecologists.

Insurance Code §1451.258 provides that a health benefit plan issuer must provide in clear and accurate language to each person covered under the plan a timely written notice of the choices of the types of physician providers available for the direct access required under Chapter 1451, Subchapter F.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1503.003 provides for coverage of certain students by a health benefit plan.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

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

TEXT.

SUBCHAPTER F. EVIDENCE OF COVERAGE

§11.501. Forms Which Must Be Approved Prior to Use.

§11.502. Filing Requirements for Evidence of Coverage.

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

§11.504. Disapproval of an Evidence of Coverage.

§11.505. Specifications for the Evidence of Coverage and Matrix Filings.

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

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

§11.508. Mandatory Benefit Standards: Group, Individual and Conversion Agreements.

§11.509. Additional Mandatory Benefit Standards: Group Agreement Only.

§11.510. Mandatory Offers.

§11.511. Optional Provisions.

§11.512. Optional Benefits.

§11.513. Additional Information May Be Required.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER G

28 TAC §11.602 and §11.603

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code Chapter 541, Subchapters B and B-1; Insurance Code §§36.001, 541.058, 542.003, 542.004, 542.005, 542.006, 542.055, 542.056, 542.057, 542.058, 542.059, 542.060, 542.061, and 547.051.

Insurance Code Chapter 541, Subchapter B, provides the definition of unfair methods of competition and unfair or deceptive acts or practices.

Insurance Code Chapter 541, Subchapter B-1, provides requirements for advertising.

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

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in the listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it receives during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer's acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code §542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

SUBCHAPTER G. ADVERTISING AND SALES MATERIAL

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

§11.603. Filings.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER H

28 TAC §§11.701 - 11.707

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §§36.001, 843.151, 1271.251, 1271.252, 1271.253, and 1271.306.

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

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271, Subchapter F.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

TEXT.

SUBCHAPTER H. SCHEDULE OF CHARGES

§11.701. Must Be Filed Prior to Use.

§11.702. Actuarial Certification.

§11.703. Supporting Documentation.

§11.704. Charges for Individuals.

§11.705. Enrollment Fees.

§11.706. Determination of Reasonability of Rates.

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

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER I
28 TAC §§11.801 - 11.810

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code Chapter 823; and Insurance Code §§32.041, 36.001; 401.051; 401.054; 401.056; 404.003(a), (c), and (d); 404.005; 421.001(c); 423.104; 441.005; 521.102; 541.058; 541.059; 541.401; 542.003; 542.004; 542.005; 542.006; 542.055; 542.056; 542.057; 542.058; 542.059; 542.060; 542.061; 547.051; 801.056; 802.001; 823.012; 842.002(28); 843.151; 843.155; 843.156; 843.157; 843.201; 843.2015; 843.205; 843.207; 843.2071; 843.251(a), (b), and (c); 843.361; 843.401; 843.403; 843.404; 843.405; 843.406(a) and (b); and 843.461.

Insurance Code Chapter 823 provides for the regulation of insurance holding company systems.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §401.051 provides, in relevant part, for the department or an examiner appointed by the department to visit a carrier to examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the laws of this state that affect the conduct of the carrier's business.

Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.003(a) provides that if the financial condition of an insurer, when reviewed as provided by Insurance Code §404.003(b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public, the commissioner may, after notice and hearing, order the insurer to take action reasonably necessary to remedy the condition.

Insurance Code §404.003(c) provides that, in an order issued under Insurance Code §404.003(a), the commissioner may take any action the commissioner considers reasonably necessary to remedy the condition described by Insurance Code §404.003(a).

Insurance Code §404.003(d) provides that the commissioner may use the remedies available under Insurance Code §404.003(c) in conjunction with the provisions of Insurance Code Chapter 83 if the commissioner determines that the financial condition of the insurer is hazardous and can be reasonably expected to cause significant and imminent harm to the insurer's policyholders or the public.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §421.001(c) provides that the commissioner adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves for each line of insurance. Each insurer writing a line of insurance to which a formula adopted under the subsection applies must establish reserves in compliance with that formula.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001.

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in the listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it receives during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer’s acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code § 542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

Insurance Code §801.056 provides that the department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Insurance Code §802.001 provides that the commissioner may change the form of any annual statement an insurance company is required to file and that the form may require only information that relates to the business of the insurance company.

Insurance Code §823.012 provides that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823, including the conducting of business and proceedings under Chapter 823. The section further provides that the commissioner by rule establish procedures to: (1) promptly consider the prepayment notices reported under §823.053(b); (2) annually review each reported ordinary dividend paid within the 12 months preceding the date of the report; and (3) take appropriate actions authorized by the Insurance Code.

Insurance Code §843.002(28) provides that the term "uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the HMO. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment for the services except as described in the evidence of coverage issued to the enrollee under Insurance Code Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.155 provides the form and contents of annual reports HMOs must file with the commissioner.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner

considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.157 provides for the rehabilitation, liquidation, supervision, or conservation of health maintenance organizations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements for language and for providing access to enrollees who have disabilities that affect their ability to communicate or read.

Insurance Code §843.207 provides that an HMO must provide reasonable notice to its enrollees of any material adverse change in the operation of the HMO that will directly affect the enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant

concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.401 provides that a director, officer, member, employee, or partner of an HMO who receives, collects, disburses, or invests funds in connection with the activities of the HMO is responsible for the funds in a fiduciary relationship to the enrollees.

Insurance Code §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §843.406(a) provides that if the financial condition of an HMO indicates that the continued operation of the HMO could be hazardous to its enrollees or creditors or the public, the commissioner may, after notice and opportunity for hearing: (1) suspend or revoke the HMO's certificate of authority; or (2) order the HMO to take action reasonably necessary to correct the condition, including: (A) reducing by reinsurance the total amount of present and potential liability for benefits; (B) reducing the volume of new business being accepted; (C) reducing expenses by specified methods; (D) suspending or limiting for a period the writing of new business; or (E) increasing the HMO's capital and surplus by contribution.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §843.461 provides for the commissioner’s power to maintain enforcement actions against HMOs.

TEXT.

SUBCHAPTER I. FINANCIAL REQUIREMENTS

§11.801. Minimum Net Worth.

§11.802. Statutory Deposit Requirements.

§11.803. Investments, Loans, and Other Assets.

§11.804. Investment Management by Affiliate Companies.

§11.805. Fiduciary Responsibility.

§11.806. Liabilities.

§11.807. Dividends.

§11.808. Guarantee from a Sponsoring Organization.

§11.810. Hazardous Conditions for HMOs.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER J

28 TAC §§11.900 - 11.904

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §§36.001, 38.001, 842.002(28), 843.151, 843.203, 843.281, 843.283, 843.3045, 843.306, 843.307, 843.308, 843.309, 843.311, 843.3115, 843.312, 843.315, 843.316, 843.319, 843.320, 843.321, 843.323, 843.336, 843.361, 843.362, 843.363, 1271.201, 1271.202, 1353.001, 1353.002, 1371.003, 1451.156, and 1661.005.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §843.002(28) provides that the term "uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the HMO. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment for the services except as described in the evidence of coverage issued to the enrollee under Insurance Code Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452,

Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.203 provides, in relevant part, an enrollee the opportunity to select and change the enrollee's primary care provider or physician.

Insurance Code §843.281 prohibits retaliatory actions by HMOs against a: (1) group contract holder or enrollee because the group or enrollee or a person acting on behalf of the group or enrollee has filed a complaint against the HMO or appealed a decision of the HMO; or (2) physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO.

Insurance Code §843.283 provides that a contract between an HMO and a physician or provider must require the physician or provider to post, in the office of the physician or provider, a notice to enrollees on the process for resolving complaints with the HMO. The notice must include the department's toll-free telephone number for filing a complaint.

Insurance Code §843.3045 provides that an HMO may not refuse to contract with a nurse first assistant, as defined by Occupations Code §301.1525, to be included in the provider's network or refuse to reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

Insurance Code §843.306 provides, in relevant part, that an HMO must provide a written explanation before terminating a contract with a physician or provider, and for the right of a physician or provider to a review by an advisory review panel of the HMO's proposed termination, except in limited circumstances.

Insurance Code §843.307 provides that, on request by the physician or provider, a physician or provider whose participation in a health care plan is being terminated or who is deselected is entitled to an expedited review process by the HMO.

Insurance Code §843.308 regulates an HMO's notification of patients of the deselection of a physician or provider.

Insurance Code §843.309 provides that a contract between an HMO and a physician or provider must provide that reasonable advance notice must be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee.

Insurance Code §843.311 provides a podiatrist's right to an HMO's coding guidelines and payment schedules, prohibits HMOs from making unilateral material retroactive revisions to the coding guidelines and payment schedules, and provides that podiatrists may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the evidence of coverage.

Insurance Code §843.3115 provides, in relevant part, that a contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service.

Insurance Code §843.312 provides that an HMO may not refuse a request by a physician participating in the HMO delivery network and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Occupations Code Chapter 157, Subchapter B, to identify a physician assistant or advanced practice nurse as a provider in the network, unless the physician assistant or advanced practice nurse does not meet the quality of care standards previously established by the HMO for participation in the network by physician assistants and advanced practice nurses.

Insurance Code §843.315 governs the payment of capitation and the assignment of a primary care physician or provider by any HMO that uses capitation to any extent as a method of compensation.

Insurance Code §843.316 provides that as an alternative to the procedures prescribed by §843.315, an HMO may request approval from the department of a capitation payment system that ensures: (1) immediate availability and accessibility of a primary care physician or primary care provider; and (2) payment to a primary care physician or primary care provider of a capitated amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk assumed.

Insurance Code §843.319 provides that, notwithstanding §843.304, an HMO may not deny a contract to a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners who joins the professional practice of a contracted physician or provider, satisfies the application procedures of the HMO, and meets the qualification and credentialing requirements for contracting with the HMO.

Insurance Code §843.320 provides that a contract between an HMO and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Insurance Code §843.321 provides a physician or provider's right to an HMO's coding guidelines and the use thereof.

Insurance Code §843.323 provides that, upon request, an HMO must include a provision in the physician's or provider's contract providing that the HMO or the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim, as defined by Chapter 843, Subchapter J, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim, and that the commissioner may issue a cease and desist order against or impose sanctions on an HMO that violates the section or a contract provision adopted under the section.

Insurance Code §843.336 defines the term "clean claim."

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.362 provides, in relevant part, that each contract between an HMO and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the HMO from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence.

Insurance Code §843.363 provides, in relevant part, that an HMO may not: (a) as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to certain matters; (b) as a condition of payment with a physician, dentist, or provider, or in any other manner, require a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient; or (c) in any manner penalize, terminate, or refuse to compensate for covered services a physician, dentist, or provider for

communicating in a manner protected by the section with a current, prospective, or former patient, or a person designated by a patient. The section further provides that a contract provision that violates the section is void.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.202 provides that if an HMO denies a request under §1271.201, the enrollee may appeal the decision through the HMO's established complaint and appeals process.

Insurance Code §1353.001 provides that a managed care entity may not: (1) require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan; (2) limit an enrollee's benefits for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued; (3) provide a financial incentive to a physician to issue an immunization or vaccination protocol; or (4) impose a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1371.003 provides, in relevant part, that a health benefit plan must provide coverage for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under §§1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395l, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable.

Insurance Code §1451.156 sets forth prohibited conduct by a managed care plan.

Insurance Code §1661.005 provides that a physician, hospital, or other health care provider that receives an overpayment from an enrollee must refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. The section does not apply to an overpayment subject to §843.350 or §1301.132.

Text.

SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

§11.900. Nonprimary Care Physician Specialist as Primary Care Physician.

§11.901. Required Provisions.

§11.902. Prohibited Actions.

§11.903. Physician or Provider Communication.

§11.904. Provision of Services Related to Immunizations and Vaccinations.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER K

28 TAC §11.1001

STATUTORY AUTHORITY. The repeal is proposed under Insurance Code §§32.041, 36.001, 38.001, 541.059, 843.076, 843.078, 843.082, 843.151, 843.154, 843.405, and 1271.251.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet,

circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

TEXT.

SUBCHAPTER K. REQUIRED FORMS

§11.1001. Required Forms.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER M

28 TAC §§11.1201 - 11.1206

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code Chapter 823, Subchapters D and E; Insurance Code Chapter 824, Subchapter A; and Insurance Code §§36.001, 843.051(g), and 843.151.

Insurance Code Chapter 823, Subchapter D, contains provisions regarding the control, acquisition, merger, change, or divestiture of domestic insurers.

Insurance Code Chapter 823, Subchapter E, provides for an acquisition statement by an acquiring person.

Insurance Code Chapter 824, Subchapter A, provides for the merger and consolidation of stock insurance corporations.

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

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for

primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

TEXT.

SUBCHAPTER M. ACQUISITION OF, CONTROL OF, OR MERGER OF, A DOMESTIC HMO

§11.1201. Definitions.

§11.1202. Filing Requirements.

§11.1203. Form Filing.

§11.1204. Form A (HMO).

§11.1205. Approval by Commissioner; Hearings.

§11.1206. Exemptions.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER N

28 TAC §11.1301 - 11.1306

STATUTORY AUTHORITY. The commissioner adopts the repeals because of the repeal of Insurance Code §§843.435 - 843.440 by HB 1951, 82nd Legislature, Regular Session (2011).

TEXT.

SUBCHAPTER N. HMO SOLVENCY SURVEILLANCE COMMITTEE PLAN OF OPERATION

§11.1301. Plan of Operation.

§11.1302. Solvency Survey Committee.

§11.1303. Operations.

§11.1304. Records and Reports.

§11.1305. Appeals.

§11.1306. Conformity of Statute.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER O

28 TAC §§11.1401 - 11.1404

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §§32.041, 36.001, 38.001, 843.151, 843.154, 843.305, and 1369.402.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.305 provides, in relevant part, that an HMO providing coverage through one or more physicians or providers who are not partners or employees of the HMO, or one or more physicians or providers who are not owned or operated by the HMO, must provide a period of 20 calendar days each calendar year during which any physician or provider in a service area may, under the terms established by the HMO for the provision of services and the designation of physicians and providers, apply to participate in providing health care services.

Insurance Code §1369.402 provides that a health benefit plan issuer or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process.

TEXT.

SUBCHAPTER O. ADMINISTRATIVE PROCEDURES

§11.1401. Commissioner's Authority to Require Additional Information.

§11.1402. Notification to Providers.

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers.

§11.1404. Pharmacy Application and Recertification.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER P
28 TAC §11.1500

STATUTORY AUTHORITY. The repeal is proposed under Insurance Code §§36.001, 843.151, 843.154, and 1271.252.

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

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

TEXT.

SUBCHAPTER P. PROHIBITED PRACTICES

§11.1500. Discrimination Based on Health Status-Related Factors.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER Q
28 TAC §§11.1600 - 11.1607

STATUTORY AUTHORITY. The commissioner adopts the repeals under Business and Commerce Code Chapter 501, Subchapter A; Health and Safety Code §62.054; Insurance Code §§36.001, 843.082, 843.107, 843.108, 843.151, 843.201, 843.2015, 843.205, 843.206, 843.209, 843.361, 1369.153, 1456.003, 1693.002, 1693.003, 4054.001, and 4151.152; and Occupations Code §162.001.

Business and Commerce Code Chapter 501, Subchapter A, restricts access to, and use of, social security numbers, and provides remedies for violations.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

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

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site must list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of

the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.206 provides that an HMO must notify a group contract holder within 30 days of any substantive change to the payment arrangements between the HMO and physicians or providers.

Insurance Code §843.209 provides that an identification card or other similar document issued by an HMO to an enrollee must indicate that the HMO is regulated under the Insurance Code, and display the enrollee’s first date of enrollment and a toll-free number a physician or provider may use to obtain that date.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §1369.153 provides for the information that must be included on identification cards issued by issuers of health benefit plans.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1693.002 provides that an identification card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must, in addition to any requirement under other law, including §§843.209, 1301.162, and 1369.153, display on the card or document in a location of the issuer's choice the acronym "QHP."

Insurance Code §1693.003 provides, in relevant part, that the commissioner monitor 45 C.F.R. Section 155.20 for amendments to the definitions listed in §1693.001 and determine if it is in the best interest of the state to adopt an amended definition for purposes of Chapter 1693.

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

Insurance Code §4151.152 provides for information that must be included in identification cards issued by a plan administrator.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

TEXT.

SUBCHAPTER Q. OTHER REQUIREMENTS

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

§11.1601. Enrollee Identification Cards.

§11.1602. Access to Certain Information.

§11.1603. Notification of Change in Payment Arrangements.

§11.1604. Requirements for Certain Contracts between Primary HMOs and ANHCs and Primary HMOs and Provider HMOs.

§11.1605. Pharmaceutical Services.

§11.1606. Organization of an HMO.

§11.1607. Accessibility and Availability Requirements.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER R

28 TAC §§11.1702 - 11.1704

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §§36.001, 843.151, 844.004, 844.005, 844.053, 844.054, and 4054.001.

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

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §844.005 provides that an approved nonprofit health corporation may arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of an HMO, and is not required to obtain a certificate of authority under Chapter 844 or under Chapter 843 to arrange for or provide health care services as provided by §844.005(a).

Insurance Code §844.053 provides that the commissioner grant a provisional certificate of authority to an applicant if: (1) the applicant has applied for accreditation from an accrediting organization described by §844.052(b)(2); (2) the applicant is diligently pursuing accreditation; (3) the accrediting organization has not denied the application for accreditation; and (4) the applicant satisfies each other requirement of Chapter 844.

Insurance Code §844.054 provides that a certificate holder has all the powers granted to and duties imposed on an HMO under the insurance laws of this state, including Chapter 843, is subject to regulation and regulatory enforcement under those laws in the same manner as an HMO, and must maintain accreditation as described by §844.052(b)(2).

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person

who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

TEXT.

SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS

§11.1702. Requirements for Issuance of Certificate of Authority to ANHC.

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder.

§11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER S

28 TAC §§11.1801 - 11.1806

STATUTORY AUTHORITY. The commissioner adopts the repeals under Health and Safety Code §62.054; Insurance Code Chapter 823; and Insurance Code §§36.001, 843.078, 843.151, and 843.404.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 823 provides for the regulation of insurance holding company systems.

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

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and

Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

TEXT.

SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID

§11.1801. Entities Covered.

§11.1802. Minimum Surplus or Net Worth.

§11.1803. Statutory Deposits.

§11.1804. Guarantees.

§11.1805. Performance and Fidelity Bonds.

§11.1806. Additional Information That May be Requested From an MCO Participating in Medicaid.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER T

28 TAC §11.1901 and §11.1902

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §§36.001, 843.102, and 843.151.

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

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

TEXT.

SUBCHAPTER T. QUALITY OF CARE

§11.1901. Quality Improvement Structure for Basic and Limited Services HMOs.

§11.1902. Quality Improvement Program for Basic and Limited Services HMOs.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER V

28 TAC §§11.2101 - 11.2104

STATUTORY AUTHORITY. The commissioner adopts the repeals under Health and Safety Code §534.101; Insurance Code Chapter 843, 844, and 1271; and Insurance Code §§36.001, 843.002(18), 843.051, 843.053, 843.073, 843.079, 843.084, 843.151, 843.318, and 1271.101.

Health and Safety Code §534.101 provides definitions applicable to Health and Safety Code Chapter 534, Subchapter B-1.

Insurance Code Chapter 843 provides regulation of HMOs.

Insurance Code Chapter 844 provides for certification of certain nonprofit health corporations.

Insurance Code Chapter 1271 regulates the benefits provided by HMOs, evidences of coverage, and charges.

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

Insurance Code §843.002(18) defines "limited health care services."

Insurance Code §843.051 sets out the application of insurance and group hospital service corporation laws.

Insurance Code §843.053 provides that: (a) an HMO that contracts with a health facility or enters into an independent contractual arrangement with physicians or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26; and (b) notwithstanding any other law, a physician who contracts with one or more physicians in the process of conducting activities that are permitted by law but that do not require a certificate of authority under Chapter 843 is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26.

Insurance Code §843.073 provides that certain physicians and providers are not required to obtain a certificate of authority under Chapter 843.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.084 provides the duration of a certificate of authority.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.318 provides for certain permissible contracts entered into by physicians and providers.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

TEXT.

SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

§11.2101. Definitions.

§11.2102. General Provisions.

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

§11.2104. Minimum Standards for Community Health Centers.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER W

28 TAC §§11.2200 - 11.2208

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §§36.001, 842.002(26), 843.082, 843.083, 843.102, 843.107, 843.108, 843.112, 843.151, 843.201, 1271.002, 1271.052, 1271.101, 1271.155, and 1273.002.

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

Insurance Code §843.002(26) defines "single health care service plan."

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §1271.002 provides that: (a) each enrollee residing in this state is entitled to evidence of coverage under a health care plan; (b) an HMO must issue the evidence of coverage, except that if the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation must issue the evidence of coverage; and (c) by agreement between the HMO, insurer, or group hospital service corporation and the subscriber or person entitled to receive the evidence of coverage, policy, or contract, the evidence of coverage required by the section may be delivered electronically.

Insurance Code §1271.052 provides that an evidence of coverage must state: (1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the plan; (2) the issuance of other benefits, if any, to which the enrollee is entitled under the plan; and (3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws

governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1273.002 provides for point-of-service plans.

TEXT.

SUBCHAPTER W. SINGLE SERVICE HMOS

§11.2200. Definitions.

§11.2201. General Provisions.

§11.2202. Limitations and Exclusions.

§11.2203. Minimum Standards, Dental Care Services and Benefits.

§11.2204. Minimum Standards, Vision Care Services and Benefits.

§11.2205. Prohibited Practices.

§11.2206. Mandatory Disclosure Statements, Certification of Compliance.

§11.2207. Quality Improvement Structure and Program for Single Service HMOs.

§11.2208. Single Health Care Services Accessibility and Availability.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER X

28 TAC §§11.2301 - 11.2315

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code §36.001 and §843.151.

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

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

TEXT.

SUBCHAPTER X. PROVIDER SPONSORED ORGANIZATIONS

§11.2301. Purpose and Scope.

§11.2302. Definitions.

§11.2303. Application for Certificate of Authority.

§11.2304. Financial Plan Requirement.

§11.2305. Issuance of Certificate of Authority.

§11.2306. Solvency Standards.

§11.2307. Minimum Net Worth Amount.

§11.2308. Liquidity.

§11.2309. Deposits.

§11.2310. Guarantees.

§11.2311. Dissolution; Liquidation; Rehabilitation.

§11.2312. Reports.

§11.2313. Examinations.

§11.2314. Suspension or Revocation of Certificate of Authority.

§11.2315. Application of Other Insurance Laws.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER Y

28 TAC §§11.2401 - 11.2406

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code Chapter 1651; and Insurance Code §§36.001, 843.002(17), 843.102, 843.151, 1271.101, 1368.004, 1368.005, 1368.006, and 1368.007.

Insurance Code Chapter 1651 provides for long term care benefit plans.

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

Insurance Code §843.002(17) defines "limited health care service plan."

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent

with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1368.004 provides that a group health benefit plan must provide coverage for the necessary care and treatment of chemical dependency, and details how that coverage may be provided.

Insurance Code §1368.005 sets minimum coverage requirements under Chapter 1368.

Insurance Code §1368.006 defines "treatment series" and provides that coverage required under Chapter 1368 is limited to a lifetime maximum of three separate treatment series for each covered individual.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and

treatment were provided in a hospital, provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

TEXT.

SUBCHAPTER Y. LIMITED SERVICE HMOS

§11.2401. Definitions.

§11.2402. General Provisions.

§11.2403. Limitations and Exclusions.

§11.2404. Prohibited Practices.

§11.2405. Minimum Standards, Mental Health and Chemical Dependency Services and Benefits.

§11.2406. Minimum Standards, Long Term Care Services and Benefits.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER Z

28 TAC §§11.2501 - 11.2503

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code Chapters 541, 542, 543, 544, 547, 843, and 1273; and Insurance Code §§36.001, 843.107, 843.108; 843.151, 843.403, and 1201.211, 1201.212, 1201.213, 1201.214, 1201.215, 1201.216, and 1201.217.

Insurance Code Chapter 541 contains provisions concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices.

Insurance Code Chapter 542 regulates the processing and settlement of claims.

Insurance Code Chapter 543 contains provisions regarding prohibited practices related to policies or certificates of membership.

Insurance Code Chapter 544 contains provisions prohibiting certain forms of discrimination.

Insurance Code Chapter 547 prohibits false advertising by unauthorized insurers.

Insurance Code Chapter 843 regulates HMOs.

Insurance Code Chapter 1273 regulates Point-of-Service Plans.

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

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §§1201.211 – 1201.217 contain provisions relating to required policy provisions.

TEXT.

SUBCHAPTER Z. POINT-OF-SERVICE RIDERS

§11.2501. Definitions.

§11.2502. Issuance of Point-of-Service Riders.

§11.2503. Coverage Relating to POS Rider Plans.

REPEAL OF 28 TAC CHAPTER 11, SUBCHAPTER AA

28 TAC §§11.2601 - 11.2612

STATUTORY AUTHORITY. The commissioner adopts the repeals under Insurance Code Chapter 1271, Subchapters B and D; and Insurance Code §§36.001, 38.001, 843.151, 1272.001, 1272.051, 1272.052, 1272.053, 1272.056, 1272.064, 1272.102, 1272.103, 1272.202, 1272.203, 1272.205, 1272.206, 1272.207, and 1272.208.

Insurance Code Chapter 1272, Subchapter B, regulates delegation agreements.

Insurance Code Chapter 1272, Subchapter D, provides reserve requirements for delegated networks.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.051 provides that Chapter 1272, Subchapter B, does not apply to a group model HMO, as defined by §843.111.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated; and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.053 provides that a delegation agreement required by §1272.052 must establish a monitoring plan and sets requirements for those plans.

Insurance Code §1272.056 provides that a delegation agreement required by §1272.052 must provide that: (1) the agreement does not limit in any way the HMO's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and (2) the delegated entity must comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.102 provides that the commissioner determine the information a HMO must provide to a delegated entity with which the HMO has entered into a delegation agreement, sets requirements for that information, and provides for the information to be provided in a standard electronic format.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.202 provides that if an HMO becomes aware of information that indicates a delegated entity with which the HMO has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the HMO must in writing: (1) notify the entity of those findings; and (2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition. The section provides that the HMO must provide to the commissioner a copy of each notice and request submitted to a delegated entity under the section and each response or other documentation the HMO receives or generates in response to the notice and request.

Insurance Code §1272.203 provides that a delegated entity must respond in writing to a request from an HMO under §1272.202 not later than the 30th day after the date the entity receives the request.

Insurance Code §1272.205 provides for examinations by the department of a delegated entity and reports of those examinations.

Insurance Code §1272.206 provides that the delegated entity and HMO must respond to the department's report under §1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

Insurance Code §1272.207 provides that the department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that: (1) relate to a function delegated by the HMO to the entity; or (2) are necessary to ensure the HMO's compliance with each statutory or regulatory requirement.

Insurance Code §1272.208 provides that the commissioner may order an HMO with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the HMO is complying with Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B.

TEXT.

SUBCHAPTER AA. DELEGATED ENTITIES

§11.2601. General Provisions.

§11.2602. Definitions.

§11.2603. Requirements for Delegation by HMOs.

§11.2604. Delegation Agreements - General Requirements and Information to be Provided to HMO.

§11.2605. Delegation Agreements - Information to be Provided by HMO to Delegated Entity.

§11.2606. Reporting Requirements.

§11.2607. Examinations of Delegated Entities.

§11.2608. Department May Order Corrective Action.

§11.2609. Reserve Requirements for Delegated Networks.

§11.2610. Penalties for Non-Compliance.

§11.2611. Filing of Delegation Agreements.

§11.2612. Applicability.

CHAPTER 11. SUBCHAPTER A

28 TAC §11.1 and §11.2

STATUTORY AUTHORITY. The commissioner adopts the new sections under Health and Safety Code §62.054; Insurance Code §§36.001, 38.001, 401.056, 404.005, 423.004, 423.104, 441.005, 541.401, 823.002, 823.012, 843.002, 843.009(f), 843.051(g), 843.076, 843.080(a) and (b), 843.082, 843.102, 843.112, 843.151, 843.154, 843.2015, 843.251(b), 843.404, 843.406(b), 844.004, 1271.004(a) and (d), 1271.151, 1271.152, 1271.306(c), 1271.307(c), 1272.001, 1272.064, 1272.103, 1272.255, 1353.002, 1358.057, 1362.005, 1363.005, 1364.004, 1367.055, 1367.105, 1367.154, 1367.207, 1368.007, 1369.0543, 1369.057, 1451.254, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1467.001, 1467.003, 1501.002, 1501.010, 1507.002, 1507.009, 1507.059, §4201.002, 4201.003, and 4201.057(d), and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of

understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section, and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and

enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §823.002 provides definitions for terms used in Insurance Code Chapter 823.

Insurance Code §823.012 provides, in relevant part, that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.009(f) provides that the commissioner adopt rules, consistent with the section, relating to applications under the section and consideration of those applications that the commissioner considers advisable.

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site must list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency

of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §1271.004(a) defines "Individual Health Care Plan."

Insurance Code §1271.004(d) provides that the commissioner may adopt rules necessary to implement §1271.004 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital, provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.057 provides that the commissioner may adopt rules necessary to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1467.001 provides definitions for use in Insurance Code Chapter 1467, including a definition of "facility-based physician."

Insurance Code §1467.003 provides that the commissioner, the Texas Medical Board, and the chief administrative law judge adopt rules necessary to implement their respective powers and duties under Chapter 1467.

Insurance Code §1501.002 provides definitions for terms used in Insurance Code Chapter 1501.

Insurance Code §1501.010 provides that the commissioner adopt rules necessary to: (1) implement Chapter 1501; and (2) meet the minimum requirements of federal law, including regulations.

Insurance Code §1507.002 provides definitions for terms used in Insurance Code Chapter 1507.

Insurance Code §1507.009 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter A.

Insurance Code §1507.059 provides that the commissioner adopt rules necessary to implement Chapter 1507, Subchapter B.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

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

Insurance Code §4201.057(d) provides that the commissioner adopt rules for appropriate verification and enforcement of compliance with §4201.057(c).

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

SUBCHAPTER A. GENERAL PROVISIONS

§11.1. General Provisions.

(a) Severability. If a court of competent jurisdiction holds that any provision of this chapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this chapter that can be given effect without the invalid provision or application. To this end, all provisions of this chapter are severable.

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

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

§11.2. Definitions.

(a) Except as otherwise provided, words and terms defined in Insurance Code Chapters 823 (concerning Insurance Holding Company Systems), 843 (concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), 1272

(concerning Delegation of Certain Functions of Health Maintenance Organizations), 1367 (concerning Coverage of Children), 1452 (concerning Physician and Provider Credentials), 1501 (concerning Health Insurance Portability and Availability Act), and 1507 (concerning Consumer Choice of Benefits Plans) have the same meanings when used in this subchapter.

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

(1) Admitted assets--Assets as defined by statutory accounting principles, as permitted and valued under Chapter 11, Subchapter I, of this title (relating to Financial Requirements).

(2) Adverse determination--A determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate, or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

(3) Affiliate--A person defined as an affiliate in §7.202 of this title (relating to Definitions).

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

(5) ANHC or approved nonprofit health corporation--A nonprofit health corporation certified under Occupations Code §162.001 (concerning Certification by Board) and defined in Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations).

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

(7) Clinical director--A health professional who is:

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

(B) an employee of, or party to a contract with, an HMO; and

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

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

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

(10) Control--As defined in §7.202 of this title.

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

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

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

(14) Department--Texas Department of Insurance.

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

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

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

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

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

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

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

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

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

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

(A) health status;

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

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

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

(H) disability.

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

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

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

(A) general hospitals;

(B) psychiatric hospitals;

(C) special hospitals;

(D) nursing homes;

(E) skilled nursing facilities;

(F) home health agencies;

(G) rehabilitation facilities;

(H) dialysis centers;

(I) free-standing surgical centers;

(J) diagnostic imaging centers;

(K) laboratories;

(L) hospice facilities;

(M) residential treatment centers;

(N) community mental health centers;

(O) pharmacies; and

(P) freestanding emergency medical care facilities.

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

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

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

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

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

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

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

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

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

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

(34) Pharmacist--An individual provider licensed to practice pharmacy under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551 - 569.

(35) Pharmacy--A facility licensed under the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551 - 569.

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

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

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

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

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

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

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

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

(A) qualifications of physicians and providers are reassessed;

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

(C) continued eligibility to provide services is determined.

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

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

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

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

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

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

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

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

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

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

(50) Subscriber--For conversion or individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO. For group coverage, the individual who

is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

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

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

(53) Telemedicine medical service--As defined in Government Code §531.001.

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

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

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

CHAPTER 11. SUBCHAPTER B

TAC §§11.101, 11.102, and 11.104 - 11.109

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code §§32.041, 36.001, §38.001, 541.059, 541.401, 843.071, 843.076, 843.078, 843.080(a), 843.083, 843.151, and 843.154.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business

condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §843.071 provides: (a) that a person may not organize or operate an HMO in this state, or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with an HMO, without obtaining a certificate of authority under Chapter 843; and (b) that a person may not use "health maintenance organization" or "HMO" in the course of operation unless the person: (1) complies with Chapter 843 and: (A) §1367.053; (B) Chapter 1452, Subchapter A; (C) Chapter 1507, Subchapter B; (D) Chapters 222, 251, and 258, as applicable to an HMO; and (E) Chapters 1271 and 1272; and (2) holds a certificate of authority under Chapter 843.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the

requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

SUBCHAPTER B. NAME APPLICATION PROCEDURE

§11.101. How to Obtain Forms.

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

§11.102. Information Required.

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

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

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

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

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

§11.104. Criteria.

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

§11.105. Use of the Term "HMO," Service Marks, Trademarks, and Assumed Name.

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

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

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

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

§11.106. Time Limits; Extension Requirements.

Names reserved for use by a proposed HMO are subject to the following time limits and extension requirements:

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

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

(A) a letter of request for extension; and

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

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

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

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

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

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

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

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

If an application is filed and then withdrawn or delayed at the request of a proposed HMO, then at the time of the withdrawal or request for delay, the proposed HMO must request that the name continue to be reserved and estimate the date on which the application will be refiled. If a 365-day name application period expires during the withdrawal period, then the requirements of §11.106(2) of this title (relating to Time Limits; Extension Requirements) must be met in order for the name application to be continued.

§11.109. Situations in Which Name Applications Will Cease.

A name will cease to be reserved when:

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

(2) the commissioner denies an application for a certificate of authority; or

(3) the commissioner revokes or cancels a certificate of authority.

Chapter 11. SUBCHAPTER C

28 TAC §§11.201 - 11.207

STATUTORY AUTHORITY. The commissioner adopts the new sections under Health and Safety Code §62.054; Insurance Code §§32.041; 36.001; 38.001; 401.056; 801.056; 802.056; 803.003; 804.102; 823.002; 843.002; 843.006; 843.076; 843.078; 843.079; 843.080(a) and (b); 843.082; 843.083; 843.102; 843.105; 843.151; 843.154; 843.201; 843.205; 843.251(a), (b), and (c); 843.361; 843.402; 843.404; 1271.155; 1271.251; 1272.052; 4201.152; 4201.153; 4201.154; and Occupations Code §162.001.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §801.056 provides that the department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

Insurance Code §803.003 provides, in relevant part, for a domestic company to locate its principal offices and any part of its books, records, and accounts outside this state if the company has given notice to the commissioner and the commissioner has not disapproved the notice before the 31st day after the date on which the company has given notice and the company meets the requirements of Chapter 803.

Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §823.002 provides definitions for terms used in Insurance Code Chapter 823.

Insurance Code §843.002 provides definitions for terms used in Insurance Code Chapter 843.

Insurance Code §843.006 provides that, in general, each application, filing, and report required under Insurance Code Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapter 222, 251, or 258, as applicable to an HMO; or Chapter 1271 or 1272 is a public document.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all

investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.402 provides for an HMO to maintain in force in its own name a fidelity bond on its officers and employees in an amount of at least $100,000 or another amount prescribed by the commissioner, the form of the bond, and for the substitution of a cash deposit with the comptroller in lieu of a bond.

Insurance Code §843.404 provides that the commissioner may adopt rules, or by rule establish guidelines, requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMO's investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated; and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §4201.152 provides that a utilization review agent must conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

Insurance Code §4201.153 provides that a utilization review agent must use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. The section provides requirements for utilization review determinations and screening criteria. The section further provides for the use of screening criteria and for the referral of a denial of requested treatment to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Insurance Code §4201.154 provides that a utilization review agent's written screening criteria and review procedures be made available for review and inspection to determine appropriateness and compliance as considered necessary by the commissioner and copying as necessary for the commissioner to accomplish the commissioner's duties under the Insurance Code.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY

§11.201. Filing Fee.

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

§11.202. Binding, Indexing, and Numbering Requirements.

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

(b) If an HMO submits an application in paper format, the applicant must submit three separate copies of the application in separate three-ring binders, so that pages may be easily replaced when necessary. Paper applications must include dividers with identifying subject tabs preceding each separate exhibit.

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

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

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

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

(g) An original application becomes the charter file once the applicant submits all required revisions and the commissioner approves the application.

(h) The application is subject to Government Code Chapter 552 (concerning Public Information).

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

§11.203. Revisions During Review Process.

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

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

(c) If an electronic file or page is to be revised or replaced, the modified document must be submitted with the changed item or information clearly designated.

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

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

(f) The applicant may request additional extensions, but must set out in writing the need for the additional time for each requested extension. A request must provide sufficient detail for the commissioner to determine if good cause for the extension exists. The commissioner may grant or deny any additional request for an extension of time at the commissioner's discretion.

§11.204. Contents.

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

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

(2) a completed certificate of authority application form;

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

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

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

(A) a completed officers and directors page;

(B) NAIC UCAA biographical data forms for all persons who are to be responsible for the day-to-day conduct of the applicant's affairs, including all members of the board of directors,

board of trustees, executive committee or other governing body or committee, the principal officers, and controlling shareholders of the applicant if the applicant is a corporation, or all partners or members if the applicant is a partnership or association; and

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

(6) organizational information, as follows:

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

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

(C) a chart showing contractual arrangements of the HMO's delivery network;

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

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

(B) a cash deposit held under Insurance Code §843.402 or as provided by Insurance Code §423.004 (concerning Statutory Deposits with Department) in the same amount and subject to the same conditions as the bond described in this paragraph;

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

(A) if the applicant is domiciled in another jurisdiction, an agent for service of legal process must be appointed in compliance with Insurance Code Chapter 804 (concerning Service of Process) using Form FIN 312 (rev. 04/00), and the applicant must furnish a copy of the certificate of authority from the domiciliary jurisdiction's licensing authority; and

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

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

(10) financial information, consisting of the following:

(A) a financial statement that includes a balance sheet reflecting the required net worth, assets, and any liabilities.

(B) if the applicant is newly formed, a balance sheet reflecting the HMO's proposed initial funding;

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

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

(11) the schedule of charges, excluding any charges for Medicaid products, with an actuarial certification and supporting documentation meeting the qualifications specified in §11.702 of this title (relating to Actuarial Certification);

(12) if the applicant proposes to write Medicaid products, an actuarial certification and supporting documentation meeting the qualifications specified in §11.702 of this title, and noting whether the proposed rates are the maximum rates allowed by the contracting state agency, if rates less than the maximum rates allowed are being proposed or if the contracting state agency rates are not available;

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

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

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

(B) any physician, medical group, association of physicians, or any other provider, and the form of any subcontract between those entities and any physician, medical group, association of physicians, or any other provider to provide health care services, provided that contracts, including subcontracts between physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees, must include a hold-harmless provision

and comply with all other provisions of §11.901 of this title (relating to Required and Prohibited Provisions);

(C) any affiliated exclusive agent or agency;

(D) any affiliated person who will perform marketing, administrative, data processing services, or claims processing services;

(E) any affiliated person who will perform management services, together with a deposit or the original or a copy of a bond with no deductible meeting the requirements of Insurance Code §843.105 (concerning Management and Exclusive Agency Contracts);

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

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

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

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

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

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

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

(C) any other arrangements offering protection against insolvency, including guarantees, as specified in §11.808 of this title (relating to Liabilities) and §11.810 of this title (relating to Guarantee from a Sponsoring Organization);

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

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

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

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

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

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

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

(i) last name;

(ii) first name;

(iii) business address;

(iv) city;

(v) state;

(vi) county;

(vii) Texas license number;

(viii) specialty;

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

(x) date of last credentialing or recredentialing; and

(xi) an indication of whether they are accepting new patients;

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

(i) name of facility;

(ii) business address;

(iii) city;

(iv) state;

(v) county;

(vi) type of facility;

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

(viii) date of last credentialing or recredentialing;

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

(i) last name;

(ii) first name;

(iii) business address;

(iv) city;

(v) state;

(vi) county;

(vii) Texas license number;

(viii) hospital-based specialty; and

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

(20) a written description of the types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made or to be made with physicians and providers in exchange for the provision of or the arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers; provided that such compensation arrangements are confidential under Insurance Code §843.078(l) and not subject to Government Code Chapter 552 (concerning Public Information);

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

(22) a description of the procedures by which:

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

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

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

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

(25) a written description of the utilization management and utilization review program;

(26) the URA name and certificate or registration number if the applicant performs utilization review under Insurance Code Chapter 4201 (concerning Utilization Review Agents) and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy), or the URA name and certificate number of the certified URA that will perform utilization review on behalf of the applicant if the applicant delegates utilization review;

(27) complaint and appeal procedures, templates of letters, and logs, including the complaint log, which must categorize each complaint using the following categories and noting all that are applicable to the complaint:

(A) quality of care or services;

(B) accessibility and availability of services;

(C) utilization review or management;

(D) complaint procedures;

(E) physician and provider contracts;

(F) group subscriber contracts;

(G) individual subscriber contracts;

(H) marketing;

(I) claims processing; and

(J) miscellaneous; and

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

§11.205. Additional Documents to be Available for Review.

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

(1) administrative: policy and procedure manuals;

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

(3) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

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

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

(6) manuals: current physician manual and current provider manual provided to each contracting physician or provider, which must contain details of the provisions that govern the physicians and providers;

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

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

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

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

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

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

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

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

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

(4) management committee meeting minutes.

§11.206. Review of Application; Examination.

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

(b) After completion of the department's review of documents, the department may perform quality of care and financial examinations. If a hearing is held in compliance with §1.809 of this title, then the examinations must occur before the date of the hearing. The commissioner may request a copy of the most recent financial examination report issued by the domiciliary regulator of an applicant that is a foreign HMO, instead of conducting a financial examination.

§11.207. Withdrawal of an Application.

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

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

CHAPTER 11. SUBCHAPTER D

28 TAC §11.301 - 11.303

STATUTORY AUTHORITY. The commissioner adopts the new sections under Health and Safety Code §62.054; Insurance Code Chapter 843, Subchapter J; Insurance Code §§32.041; 36.001; 38.001; 401.051; 401.052; 401.054; 401.056; 404.005; 423.004; 802.056; 803.003; 804.102; 843.076; 843.078; 843.079; 843.080(a) and (b); 843.082; 843.101; 843.102; 843.103; 843.105; 843.151; 843.154; 843.156; 843.201; 843.205; 843.251(a), (b), and (c); 1271.102; 1271.155; 1271.251; 1271.306(c); 1271.307(c); 1272.052; 1272.064; 1272.103; 1272.255; 1353.002; 1358.057; 1362.005; 1363.005; 1364.004; 1367.055; 1367.105; 1367.154; 1367.207; and 1369.0541.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 843, Subchapter J, provides for various matters relating to the payment of claims by HMOs to physicians and providers, including clean claims, the timing of claims and submission of claims, deadlines for action on claims, claim auditing, verification, coordination of payment, and payment for emergency care payments, and provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §32.041 provides that the department must furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §401.051 provides, in relevant part, for the department or an examiner appointed by the department to visit a carrier to examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the laws of this state that affect the conduct of the carrier's business.

Insurance Code §401.052 provides, in relevant part, for the department to visit and examine a carrier as frequently as the department considers necessary.

Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a

hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §423.004 provides that: (1) a domestic insurer may develop ownership of a security through a definitive certificate or in accordance with rules adopted under the section, and (2) the commissioner adopt rules under which a domestic insurer may demonstrate ownership of a security.

Insurance Code §802.056 provides that a report or any other information resulting from the collection, review, analysis, and distribution of information developed from the filing of annual statement convention blanks and provided to the department by the National Association of Insurance Commissioners is considered part of the process of examination of insurance companies under the Insurance Code.

Insurance Code §803.003 provides, in relevant part, for a domestic company to locate its principal offices and any part of its books, records, and accounts outside this state if the company has given notice to the commissioner and the commissioner has not disapproved the notice before the 31st day after the date on which the company has given notice and the company meets the requirements of Chapter 803.

Insurance Code §804.102 provides, in relevant part, that a domestic company that has moved its principal offices and any part of its books, records, and accounts outside this state under Chapter 803 and the controlling person of an affiliated insurance holding company system must appoint and maintain as agent for service of process a person in this state on whom a judicial or administrative process may be served.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.080(a) provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in §843.078 and §843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the HMO to indicate the modifications to the commissioner at the time of the next site visit or examination.

Insurance Code §843.080(b) provides for the approval or disapproval of a filing under §843.080 and for the commissioner to delay action on the application.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.101 provides, in relevant part, that an HMO may provide or arrange for medical care services only through: (1) other HMOs; or (2) physicians or groups of physicians who have independent contracts with the HMOs. The section also provides that HMOs may provide or arrange for health care services only through: (1) other HMOs; (2) providers or groups of providers who are under contract with or are employed by the HMO; or (3) additional HMOs or physicians or providers who have contracted for health care services with: (A) the other HMOs; (B) physicians with whom the HMO has contracted; or (C) providers who are under contract with or are employed by the HMO. The section also provides that an HMO may provide or authorize the following in a manner approved by the commissioner: (1) emergency care; (2) services by referral; and (3) services provided outside the service area.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.103 provides, in relevant part, that an HMO may: (1) purchase, lease, construct, renovate, operate, or maintain hospitals or medical facilities and ancillary equipment and other property reasonably required for the principal office of the HMO or for another purpose necessary in engaging in the business of the HMO; and (2) make loans to a medical group, under an independent

contract with the group to further its program, or corporations under its control, to acquire or construct medical facilities and hospitals, or to further a program providing health care services to enrollees. The section provides that if the exercise of a power granted under subsection (a) involves an affiliate, as described by §823.003, the HMO must file notice and adequate supporting information with the commissioner for approval before exercising that power. The section provides that the commissioner disapprove the exercise of a power described by subsection (a) that would in the commissioner's opinion: (1) substantially and adversely affect the financial soundness of the HMO and endanger its ability to meet its obligations; or (2) impair the interests of the public or the HMO's enrollees or creditors in this state. The section provides for the commissioner to disapprove the exercise of a power within 31 days after the HMO files its notice, with a 30-day extension.

Insurance Code §843.105 provides that an HMO may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner. It further provides for the commissioner to approve or disapprove the contract, and provides that commissioner disapprove the proposed contract under certain conditions.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other

arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and that If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The section also provides for the extension of the period of time for approval or disapproval and for a hearing on the disapproval of a form.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other

provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.306(c) provides that a conversion contract must meet the minimum standards for services and benefits for conversion contracts and provides that the commissioner adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

Insurance Code §1271.307(c) provides that the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated; and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.255 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter F.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to implement Chapter 1362.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to implement Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to implement Chapter 1364.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

SUBCHAPTER D. REGULATORY REQUIREMENTS FOR AN HMO AFTER ISSUANCE OF CERTIFICATE OF AUTHORITY

§11.301. Filing Requirements.

After the commissioner issues an HMO's certificate of authority, the HMO is required to file with the commissioner, either for approval before effect or for information only, any items specified in §11.204 of this title (relating to Contents) that the HMO has deleted, amended, or revised as outlined in paragraphs (4) and (5) of this section and any items specified in §11.302 of this title (relating to Service Area Expansion or Reduction Applications). These requirements include filing changes made necessary by federal or state law or regulations. All requirements in this section apply to both electronic and paper filings unless stated otherwise.

(1) Completeness and format of filings.

(A) The department will not accept a filing for review until the filing is complete. An application to modify an approved application for a certificate of authority that requires the commissioner's approval under Insurance Code §843.080 (concerning Modification or Amendment of Application Information) or Insurance Code Chapter 1271, Subchapter C, (concerning Commissioner Approval) is considered complete when all information required by this section; §11.302; and Chapter 11, Subchapter T, of this title (relating to Quality of Care) that is applicable and reasonably necessary for the department to make a final determination has been filed.

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

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

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

(ii) not be submitted in bound booklets;

(iii) be legible;

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

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

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

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

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

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

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

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

(ii) A new edition date added to the original identifying form number is an acceptable way of revising the number so that it is identifiable from any previously approved item; for example, if "G-100" was the originally approved number, then the revision may be numbered "G-100 12/79."

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

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

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

(B) the supporting documentation considered necessary by the commissioner to review the filing and, for filings submitted on paper, a cover letter which includes the following:

(i) company name;

(ii) form numbers that are being submitted; and

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

(C) the applicable filing fee as determined by §7.1301 of this title (relating to Regulatory Fees), unless the filing is made electronically through the NAIC's System for Electronic Rate and Form Filing, in which case the fees should not be attached to the filing. For filings made electronically, the department will send an invoice for the fees, and the HMO must pay, as provided in §7.1302 of this title (relating to Billing System).

(4) Filings requiring approval. After issuance of a certificate of authority, each HMO must file with the commissioner, using the method specified below, a written request to implement or modify the following operations or documents and receive the commissioner's approval before putting the modifications into effect:

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

(i) evidence of coverage filings, as described in §11.501 of this title (relating to Contents of the Evidence of Coverage);

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

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

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

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

(i) any material change in network configuration; and

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

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

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

(ii) the form of all contracts or subcontracts between affiliated physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees described in §11.204(14)(B) of this title, including any amendments to those contracts;

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

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

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

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

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

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

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

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

(5) Filings for information. Material filed under this paragraph is not to be considered approved, but may be subject to review for compliance with Texas law and consistency with other HMO documents. Each item filed under this paragraph must be accompanied by a completed HMO certification and transmittal form in addition to those attachments required under paragraph (3) of this

section. Within 30 days of the effective date, an HMO must file with the commissioner, for information, deletions and modifications to the following previously approved or filed operations and documents:

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

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

(ii) any modification of drug coverage under Insurance Code §1369.0541 (concerning Modification of Drug Coverage Under Plan); and

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

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

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

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

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

(C) as provided in §7.201 of this title, a copy of any notice of cancellation of fidelity bonds, new fidelity bonds, or amendments to fidelity bonds, for officers and employees,

including notarized certification by the corporate secretary or corporate president that the material is true, accurate, and complete, as described in §11.204(7) and (14)(D) of this title;

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

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

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

(6) Approval period. Any modification for which the commissioner's approval is required may be considered approved, unless it is disapproved within 30 days from the date the filing is determined by the department to be complete. The commissioner may postpone the action for a period not to exceed 30 days, as necessary for proper consideration. The department will notify the HMO in writing if it postpones a decision on a modification.

(7) Approval, disapproval, and pending.

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

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

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

(D) If the HMO has not addressed the department's request for corrections or additional information within 15 calendar days, then the HMO may withdraw the filing before the end of the applicable review period, which is either the 30th day after filing or the 60th day after filing for an extended review period.

§11.302. Service Area Expansion or Reduction Applications.

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

(b) For the purposes of an application to expand an existing service area, reduce an existing service area, or add a new service area, an HMO must file the following items:

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

(2) network configuration information, as required by §11.204(19) of this title;

(3) combined financial projections as described in §11.204(10)(B) of this title, including a breakdown of the income statement for existing business, and the effect of the proposed service area expansion or reduction; and

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

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

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

§11.303. Examination.

(a) The department has authority to conduct examinations of HMOs under Insurance Code Chapters 401 (concerning Audits and Examinations) and 751 (concerning Market Conduct Surveillance), and Insurance Code §843.156 (concerning Examinations) and §843.251 (concerning Complaint System

Required; Commissioner Rules and Examination). The department will conduct examinations to determine the financial condition (financial exams), quality of health care services (quality of care exams), or compliance with laws affecting the conduct of business (market conduct exams).

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

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

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

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

(4) complaints and appeals: policies and procedures and templates of letters; complaint and appeal logs, including documentation and details of actions taken; and complaint and appeal files;

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

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

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

(8) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

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

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

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

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

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

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

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

(c) The department will conduct quality of care exams as follows:

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

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

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

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

(5) Corrective action plan. If the examination team or examiner cites significant deficiencies, the HMO must provide a signed corrective action plan to the department no later than 30 days from receipt of the written examination report. The HMO's plan must provide for correction of these deficiencies no later than 90 days from the receipt of the written examination report.

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

CHAPTER 11. SUBCHAPTER F

28 TAC §11.501 - 11.509, 11.511, and 11.512

STATUTORY AUTHORITY. The commissioner adopts the new sections under Civil Practice and Remedies Code Chapter 140; Civil Practice and Remedies Code Chapter 171; Insurance Code Title 8, Subtitle E; Insurance Code Chapter 4201, Subchapters H and I; Insurance Code §§32.041, 36.001, 521.102, 541.059, 541.401, 542.057, 843.151, 843.154, 843.201, 843. 207, 843.2071, 1201.062, 1203.002, 1203.003, 1203.052, 1203.053, 1203.054, 1271.005, 1271.006, 1271.051, 1271.101, 1271.102, 1271.103, 1271.104, 1271.151, 1271.152, 1271.153, 1271.154, 1271.155, 1271.201, 1271.251, 1271.253,1271.304, 1271.306, 1271.307, 1354.002, 1356.005, 1358.054, 1358.055, 1358.056, 1358.057, 1359.003, 1362.003, 1362.004, 1362.005, 1363.003, 1363.004, 1363.005, 1364.004, 1367.053, 1363.054, 1367.055, 1367.105, 1367.153, 1367.154, 1367.207, 1369.054, 1369.0541, 1369.0542, 1369.0543, 1369.0544, 1369.055, 1369.056, 1369.057, 1451.254, 1451.255, 1451.256, 1451.257, 1451.258, 1452.001, 1452.052, 1452.101, 1452.151, 1452.201, 1453.003, 1456.003, 1503.003, 4201.002, and 4201.003.

Civil Practice and Remedies Code Chapter 140 provides for subrogation rights for the issuer of a plan that provides benefits under which the policy or plan issuer may be obligated to make payments or provide medical or surgical benefits to or on behalf of a covered individual as a result of a personal injury to the individual caused by the tortious conduct of a third party.

Civil Practice and Remedies Code Chapter 171 provides for arbitration agreements.

Insurance Code Title 8, Subtitle E, provides for benefits payable under health coverages.

Insurance Code Chapter 4201, Subchapter H, provides for the appeal of adverse determinations.

Insurance Code Chapter 4201, Subchapter I, provides for the independent review of adverse determinations.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.207 provides that an HMO must provide reasonable notice to its enrollees of any material adverse change in the operation of the HMO that will directly affect the enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §1201.062 provides that an individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that

provides coverage for a child of an insured or group member, on payment of a premium, must provide certain coverage for children and grandchildren.

Insurance Code §1203.002 places restrictions on coordination of benefits provisions in evidences of coverage.

Insurance Code §1203.003 provides that a provision of an insurance policy that violates §1203.003 is void.

Insurance Code §1203.052 allows the coordination of dental benefits between primary and secondary insurers.

Insurance Code §1203.053 prohibits certain dental coordination of benefits provisions.

Insurance Code §1203.054 provides that a provision of an insurance policy that violates §1203.053 is void.

Insurance Code §1271.005 provides that: (a) Chapters 1368 and 1652 apply to an HMO other than an HMO that offers only a single health care service plan; (b) Chapter 1355, Subchapter B, applies to an HMO providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that: (1) Chapter 1355, Subchapter B, does not conflict with Chapter 1271, Chapter 843, Subchapter A; Chapter 1452, or Chapter 1507, Subchapter B; and (2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the service area of the HMO and is subject to inspection and review as required by Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; or rules adopted under Chapter 1271; Chapter 843; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B; (c) an HMO must comply with Chapter 542, Subchapter B, with respect to prompt payment to an enrollee; (d) notwithstanding any other law, Chapter 1355, Subchapter C, applies to a group contract issued by an HMO; and (e) notwithstanding any other law, §1201.062 applies to an evidence of coverage issued by an HMO.

Insurance Code §1271.006 provides for a limiting age of 25 for children and grandchildren and for benefits to an enrollee's dependent grandchild who is living with and in the household of the enrollee.

Insurance Code §1271.051 provides that: (a) an evidence of coverage that is a contract must contain a clear and complete statement of the information required by §§1271.052, 1271.053, and

1271.054; and (b) an evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by §§1271.052, 1271.053, and 1271.054.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.102 provides that the commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of Chapter 1271 and that if the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The section also provides for the extension of the period of time for approval or disapproval and for a hearing on the disapproval of a form.

Insurance Code §1271.103 provides that: (a) after notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the commissioner; and (b) if the commissioner withdraws approval of a form under the section, the form may not be issued until it is approved.

Insurance Code §1271.104 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Chapter 1271, Subchapter C.

Insurance Code §1271.151 provides that an HMO that offers a basic health care plan must provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Insurance Code §1271.152 provides that the commissioner may adopt minimum standards relating to basic health care services.

Insurance Code §1271.153 provides basic health care services provided under an evidence of coverage include periodic health evaluations for each adult enrollee, and that the section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Insurance Code §1271.154 provides, in relevant part, that an HMO must ensure that each health care plan provided by the HMO includes well-child care from birth.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271, Subchapter F.

Insurance Code §1271.304 provides constraints on the termination of group continued coverage.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

Insurance Code §1271.307 provides that an individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee, an HMO may decline to renew an individual health care plan or conversion contract only under specified conditions, and the commissioner may adopt rules necessary to implement §1271.307 and to meet the minimum requirements of federal law, including regulations.

Insurance Code §1354.002 provides that if a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits for Alzheimer's disease, the proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies.

Insurance Code §1356.005 provides that a health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer, and contains conditions regarding that coverage.

Insurance Code §1358.054 provides that: (a) a health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for: (1) diabetes equipment; (2) diabetes supplies; and (3) diabetes self-management training in accordance with the requirements of §1358.055; and (b) a health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under §1358.054. The section also provides that the amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

Insurance Code §1358.055 contains conditions governing the provision of diabetes self-management training.

Insurance Code §1358.056 provides that a health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug,

approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

Insurance Code §1358.057 provides that the commissioner may adopt rules to implement Chapter 1358, Subchapter B, and may consult with the commissioner of public health and other entities.

Insurance Code §1359.003 provides that: (a) a group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease; and (b) the group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician.

Insurance Code §1362.003 provides that: (a) a health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer; (b) that coverage required under the section includes at a minimum: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male who: (A) is at least 50 years of age and is asymptomatic; or (B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Insurance Code §1362.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1362, and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1362.005 provides that the commissioner may adopt rules necessary to administer Chapter 1362.

Insurance Code §1363.003 provides that: (a) a health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer; and (b) provides for minimum coverage required under the section.

Insurance Code §1363.004 provides that: (a) a health benefit plan issuer must provide to each individual enrolled in the plan written notice of the coverage required under Chapter 1363, and (b) the notice must be provided in accordance with rules adopted by the commissioner.

Insurance Code §1363.005 provides that the commissioner may adopt rules as necessary to administer Chapter 1363.

Insurance Code §1364.004 provides, in relevant part, that the commissioner may adopt rules necessary to administer Chapter 1364.

Insurance Code §1367.053 provides that a health benefit plan that provides coverage for a family member of an insured or enrollee must provide for each covered child from birth through the date of the child's sixth birthday coverage for certain immunizations, and defines "covered child" for the purposes of the section.

Insurance Code §1367.054 provides that coverage required under §1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement, and that this does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered.

Insurance Code §1367.055 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §1367.105 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter C.

Insurance Code §1367.153 provides that a health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Insurance Code §1367.154 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter D.

Insurance Code §1367.207 provides that the commissioner may adopt rules necessary to implement Chapter 1367, Subchapter E.

Insurance Code §1369.054 provides for notice and disclosure of certain information to enrollees and other individuals by an issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan.

Insurance Code §1369.0541 provides for the modification of drug coverage by a health benefit plan issuer under certain conditions and for notice of the modification to the commissioner and others.

Insurance Code §1369.0542 provides that a health benefit plan issuer must display on a public Internet website maintained by the issuer formulary information as required by the commissioner by

rule, requires a direct electronic link to the formulary information to be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the health benefit plan issuer's Internet website, and provides that the information must be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information.

Insurance Code §1369.0543 provides that the commissioner develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among health benefit plans, places conditions on those requirements, and allows the commissioner by rule to allow an alternative method of making cost-sharing disclosures required under the section.

Insurance Code §1369.0544 provides that a health benefit plan issuer may make the information described by 1369.0543(d)(1) available to enrollees, prospective enrollees, and others through a toll-free telephone number that operates at least during normal business hours.

Insurance Code §1369.055 provides that an issuer of a health benefit plan that covers prescription drugs must offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. The section also provides that this does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is: (1) covered under the health benefit plan; and (2) medically appropriate for the enrollee.

Insurance Code §1369.056 provides that the refusal of a health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of §4201.002 if: (1) the drug is not included in a drug formulary used by the health benefit plan; and (2) the enrollee's physician has determined that the drug is medically necessary. The section also provides that the enrollee may appeal the adverse determination under Chapter 4201, Subchapters H and I.

Insurance Code §1369.057 provides that the commissioner may adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1451.254 provides that the commissioner adopt rules necessary to implement Chapter 1451, Subchapter B.

Insurance Code §1451.255 provides that a health benefit plan must permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist. The section provides that a health benefit plan may limit an enrollee's self-referral to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee, and makes other provisions concerning the selection of a physician to provide such care.

Insurance Code §1451.256 provides, in relevant part, that a health benefit plan must permit an enrollee who selects an obstetrician or gynecologist under §1451.255 to have direct access to the health care services of that selected physician without a referral from the enrollee's primary care physician or prior authorization or precertification from the plan issuer. The section provides that a health benefit plan may not impose a copayment or deductible for direct access to health care services as required by the section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

Insurance Code §1451.257 provides that a health benefit plan must include in the classification of persons authorized to provide medical services under the plan a sufficient number of properly credentialed obstetricians and gynecologists.

Insurance Code §1451.258 provides that a health benefit plan issuer must provide in clear and accurate language to each person covered under the plan a timely written notice of the choices of the types of physician providers available for the direct access required under Chapter 1451, Subchapter F.

Insurance Code §1452.001 provides that terms used in Insurance Code Chapter 1452, Subchapter B, have the meaning assigned by Insurance Code §843.002.

Insurance Code §1452.052 provides, in relevant part, that the commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, an HMO operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Insurance Code §1452.101 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter C.

Insurance Code §1452.151 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter D.

Insurance Code §1452.201 provides definitions for terms used in Insurance Code Chapter 1452, Subchapter E.

Insurance Code §1453.003 provides that the commissioner adopt rules as necessary to implement Chapter 1453.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1503.003 provides for coverage of certain students by a health benefit plan.

Insurance Code §4201.002 provides definitions for terms used in Insurance Code Chapter 4201.

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

SUBCHAPTER F. EVIDENCE OF COVERAGE

§11.501. Contents of the Evidence of Coverage.

(a) An evidence of coverage or an amendment to an evidence of coverage may not be issued, delivered, or used in Texas unless it has been filed for review and has received the approval of the commissioner. The following forms are always considered to be part of the evidence of coverage:

(1) group agreement;

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

(3) conversion and individual agreements;

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

(5) group subscriber enrollment form;

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

(7) matrix filings;

(8) schedule of benefits; and

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

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

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

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

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

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

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

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

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

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

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

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

(a) After receipt of a certificate of authority, no evidence of coverage filing may be amended or altered in any manner, and no new evidence of coverage filing may be used, unless the proposed new or revised evidence of coverage filing has been filed for review and has received the approval of the commissioner. The evidence of coverage must be filed as provided in §11.301 of this title (relating to Filing Requirements).

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

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

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

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

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

§11.504. Disapproval of an Evidence of Coverage.

(a) If the department disapproves any portion of an evidence of coverage, the department will specify the reason for the disapproval. The department may disapprove any form or withdraw any previous approval if a form:

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

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

(3) contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate Insurance Code Chapters 541 (concerning Unfair Methods of

Competition and Unfair or Deceptive Acts or Practices), 542 (concerning Processing and Settlement of Claims), 543 (concerning Prohibited Practices Related to Policy or Certificate of Membership), 544 (concerning Prohibited Discrimination), or 547 (concerning False Advertising by Unauthorized Insurers), or any other applicable law or regulations;

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

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

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

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

(b) If the department disapproves a form, the HMO may file a written request for a hearing on the matter under Insurance Code §1271.102 (concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval).

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

(a) The filing and formatting requirements of §11.301 of this title (relating to Filing Requirements) apply to an evidence of coverage.

(b) The style, arrangement, and overall appearance of documents must give no undue prominence to any portion of the text. The text of the group, individual, and conversion agreements, the certificate, and all amendments include all printed matter except:

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

(2) the name or title of the form;

(3) the captions and subcaptions; and

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

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

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

(e) Certain language must not be varied or changed without resubmitting a form for the commissioner's approval. Changeable language must be enclosed in brackets, include the range of variable information or amounts, and include an explanation of how and under what circumstances the information will vary.

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

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

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

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

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

(i) Any HMO submitting an insert page filing:

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

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

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

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

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

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

(a) Each enrollee residing in Texas is entitled to an evidence of coverage under a health care plan. An HMO may deliver the evidence of coverage electronically but must provide a paper copy on request.

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

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

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

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

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

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

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

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

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

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

(B) Deductibles. A deductible must be for a specific dollar amount of the cost of the basic, limited, or single health care service. Except for a consumer choice benefit plan authorized by Insurance Code Chapter 1507 (concerning Consumer Choice of Benefits Plans), an HMO may not charge a deductible for services received in the HMO’s delivery network. Except in cases involving emergency care and services that are not available in the HMO's delivery network, as described in §11.1611, an HMO may charge an out-of-network deductible for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

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

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

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

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

(D) Immunizations. An HMO may not charge a copayment or deductible for immunizations as described in Insurance Code Chapter 1367, Subchapter B, (concerning Childhood

Immunizations) for a child from birth through the date the child is six years of age, except that a small employer health benefit plan as defined by Insurance Code §1501.002 (concerning Definitions) that covers the immunizations may charge a copayment, and a consumer choice benefit plan under Insurance Code Chapter 1507 may charge a copayment and a deductible.

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

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

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

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

(iii) after not less than 15-days written notice, in the case of fraud in the use of services or facilities;

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

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

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

(i) for nonpayment of premium, at the end of the grace period as described in paragraph (12) of this subsection;

(ii) in the case of fraud on the part of the group, after 15-days written notice;

(iii) for employer groups, for violation of participation or contribution rules, under §26.8(h) of this title (relating to Guaranteed Issue; Contribution and Participation Requirements) and §26.303(j) of this title (relating to Coverage Requirements);

(iv) for employer groups, under §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market) and §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) on discontinuance of:

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

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

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

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

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

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

(i) for nonpayment of premiums under the terms of the contract, including any timeliness provisions, without written notice, subject to paragraph (12) of this subsection;

(ii) in the case of fraud or intentional material misrepresentation, except as described in paragraph (13) of this subsection, after not less than 15-days written notice;

(iii) in the case of fraud in the use of services or facilities, after not less than 15-days written notice;

(iv) after not less than 30-days written notice where the subscriber does not reside, live, or work in the service area of the HMO or area in which the HMO is authorized to do

business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area;

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

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

(4) Claim payment procedure. A provision that sets forth the procedure for paying claims, including any time frame for payment of claims that must comply with Insurance Code Chapter 542, Subchapter B, (concerning Prompt Payment of Claims); Insurance Code §1271.005 (concerning Applicability of Other Law); and rules adopted under these Insurance Code provisions.

(5) Complaint and appeal procedures. A description of the HMO's complaint and appeal process available to complainants, including internal adverse determination appeal and independent review procedures under Insurance Code Chapter 4201 (concerning Utilization Review Agents) and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy).

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

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

(8) Eligibility. A statement of the eligibility requirements for membership.

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

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

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

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

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

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

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

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

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

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

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

(iv) The HMO may not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency or born in a non-network facility to a mother who does not have HMO coverage, but may require that the newborn be transferred to a network facility at the

HMO's expense and, if applicable, to a network provider when the transfer is medically appropriate as determined by the newborn's treating physician.

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

(E) The statement must include a clear statement regarding the coverage of the enrollee's grandchildren that complies with Insurance Code §1201.062 (concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program) and §1271.006 (concerning Benefits to Dependent Child and Grandchild).

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

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

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

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

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

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

(i) the HMO must approve or deny coverage of poststabilization care as requested by a treating physician or provider; and

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

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

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

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

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

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

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

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

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

(VI) a hospital operated by a federal agency.

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

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

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

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

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

(13) Incontestability:

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

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

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

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

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

(14) Out-of-network services. Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, on the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and must fully reimburse the non-network provider at the usual and customary or an agreed rate.

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

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

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

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

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

(17) Termination due to attaining limiting age. A provision that a child's attainment of a limiting age does not operate to terminate the child's coverage while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent on the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of the limiting age.

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

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

part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

(20) Conformity with Medicare supplement minimum standards and long-term care minimum standards. Each group, individual, and conversion agreement, and group certificate must comply with Chapter 3, Subchapter T, of this title (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y, of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement or long-term care rules, or both, and the HMO rules, the Medicare supplement or long-term care rules will govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO must follow the Medicare supplement, the long-term care rules, and the HMO rules where applicable.

(21) Nonprimary care physician specialist as primary care physician. A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician as set out in Insurance Code §1271.201 (concerning Designation of Specialist as Primary Care Physician).

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

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

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

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

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

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

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

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

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

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

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

(24) Drug Formulary. An agreement that covers prescription drugs and uses one or more formularies must comply with Insurance Code Chapter 1369, Subchapter B, (concerning Coverage of Prescription Drugs Specified by Drug Formulary) and Chapter 21, Subchapter V, of this title (relating to Pharmacy Benefits).

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

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

Conversion and individual agreements must contain the following additional mandatory provisions:

(1) Reinstatement. A provision clearly setting forth the requirements for reinstatement and disclosing how reinstatement changes or affects the rights and coverages originally provided. New evidence of insurability may be required.

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

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

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

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

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

(1) outpatient services, including the following:

(A) primary care and specialist physician services;

(B) outpatient services by other providers;

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

(D) therapeutic radiology services;

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

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

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

(H) preventive services, including:

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

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

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

(iv) cancer screenings as required by Insurance Code Chapters 1356 (concerning Low-Dose Mammography), 1362 (concerning Certain Tests for Detection of Prostate Cancer), and 1363 (concerning Certain Tests for Detection of Colorectal Cancer);

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

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

(I) coverage for outpatient mental health services complying with the mental health parity requirements in Chapter 21, Subchapter P, of this title (relating to Mental Health Parity); and

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

(2) inpatient hospital services, including room and board, general nursing care, meals and special diets when medically necessary; use of operating room and related facilities; use of intensive care unit and services; X-ray services; laboratory and other diagnostic tests; drugs, medications, biologicals, anesthesia, and oxygen services; private duty nursing when medically necessary; radiation therapy; inhalation therapy; whole blood including cost of blood, blood plasma, and blood plasma expanders, that are not replaced by or for the enrollee; administration of whole blood and blood plasma; and short-term rehabilitation therapy services in the acute hospital setting;

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

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

(b) Each evidence of coverage must also include coverage for services as follows:

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

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

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

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

(d) A state-mandated health benefit plan must provide coverage for basic health care services as described in subsection (a) of this section, as well as all state-mandated benefits as described in Insurance Code Chapter 1507 (concerning Consumer Choice of Benefit Plans), and must provide the services without limitation as to time and cost, other than limitations specifically prescribed in this subchapter.

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

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

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

(1) Certificate. Group agreements must include provisions that the contract holder must be provided with subscriber certificates to be delivered to each subscriber, the certificate is a part of the group contract as if fully incorporated, and any direct conflict between the group agreement and the

certificate will be resolved according to the terms most favorable to the subscriber. If the same form is used as both the group contract and the certificate, a copy of the group contract must be delivered to each subscriber.

(2) New enrollees. Group agreements must include a provision specifying the conditions under which new enrollees may be added to those originally covered, including effective date requirements. For coverage issued to employers, group agreements must include a provision for special enrollment under 45 C.F.R. §146.117 (concerning Special Enrollment Periods).

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

(4) Inability to undergo dental treatment. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans, may not exclude from coverage under the plan an enrollee who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the enrollee's physician or the dentist providing the dental care. This benefit does not require an HMO to provide dental services if dental services are not otherwise scheduled or provided as part of the benefits covered by the agreement.

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

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

§11.511. Optional Provisions.

Evidences of coverage may contain optional provisions, including, but not limited to, the following:

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

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

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

(C) Group plans issued or renewed on or after March 25, 2014, may coordinate benefits with other plans subject to the requirements of Insurance Code Chapter 1203 (concerning Coordination of Benefits Provisions) and Chapter 3, Subchapter V, of this title (relating to Coordination of Benefits).

(2) Subrogation. Plans may contain a provision that the HMO is subrogated to and has a right to reimbursement from an individual's recovery for a personal injury for payments made or costs of benefits provided by the HMO as a result of that injury, subject to and limited by the provisions of Civil Practice and Remedies Code Chapter 140 (concerning Contractual Subrogation Rights of Payors of Certain Benefits), as added by Acts 2013, 83rd Leg., R.S., Ch. 180, §1 (HB 1869).

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

(4) Conversion privilege. Group agreements and certificates for an HMO may, at the HMO's option, contain a conversion privilege. If an HMO elects to offer a conversion privilege, it must provide that, on termination of coverage, each enrollee who resides, lives, or works in the service area who has been covered under the group contract for a period of at least three months, or in the case of a court-ordered dependent, lives outside the service area but within the United States, has the right to convert within 31 days to a conversion agreement without presenting evidence of insurability. A single service or limited service HMO must offer a conversion contract without requiring evidence of insurability. Charges must comply with §11.704 of this title (relating to Conversion Rates).

(5) Arbitration. Plans may contain a statement of any arbitration procedure. If enrollee complaints and grievances are resolved through a specified arbitration agreement, the arbitration must be conducted under Texas Civil Practice and Remedies Code Chapter 171 (concerning General Arbitration).

§11.512. Optional Benefits.

An HMO may provide health services to its enrollees in addition to the services required in §11.508 of this title (relating to Basic Health Care Services and Mandatory Benefit Standards: Group, Individual and Conversion Agreements). An HMO may limit these optional health services as to time and cost. Evidences of coverage may contain optional benefits, including:

(1) corrective appliances and artificial aids;

(2) cosmetic surgery;

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

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

(5) dental services, except as otherwise required;

(6) vision care;

(7) custodial or domiciliary care;

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

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

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

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

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

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

(12) reversal of voluntary sterilization;

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

(14) noninsurance benefits, provided that the HMO complies with Chapter 21, Subchapter NN, of this title (relating to Noninsurance Benefits and Features).

CHAPTER 11. SUBCHAPTER G

28 TAC §11.602 and §11.603

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code Chapter 541, Subchapters B and B-1; and Insurance Code §§36.001, 541.058, 542.003, 542.004, 542.005, 542.006, 542.055, 542.056, 542.057, 542.058, 542.059, 542.060, 542.061, and 547.051.

Insurance Code Chapter 541, Subchapter B, provides the definition of unfair methods of competition and unfair or deceptive acts or practices.

Insurance Code Chapter 541, Subchapter B-1, provides requirements for advertising.

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

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in certain listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it receives during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer’s acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code §542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

SUBCHAPTER G. ADVERTISING AND SALES MATERIAL

§11.602. HMOs Subject to Insurance Code Chapters 541, 542, and 547, and Related Rules.

HMOs must comply with Insurance Code Chapters 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542 (concerning Processing and Settlement of Claims), and 547 (concerning False Advertising by Unauthorized Insurers) and related rules, to the extent these rules may be applied to HMOs in the same manner as insurance companies.

§11.603. Filings.

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

CHAPTER 11. SUBCHAPTER H

28 TAC §11.701 - 11.704

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code §§36.001, 843.151, 1271.251, 1271.252, 1271.253, and 1271.306.

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

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for

primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271, Subchapter F.

Insurance Code §1271.306 provides for the offer and provision of conversion contracts by HMOs.

SUBCHAPTER H. SCHEDULE OF CHARGES

§11.701. Schedule of Charges Must be Filed Before Use.

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

(b) The schedule of charges must include all charges made for group, conversion, or individual coverage.

§11.702. Actuarial Certification.

Each formula or method for calculating the schedule of charges must be accompanied by the certification of a qualified actuary that, based on reasonable assumptions, the formula is appropriate to produce rates that are not excessive, inadequate, or unfairly discriminatory. An actuary is considered qualified if he or she is a member in good standing of both the American Academy of Actuaries and the Society of Actuaries.

§11.703. Filings and Supporting Documentation.

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

(1) rates for a new product:

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

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

(C) actuarial memorandum:

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

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

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

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

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

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

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

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

(2) rate adjustments for an existing product:

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

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

(C) actuarial memorandum:

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

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

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

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

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

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

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

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

§11.704. Conversion Rates.

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

(b) The charge by an HMO for individual coverage that has been converted from group coverage may not exceed 200 percent of the rate that the individual would be charged for comparable group coverage.

CHAPTER 11. SUBCHAPTER I

28 TAC §§11.801 - 11.808, 11.810, and 11.811

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code §§32.041; 36.001; 401.051; 401.054; 401.056; 404.003(a), (c), and (d); 404.005; 421.001(c); 423.104; 441.005; 521.102; 541.058; 541.059; 541.401; 542.003; 542.004; 542.005; 542.006; 542.055; 542.056; 542.057; 542.058; 542.059; 542.060; 542.061; 547.051; 801.056; 802.001; 823.012; 843.002(28); 843.151; 843.155; 843.156; 843.157; 843.201; 843.2015; 843.205; 843.207; 843.2071; 843.251(a), (b), and (c); 843.361; 843.401; 843.403; 843.404; 843.405; 843.406(a) and (b); and 843.461.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §401.051 provides, in relevant part, for the department or an examiner appointed by the department to visit a carrier to examine the carrier's financial condition and ability to meet the carrier's liabilities and compliance with the laws of this state that affect the conduct of the carrier's business.

Insurance Code §401.054 provides, in relevant part, that the department or the examiner appointed by the department: (1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's business and affairs; and (2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition.

Insurance Code §401.056 provides, in relevant part, that the commissioner by rule adopt: (1) procedures governing the filing and adoption of an examination report; (2) procedures governing a

hearing to be held under Insurance Code Chapter 401, Subchapter B; and (3) guidelines governing an order issued under Insurance Code Chapter 401, Subchapter B.

Insurance Code §404.003(a) provides that if the financial condition of an insurer, when reviewed as provided by Insurance Code §404.003(b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public, the commissioner may, after notice and hearing, order the insurer to take action reasonably necessary to remedy the condition.

Insurance Code §404.003(c) provides that, in an order issued under Insurance Code §404.003(a), the commissioner may take any action the commissioner considers reasonably necessary to remedy the condition described by Insurance Code §404.003(a).

Insurance Code §404.003(d) provides that the commissioner may use the remedies available under Insurance Code §404.003(c) in conjunction with the provisions of Insurance Code Chapter 83 if the commissioner determines that the financial condition of the insurer is hazardous and can be reasonably expected to cause significant and imminent harm to the insurer's policyholders or the public.

Insurance Code §404.005 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §421.001(c) provides that the commissioner adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves for each line of insurance. Each insurer writing a line of insurance to which a formula adopted under the subsection applies must establish reserves in compliance with that formula.

Insurance Code §423.104 provides, in relevant part, that the commissioner by rule may: (1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and (2) establish standards for evaluating the financial condition of an insurer.

Insurance Code §441.005 provides that the commissioner may: (1) adopt reasonable rules as necessary to implement and supplement Chapter 441 and the purposes of Insurance Code Chapter 441; and (2) take any administrative action required by the findings of Insurance Code §441.001.

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §541.058 provides that specified acts do not constitute discrimination or inducement.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §541.401 provides, in relevant part, that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Chapter 541.

Insurance Code §542.003 provides that insurers engaged in business in the state of Texas may not engage in certain listed unfair claim settlement practices.

Insurance Code §542.004 provides that insurers subject to regulation under the Texas Insurance Code may not require claimants to produce federal income tax returns as a condition of settling a claim, and provides the remedies for violations of the section.

Insurance Code §542.005 provides, in relevant part, that an insurer must maintain complete records of all complaints it receives during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter.

Insurance Code §542.006 provides that the department may require an insurer to file periodic reports with the department upon a finding that the insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices.

Insurance Code §542.055 provides deadlines for an insurer to acknowledge receipt of claims, commence any investigation of claims, and request any information it reasonably believes will be required from the claimant.

Insurance Code §542.056 provides for the notice an insurer must provide to a claimant regarding the insurer’s acceptance or rejection of a claim.

Insurance Code §542.057 provides deadlines for the payment of claims.

Insurance Code §542.058 provides, in relevant part, that an insurer is liable for damages and other items for the untimely payment of claims pursuant to Insurance Code § 542.060.

Insurance Code §542.059 provides for possible extensions of deadlines under Insurance Code Chapter 542, Subchapter B.

Insurance Code §542.060 provides, in relevant part, that if an insurer that is liable for a claim under an insurance policy is not in compliance with Insurance Code Chapter 542, Subchapter B, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

Insurance Code §542.061 provides that the remedies provided for under Insurance Code Chapter 542, Subchapter B, are in addition to any other remedy or procedure provided by law or at common law.

Insurance Code §547.051 prohibits certain misrepresentations by insurers.

Insurance Code §801.056 provides that the department may deny an application for an authorization if the applicant or a corporate officer of the applicant fails to provide a complete set of fingerprints on request by the department.

Insurance Code §802.001 provides that the commissioner may change the form of any annual statement an insurance company is required to file and that the form may require only information that relates to the business of the insurance company.

Insurance Code §823.012 provides that the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Chapter 823, including the conducting of business and proceedings under Chapter 823. The section further provides that the commissioner by rule establish procedures to: (1) promptly consider the prepayment notices reported under §823.053(b); (2) annually review each reported ordinary dividend paid within the 12 months preceding the date of the report; and (3) take appropriate actions authorized by the Insurance Code.

Insurance Code §843.002(28) provides that the term "uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the HMO. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment for the services except as described in the evidence

of coverage issued to the enrollee under Insurance Code Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.155 provides the form and contents of annual reports HMOs must file with the commissioner.

Insurance Code §843.156 provides, in relevant part, that the commissioner may examine the quality of health care services and the affairs of any HMO or applicant for a certificate of authority under Chapter 843; that the commissioner may conduct an examination as often as the commissioner considers necessary; that an HMO must make its books and records relating to its operations available for an examination and must facilitate an examination in every way; that on request of the commissioner, an HMO must provide to the commissioner a copy of any contract, agreement, or other arrangement between the HMO and a physician or provider; and that the commissioner may examine and use the records of an HMO, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of Chapter 843; §1367.053; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including commencement of an enforcement action under §843.461 or §843.462.

Insurance Code §843.157 provides for the rehabilitation, liquidation, supervision, or conservation of health maintenance organizations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements for language and for providing access to enrollees who have disabilities that affect their ability to communicate or read.

Insurance Code §843.207 provides that an HMO must provide reasonable notice to its enrollees of any material adverse change in the operation of the HMO that will directly affect the enrollees.

Insurance Code §843.2071 provides that an HMO must give each enrollee notice of an increase in a charge for coverage and specifies the form and content of that notice.

Insurance Code §843.251(a) provides that an HMO implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

Insurance Code §843.251(b) provides that the commissioner may adopt reasonable rules as necessary or proper to implement the provisions of Chapter 843, Subchapter G, relating to the complaint system and administer matters relating to the complaint system.

Insurance Code §843.251(c) provides that the commissioner may examine a complaint system for compliance with this subchapter and may require the HMO to make corrections as the commissioner considers necessary.

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.401 provides that a director, officer, member, employee, or partner of an HMO who receives, collects, disburses, or invests funds in connection with the activities of the HMO is responsible for the funds in a fiduciary relationship to the enrollees.

Insurance Code §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §843.406(a) provides that if the financial condition of an HMO indicates that the continued operation of the HMO could be hazardous to its enrollees or creditors or the public, the commissioner may, after notice and opportunity for hearing: (1) suspend or revoke the HMO's certificate of authority; or (2) order the HMO to take action reasonably necessary to correct the condition, including: (A) reducing by reinsurance the total amount of present and potential liability for benefits; (B) reducing the volume of new business being accepted; (C) reducing expenses by specified methods; (D) suspending or limiting for a period the writing of new business; or (E) increasing the HMO's capital and surplus by contribution.

Insurance Code §843.406(b) provides that the commissioner by rule may establish, in a manner consistent with the purposes of the section: (1) uniform standards and criteria for early warning that the continued operation of an HMO could be hazardous to the HMO's enrollees or creditors or the public; and (2) standards for evaluating the financial condition of an HMO.

Insurance Code §843.461 provides for the commissioner's power to maintain enforcement actions against HMOs.

SUBCHAPTER I. FINANCIAL REQUIREMENTS

§11.801. Accounting Guidance.

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

§11.802. Minimum Net Worth.

(a) An applicant for a certificate of authority to operate an HMO must have unencumbered assets that satisfy the requirements of Insurance Code §843.403 (concerning Minimum Net Worth).

(b) For the purpose of calculating assets to satisfy the minimum net worth requirements of Insurance Code §843.403, lawful money of the United States of America includes deposits in an institution that is a member of the Federal Deposit Insurance Corporation. Demand deposits, savings deposits, or time deposits, of the type that are federally insured in solvent banks, savings and loan associations, and their branches, which are organized under the laws of the United States of America or under the laws of any state of the United States of America may not exceed the greater of:

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

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

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

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

§11.803. Statutory Deposit Requirements.

(a) Statutory deposits made under Insurance Code §843.405 (concerning Deposit with Comptroller) consisting of certificates of deposit must be issued by a solvent, federally insured bank.

(b) Before issuance of the certificate of authority, the HMO must submit proof of statutory deposits satisfying the requirements of Insurance Code §843.405 and meeting the investment requirements of §11.802 of this title (relating to Minimum Net Worth), with a completed Statutory Deposit Transaction Form, Form No. FIN407 (rev. 11/15), and Declaration of Trust Form, Form No. FIN453 (rev. 11/15) as adopted in §13.562(b) of this title (relating to Deposit or Letter of Credit Required), as well as a safekeeping receipt showing that the security is pledged to the department, and the applicable fees under §7.1301(d) of this title (relating to Regulatory Fees) to the bond and securities officer of the department.

(c) Each HMO must annually determine the amount of statutory deposit required as specified in Insurance Code §843.405 and adjust the amount of statutory deposit by March 15 of that year.

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

(e) If the HMO wishes to request a waiver or release, or a waiver and a release, of all or part of the statutory deposit requirements under Insurance Code §843.405, then the request must provide adequate information, including the following, to justify the relief requested:

(1) specification of the pertinent provisions of the Insurance Code under which the relief is being requested;

(2) the amount of the statutory deposit for which the relief is being requested;

(3) supporting documentation that justifies the relief requested including:

(A) reasons for requesting the relief;

(B) discussion of the impact of granting the relief requested and assurance that the HMO and its enrollees will not be harmed if the relief is granted; and

(C) if a request is based on a guarantee:

(i) a copy of the guarantee;

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

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

(iv) disclosure of the dollar amount of all obligations guaranteed, the amounts reflected as liabilities, and the amounts guaranteed that are not reflected as liabilities in the sponsoring organization's consolidated financial statements;

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

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

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

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

(5) if an HMO requests a release under Insurance Code §843.405(e) or (f):

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

(B) an explanation of the reasons for the decrease in uncovered health care expenses from that incurred during previous years;

(6) if a waiver is granted by the commissioner, the assets supporting the uncovered medical expenses may be invested under §11.804(3) of this title (relating to Invested Assets).

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

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

§11.804. Invested Assets.

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

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

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

(3) Investments of assets in excess of minimum net worth and uncovered medical expenses. An HMO may invest its funds in excess of minimum net worth and uncovered medical expenses only in the following:

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

(B) direct general obligations of any state of the United States of America for the payment of money, or obligations for the payment of money, to the extent guaranteed or insured as to the payment of principal and interest by any state of the United States of America, provided that:

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

(ii) the state is not in default in the payment of principal or interest on any of its direct, guaranteed, or insured general obligations at the date of the investment;

(C) bonds, interest-bearing warrants, or other obligations issued by authority of law by any county, city, town, school district, or other municipality or political subdivision that is now or hereafter may be construed or organized under the laws of any state in the United States of America and that is authorized to issue the bonds, warrants, or other obligations under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet the obligations or a special revenue or income to meet the principal and interest payments as they accrue on the obligations has been appropriated, pledged, or otherwise provided; and

(ii) the county, city, town, school district, or other municipality or political subdivision is not in default in the payment of principal or interest on any of its obligations at the date of the investment;

(D) bonds, interest-bearing warrants, or other obligations issued by authority of law by any educational institution that is now or hereafter may be construed or organized under the laws of any state of the United States of America, and that is authorized to issue the bonds and warrants under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet the obligations or a special revenue or income to meet the principal and interest payments as they accrue on the obligations has been appropriated, pledged, or otherwise provided; and

(ii) the educational institution is not in default in the payment of principal or interest on any of its obligations at the date of the investment;

(E) investments issued by insurers or HMOs subject to the following conditions:

(i) an HMO may not make an investment under this subparagraph in any other HMO or insurer unless the other HMO or insurer is duly licensed to do business in its domestic state and at the time of the investment is in compliance with the minimum capital and surplus requirements then applicable under the provisions of that state's statutes and regulations; however, an HMO may make an investment under this paragraph in another HMO that has not yet received its certificate of authority to conduct the business of an HMO in its domestic state or that does not yet possess the minimum capital and surplus required by its domestic state if the investment will be sufficient to give the investing HMO at least 50 percent control in the other HMO;

(ii) an HMO may not invest, except as provided in subparagraphs (F) and (G) of this paragraph, in any other HMO or insurer unless the investments will result, within 180 days of the first investment, in the investing HMO having control in the other HMO or insurer;

(iii) an HMO may not invest more than 50 percent of its net worth in excess of minimum net worth in any other HMO or insurer;

(iv) the total investments made by an HMO in all other HMOs or insurers under this subparagraph may not exceed 75 percent of the investing HMO's net worth in excess of minimum net worth; and

(v) the restrictions of clauses (iii) and (iv) of this subparagraph do not apply if the HMO is purchasing 100 percent of the stock of another HMO for the purpose of a merger anticipated to take place no later than three months from the purchase date, unless the period is extended by the commissioner, and the resulting assets of the surviving HMO meet the requirements set forth in this subchapter within three months after the merger, unless the period is extended by the commissioner;

(F) bonds, debentures, bills of exchange, commercial notes, or any other bills and obligations of any corporation, incorporated under the laws of any state of the United States of America or of the United States of America, that, at the time of investment, is designated highest quality (NAIC designation 1) or high quality (NAIC designation 2) in compliance with the guidance provided by the NAIC Valuation of Securities Manual;

(G) equity interests, including common stocks issued by any business entity created under the laws of the United States of America or of any state of the United States, provided that:

(i) the business entity is solvent, with a net worth of at least $1 million;

(ii) if the business entity is a dividend paying business entity, no cumulative dividends are in arrears;

(iii) an HMO may not invest in a partnership, as a general partner, except through a wholly owned subsidiary; and

(iv) the restrictions of clauses (i) and (ii) of this subparagraph do not apply if the business entity of which the HMO wishes to purchase the equity interest is, or is to be, a contracted provider of services;

(H) shares of mutual funds doing business under the Investment Company Act of 1940 (15 United States Code §80a-1, et seq.) and shares in real estate investment trusts as defined in Internal Revenue Code of 1986 (26 United States Code §856), provided that the mutual funds and real estate investment trusts be solvent with at least $1 million of net assets as of the date of its latest annual, or more recent, certified audited financial statement;

(I) mortgage loans by an HMO that are secured by valid first liens on improved real estate, provided that:

(i) there is a title insurance policy or attorney's opinion showing that the borrower owns the real estate;

(ii) there is an appraisal of the real estate and its improvements and the loan does not exceed 75 percent of the appraised value;

(iii) there is an executed note evidencing the loan;

(iv) there is a recorded deed of trust;

(v) the value of the improvements is adequately insured by a company authorized to do business in Texas or in the state in which the real estate is located, and the insurance policy is made payable to the HMO in an amount equal to at least 50 percent of the value of the building, but the insurance coverage need not exceed the outstanding balance owed to the HMO when the outstanding balance falls below 50 percent of the value of the building; and

(vi) the commissioner has the right to obtain an independent appraisal, at the HMO's expense, of real estate securing any loan;

(J) loans secured by collateral, of a nature specified in Insurance Code §843.403 (concerning Minimum Net Worth) and §11.802 of this title (relating to Minimum Net Worth), although the amount loaned may not exceed the value of the securities held as collateral;

(K) loans, whether secured or unsecured and that are not in default, to medical and other health care providers under contract with the HMO for the provision of health care services; however, the admitted value of any loan made under this subparagraph may not exceed the maker's ability to repay the loan, which is calculated by only considering assets that an HMO may hold toward determining any excess of assets over all liabilities of the maker;

(L) real estate acquired in satisfaction of debt; all real property not qualifying under any other provisions of this section must be sold and disposed of within five years after the HMO has acquired title unless the time for disposal is extended by the commissioner;

(M) investments in improved, income-producing real estate;

(N) additional investments that are not otherwise specified by this section, provided that:

(i) the amount of any one investment may not exceed 10 percent of the net worth in excess of the HMO's minimum net worth plus uncovered medical expenses at the time of investment; and

(ii) the total amount of investments authorized by this paragraph may not exceed the HMO's net worth in excess of its minimum net worth plus uncovered medical expenses at the time of investment.

(4) Valuation and Amortization. Except where elsewhere specifically provided, assets must be valued and amortized in compliance with §11.801 of this title (relating to Accounting Guidance) as it applies to entities not required to maintain an asset valuation reserve. If no such standard applies, then the valuation must be at fair value.

(5) Evidence of ownership. A domestic HMO may demonstrate ownership of its securities by complying with §7.86 of this title (relating to Custodied Securities).

(6) Sale of investment. Section 7.4 of this title (relating to Admissible Assets) applies to investments not specifically allowed under this subchapter. The commissioner may require any investment to be sold that would otherwise be authorized under the provisions of this section if the commissioner finds that the investment would cause the investing HMO to operate in a condition that is hazardous to its enrollees, creditors, or the general public.

§11.805. Other Assets.

(a) Other assets an HMO may find necessary in its operations include, but are not limited to, the following:

(1) uncollected premiums or subscriptions with an adequate provision for uncollectable premiums or subscriptions;

(2) advances of capitation or other fees expected to be paid for the next month to medical and other health care service providers under contract with the HMO, provided that no termination of the contract may take place before the end of the period for which advances were paid;

(3) the following items, provided that a detailed inventory is maintained with each item marked by any identifying number and the proof of cost maintained:

(A) furniture, labor-saving devices, machines, and all other office equipment used in the administration of the HMO;

(B) furniture, medical equipment, and vehicles used in connection with the direct provision of health care services; and

(C) electronic machines, constituting a data processing system or systems and operating systems software used directly for the provision of medical services and the administration of the HMO;

(4) inventories of necessary pharmaceutical and surgical supplies used directly in the treatment of medical conditions, it being the duty of the HMO to sufficiently prove the value of the inventories;

(5) real estate and leasehold estates, including buildings and improvements, and leasehold improvements on rented space, for the accommodation of the HMO's current or expected business operations used in the provision or support of health care services, including space for rent to any physician or provider under contract with the HMO, which property will be used in the provision of health care services to members of the HMO by that physician or provider; and

(6) claims overpayments, with the right of offset supported by a contractual agreement, which are specifically identifiable payments, may be admitted to the extent a liability to that physician or provider exists.

(b) All noninvested assets of an HMO must be accounted for in compliance with §11.801 of this title (relating to Accounting Guidance) except that the assets listed in subsection (a) of this section are admissible.

§11.806. Investment Management by Affiliate Companies.

(a) Subject to compliance with Insurance Code Chapter 843 (concerning Health Maintenance Organizations), this chapter, and other applicable insurance laws and regulations of this state, a domestic HMO, which is a member of a holding company system with assets in an aggregate amount in excess of $1 billion and a tangible net worth of at least $100 million and having affiliates licensed in this state may authorize an affiliated corporation that, if other than the ultimate holding company, is solvent with at least $10 million tangible net worth and whose performance and obligations under a written agreement with the HMO are guaranteed by the ultimate holding company to invest, hold, and administer as agent or nominee on behalf of the domestic HMO bonds, notes, or other evidences of indebtedness that are authorized and permissible investments under Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state that apply to HMOs, and which mature within one year of the date of acquisition. The securities must be invested, held, and administered

under a written agreement authorized by the board of directors of the HMO or an authorized committee, and submitted to the commissioner for prior approval. Approval must be based on satisfactory evidence that the agreement will facilitate the operations of the domestic HMO and will not unreasonably diminish the service to or protection of the domestic HMO's enrollees within this state.

(b) The agreement must:

(1) specify in which office location it will maintain records adequate to identify and verify the securities (or proportionate interest therein) belonging to the HMO; and

(2) allow the commissioner or the commissioner's designee to examine all records relating to those securities held subject to the agreement and must agree to furnish these records at the principal office of the HMO within 10 business days of a request by the commissioner or any of the department's commissioned examiners.

(c) The HMO may authorize the affiliate to:

(1) hold the securities of the HMO in bulk, in certificates issued in the name of the affiliate or its nominee, and to commingle them with securities owned by other affiliates of the affiliate;

(2) provide for the securities to be held by a custodian, including the custodian of securities of the affiliate, or in a clearing corporation or the Federal Reserve Book Entry System as provided in this subchapter; and

(3) purchase, sell, or otherwise dispose of the securities in compliance with instructions received from the HMO.

(d) If required by the commissioner, the HMO must report annually to the department:

(1) all investments with the affiliate under this section;

(2) the market value of all securities held by the affiliate on behalf of the HMO as of December 31 of the year next preceding or other date as the commissioner may require; and

(3) the financial condition of the affiliate including, at the commissioner's discretion, balance sheets, income statements, and supporting schedules with an opinion on those financial statements by an independent certified public accountant for the most recent fiscal year.

(e) All of the investments and transactions between or among affiliates and the HMO must otherwise comply with all other applicable provisions of Insurance Code Chapters 823 (concerning Insurance Holding Systems) and 843, and other applicable insurance laws and regulations of this state.

(f) If the HMO or the affiliate does not comply with Insurance Code Chapters 823 and 843 and other applicable insurance laws and regulations of this state, or does not comply with the written agreement governing the investing, holding, and administering of securities, then the commissioner's approval will be withdrawn after reasonable notice and ample opportunity to cure the noncompliance. If the HMO wishes to continue the arrangement, it must submit a request to the commissioner for approval.

(g) On the withdrawal of approval of the agreement, the HMO must undertake to obtain, and the affiliated corporation must undertake to return, investments or funds resulting from the sale or maturity of those investments in which the affiliated corporation invested, held, and administered on behalf of the HMO and the return must be accomplished within 90 days unless:

(1) the commissioner determines that the 90-day period creates a hazard to the public, in which case the commissioner may designate that the period may not exceed 30 days from the date of determination; or

(2) the commissioner extends the period for specific investments on request by the HMO and affiliated corporation, but in no event to exceed one year from the date of the withdrawal of approval.

(h) The affiliate must be organized under the laws of one of the states of the United States of America or of the District of Columbia.

§11.807. Fiduciary Responsibility.

Any director, member of a committee, officer, or any representative of a domestic HMO, who is charged with the duty of handling or investing its funds, may not intentionally:

(1) deposit or invest the funds, except in the corporate name of the HMO or in the name of the nominee of the HMO as may be allowed elsewhere in this subchapter; or

(2) take or receive to his or her own use any fee, brokerage, or commission, on account of a loan made by or on behalf of the HMO, except that reasonable interest may be received on amounts loaned to the HMO.

§11.808. Liabilities.

(a) Each HMO must account for liabilities as provided for in §11.801 of this title (relating to Accounting Guidance), and must segregate its liabilities into classifications of "covered" or "uncovered." Agreements to loan money or to make future capital or surplus contributions do not, in themselves, cause liabilities to be covered. Any guarantee of future contributions to surplus that are directed and based on the payment of a debt will allow that debt to be reflected as a covered liability. A liability, for which provision is made other than by the assets of the HMO, may qualify as a covered liability if the amount owed is:

(1) based on a physician or provider contract with a hold-harmless clause as provided in §11.901 of this title (relating to Required and Prohibited Provisions);

(2) subordinated in writing to the uncovered health care liabilities of the HMO; or

(3) unconditionally guaranteed and the guarantee is without monetary limit, as specified in §11.810 of this title (relating to Guarantee from a Sponsoring Organization), by a sponsoring organization that has a tangible net worth of at least $10 million in excess of all amounts that the sponsoring organization has guaranteed.

(b) An HMO may not decrease its liabilities or establish an asset on its balance sheet for any capitated risk or other risk-sharing arrangement with a network physician or provider relating to out-of-service area or emergency care provided by any non-network physician or provider. For purposes of this subsection, non-network physician or provider means a physician or provider who has not directly or indirectly contracted with an HMO or an HMO's network physicians or providers to provide medical or health care services to the HMO's enrollees.

§11.810. Guarantee from a Sponsoring Organization.

(a) The following items must be incorporated into a guarantee from a sponsoring organization for the HMO to report expenses and liabilities as covered:

(1) the guarantee must be approved by a board resolution of the sponsoring organization;

(2) the sponsoring organization must have a tangible net worth of at least $10 million for each guarantee issued;

(3) the sponsoring organization must agree to file audited financial statements annually with the department's Financial Analysis Section within 180 days of the end of the sponsoring organization's fiscal year;

(4) the guarantee must be unconditional and may not be monetarily limited;

(5) the guarantee, at a minimum, must cover otherwise "uncovered" health care expenses and liabilities, including any present or future contingencies that may arise from the delivery of health care. If the HMO is offering Medicaid products, all expenses and liabilities must be covered;

(6) the guarantee must not be limited in duration;

(7) the guarantee must provide for six-months' advance notice to the department before its cancellation; and

(8) the guarantee must be notarized and signed by the president and another officer of the sponsoring organization.

(b) If at any time a guarantee does not comply with every requirement of this section, then the HMO will no longer qualify for covered expenses and liabilities.

(c) If the sponsoring organization has guaranteed the payment of any debts, expenses, or contingent obligations of another person, or guaranteed the performance of any service or other obligation of another person, then the HMO must provide a certification from the sponsoring organization of the following:

(1) the name of each person guaranteed;

(2) the type of business of that person; and

(3) the extent of each guarantee issued, and the dollar amount of debts and contingent obligations guaranteed individually and in the aggregate.

(d) The HMO must also certify that the guaranteed debts are reported as liabilities or contingent liabilities of the guarantor. This certification must be submitted annually with the sponsoring organization's audited financial statements. The certified copy must be notarized and signed by the president or chief financial officer of the sponsoring organization, with an acknowledgment of the guarantee by the HMO's president or chief financial officer.

§11.811. Action under Insurance Code §843.157 and Insurance Code §843.461.

(a) In addition to any other actions available under the Insurance Code, the commissioner may take action against an HMO under §843.157 (concerning Rehabilitation, Liquidation, Supervision, or Conservation of Health Maintenance Organizations) and Insurance Code §843.461 (concerning Enforcement Actions). In evaluating the conditions in this section, the commissioner will evaluate all relevant circumstances concerning the HMO's operation. The evaluation of the information relating to these conditions is a part of the examination process. The conditions listed in this section do not conclusively indicate that action must be taken. One or more of the conditions can exist in an HMO that is in satisfactory condition; however, one or more of these conditions has often been found in an HMO that was unable to perform its obligations to enrollees, creditors, or the general public, or has required the commissioner to initiate regulatory action to protect enrollees, creditors, and the general public.

(b) The commissioner may take action under this section, if the commissioner finds that one or more of the conditions listed below or in §8.3 of this title (relating to Hazardous Conditions and Remedy of Hazardous Conditions) exist:

(1) an HMO's federal qualification designation, or NCQA accreditation, or both, are revoked or discontinued;

(2) an HMO's reported claims in process exceed 12 percent of annualized medical and hospital expenses (12 percent is approximately a 45-day backlog);

(3) an HMO fails to comply with Insurance Code Chapter 843 (concerning Health Maintenance Organizations), this chapter, or other applicable insurance laws and regulations of this state;

(4) an HMO has an inadequate provider network;

(5) an HMO contracts with a management or administrative company on a capitated or percentage of premium basis and the administrative or management company refuses to submit financial statements to the HMO;

(6) a physician or provider that is under contract, directly or indirectly, with an HMO, has a pattern of balance billing; or

(7) an HMO does not have the minimum net worth required by Insurance Code §843.403 (concerning Minimum Net Worth) and §11.802 of this title (relating to Minimum Net Worth).

(c) This section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code.

CHAPTER 11. SUBCHAPTER J

28 TAC §§11.900 - 11.904

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code §§36.001, 38.001, 843.002(28), 843.151, 843.203, 843.281, 843.283, 843.3045, 843.306, 843.307, 843.308, 843.309, 843.311, 843.3115; 843.312, 843.315, 843.316, 843.319, 843.320, 843.321, 843.323, 843.336, 843.361, 843.362, 843.363, 1271.201, 1271.202, 1353.001, 1353.002, 1371.003, 1451.156, and 1661.005.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §843.002(28) provides that the term "uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the HMO. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment for the services except as described in the evidence of coverage issued to the enrollee under Insurance Code Chapter 1271. The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to

health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.203 provides, in relevant part, an enrollee the opportunity to select and change the enrollee's primary care provider or physician.

Insurance Code §843.281 prohibits retaliatory actions by HMOs against a: (1) group contract holder or enrollee because the group or enrollee or a person acting on behalf of the group or enrollee has filed a complaint against the HMO or appealed a decision of the HMO; or (2) physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO.

Insurance Code §843.283 provides that a contract between an HMO and a physician or provider must require the physician or provider to post, in the office of the physician or provider, a notice to enrollees on the process for resolving complaints with the HMO. The notice must include the department's toll-free telephone number for filing a complaint.

Insurance Code §843.3045 provides that an HMO may not refuse to contract with a nurse first assistant, as defined by §301.1525, Occupations Code, to be included in the provider's network or refuse to reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

Insurance Code §843.306 provides, in relevant part, that an HMO must provide a written explanation before terminating a contract with a physician or provider, and for the right of a physician or provider to a review by an advisory review panel of the HMO's proposed termination, except in limited circumstances.

Insurance Code §843.307 provides that, on request by the physician or provider, a physician or provider whose participation in a health care plan is being terminated or who is deselected is entitled to an expedited review process by the HMO.

Insurance Code §843.308 regulates an HMO's notification of patients of the deselection of a physician or provider.

Insurance Code §843.309 provides that a contract between an HMO and a physician or provider must provide that reasonable advance notice must be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee.

Insurance Code §843.311 provides a podiatrist's right to an HMO's coding guidelines and payment schedules, prohibits HMOs from making unilateral material retroactive revisions to the coding guidelines and payment schedules, and provides that podiatrists may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the evidence of coverage.

Insurance Code §843.3115 provides, in relevant part, that a contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service.

Insurance Code §843.312 provides that HMO may not refuse a request by a physician participating in the HMO delivery network and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Occupations Code Chapter 157, Subchapter B, to identify a physician assistant or advanced practice nurse as a provider in the network, unless the physician assistant or advanced practice nurse does not meet the quality of care standards previously established by the HMO for participation in the network by physician assistants and advanced practice nurses.

Insurance Code §843.315 governs the payment of capitation and the assignment of a primary care physician or provider by any HMO that uses capitation to any extent as a method of compensation.

Insurance Code §843.316 provides that as an alternative to the procedures prescribed by §843.315, an HMO may request approval from the department of a capitation payment system that ensures: (1) immediate availability and accessibility of a primary care physician or primary care provider; and (2) payment to a primary care physician or primary care provider of a capitated amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk assumed.

Insurance Code §843.319 provides that, notwithstanding §843.304, an HMO may not deny a contract to a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners who joins the professional practice of a contracted physician or provider, satisfies the application procedures of the HMO, and meets the qualification and credentialing requirements for contracting with the HMO.

Insurance Code §843.320 provides that a contract between an HMO and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Insurance Code §843.321 provides a physician or provider's right to an HMO's coding guidelines and the use thereof.

Insurance Code §843.323 provides that, upon request, an HMO must include a provision in the physician's or provider's contract providing that the HMO or the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim, as defined by Chapter 843, Subchapter J, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim, and that the commissioner may issue a cease and desist order against or impose sanctions on an HMO that violates the section or a contract provision adopted under the section.

Insurance Code §843.336 defines the term "clean claim."

Insurance Code §843.361 provides that a contract or other agreement between an HMO and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the HMO does not pay the physician or provider for those services.

Insurance Code §843.362 provides, in relevant part, that each contract between an HMO and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the HMO from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence.

Insurance Code §843.363 provides, in relevant part, that an HMO may not: (a) as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to certain matters; (b) as a condition of payment with a physician, dentist, or provider, or in any other manner, require a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient; or (c) in any manner penalize, terminate, or refuse to compensate for covered services a physician, dentist, or provider for communicating in a manner protected by the section with a current, prospective, or former patient, or a person designated by a patient. The section further provides that a contract provision that violates the section is void.

Insurance Code §1271.201 provides, in relevant part, that an evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

Insurance Code §1271.202 provides that if an HMO denies a request under §1271.201, the enrollee may appeal the decision through the HMO's established complaint and appeals process.

Insurance Code §1353.001 provides that a managed care entity may not: (1) require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan; (2) limit an enrollee's benefits for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued; (3) provide a financial incentive to a physician to issue an immunization or vaccination protocol; or (4) impose a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol.

Insurance Code §1353.002 provides that the commissioner may adopt rules to implement Chapter 1353.

Insurance Code §1371.003 provides, in relevant part, that a health benefit plan must provide coverage for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled under Sections 1832, 1833, and 1834, Social Security Act (42 U.S.C. Sections 1395k, 1395l, and 1395m), and 42 C.F.R. Sections 410.100, 414.202, 414.210, and 414.228, as applicable.

Insurance Code §1451.156 sets forth prohibited conduct by a managed care plan.

Insurance Code §1661.005 provides that a physician, hospital, or other health care provider that receives an overpayment from an enrollee must refund the amount of the overpayment to the enrollee not later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. The section does not apply to an overpayment subject to §843.350 or §1301.132.

SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

§11.900. Nonprimary Care Physician Specialists as Primary Care Physician.

(a) An HMO must allow an enrollee with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician, provided that:

(1) the enrollee makes a request for special consideration that includes:

(A) a certification by the nonprimary care physician specialist of the medical need for the enrollee to use the nonprimary care physician specialist as a primary care physician;

(B) a statement signed by the nonprimary care physician specialist that the specialist is willing to accept responsibility for the coordination of all of the enrollee's health care needs; and

(C) the signature of the enrollee;

(2) the nonprimary care physician specialist meets the HMO's requirements for primary care physician participation, including credentialing;

(3) the HMO has ensured that the contractual obligations of the nonprimary care physician specialist are consistent with the contractual obligations of the HMO's primary care physicians; and

(4) the HMO must provide the nonprimary care physician specialist with a current directory of participating specialist physicians and providers.

(b) An HMO must approve or deny the request for special consideration and provide written notification of the decision to the enrollee not later than 30 days after receiving the request. If the HMO denies the request, the HMO must provide the reasons for denial in the written notification. An HMO must establish written criteria for determining medical need for an enrollee to use a nonprimary care physician specialist as a primary care provider, and must include the criteria in the provider manual.

(c) If the HMO denies a request for special consideration, an enrollee may appeal the decision through the HMO's established complaint and appeal process.

§11.901. Required and Prohibited Provisions.

(a) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding a hold-harmless clause as described in Insurance Code §843.361 of this title (concerning Enrollees Held Harmless).

(1) A hold-harmless clause is a provision in a physician or health care provider agreement that obligates the physician or provider to look only to the HMO and not its enrollees for payment for covered services (except as described in the evidence of coverage issued to the enrollee).

(2) In compliance with Insurance Code §843.002 (concerning Definitions) relating to an "uncovered expense," if a physician or health care provider agreement contains a hold-harmless clause, then the costs of the services will not be considered uncovered health care expenses in determining amounts of deposits necessary for insolvency protection under Insurance Code §843.405 (concerning Deposit with Comptroller).

(3) The following is an example of an approvable hold-harmless clause: "(Physician or Provider) hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency, or breach of this agreement, may (Physician or Provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than the HMO acting on their behalf for services provided under this agreement. This provision does not prohibit collection of supplemental charges or copayments made in compliance with the terms of (applicable agreement) between HMO and subscriber or enrollee. (Physician or Provider) further agrees that:

(A) this provision will survive the termination of this agreement regardless of the cause giving rise to termination and must be construed to be for the benefit of the HMO subscriber or enrollee; and

(B) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Physician or Provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than 15 days after the commissioner has received written notice of the proposed changes."

(b) Physician and provider contracts, subcontracts, and arrangements must include provisions:

(1) regarding retaliation as described in Insurance Code §843.281 (concerning Retaliatory Action Prohibited);

(2) regarding continuity of treatment, if applicable, as described in Insurance Code §843.309 (concerning Contracts with Physicians or Providers; Notice to Certain Enrollees of Termination

of Physician or Provider Participation Plan) and §843.362 (concerning Continuity of Care; Obligation of Health Maintenance Organization);

(3) regarding written notification to enrollees receiving care from a physician or provider of the termination of that physician or provider in compliance with Insurance Code §843.308 (concerning Notification of Patients of Deselected Physician or Provider) and §843.309 (concerning Contracts With Physicians or Providers: Notice to Certain Enrollees of Termination of Physician or Provider Participation in a Plan);

(4) regarding posting of complaint notices in physician or provider offices as described in Insurance Code §843.283 (concerning Posting of Information on Complaint Process Required), provided that a representative notice that complies with this requirement may be obtained from the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or the department's website at www.tdi.texas.gov;

(5) regarding indemnification of the HMO as described in Insurance Code §843.310 (concerning Contracts with Physicians or Providers; Certain Indemnity Clauses Prohibited);

(6) regarding prompt payment of claims as described in Insurance Code Chapter 542, Subchapter B, (concerning Prompt Payment of Claims); §1271.005 (concerning Applicability of Other Law); and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J, (concerning Payment of Claims to Physicians and Providers); and Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims) with respect to payment to the physician or provider for covered services rendered to enrollees;

(7) regarding capitation, if applicable, as described in Insurance Code §843.315 (concerning Payment of Capitation; Assignment of Primary Care Physician or Provider) and §843.316 (concerning Alternative Capitation System);

(8) regarding selection of a primary care physician or provider, if applicable, as described in Insurance Code §843.203 (concerning Selection of Primary Care Physician or Provider);

(9) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish X-rays and non-prefabricated orthotics covered by the evidence of coverage as described in Insurance Code §843.311 (concerning Contracts with Podiatrists);

(10) regarding the requirements of §21.3701 of this title (relating to Electronic Claims Filing Requirements) if the contract requires electronic submission of any information described by that section;

(11) requiring the preferred provider to comply with all applicable requirements of Insurance Code §1661.005 (concerning Refunds of Overpayments); and

(12) requiring a contracting physician or provider to retain in the contracting physician's or provider's records updated information concerning a patient's other health benefit plan coverage.

(c) Physician and provider contracts and arrangements must include provisions entitling the physician or provider, on request, to all information necessary to determine that the physician or provider is being compensated in compliance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. The information provided must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including email, computer disks, or other electronic storage and transfer technology, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided under this paragraph must comply with paragraph (4) of this subsection. The HMO must provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(1) The information provided must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider, including at a minimum, the:

(A) fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM, ICD-10-CM, and successor codes, and modifiers:

(i) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider; or

(ii) that pertains to the range of health care services reasonably expected to be delivered under the contract by that contracting physician or provider on a routine basis, along with a toll-free number or electronic address through which the contracting physician or provider

may request the fee schedules applicable to any covered services that the physician or provider intends to provide to an enrollee, and any other information required by this subsection, that pertains to the service for which the fee schedule is being requested if the HMO has not previously provided that information to the physician or provider;

(B) all applicable coding methodologies;

(C) all applicable bundling processes, which must be consistent with nationally recognized and generally accepted bundling edits and logic;

(D) all applicable downcoding policies;

(E) a description of any other applicable policy or procedure the HMO may use that affects the payment of specific claims submitted by or on behalf of the contracting physician or provider, including recoupment;

(F) any addenda, schedules, exhibits, or policies used by the HMO in carrying out the payment of claims submitted by or on behalf of the contracting physician or provider that are necessary to provide a reasonable understanding of the information provided under this subsection; and

(G) the published product name and version of any software the HMO uses to determine bundling and unbundling of claims.

(2) In the case of a reference to source information outside the control of the HMO as the basis for fee computation, such as state Medicaid or federal Medicare fee schedules, the information the HMO provides must clearly identify the source and explain the procedure by which the physician or provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(3) Nothing in this subsection may be construed to require an HMO to provide specific information that would violate any applicable copyright law or licensing agreement. However, the HMO must supply, instead of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services that are rendered to enrollees as required by paragraph (1) of this subsection.

(4) No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this subsection will be effective as to the contracting physician or provider, unless the HMO provides at least 90-calendar-days written notice to the

contracting physician or provider identifying with specificity the amendment, revision, or substitution. An HMO may not make retroactive changes to claims payment procedures or any of the information required to be provided by this subsection. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this subsection, the written notice specified in this section does not supersede the requirement for mutual agreement.

(5) The HMO must provide the information required by paragraphs (1) - (4) of this subsection to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.

(6) A physician or provider receiving information under this subsection may not:

(A) use or disclose the information for any purpose other than:

(i) the physician's or provider's practice management,

(ii) billing activities,

(iii) other business operations, or

(iv) communications with a governmental agency involved in the regulation of health care or insurance;

(B) use the information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; or

(C) rely on information provided under this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(7) A physician or provider that receives information under this subsection may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider must provide for reasonable advance notice to enrollees being treated by the physician or provider before the termination consistent with Insurance Code §843.309.

(8) The provisions of this subsection may not be waived, voided, or nullified by contract.

(d) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding written notification of termination to a physician or provider in compliance with Insurance Code §843.306 (concerning Termination of Participation; Advisory Review Panel) and §843.307 (concerning Expedited Review Process on Termination or Deselection), including provisions providing that:

(1) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days before the effective date of the termination;

(2) not later than 30 days following receipt of the written notification of termination, a physician or provider may request a review by the HMO's advisory review panel except in a case involving:

(A) imminent harm to patient health;

(B) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(C) fraud or malfeasance; and

(3) within 60 days after receipt of the physician or provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the physician or provider.

(e) On request by a participating physician or provider, an HMO must include a provision in the physician's or provider's contract providing that the HMO and the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" means "a group of electronic claims submitted for processing at the same time within a Health Insurance Portability and Accountability Act (HIPAA) standard ASC X12N 837 Transaction Set and identified by a batch control number." This subsection applies to a contract entered into or renewed on or after the effective date of this subsection. For a contract entered into or renewed before the effective date of this subsection, the law and regulations in effect at the time the contract was entered or renewed, whichever is later, governs.

(f) A contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115 (concerning Contracts with Dentists).

§11.902. Prohibited Actions.

An HMO may not:

(1) require a physician to use a hospitalist for a hospitalized patient by contract under Insurance Code §843.320 (concerning Use of Hospitalist);

(2) refuse to contract with a nurse first assistant to be part of a provider network or refuse to reimburse a nurse first assistant under Insurance Code §843.3045 (concerning Nurse First Assistant);

(3) require a physician to use the services of a nurse first assistant as defined by Occupations Code §301.354 (concerning Nurse First Assistants; Assisting at Surgery by Other Nurses);

(4) refuse to contract with a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners who joins the professional practice of a contracted physician or provider under Insurance Code §843.319 (concerning Certain Required Contracts);

(5) refuse a request to identify a physician assistant or advanced practice registered nurse as a provider in the HMO's network-under Insurance Code §843.312 (concerning Physician Assistants and Advanced Practice Nurses);

(6) employ an optometrist or therapeutic optometrist to provide a vision care product or service, pay an optometrist or therapeutic optometrist for a service not provided, or restrict or limit an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials under Insurance Code §1451.156 (concerning Prohibited Conduct); or

(7) contract with a dentist to limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115.

§11.903. Physician or Provider Communication.

(a) An HMO may not, as a condition of a contract with a physician or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or

communicating to a current, prospective, or former patient, or a party designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options, or the availability of facilities both in-network and out-of-network for the treatment of a patient's medical condition;

(2) information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient;

(3) the fact that the physician's or provider's contract with the HMO has terminated or that the physician or provider will otherwise no longer be providing medical care or health care services under the health care plan; or

(4) the fact that, if medically necessary covered services are not available through network physicians or providers, the HMO must, on the request of a network physician or provider and within time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow referral to a non-network physician or provider.

(b) An HMO may not in any way penalize, terminate, or refuse to compensate for covered services, a physician or provider for communicating with a current, prospective, or former patient, or a party designated by a patient, in any way protected by this section.

(c) An HMO may not require a physician or provider to provide a notification form stating that the physician or provider is an out-of-network provider to a current, prospective, or former patient, or a party designated by a patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

§11.904. Provision of Services Related to Immunizations and Vaccinations.

(a) In compliance with Insurance Code Chapter 1353 (concerning Immunization or Vaccination Protocols Under Managed Care Plans), an HMO may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee by a pharmacist.

(b) No contract between an HMO and a pharmacy or pharmacist may prohibit a pharmacist from administering immunizations or vaccinations if the immunizations or vaccinations are administered in

compliance with the Texas Pharmacy Act, Occupations Code, Title 3, Subtitle J, Chapters 551 - 569 (concerning Pharmacy and Pharmacists), and related rules.

CHAPTER 11. SUBCHAPTER K

28 TAC §11.1001

STATUTORY AUTHORITY. The proposed new section is proposed under Insurance Code §§32.041, 36.001, 38.001, 541.059, 843.076, 843.078, 843.082, 843.151, 843.154, 843.405, and 1271.251.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §541.059 provides, in relevant part, that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media certain names, words, devices, symbols, or slogans.

Insurance Code §843.076 provides requirements concerning an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.405 provides for the cash, securities, or combination of cash, securities, and other guarantees that are acceptable to the commissioner, that HMOs must deposit with the comptroller.

Insurance Code §1271.251 provides that the formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan. The section provides that the formula or method must be established in accordance with actuarial principles for the various categories of enrollees, and that the filing of the method or formula must contain: (1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and (2) supporting information that the commissioner considers adequate. The section also provides that the formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and that benefits must be reasonable with respect to the rates produced by the formula or method.

SUBCHAPTER K. REQUIRED FORMS

§11.1001. Required Forms.

The following forms are to be used in conjunction with the rules adopted under this chapter. Copies of these forms may be obtained by contacting the Company Licensing and Registration Office, Mail Code 103-CL, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or from the department's website at www.tdi.texas.gov. Each HMO or other person or entity must use the form or forms required by this title as appropriate to its particular activities. The forms are listed as follows:

(1) Name Application Form, (rev. 03/14);

(2) Application for a Certificate of Authority to do business in the State of Texas, (rev. 09/04);

(3) State of Texas Officers and Directors Page, TDI Form FIN306, (rev. 06/10);

(4) State of Texas Biographical Affidavit, NAIC UCAA Form 11, (rev. 04/13);

(5) HMO Certification and Transmittal Form, TDI Form LHL 259, (rev. 07/14);

(6) Reconciliation of Benefits to Schedule of Charges Form, TDI Form LHL 654, (rev. 01/13);

(7) Statutory Deposit Transaction Form, Form No. FIN407 (rev.11/15); and

(8) Declaration of Trust Form, Form No. FIN453 (rev.11/15).

CHAPTER 11. SUBCHAPTER M

28 TAC §11.1201

STATUTORY AUTHORITY. The new section is proposed under Insurance Code Chapter 823, Subchapters D and E; Insurance Code Chapter 824, Subchapter A; and Insurance Code §36.001 and §843.051(g).

Insurance Code Chapter 823, Subchapter D, contains provisions regarding the control, acquisition, merger, change, or divestiture of domestic insurers.

Insurance Code Chapter 823, Subchapter E, provides for an acquisition statement by an acquiring person.

Insurance Code Chapter 824, Subchapter A, provides for the merger and consolidation of stock insurance corporations.

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

Insurance Code §843.051(g) provides that the merger of an HMO with another HMO is subject to Chapter 824 as if the HMOs were insurance corporations under that chapter, and that the commissioner may adopt rules as necessary to implement the subsection in a way that reflects the nature of HMOs, health care plans, or evidences of coverage.

SUBCHAPTER M. ACQUISITION, CONTROL, OR MERGER OF A DOMESTIC HMO

§11.1201. Acquisition, Control, or Merger of a Domestic HMO.

An HMO is subject to the requirements of Insurance Code Chapter 823 (concerning Insurance Holding Company Systems); Insurance Code Chapter 824 (concerning Merger and Consolidation of Stock Insurance Corporations); and Chapter 7, Subchapter B, of this title (relating to Insurance Holding Company Systems).

CHAPTER 11. SUBCHAPTER O

28 TAC §§11.1401 - 11.1404

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code §§32.041, 36.001, 38.001, 843.151, 843.154, 843.305, and 1369.402.

Insurance Code §32.041 provides that the department furnish to the companies required to report to the department the necessary forms for the required statements.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for

primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §843.305 provides, in relevant part, that an HMO providing coverage through one or more physicians or providers who are not partners or employees of the HMO, or one or more physicians or providers who are not owned or operated by the HMO, must provide a period of 20 calendar days each calendar year during which any physician or provider in a service area may, under the terms established by the HMO for the provision of services and the designation of physicians and providers, apply to participate in providing health care services.

Insurance Code §1369.402 provides that a health benefit plan issuer or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process.

SUBCHAPTER O. ADMINISTRATIVE PROCEDURES

§11.1401. Commissioner's Authority to Require Additional Information.

The commissioner may require additional information as needed to make any determination required by Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, and other applicable insurance laws and regulations of this state.

§11.1402. Notification to Physicians and Providers.

(a) An HMO that provides coverage for health care services or medical care through one or more physicians or providers is required by Insurance Code §843.305 (concerning Annual Application Period for Physician and Providers to Contract) to provide a 20-calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in each of the HMO's networks providing health care services or medical care under the terms and conditions established by the HMO for the provision of the services and the designation of the physicians and providers. Section 843.305 may not be construed to:

(1) require that an HMO use a particular type of provider or physician in its operation;

(2) require that an HMO accept a physician or provider of a category or type that does not meet the practice standards and qualifications established by the HMO; or

(3) require that an HMO contract directly with the physicians or providers.

(b) An HMO subject to Insurance Code §843.305 must publish a notice of an application period to physicians and providers both in the public notice section of at least one major newspaper with general circulation in each of its service areas and on the HMO's website. The notice must be published for at least five consecutive days during the period of January 2 through January 23 of each calendar year and must include the caption "Notice to Physicians and Providers" in bold type, the name and address of the HMO, what networks the HMO provides, and the specific dates of the 20-day period during which physicians and providers may make application to be a participating physician or provider in each network.

(c) An HMO must notify a physician or provider of acceptance or nonacceptance, in writing, no later than 90 days from receipt of an application for participation by that physician or provider in a network.

(d) An HMO must file a copy of the published notice with the department in compliance with §11.301 of this title (relating to Filing Requirements), for information, within 30 days of publication. The filing must include the following:

(1) the name of the newspaper and the beginning and ending date of the publication; and

(2) a copy of the website screen shots and the beginning and ending date of the publication.

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers.

(a) HMOs must include the following notice in information provided to new subscribers:

Figure: 28 TAC §11.1403(a)

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-832-9623

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

(b) The entire notice must be in at least 10-point type. If the newsletter or other mailing is in larger than 10-point type, the notice must be in the same type as the rest of the newsletter or mailing. Paragraphs 1 - 4 of the English notice and paragraphs 1 - 4 of the Spanish notice must be in boldface type. Paragraphs 1 and 2 of the English and Spanish notices must be in capital letters. A final print of the mailing must be submitted to the Life and Health Lines Office of the Texas Department of Insurance for filing within 30 days following distribution to enrollees.

§11.1404. Pharmacy Application and Recertification.

(a) An HMO may not require any pharmacy or pharmacist participating or applying to participate as a contracted provider in an HMO delivery network to:

(1) provide financial statements to the HMO; or

(2) deposit with the HMO any monies or other form of consideration, except for reasonable application and recertification fees.

(b) An HMO or a pharmacy benefit manager may not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of, or component or mechanism related to, the claim adjudication process in violation of Insurance Code §1369.402 (concerning Certain Fees Prohibited).

CHAPTER 11. SUBCHAPTER P

28 TAC §11.1500

STATUTORY AUTHORITY. The new section is proposed under Insurance Code §§36.001, 843.151, 843.154, and 1271.252.

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

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.154 limits some fees, provides for the commissioner to prescribe fees to be charged under the section, and provides for the disposition of fees.

Insurance Code §1271.252 provides that the charges resulting from the application of a formula or method described by Insurance Code §1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

SUBCHAPTER P. PROHIBITED PRACTICES

§11.1500. Discrimination Based on Health Status-Related Factors.

An HMO may not require an enrollee in a group health plan to pay a premium or contribution that is different from the premium or contribution for a similarly situated enrollee based on a health status-related factor. For purposes of this section, the term "similarly situated” has the meaning assigned to it in 45 CFR §146.121 (concerning Prohibiting Discrimination Against Participants and

Beneficiaries Based on a Health Factor). An HMO may not establish policies or procedures that are based on health status-related factors for the eligibility of any individual to enroll under a group plan.

CHAPTER 11. SUBCHAPTER Q

28 TAC §§11.1600 - 11.1607 and 11.1610 - 11.1612

STATUTORY AUTHORITY. The commissioner adopts the new sections under Business and Commerce Code Chapter 501, Subchapter A; Health and Safety Code §62.054; Insurance Code Chapter 1451, Subchapter K; and Insurance Code §§36.001, 521.102, 843.082, 843.084, 843.107, 843.108, 843.151, 843.201, 843.2015, 843.205, 843.206, 843.209, 1271.104, 1271.155, 1369.153, 1456.003, 1693.002, 1693.003, 4054.001, and 4151.152; and Occupations Code §162.001.

Business and Commerce Code Chapter 501, Subchapter A, restricts access to and use of social security numbers, and it provides remedies for violations.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 1451, Subchapter K, provides, in relevant part, that a health benefit plan issuer that offers coverage for health care services through preferred providers, exclusive providers, or a network of physicians or health care providers must develop and maintain a physician and health care provider directory, provides for certain information to be provided in that directory, and provides for the display of the directory and other information on a public Internet website maintained by the issuer.

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

Insurance Code §521.102 provides, in relevant part, that an HMO must maintain a toll-free number to provide information concerning evidences of coverage and receive complaints from enrollees.

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.084 provides the duration of a certificate of authority.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §843.2015 provides that an HMO that maintains an Internet site must list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The section provides that the listing must identify those physicians and providers who continue to be available to provide services to new patients or clients. The section provides for quarterly updates. The section also provides that the commissioner may adopt rules as necessary to implement the section, and that the rules may govern the form and content of the information required to be provided under subsection (a) of the section.

Insurance Code §843.205 provides for an HMO to provide a member handbook and lists some requirements regarding language and the provision of access to enrollees with disabilities affecting their ability to communicate or read.

Insurance Code §843.206 provides that an HMO must notify a group contract holder within 30 days of any substantive change to the payment arrangements between the HMO and physicians or providers.

Insurance Code §843.209 provides that an identification card or other similar document issued by an HMO to an enrollee must indicate that the HMO is regulated under the Insurance Code, and display the enrollee's first date of enrollment and a toll-free number a physician or provider may use to obtain that date.

Insurance Code §1271.104 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Chapter 1271, Subchapter C.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1369.153 provides for the information that must be included on identification cards issued by issuers of health benefit plans.

Insurance Code §1456.003 provides for notice each health benefit plan that provides health care through a provider network must provide to its enrollees.

Insurance Code §1693.002 provides that an identification card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must, in addition to any requirement under other law, including §§843.209, 1301.162, and 1369.153, display on the card or document in a location of the issuer's choice the acronym "QHP."

Insurance Code §1693.003 provides, in relevant part, that the commissioner monitor 45 C.F.R. Section 155.20 for amendments to the definitions listed in §1693.001 and determine if it is in the best interest of the state to adopt an amended definition for purposes of Chapter 1693.

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person

who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

Insurance Code §4151.152 provides for information that must be included in identification cards issued by a plan administrator.

Occupations Code §162.001 provides for the Texas Medical Board to approve and certify certain nonprofit health corporations.

SUBCHAPTER Q. OTHER REQUIREMENTS

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

(a) An HMO must provide an accurate written description of health care plan terms and conditions to allow any prospective contract holder or enrollee or current contract holder or enrollee to make comparisons and informed decisions before selecting among health care plans. The HMO may deliver the written description of health care plan terms and conditions electronically but must provide a paper copy on request.

(b) The written or electronic plan description must be filed for approval in compliance with §11.301 of this title (relating to Filing Requirements); be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements), by category; and include these items in the following order:

(1) a statement that the entity providing the coverage is an HMO;

(2) a toll-free number, unless exempted by statute or rule, and address for obtaining additional information, including physician and provider information;

(3) a clear, complete, and accurate description of all covered services and benefits, including a description of the options, if any, for prescription drug coverage, both generic and brand name, and if applicable, an explanation of how to access formulary information consistent with §21.3031(b) of this title (relating to Formulary Information on Issuer's Website);

(4) a clear, complete, and accurate description of emergency care services and benefits, including coverage for out-of-area emergency care services and information on access to after-hours care;

(5) a clear, complete, and accurate description of out-of-area services and benefits (if any);

(6) as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), statements that:

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

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

(C) if the enrollee receives a balance bill, the enrollee should contact the HMO;

(7) a clear, complete, and accurate explanation of enrollee financial responsibility for payment of premiums, copayments, deductibles, and any other out-of-pocket expenses for noncovered or out-of-plan services, and an explanation that network physicians and providers have agreed to look only to the HMO and not to its enrollees for payment of covered services, except as set forth in this description of the plan;

(8) a clear, complete, and accurate description of any limitations or exclusions, including the existence of any drug formulary limitations;

(9) a clear, complete, and accurate description of any prior authorization requirements, including limitations or restrictions, and a summary of procedures to obtain approval for referrals to physicians and providers other than primary care physicians or dentists, and other review requirements, including preauthorization review, concurrent review, post service review, and post payment review, and the consequences resulting from the failure to obtain any required authorizations;

(10) a provision for continuity of treatment in the event of the termination of a primary care physician or dentist;

(11) a clear, complete, and accurate summary of the HMO's complaint and appeal procedures, a statement of the availability of the independent review process, and a statement that the HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO;

(12) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, with the information necessary to fully inform prospective or current enrollees about the network, including the information required by §11.1612 of this title (relating to Mandatory Disclosure Requirements), together with a link to the online directory required under §11.1612(a) of this title;

(13) a clear, complete, and accurate description of the service area;

(14) when the HMO product includes point-of-service coverage, including when such coverage is provided by an insurer, or when the product is explicitly marketed with the option of purchasing point-of-service coverage, a clear, complete, and accurate explanation of the point-of-service coverage, including:

(A) an explanation of how any deductible is calculated, clearly explaining if multiple deductibles may be applied under the plan as a whole;

(B) a method to obtain a real-time estimate of the amount of reimbursement that will be paid to a non-network provider for a particular service;

(C) a clear, complete, and accurate explanation of how reimbursements of non-network point-of-service services will be determined subject to §11.2503 of this title (relating to Coverage Relating to Point-of-Service Rider Plans) for point-of-service riders or §21.2902 of this title (relating to Arrangements between Indemnity Carriers and HMOs to Provide Coverage) for dual and blended point-of-service arrangements;

(D) if point-of-service coverage is provided under a dual or blended point-of-service arrangement, a clear, complete, and accurate explanation of how the coverage will be coordinated and who the enrollee should contact for common issues, including;

(i) the identity and contact information for each entity, the HMO, the indemnity carrier, or any third party administrator (TPA) that will administer the coverages offered under the point-of-service plan;

(ii) a clear, complete, and accurate description of all duties of the HMO and other carrier to each other relating to the point-of-service plan issued under this subchapter; and

(iii) as applicable, a clear, complete, and accurate explanation of out-of-plan coverage for point-of-service coverage offered in conjunction with plans subject to Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans);

(E) a clear, complete, and accurate explanation that for an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the HMO delivery network.

(c) An HMO may use its member handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure as the written or electronic description prescribed by the commissioner and contains all the information required under this section.

(d) An HMO offering a Children's Health Insurance Program plan that files its plan description in the form of its member handbook in compliance with §11.301 of this title (relating to Filing Requirements), for information only, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook is exempt from the filing and approval requirements of subsection (b) of this section.

(e) If an HMO limits enrollees' access to health care to a limited provider network, then it must provide a notice in substantially the following form to prospective and current group contract holders: "Choosing Your Physician--Now that you have chosen (Name of HMO), your next choice will be deciding who will provide the majority of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP is also part of a 'network' or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer."

(f) If an HMO does not limit an enrollee's selection of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or provider belongs, then it must provide a notice in compliance with Insurance Code Chapter 1451, Subchapter F, (concerning Access to Obstetrical or Gynecological Care) in substantially the following form to current or prospective

enrollees: "ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

(g) An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in each limited provider network. An HMO must include an index of the alphabetical listing of all contracted physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network(s) to which the physician or provider belongs and the page number where the physician or provider's name can be found.

(h) An HMO must provide notice to enrollees informing them to contact the HMO on receipt of a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner. The notice must inform enrollees of the method(s) for contacting the HMO for this purpose.

(i) If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (for example, a hospital or skilled nursing facility), the plan description must disclose that on admission to the inpatient facility, a physician other than the primary care physician may direct and oversee the enrollee's care.

(j) An HMO that maintains a website must list the information on its website as required by subsections (b) - (g) of this section and Insurance Code §843.2015 (concerning Information Available Through Internet Site) and §1456.003 (concerning Required Disclosure: Health Benefit Plan). The information must be easily accessible from the home page of the HMO's website.

§11.1601. Enrollee Identification Cards.

(a) If an HMO issues identification (ID) cards to enrollees, the HMO must issue the ID cards within 30 calendar days of receiving notice of the enrollee's selection of a primary care physician. The enrollee ID card will include, at a minimum, all necessary information to allow an enrollee to access all services under the certificate or evidence of coverage that require presentation of the card.

(b) All ID cards an HMO issues must comply with the requirements of Insurance Code §843.209 (concerning Identification Card) and §1693.002 (concerning Identification Card and Required Information) and §21.2820 of this title (relating to Identification Cards).

(c) If an evidence of coverage provides benefits for prescription drugs, an HMO must issue an ID card in compliance with Insurance Code §1369.153 (concerning Information Required on Identification Card) and §4151.152 (concerning Identification Cards) and §§21.3002 - 21.3004 of this title (relating to Definitions; Pharmacy Identification Cards, Standard Identification Cards, and Issuance of Standard Identification Cards).

(d) All ID cards issued by an HMO must comply with the requirements of Business and Commerce Code §501.001 (concerning Certain Uses of Social Security Number Prohibited) and §501.002 (concerning Certain Uses of Social Security Number Prohibited; Remedies), which restrict the display of social security numbers on ID cards.

(e) An ID card or other similar document issued by a qualified health plan issuer to an enrollee of a qualified health plan purchased through an exchange must display on the card or document in a location of the issuer's choice the acronym "QHP."

§11.1602. Enrollment Form and Access to Certain Information.

(a) An HMO must include on its enrollment form a space in which an enrollee may indicate:

(1) the enrollee's primary language; and

(2) whether the enrollee has a disability affecting the enrollee's ability to communicate or read.

(b) The HMO must provide, at its own expense, a member handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the language of the major population of the HMO's enrolled population under Insurance Code §843.205 (concerning Member's Handbook; Information About Complaints and Appeals). The HMO may deliver the member handbook and materials electronically but must provide a paper copy on request.

(c) If a member has a disability affecting the member's ability to communicate or read, then the HMO must provide, at its own expense, a member handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the appropriate format, including, but not limited to:

(1) Braille;

(2) large print, no smaller than 17 point;

(3) audio tape;

(4) TDD access;

(5) an interpreter; or

(6) any combination of the above.

§11.1603. Notification of Change in Payment Arrangements.

An HMO must provide written notification to affected group contract holders of a substantive change in the payment arrangement for physicians and providers within 30 days of any change in the type of payment arrangement; for example, a change from capitation to fee for service, or from fee for service to capitation, for any type of service. The notification of the change must include a description of the changed payment arrangement and a description of the new payment arrangement.

§11.1604. Requirements for Certain Contracts Between Primary HMOs and ANHCs and Between Primary HMOs and Provider HMOs.

A primary HMO that enters into a contract with an ANHC in which the ANHC agrees to arrange for or provide health care services other than medical care or services ancillary to the practice of medicine, or with a provider HMO in which the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the primary HMO as part of the primary HMO delivery network must:

(1) submit a monitoring plan to the department setting out:

(A) how the primary HMO will ensure that the ANHC or provider HMO has an effective administrative system for providing timely and accurate reimbursement to all physicians and providers under contract with the ANHC or provider HMO; and

(B) how the primary HMO will ensure that all HMO functions delegated or assigned under contract with the ANHC or provider HMO are consistent with full compliance by the primary HMO with all department regulatory requirements;

(2) file with the department a copy of the form of the written contract with an ANHC or provider HMO, in accordance with §11.301(5) of this title (relating to Filing Requirements), that:

(A) requires that the ANHC or provider HMO cannot terminate the contract without 90-days written notice;

(B) contains a hold-harmless provision that prohibits the ANHC or provider HMO and its contracted physicians and providers from billing for or attempting to collect from HMO members, except for authorized copayments and deductibles, charges for covered services under any circumstance, including the insolvency of the primary HMO, ANHC, or provider HMO;

(C) contains a provision stating that nothing in the contract will be construed to in any way limit the HMO's authority or responsibility to comply with all of the department's regulatory requirements;

(D) includes the ANHC's or provider HMO's acknowledgment and agreement that:

(i) the primary HMO is required to establish, operate, and maintain a health care delivery system, quality assurance system, physician and provider credentialing system, and other systems and programs meeting department standards and is directly accountable for compliance with the standards;

(ii) the role of the ANHC or provider HMO in contracting with the primary HMO is limited to implementing certain systems of the primary HMO, utilizing standards approved by the primary HMO, and subject to the primary HMO's oversight and monitoring of the ANHC's or provider HMO's performance; and

(iii) the primary HMO may take necessary action to ensure that all HMO systems and functions that are delegated or assigned under the contract with the ANHC or provider HMO are in full compliance with all department regulatory requirements;

(E) requires the ANHC to make available to the primary HMO the ANHC's contracts with physicians and providers to ensure compliance with contractual requirements set out in subparagraphs (B) and (C) of this paragraph;

(F) requires the ANHC to provide the primary HMO with evidence of both financial solvency and financial ability to perform, such as a certified financial audit of the ANHC conducted by an independent certified public accountant, using generally accepted accounting and auditing principles; and

(G) requires the ANHC or provider HMO to provide the primary HMO, on at least a monthly basis and in a usable form necessary for audit purposes, the data necessary for the HMO to comply with department reporting requirements with respect to any services provided under the HMO-ANHC or HMO-provider HMO agreement, including the following data:

(i) number of primary HMO enrollees served or assigned to the ANHC or primary HMO to receive services, including the number added and terminated since the last reporting period;

(ii) form of the contracts and subcontracts between the ANHC and physicians and providers who will be providing services to enrollees of the primary HMO and any material changes to the contracts and subcontracts;

(iii) copayments received by the ANHC or provider HMO;

(iv) summary of the amounts paid by the ANHC or provider HMO to physicians and providers;

(v) methods by which physicians and providers were paid by the ANHC or provider HMO, for example, capitation, fee-for-services, or other risk-sharing arrangements;

(vi) utilization data;

(vii) summary of the amounts paid by the ANHC or provider HMO for administrative services relating to the primary HMOs;

(viii) the time that claims and debts related to claims owed by the ANHC or provider HMO have been pending;

(ix) information required for the primary HMO to be able to file claims for reinsurance, coordination of benefits, and subrogation;

(x) physician and provider and enrollee satisfaction data;

(xi) complaint data;

(xii) documentation of any inquiry or investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider, made by regulatory agencies, and documentation of the final resolution of the inquiry or investigation; and

(xiii) any other data necessary to ensure proper monitoring and control of the primary HMO delivery network by the primary HMO;

(3) conduct an on-site audit of the ANHC or provider HMO at least annually, or more frequently on indication of material noncompliance, to obtain information necessary to verify compliance with all of the department's regulatory requirements, and provide written documentation of each audit to the department on request; and

(4) take prompt action to correct any failure by the ANHC or provider HMO to comply with the department's regulatory requirements relating to any matters delegated by the primary HMO to the ANHC or provider HMO and necessary to ensure the primary HMO's compliance with the regulatory requirements.

§11.1605. Pharmaceutical Services.

(a) Prescription drug coverage that includes copayments must do so for both generic drugs and name-brand drugs. If the negotiated or usual and customary cost of the drug is less than the copayment, the enrollee may only be required to pay the lower cost. The copayments may be the same, or if different, must be applied as follows:

(1) if the prescription is for a generic drug, the enrollee may be required to pay no more than the generic copayment;

(2) if the prescription is for a name-brand drug, the enrollee may be required to pay no more than the name-brand copayment if:

(A) the prescription is written "dispense as written"; or

(B) there is no generic equivalent for the prescribed drug;

(3) if the prescription is written "product selection permitted" and the enrollee elects to receive a name-brand drug when a generic equivalent is available, then the enrollee may be required to pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name-brand drug; and

(4) if the enrollee's prescription benefit requires the use of generic-equivalent drugs (required generic) and the enrollee receives a name-brand drug when a generic equivalent is available, then the enrollee may be required to pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name-brand drug, even when the prescription is written "dispense as written."

(b) Pharmacy service must be available and accessible within the service area for the enrolled population through pharmacies licensed by the Texas State Board of Pharmacy. The HMO must offer the pharmacy services directly or through contracts.

§11.1606. Organization of an HMO.

(a) The governing body of an HMO, as described in Insurance Code §843.004 (concerning Governing Body of Health Maintenance Organization), has ultimate responsibility for the development, approval, implementation, and enforcement of administrative, operational, personnel, and patient care policies and procedures related to the HMO's operation.

(b) The HMO must have a chief executive officer or operations officer who is accountable for the administration of the health plan, including:

(1) developing corporate strategy;

(2) overseeing marketing programs;

(3) overseeing medical management functions; and

(4) ensuring compliance with all applicable statutes and rules pertaining to the operations of the HMO.

(c) The HMO must have a full-time clinical director who:

(1) is licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HMO, for example:

(A) a basic HMO must have a physician;

(B) a dental HMO must have a dentist or physician;

(C) a vision HMO must have an optometrist or physician; and

(D) a limited services HMO must have a physician;

(2) resides in the state of Texas;

(3) is available at all times to address complaints, clinical issues, utilization review, and any quality of care issues on behalf of the HMO;

(4) demonstrates active involvement in all quality management activities; and

(5) will be subject to the HMO's credentialing requirements and must be credentialed in compliance with NCQA or American Accreditation HealthCare Commission, Inc., standards.

(d) The HMO may establish one or more service areas within Texas; each defined service area must:

(1) demonstrate to the department the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties, or any portions of counties, included in the service area;

(3) provide a complete physician and provider listing for all enrollees residing, living, or working in the service area, as provided in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees); and

(4) maintain separate cost center accounting for each service area to facilitate the reporting of divisional operations as required for HMO financial reporting.

§11.1607. Accessibility and Availability Requirements.

(a) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network that is adequate and complies with Insurance Code §843.082 (concerning Requirements for Approval of Application).

(b) There must be a sufficient number of primary care physicians and specialists with hospital admitting privileges to participating facilities who are available and accessible 24 hours per day, seven days per week, within the HMO's service area to meet the health care needs of the HMO's enrollees.

(c) An HMO must make general, special, and psychiatric hospital care available and accessible 24 hours per day, seven days per week, within the HMO's service area.

(d) If an HMO limits enrollees' access to a limited provider network, it must ensure that the limited provider network complies with all requirements of this section.

(e) An HMO must make emergency care available and accessible 24 hours per day, seven days per week, without restrictions on where the services are rendered.

(f) All covered services that are offered by an HMO must be sufficient in number and location to be readily available and accessible within the service area to all enrollees.

(g) An HMO must arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis on request and consistent with these guidelines:

(1) urgent care must be available within 24 hours for medical, dental, and behavioral health conditions;

(2) routine care must be available within:

(A) three weeks for medical conditions;

(B) eight weeks for dental conditions; and

(C) two weeks for behavioral health conditions.

(3) Preventive health services must be available within:

(A) two months for a child;

(B) three months for an adult; and

(C) four months for dental services.

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) 30 miles for primary care and general hospital care; and

(2) 75 miles for specialty care, special hospitals, and single health care service plan physicians or providers.

(i) Access to certain institutional providers. An HMO network providing access to more than one institutional provider in a region must make a good-faith effort to have a mix of for-profit, nonprofit, and tax-supported institutional participating providers, unless the mix is not feasible due to geographic, economic, or other operational factors. An HMO must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(j) An HMO that is unable to meet the requirements of subsections (b) - (h) of this section must file an access plan for approval with the department in compliance with §11.301 of this title (relating to Filing Requirements). The access plan must specify:

(1) the geographic area within the service area in which a sufficient number of contracted physicians and providers are not available, including a specification of the class of physician or provider;

(2) a map for each specialty, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, and providers are not available;

(3) the reason or reasons that the network does not meet the adequacy requirements specified in this section;

(4) procedures that the HMO will use to assist enrollees in obtaining medically necessary services when no network physician or provider is available, including procedures to coordinate care to hold enrollees harmless and eliminate or limit the likelihood of balance billing;

(5) a list of the physicians and providers within the relevant service area that the HMO attempted to contract with, identified by name and specialty or facility type, with:

(A) a description of how and when the HMO last contacted each physician, provider, or facility; and

(B) a description of the reason each physician, provider, or facility gave for declining to contract with the HMO;

(6) procedures detailing how out-of-network benefit claims will be handled when no physicians or providers are available, including procedures for compliance with §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers);

(7) steps the HMO will take to attempt to bring its network into compliance with this section; and

(8) a process for negotiating with a non-network physician or provider before services being rendered, when feasible.

(k) An HMO must submit an access plan that complies with subsection (j) of this section along with the annual report on network adequacy under §11.1610 of this title (relating to Annual Network Adequacy Report).

(l) Notwithstanding subsection (h) of this section, an HMO that has a contract with the Health and Human Services Commission is not required to meet the access requirements prescribed in this section for covered services provided to participants in the Children's Health Insurance Program Perinatal Program.

(m) An HMO may make arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level available within the HMO service area, such as, but not limited to, transplants and treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive the services.

(n) An HMO is not required to expand services outside its service area to accommodate enrollees who live outside the service area but work within the service area.

(o) In compliance with Insurance Code Chapter 1455 (concerning Telemedicine and Telehealth), each evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or telemedicine service.

§11.1610. Annual Network Adequacy Report.

(a) An HMO must file a network adequacy report with the department on or before August 15 of each year and before marketing any plan in a new service area after August 15, 2017. The network adequacy report must specify:

(1) the trade name of each HMO plan in which enrollees currently participate;

(2) the applicable service area of each plan; and

(3) whether the HMO service delivery network supporting each plan meets the requirements in §11.1607 of this title (relating to Accessibility and Availability Requirements).

(b) If applicable, the network adequacy report must include an access plan that complies with §11.1607 of this title.

(c) As part of the annual network adequacy report, the HMO must provide additional data specified in this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the HMO's plans include a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The HMO report must include the number of:

(1) claims paid for out-of-network benefits that were not based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 (concerning Emergency Care) or §1271.055 (concerning Out-of-Network Services);

(2) claims for out-of-network benefits that were based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 or §1271.055;

(3) complaints by non-network physicians and providers;

(4) complaints by network physicians and providers relating to inability to refer enrollees to network physicians or providers because network physicians or providers are not available;

(5) complaints by enrollees relating to the dollar amount of the HMO's payment for basic health care benefits;

(6) complaints by enrollees concerning balance billing;

(7) complaints by enrollees relating to the unavailability of network physicians or providers;

(8) complaints by enrollees relating to the accuracy of network physician and provider listings; and

(9) complaints by physicians and providers relating to the accuracy of network physician and provider listings.

(d) The annual network adequacy report required under this section must be submitted electronically in a format and by a method acceptable to the department. Unless and until a standardized form and method for submitting the above information is made available by the department, acceptable formats include Microsoft Word and Excel documents. Unless and until another electronic method of submission is required, the report must be submitted to the department's email address, mcqa@tdi.texas.gov, and must indicate in the subject field that the email relates to the filing of the annual network adequacy report.

(e) If the commissioner determines that the HMO's network and any access plan supporting the network are inadequate to ensure that benefits are available to all enrollees or are inadequate to ensure that all covered health care services are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions under the commissioner's authority in Insurance Code Chapter 82 (concerning Sanctions) and Insurance Code Chapter 83 (concerning Emergency Ceases and Desist Orders) to issue cease and desist orders:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and

(3) cessation of marketing entirely and withdrawal from the HMO market.

(f) This section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code.

§11.1611. Out-of-Network Claims; Non-Network Physicians and Providers.

(a) When services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee is not given the choice of a network physician or provider, the HMO must fully reimburse the non-network facility-based physician or provider at the usual and customary rate as described in subsection (e) of this section or at an agreed rate.

(b) In circumstances where an enrollee receives emergency care in a non-network facility, the HMO must fully reimburse a non-network physician or provider for emergency care services at the usual and customary rate as described in subsection (e) of this section or at an agreed rate until the enrollee can reasonably be expected to transfer to a network physician or provider.

(c) If medically necessary covered services, other than emergency care, are not available through a network physician or provider on the request of a network physician or provider, the HMO must:

(1) approve a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(2) provide for a review by a physician or provider with expertise in the same specialty as or a specialty similar to the type of health care physician or provider to whom a referral is requested under paragraph (1) of this subsection before the HMO may deny the referral.

(d) An HMO reimbursing a non-network physician or provider providing services under subsection (a), (b), or (c) of this section must ensure that the enrollee is held harmless for any amounts beyond the copayment or other out-of-pocket amounts that the enrollee would have paid had the HMO network included network physicians or providers from whom the enrollee could obtain the services.

(e) After determining that a claim from a non-network physician or provider for services provided under subsection (a), (b), or (c) of this section is payable, an HMO must issue payment to the non-network physician or provider at the usual and customary rate or at a rate agreed to by the HMO and the non-network physician or provider. If the rate was not agreed to by the physician or provider, the HMO must provide an explanation of benefits to the enrollee that includes a statement that the HMO's payment is at least equal to the usual and customary rate for the service, that the enrollee should notify the HMO if the non-network physician or provider bills the enrollee for amounts beyond the amount paid by the HMO, of the procedures for contacting the HMO on receipt of a bill from the

non-network physician or provider for amount beyond the amount paid by the HMO, and the number for the department's Consumer Protection Section for complaints regarding payment.

(f) Any methodology used by an HMO to calculate reimbursements of non-network physicians or providers for covered services not available from network physicians or providers must comply with the following:

(1) if based on usual and customary charges, then the methodology must be based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflect market rates, including geographic differences in costs;

(2) if based on claims data, then the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

(3) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than three years old; and

(4) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

§11.1612. Mandatory Disclosure Requirements.

(a) Online directory. An HMO must develop and maintain a directory of contracting physicians and health care providers, display the directory on a public Internet website maintained by the HMO, and ensure that a direct electronic link to the directory is conspicuously displayed on the electronic summary of benefits and coverage of each plan issued by the HMO. The directory must:

(1) include the name, address, and telephone number of each physician and provider;

(2) clearly indicate each health benefit plan issued by the HMO that may provide coverage for services provided by each physician or provider included in the directory;

(3) be electronically searchable by physician or health care provider name and location;

(4) be publicly accessible without the necessity or providing a password, a username, or personally identifiable information; and

(5) be reviewed on an ongoing basis and corrected or updated, if necessary, not less than once each month.

(b) Identification of limited networks and index. An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an

alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. An HMO must include an index of the alphabetical listing of all physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network(s) to which the physician or provider belongs and the page number where the physician or provider's name can be found.

(c) Notice of rights under an HMO plan required. An HMO must include the notice specified in Figure: 28 TAC §11.1612(c), in all evidences of coverage certificates, disclosures of plan terms, and member handbooks in at least a 12-point font:

Figure: 28 TAC §11.1612(c)

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

- You may obtain a current directory of network physicians and providers at the following website: (website address to be filled out by the HMO) or by calling (to be filled out by the HMO) for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-

network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

(d) Disclosure concerning access to network physician and provider listing. An HMO must provide notice to all enrollees at least annually describing how the enrollee may access a current listing of all network physicians and providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which enrollees may obtain assistance during regular business hours to find available network physicians and providers.

(e) Disclosure concerning network information. An HMO must provide notice to all enrollees at least annually of:

(1) information that is updated at least annually regarding the following network information for each service area, or for the entire state if the plan is offered on a statewide service-area basis:

(A) the number of enrollees in the service area or region;

(B) for each physician and provider area of practice, including at a minimum internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of contracted physicians and providers, an indication of whether an active access plan under §11.1607 of this title (relating to Accessibility and Availability Requirements) applies to the services furnished by that class of physician or provider in the service area or region, and how the access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of contracted hospitals in the service area or region, an indication of whether an active access plan in compliance with §11.1607 of this title applies to hospital services in that service area or region, and how the access plan may be obtained or viewed, if applicable;

(2) information that is updated at least annually regarding whether any access plans approved under §11.1607 of this title apply to the plan and that complies with the following:

(A) if an access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the HMO's plan is not offered on a statewide service area basis, or for the entire state if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the access plan.

(f) Website disclosures. An HMO must provide information on its website regarding the HMO or health benefit plans offered by the HMO for use by current or prospective enrollees must provide a:

(1) web-based physician and provider listing for use by current and prospective enrollees; and

(2) web-based listing of the state regions, counties, or three-digit ZIP code areas within the HMO's service area(s), indicating, as appropriate, for each region, county, or ZIP code area, as applicable, that the HMO has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter.

(g) Reliance on physician and provider listing in certain cases. A claim for services rendered by a noncontracted physician or provider must be paid in the same manner as if no contracted physician or provider had been available under §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers), as applicable, if an enrollee demonstrates that:

(1) in obtaining services, the enrollee reasonably relied on a statement that a physician or provider was a contracted physician or provider as specified in:

(A) a physician and provider listing; or

(B) provider information on the HMO's website;

(2) the physician and provider listing or website information was obtained from the HMO, the HMO's website, or the website of a third party designated by the HMO to provide that information for use by its enrollees;

(3) the physician and provider listing or website information was obtained not more than 30 days before the date of services; and

(4) the physician and provider listing or website information obtained indicates that the provider is a contracted provider within the HMO's network.

(h) Additional listing-specific disclosure requirements. In all contracted physician and provider listings, including any web-based postings of information made available by the HMO to provide information to enrollees about contracted physicians and providers, the HMO must comply with the following requirements:

(1) the physician and provider information must include a method for enrollees to identify the hospitals that have contractually agreed with the HMO to facilitate the usage of contracted providers by exercising good-faith efforts to accommodate requests from enrollees to use contracted physicians and providers;

(2) the physician and provider information must indicate whether each contracted physician and provider is accepting enrollees as new patients or participates in closed provider networks serving only certain enrollees;

(3) the physician and provider information must provide an email address and a toll-free telephone number through which enrollees may notify the HMO of inaccurate information in the listing, with specific reference to:

(A) information about the physician's or provider's contract status; and

(B) whether the physician or provider is accepting new patients;

(4) the physician and provider information must provide a method by which enrollees may identify contracted facility-based physicians able to provide services at contracted facilities;

(5) the physician and provider information must include a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network;

(6) as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), the physician and provider information must give the identity of any health care facilities within the provider network in which facility-based physicians or other health care practitioners do not participate in the health benefit plan's provider network;

(7) the provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based physician or provider, specifying the applicable provider class;

(8) the physician and provider information must be dated; and

(9) the physician and provider information must be provided in at least 10-point font.

(i) Annual enrollee notice concerning use of an access plan. An HMO operating a plan that relies on an access plan as specified in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees) and §11.1607 of this title must provide notice of this fact to each enrollee participating in the plan at issuance and at least 30 days before renewal. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available under subsection (e)(2) of this section; and

(2) information on how to obtain or view any access plan or plans the HMO uses.

(j) Disclosure of substantial decrease in the availability of certain contracted physicians. An HMO is required to provide notice as specified in this subsection of a substantial decrease in the availability of contracted facility-based physicians at a contracted facility.

(1) A decrease is substantial if:

(A) the contract between the HMO and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates, and the HMO receives notice as required under §11.901 of this title (relating to Required and Prohibited Provisions).

(2) Despite paragraph (1) of this subsection, no notice of a substantial decrease is required if:

(A) alternative contracted physicians or providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made available to enrollees at the facility so the percentage level of contracted physicians of that specialty at

the facility is returned to a level equal to or greater than the percentage level that was available before the substantial decrease; or

(B) the HMO certifies to the department, by email to mcqa@tdi.texas.gov, that the HMO's determination that the termination of the physician contract has not caused the contracted physician service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §11.1607 of this title, as those standards apply to the applicable physician specialty.

(3) An HMO must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of contracted physicians on the portion of the HMO's website where its physician and provider listing is available to enrollees.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of physicians must be maintained on the HMO's website until the earlier of:

(A) the date on which adequate contracted physicians of the same specialty become available to enrollees at the facility at the percentage level specified in paragraph (2)(A) of this subsection;

(B) six months from the date that the HMO initially posts the notice; or

(C) the date on which the HMO provides to the department, by email to mcqa@tdi.texas.gov, the certification specified in paragraph (2)(B) of this subsection.

(5) An HMO must post notice as specified in paragraph (3) of this subsection and update its web-based contracted physician and provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an HMO receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

CHAPTER 11. SUBCHAPTER R

28 TAC §§11.1702 - 11.1704

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code Chapter 4054; and Insurance Code §§36.001, 843.151, 844.004, 844.005, 844.053, 844.054, and 4054.001.

Insurance Code Chapter 4054 regulates life, accident, and health agents.

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

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §844.004 provides that except as provided by §844.101(b), the commissioner adopt rules to implement Chapter 844.

Insurance Code §844.005 provides that an approved nonprofit health corporation may arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of an HMO, and is not required to obtain a certificate of authority under Chapter 844 or under Chapter 843 to arrange for or provide health care services as provided by §844.005(a).

Insurance Code §844.053 provides that the commissioner grant a provisional certificate of authority to an applicant if: (1) the applicant has applied for accreditation from an accrediting organization described by §844.052(b)(2); (2) the applicant is diligently pursuing accreditation; (3) the accrediting organization has not denied the application for accreditation; and (4) the applicant satisfies each other requirement of Chapter 844.

Insurance Code §844.054 provides that a certificate holder has all the powers granted to and duties imposed on an HMO under the insurance laws of this state, including Chapter 843, is subject to regulation and regulatory enforcement under those laws in the same manner as an HMO, and must maintain accreditation as described by §844.052(b)(2).

Insurance Code §4054.001 provides that Insurance Code Chapter 4054 applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in Texas, and every person who performs the acts of an agent, or represents or purports to represent an HMO in soliciting, negotiating, procuring, or effecting membership in the HMO.

SUBCHAPTER R. APPROVED NONPROFIT HEALTH CORPORATIONS

§11.1702. Requirements for Issuance of Certificate of Authority to an ANHC.

(a) Before obtaining a certificate of authority under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations), an applicant ANHC must:

(1) comply with each requirement for the issuance of a certificate of authority imposed on an HMO under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, and other applicable insurance laws and regulations of this state; and

(2) demonstrate by appropriate documentation that the applicant ANHC has established and maintains accreditation by the:

(A) NCQA; or

(B) Joint Commission on Accreditation of Health Care Organizations network accreditation program.

(b) The commissioner may grant a provisional certificate of authority to an applicant ANHC under Insurance Code Chapter 844, if the:

(1) applicant ANHC complies with each requirement for the issuance of a certificate of authority imposed on an HMO under Insurance Code Chapters 843 and 1271, this chapter, and other applicable insurance laws and regulations of this state;

(2) applicant ANHC demonstrates that it has applied for accreditation;

(3) applicant ANHC is diligently pursuing accreditation as determined by the commissioner; and

(4) accrediting organization has not denied the accreditation.

(c) An ANHC with a certificate of authority or a provisional certificate of authority must comply with all the appropriate requirements that an HMO must comply with under Insurance Code Chapter 843 and 1271, this chapter, and other applicable insurance laws and regulations of this state in order to maintain a certificate of authority.

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code Chapters 843 and 844, including an ANHC that contracts to arrange for or provide only medical care as defined in Insurance Code §843.002 (concerning Definitions).

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder.

Any agent for an ANHC with a certificate of authority or a provisional certificate of authority will be considered an HMO agent and must comply with the applicable requirements of Insurance Code Chapter 4054 (concerning Life, Accident, and Health Agents) and Chapter 19 of this title (relating to Agents' Licensing).

§11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority.

An ANHC with a certificate of authority or provisional certificate of authority under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations) and this subchapter is subject to the same statutes and rules as an HMO and is considered an HMO for purposes of regulation and regulatory enforcement.

CHAPTER 11. SUBCHAPTER S

28 TAC §11.1801 and §11.1806

STATUTORY AUTHORITY. The commissioner adopts the new sections under Health and Safety Code §62.054; Insurance Code Chapter 823; and Insurance Code §§36.001, 843.078, 843.151, and 843.404.

Health and Safety Code §62.054 provides that: (a) at the request of the State Health Services Commission, the department provide any necessary assistance with the state child health plan and

monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers; (b) the commission and the department may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan; and (c) the department, in consultation with the commission, adopt rules as necessary to implement the section.

Insurance Code Chapter 823 provides for the regulation of insurance holding company systems.

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

Insurance Code §843.078 provides directions concerning the contents of an application for a certificate of authority to organize and operate an HMO.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.404 provides that the commissioner may adopt rules or by rule establish guidelines requiring an HMO to maintain a specified net worth based on: (1) the nature and kind of risks the HMO underwrites or reinsures; (2) the premium volume of risks the HMO underwrites or reinsures; (3) the composition, quality, duration, or liquidity of the HMOs investment portfolio; (4) fluctuations in the market value of securities the HMO holds; (5) the adequacy of the HMO's reserves; (6) the number of individuals enrolled by the HMO; or (7) other business risks. The section also provides that rules adopted or guidelines established under the section must be designed to ensure the financial solvency of HMOs for the protection of enrollees, and that the rules or guidelines may provide for an HMO to comply with a risk-based net worth requirement established under the section in stages over a two-year period.

SUBCHAPTER S. SOLVENCY STANDARDS FOR MANAGED CARE ORGANIZATIONS PARTICIPATING IN MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

§11.1801. Entities Covered.

(a) As used in this subchapter, a managed care organization is an entity holding a certificate of authority to operate as an HMO under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), or as an ANHC under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations).

(b) Any managed care organization or other entity providing the services specified in 42 United States Code §1396b(m)(2)(A) and participating in the State Medicaid Program or Children's Health Insurance Program (CHIP) (MCO) must comply with the requirements of Insurance Code §843.403 (concerning Minimum Net Worth) and §7.402 of this title (relating to Risk-Based Capital and Surplus Requirements for Insurers and HMOs).

§11.1806. Additional Information That May be Requested from an MCO Participating in Medicaid.

(a) Whenever requested by the department, an MCO participating in Medicaid must file with the department a complete set of financial exhibits pertaining to the state Medicaid program, in the format of the Managed Care Financial Statistical Report, as may be modified or amended by the Texas Health and Human Services Commission. When a request is received, the MCO must then file a Managed Care Financial Statistical Report reflecting the state Medicaid program operations for each contract year in the same format as the monthly Managed Care Financial Statistical Report. These reports must comply with the instructions issued by the Texas Health and Human Services Commission.

(b) For any new or modified request to the Texas Health and Human Services Commission for participation in the Medicaid managed care program, all financial projections, including enrollment projections, from the effective or renewal date of a Medicaid contract that are submitted to the Texas Health and Human Services Commission, must also be submitted to the department. The MCO must submit the same financial projections, including a cash flow statement, submitted to the Texas Health and Human Services Commission with the request to participate in the Medicaid program. This information must be submitted with the application for a certificate of authority if the MCO is not

already a licensed MCO. If the MCO is a licensed operation, then the financial projections must be sent with the application for service area expansion.

(c) The MCO must notify the department of any similar financial or statistical reports required by other contracting state agencies and must submit copies of these reports to the department when requested by the department.

(d) Information submitted under this section must be sent to the Financial Analysis Section, Mail Code 303-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

CHAPTER 11. SUBCHAPTER T

28 TAC §11.1901 and §11.1902

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code §§36.001, 843.102, and 843.151.

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

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

SUBCHAPTER T. QUALITY OF CARE

§11.1901. Quality Improvement Structure for Basic, Single Service, and Limited Service HMOs.

(a) Basic, single service, and limited service HMOs must develop and maintain an ongoing QI program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Unless the HMO has no enrollees, the QI program should include the active involvement of one or more enrollee(s) who are not employees of the HMO.

(b) The HMO governing body is ultimately responsible for the QI program. The governing body must:

(1) appoint a quality improvement committee (QIC) that must include practicing physicians and individual providers, and may include one or more enrollee(s) from throughout the HMO's service area, none of whom may be employees of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet at least annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC must evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians, individual providers, and enrollees from the service area.

(A) All committees must collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

(B) All committees must meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC must use multidisciplinary teams, when indicated, to accomplish QI program goals.

§11.1902. Quality Improvement Program for Basic, Single Service, and Limited Service HMOs.

The QI program for basic, single service, and limited service HMOs must be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO must dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program must include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program must include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status. The work plan must:

(A) include objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, responsible individuals, and evaluation methodology; and

(B) address each program area, including:

(i) network adequacy, which includes availability and accessibility of care, including assessment of open and closed physician and individual provider panels;

(ii) continuity of health care and related services;

(iii) clinical studies;

(iv) the adoption and periodic updating of clinical practice guidelines or clinical care standards, which the QI program must ensure:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services;

(v) enrollee, physician, and individual provider satisfaction;

(vi) the complaint and appeals process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians, and providers from effectively making complaints against the HMO;

(vii) preventive health care through health promotion and outreach activities;

(viii) claims payment processes;

(ix) contract monitoring, including delegation oversight and compliance with filing requirements;

(x) utilization review processes;

(xi) credentialing;

(xii) member services; and

(xiii) pharmacy services, including drug utilization.

(3) Evaluation. The QI program must include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO must implement a documented process for selection and retention of contracted physicians and providers. The credentialing process must comply with NCQA or American Accreditation HealthCare Commission, Inc., standards, to the extent that those standards do not conflict with the laws of this state. An HMO must have a documented process for expedited credentialing of physicians, podiatrists, and therapeutic optometrists, including a documented process for payment of claims during the expedited credentialing process, in compliance with Insurance Code Chapter 1452 (concerning Physician and Provider Credentials).

(5) Site visits for cause.

(A) The HMO must have procedures for detecting deficiencies after a site visit. When the HMO identifies new deficiencies, the HMO must reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO may conduct the site visit to evaluate a complaint or other precipitating event, which may include an evaluation of any facilities or services related to a complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program must provide for a peer review procedure for physicians and individual providers, as required by the Medical Practice Act, Occupations Code, Chapter 151, Subchapter A, (concerning General Provisions). The HMO must designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of this state.

CHAPTER 11. SUBCHAPTER V

28 TAC §§11.2101 - 11.2104

STATUTORY AUTHORITY. The commissioner adopts the new sections under Health and Safety Code §534.101; Insurance Code Chapters 843, 844, 1271; Insurance Code §§36.001, 843.002(18), 843.051, 843.053, 843.073, 843.079, 843.084, 843.151, 843.318, and 1271.101.

Health and Safety Code §534.101 provides definitions applicable to Health and Safety Code Chapter 534, Subchapter B-1.

Insurance Code Chapter 843 provides regulation of HMOs.

Insurance Code Chapter 844 provides for certification of certain nonprofit health corporations.

Insurance Code Chapter 1271 regulates the benefits provided by HMOs, evidences of coverage, and charges.

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

Insurance Code §843.002(18) defines "limited health care services."

Insurance Code §843.051 sets out the application of insurance and group hospital service corporation laws.

Insurance Code §843.053 provides that: (a) an HMO that contracts with a health facility or enters into an independent contractual arrangement with physicians or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26; and (b) notwithstanding any other law, a physician who contracts with one or more physicians in the process of conducting activities that are permitted by law but that do not require a certificate of authority under Chapter 843 is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Business and Commerce Code §§15.01 - 15.26.

Insurance Code §843.073 provides that certain physicians and providers are not required to obtain a certificate of authority under Chapter 843.

Insurance Code §843.079 provides directions concerning the contents of an application for a limited health care service plan.

Insurance Code §843.084 provides the duration of a certificate of authority.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.318 provides for certain permissible contracts entered into by physicians and providers.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

SUBCHAPTER V. STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

§11.2101. Community Health Maintenance Organization.

A Community Health Maintenance Organization (CHMO) is an entity created by one or more community centers under Health and Safety Code §534.001 (concerning Establishment), and authorized by the department to provide a plan for limited health care services as defined in Insurance Code §843.002(18) (concerning Definitions).

§11.2102. General Provisions.

(a) Each CHMO must comply with all requirements for a limited health care service plan specified in this subchapter.

(b) Each CHMO must provide coverage for work in progress and must clearly specify that the enrollee must agree to have the work completed by a participating physician or provider in the HMO delivery network, as defined under Insurance Code §843.002(15) (concerning Definitions), or as otherwise arranged by the limited service HMO.

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

(a) Before obtaining a certificate of authority, an applicant CHMO must comply with each requirement for the issuance of a certificate of authority imposed on a limited health care service plan under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Insurance Code Chapter 1271 (concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges), this chapter, and other applicable insurance laws and regulations of this state.

(b) A CHMO with a certificate of authority must comply with all the appropriate requirements that a limited health care service plan must comply with under Insurance Code Chapters 843 and 1271, this chapter, and other applicable insurance laws and regulations of this state to maintain a certificate of authority. A CHMO is subject to the same statutes and rules as a limited service HMO and considered a limited service HMO for purposes of regulation and regulatory enforcement.

(c) Nothing in this subchapter prevents one or more community centers from forming a nonprofit corporation under Occupations Code §162.001 (concerning Certification by Board) to provide services on a risk-sharing or capitated basis as permitted under Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations).

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code §§843.051 (concerning Applicability of Insurance and Group Hospital Service Corporation Laws), 843.053 (concerning Laws Relating to Restraint of Trade), 843.073 (concerning Certificate of Authority Requirement; Applicability to Physicians and Providers), or 843.318 (concerning Certain Contracts of Participating Physicians or Provider Not Prohibited).

§11.2104. Minimum Standards for Community Health Centers.

Each evidence of coverage providing limited mental health care services by a CHMO must provide benefits as described in Chapter 11, Subchapter Y, of this title (relating to Limited Service HMOs) as minimum covered services for mental illness and chemical dependency.

CHAPTER 11. SUBCHAPTER W

28 TAC §§11.2200 - 11.2206 and 11.2208

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code §§36.001, 842.002(26), 843.082, 843.083, 843.102, 843.107, 843.108, 843.112, 843.151, 843.201, 1271.002, 1271.003, 1271.052, 1271.101, 1271.155, and 1273.002.

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

Insurance Code §843.002(26) defines "single health care service plan."

Insurance Code §843.082 provides requirements for the approval of an application for a certificate of authority.

Insurance Code §843.083 provides for the denial of an application for a certificate of authority if the commissioner determines that the HMO's proposed plan of operation does not meet the requirements of §843.082 and for the commissioner to notify the applicant that the plan is deficient and specify the deficiencies.

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.112 provides for a dental point-of-service option and imposes conditions on those options.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.201 provides for an HMO to disclose information about its health care plan terms to current or prospective group contract holders and enrollees.

Insurance Code §1271.002 provides that each enrollee residing in this state is entitled to evidence of coverage under a health care plan, provides for the issuance of the evidence of coverage, and provides for electronic delivery.

Insurance Code §1271.003 provides that: (a) each enrollee residing in this state is entitled to evidence of coverage under a health care plan; (b) an HMO must issue the evidence of coverage, except that if the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation must issue the evidence of coverage; and (c) by agreement between the HMO, insurer, or group hospital service corporation and the subscriber or person entitled to receive the evidence of coverage, policy, or contract, the evidence of coverage required by the section may be delivered electronically.

Insurance Code §1271.052 provides that an evidence of coverage must state: (1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the plan; (2) the issuance of other benefits, if any, to which the enrollee is entitled under the plan; and (3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the

evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1271.155 provides for an HMO to pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate and contains other provisions regarding the coverage of emergency care and the approval or denial of coverage of poststabilization care.

Insurance Code §1273.002 provides for point-of-service plans.

SUBCHAPTER W. SINGLE SERVICE HMOS

§11.2200. Definitions.

The following words and terms, when used in this subchapter, have the meaning indicated below unless the context clearly indicates otherwise:

(1) ADA--The American Dental Association.

(2) CDT--The current dental terminology manual developed and revised periodically by the ADA.

(3) ADA code/dental procedure description--Numerical codes and corresponding descriptions specified in the CDT to describe bona fide dental procedures.

(4) Comparable facility--The location where emergency dental services are rendered, including, but not limited to, the office of a licensed dentist, a dental clinic, hospital, freestanding emergency clinic, urgent care clinic, or other facility.

(5) Emergency dental services--Under a single service plan providing dental care services and benefits, emergency dental services are limited to procedures administered in a comparable facility,

to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

(6) Insurer--An insurance company, a group hospital service corporation operating under Insurance Code Chapter 842 (concerning Group Hospital Service Corporations), a fraternal benefit society operating under Insurance Code Chapter 885 (concerning Fraternal Benefit Societies), or a stipulated premium insurance company operating under Insurance Code Chapter 884 (concerning Stipulated Premium Insurance Companies).

(7) Point-of-service group disclosure statement--A written statement containing information about dental benefits that the HMO must provide to:

(A) an employer, an association, or other private group arrangement to whom the HMO must offer a dental point-of-service plan; and

(B) any prospective enrollees in a dental point-of-service plan, if the employer, association, or private group arrangement accepts the dental point-of-service plan.

(8) Point-of-service plan--A plan provided through a contractual arrangement under which indemnity benefits for the cost of dental care services other than emergency care or emergency dental care are provided by an insurer in conjunction with corresponding benefits arranged or provided by an HMO that provides dental benefits and under which an enrollee may choose to obtain benefits or services under either the indemnity plan or the HMO plan in compliance with Insurance Code §843.112 (concerning Dental Point-of-Service Option).

(9) Qualified actuary--As defined in §11.702 of this title (relating to Actuarial Certification).

§11.2201. General Provisions.

(a) Each single service HMO must provide uniquely described services with any corresponding copayments for each covered service and benefit and must provide a single health care service plan as defined in Insurance Code §843.002 (concerning Definitions). Each single service HMO must comply with all requirements for a single health care service plan specified in this subchapter.

(b) Each single service HMO schedule of enrollee copayments must specify an appropriate description of covered services and benefits, as required by §11.506 of this title (relating to Mandatory

Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), and may specify recognized procedures or other information used for the purpose of maintaining a statistical reporting system.

(c) Each single service HMO evidence of coverage must include a glossary of terminology, including the terms used in the evidence of coverage required by §11.501 of this title (relating to Contents of the Evidence of Coverage). The glossary must be included in the information to prospective and current group contract holders and enrollees, as required by Insurance Code §843.201 (concerning Disclosure of Information About Health Care Plan Terms).

(d) In the event of a conflict between the provisions of this subchapter and other provisions of this chapter, this subchapter prevails with regard to single service HMOs. It is not considered a conflict if a topic that is not addressed in this subchapter appears elsewhere in this chapter.

§11.2202. Limitations and Exclusions.

Single service HMOs are prohibited from:

(1) excluding services required for preexisting conditions that would otherwise be covered under the plan; and

(2) establishing waiting periods for coverage of preexisting conditions.

§11.2203. Minimum Standards - Dental Care Services and Benefits.

(a) Each single service HMO evidence of coverage that uses any dental procedure codes must use the codes as specified in the current version of the CDT and certify that the codes referenced in its evidence of coverage are as specified in the current version of the CDT.

(b) Each single service HMO evidence of coverage providing coverage for dental care services must provide benefits for covered dental treatment in progress and may, if clearly disclosed, require the enrollee to have the treatment completed by a participating provider in the HMO delivery network, as defined in Insurance Code §843.002 (concerning Definitions), or as otherwise arranged by the single service HMO.

(c) Each single service HMO evidence of coverage providing coverage for dental care services and benefits must provide services for the purposes of preventing, alleviating, curing, or healing dental disease, including dental caries and periodontal disease. The services may include an infection control

(sterilization) fee. Single service HMOs providing coverage for dental care services must provide coverage for the following primary and preventive services provided by a general dentist or hygienist, as applicable:

(1) office visit during and after regularly scheduled hours;

(2) oral evaluations;

(3) X-rays;

(4) bitewings;

(5) panoramic film;

(6) dental prophylaxis (adult and child);

(7) topical fluoride treatment for children;

(8) dental sealants for children;

(9) amalgam fillings (one, two, three, and four or more surfaces, primary and permanent, including polishing);

(10) anterior resin fillings (one, two, three, and four or more surfaces, or involving incisal angle, primary and permanent, including polishing);

(11) simple oral extractions;

(12) surgical incision and drainage of abscess, intraoral soft tissue; and

(13) palliative (emergency) treatment of dental pain, provided that the enrollee may obtain emergency treatment of dental pain in a comparable facility.

(d) Each single service HMO evidence of coverage providing coverage for dental care services and benefits may provide secondary dental care services and benefits. Each single service HMO evidence of coverage providing coverage for dental care services and benefits may include an infection control (sterilization) fee, and may provide secondary dental care services and benefits, including:

(1) posterior resin restorations, one, two, three, and four or more surfaces (to include polishing);

(2) crowns and crown recementation;

(3) composite resin crowns, anterior-primary;

(4) sedative fillings;

(5) core buildup, including any pins, and pin retention;

(6) pulp cap (direct and indirect);

(7) therapeutic pulpotomy;

(8) root canal therapy, anterior, bicuspid, and molar;

(9) gingival curettage;

(10) osseous surgery;

(11) periodontal scaling and root planing;

(12) periodontal maintenance procedures;

(13) complete denture (maxillary and mandibular);

(14) partial denture (maxillary and mandibular);

(15) root removal-exposed roots;

(16) surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone or section of tooth;

(17) removal of impacted tooth (soft tissue and completely bony);

(18) tooth reimplantation or stabilization, or both, of accidentally evulsed or displaced tooth or alveolus, or both;

(19) alveoplasty;

(20) occlusal guard (bruxism appliance); or

(21) orthodontia.

(e) Each single service HMO providing coverage for dental care services and benefits may also offer a preventive services plan as a supplement to a basic health care service plan offered by an affiliate or another carrier, as long as a plan described in subsection (c) of this section has first been offered to and rejected in writing by the group contract holder. The preventive plan must include:

(1) oral evaluations;

(2) X-rays;

(3) bitewings;

(4) panoramic film; and

(5) prophylaxis.

§11.2204. Minimum Standards - Vision Care Services and Benefits.

(a) Each single service HMO evidence of coverage providing vision care services and benefits must provide the following as covered primary and preventive vision services:

(1) comprehensive eye examination to include medical history;

(2) visual acuities, with and without correction (distance and near);

(3) cover test at 20 feet and at 16 inches;

(4) versions;

(5) external examination of the eye lids, cornea, conjunctiva, pupillary reaction (neurological integrity), and muscle function;

(6) binocular measurements for far and near;

(7) internal eye examination (ophthalmoscopy);

(8) autorefraction/refraction (far point and near point);

(9) tonometry (reasonable attempt or equivalent testing if contraindicated);

(10) retinoscopy;

(11) biomicroscopy;

(12) intraocular pressure glaucoma test;

(13) slit lamp examination; and

(14) urgent care.

(b) A single service HMO evidence of coverage providing vision care services and benefits may provide coverage for secondary vision care services, which include:

(1) contact lens examination;

(2) fitting;

(3) training;

(4) follow-up visits; or

(5) eye glasses.

§11.2205. Prohibited Practices.

(a) Under an individual plan, a single service HMO may not limit or otherwise interfere with an enrollee's right to terminate his or her membership in the plan before the end of the enrollment year.

(b) A single service HMO may not limit coverage for emergency services under a single health care service plan.

(c) A single service HMO may not charge an emergency fee in addition to a copayment for emergency services.

§11.2206. Mandatory Disclosure Statements; Certification of Compliance.

(a) Each point-of-service group enrollment application and, if the employer, association, or private group arrangement elects to offer the point-of-service option, each enrollment form, must include a disclosure statement written in a readable and understandable format that includes the following information:

(1) a statement that the dental indemnity benefits are provided through an insurer and that the dental care services are offered or arranged by the HMO;

(2) the name of the insurer and the name of the HMO offering the benefits; and

(3) an explanation that, in order to receive benefits:

(A) under the HMO, an enrollee must use only network providers, except for emergency dental care, and pay the copayments specified in the evidence of coverage;

(B) under the indemnity plan, an enrollee may use any provider but before receiving reimbursement, the enrollee must meet the required deductible and is responsible for the coinsurance amount specified in the policy or certificate.

(b) Each HMO offering a point-of-service plan must retain on file a certification by an HMO officer that the point-of-service plan includes dental indemnity benefits that correspond to the benefits contained in the HMO evidence of coverage. The HMO may enter into agreement with the insurer or a qualified actuary to prepare the certification, provided that the HMO retains responsibility for obtaining the certification and must keep the certification in its possession.

§11.2208. Single Service Accessibility and Availability.

A single service HMO that chooses to offer a particular service to an enrolled population must comply with §11.1607 of this title (relating to Accessibility and Availability Requirements). Any single service must be provided directly by the HMO or by contract.

CHAPTER 11. SUBCHAPTER Y

28 TAC §§11.2401 - 11.2403, 11.2405, and 11.2406

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code Chapter 1651 and Insurance Code §§36.001, 843.002(17), 843.102, 843.151, 1271.101, 1368.004, 1368.005, 1368.006, and 1368.007.

Insurance Code Chapter 1651 provides for long-term care benefit plans.

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

Insurance Code §843.002(17) defines "limited health care service plan."

Insurance Code §843.102 provides for an HMO to establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice, and provides that the procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1271.101 provides that: (a) an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner; (b) except as provided by subsection (c) of the section, the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of §1271.102; and (c) if the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. The section also provides that Subchapters B and E of Chapter 1271 apply

to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Insurance Code §1368.004 provides that a group health benefit plan must provide coverage for the necessary care and treatment of chemical dependency, and details how that coverage may be provided.

Insurance Code §1368.005 sets minimum coverage requirements under Chapter 1368.

Insurance Code §1368.006 defines "treatment series" and provides that coverage required under Chapter 1368 is limited to a lifetime maximum of three separate treatment series for each covered individual.

Insurance Code §1368.007 provides that coverage provided under Chapter 1368 for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital, provides that the department by rule adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers, and deals with standards of treatment.

SUBCHAPTER Y. LIMITED SERVICE HMOS

§11.2401. Definitions.

The following words and terms, when used in this subchapter, have the meaning indicated below unless the context clearly indicates otherwise:

(1) Acute day treatment--Program-based services focused on the short-term, acute treatment of individuals who require multi-disciplinary treatment to obtain maximum control of psychiatric symptoms. Services are provided in a highly structured and safe environment with constant supervision. Contacts with staff are frequent, activities and services constantly available, and developmental and social supports encouraged and facilitated. Staff receive specialized training in crisis management. Activities are goal oriented, focusing on improving peer interaction, appropriate social behavior, and stress tolerance.

(2) Assessment--The clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental, or other information from the individual and family seeking

services to determine level of need (including urgency) and specific treatment needs (including the preferences of the individual seeking services).

(3) Case management--Case management activities are provided to assist individuals in gaining access to medical, social, educational, and other appropriate services that will help them achieve a quality of life and community participation acceptable to each individual. The role of individuals who provide case management activities is to support and assist the person in achieving goals.

(4) Crisis hotline--A continuously available, staffed telephone service providing information, support, and referrals to callers 24 hours per day, seven days per week.

(5) Crisis respite--Services provided for temporary, short term, periodic relief to individuals or their primary caregivers during a crisis. Program-based respite services involve temporary residential placement outside the usual living situation. Community-based respite services involve introducing respite staff into the usual living situation or providing a place for the individual to go during the day or other services considered to provide respite.

(6) Crisis services—Services, including crisis hotline, crisis intervention, and crisis respite.

(7) Intensive outpatient service--An organized nonresidential service providing structured group and individual therapy, educational services, and life-skills training for less than 24 hours per day.

(8) Medication administration--A service provided to an individual by a licensed nurse or other appropriately trained and certified person under the supervision of a physician or registered nurse as provided by state law to ensure the direct application of a medication to the body of the individual by any means including handing the individual a single dose of medication to be taken orally.

(9) Medication monitoring--A service provided to an individual, family member, or other collateral by a licensed nurse or other appropriately trained and certified person under the supervision of a physician or registered nurse as provided by state law for the purpose of assessment of medication actions, target symptoms, side effects and adverse effects, potential toxicity, and the impact of medication for the individual and family in compliance with the plan of care.

(10) Medication training--A service to an individual, family member, or other collateral by a licensed nurse or other appropriately trained professional or paraprofessional as provided by state law for the purpose of teaching the knowledge and skills needed by the individual, family member, or

other collateral in the proper administration and monitoring of prescribed medication in compliance with the individual's plan of care.

(11) Medication-related services--Services, including medication administration, medication monitoring, medication training, and pharmacological management.

(12) Partial hospitalization--The provision of treatment for mental health care or chemical dependency for individuals who require care or support or both in a hospital or chemical dependency treatment center but who do not require 24-hour supervision.

(13) Pharmacological management--Service provided to an individual, family member, or collateral by a physician or other appropriately trained and certified professional as provided by state law for the purpose of determining symptom remission and the medication regimen needed to initiate or maintain an individual's plan of care.

(14) Screening--Gathering triage information necessary to determine a need for in-depth assessment. This information is collected through interview, in person or by phone, with the individual, family member, or collateral as part of the admission or intake process or as necessary.

(15) Treatment planning--Activities for the purpose of medically necessary, prioritized, comprehensive, collaborative, and measurable treatment that reflects the needs and wishes of the individual and builds on the strengths of the individual.

§11.2402. General Provisions.

(a) A limited service HMO must develop and maintain an ongoing quality improvement structure and program that complies with Chapter 11, Subchapter T, of this title (relating to Quality of Care).

(b) Each limited service HMO must provide uniquely described services with any corresponding copayments for each covered service and benefit, and provide a limited health care service plan as defined in Insurance Code §843.002 (concerning Definitions). Each limited service HMO must comply with all requirements for a limited health care service plan specified in this subchapter.

(c) Each limited service HMO schedule of enrollee copayments must specify an appropriate description of covered services and benefits, as required by §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), and may specify recognized procedure codes or other information used for maintaining a statistical reporting system.

(d) Each limited service HMO evidence of coverage must include a glossary of terms, including the terms used in the evidence of coverage required by §11.501 of this title (relating to Contents of the Evidence of Coverage). The glossary must be included in the information to prospective and current group contract holders and enrollees, as required by Insurance Code §843.201 (concerning Disclosure of Information about Health Care Plan Terms).

§11.2403. Prohibited Practices.

A limited service HMO may not:

(1) exclude services required for preexisting conditions which would otherwise be covered under the plan;

(2) establish waiting periods for coverage of preexisting conditions;

(3) impose a lifetime coverage maximum for any covered service or benefit;

(4) limit or otherwise interfere with an enrollee's right to terminate his or her membership in the plan before the end of the enrollment year;

(5) limit coverage for emergency services under a limited health care service plan;

(6) charge an emergency fee in addition to a copayment for emergency services; or

(7) count medication-related services and services provided by telephone toward the annual outpatient visit total for either serious or nonserious mental illness.

§11.2405. Minimum Standards - Mental Health and Chemical Dependency Services and Benefits.

Each limited service HMO evidence of coverage providing coverage for mental health and chemical dependency services and benefits must:

(1) cover, in compliance with the limited service HMO's standards of medical necessity, court-ordered mental health and chemical dependency treatment and may, if clearly disclosed, require the enrollee to have the treatment completed by a participating physician or provider in the HMO delivery network, as defined in Insurance Code §843.002 (concerning Definitions), or as otherwise arranged by the limited service HMO;

(2) comply with Chapter 21, Subchapter P, of this title (relating to Mental Health Parity)

(3) provide primary mental health and chemical dependency services and benefits, including:

(A) for treatment of serious mental illness, as defined in Insurance Code Chapter 1355, Subchapter A, (concerning Group Health Benefit Plan Coverage for Certain Serious Mental Illnesses and Other Disorders), up to 45 inpatient days per year and up to 60 outpatient visits per year, which include assessment or screening, treatment planning, and crisis services;

(B) for treatment of nonserious mental illness, up to 30 inpatient days per year and up to 30 outpatient visits per year, which include screening and assessment, treatment planning, and crisis services;

(C) treatment of chemical dependency in compliance with the levels of care and clinical criteria specified in Chapter 3, Subchapter HH, of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers); and

(D) any other services necessary and appropriate to treat mental health and chemical dependency services or required by the Insurance Code, Health and Safety Code, and other applicable laws and regulations of this state; and

(4) demonstrate the capacity to provide, and may provide, secondary intensive rehabilitative, and community support services for mental illness and chemical dependency, including, but not limited to, case management, partial hospitalization, residential, acute day treatment, intensive outpatient service, Assertive Community Treatment teams, and habilitative or rehabilitative services for pervasive developmental disorders.

§11.2406. Minimum Standards – Long-Term Care Services and Benefits.

Each limited service HMO evidence of coverage providing long-term care services and benefits must comply with Insurance Code Chapter 1651 (concerning Long-Term Care Benefit Plans) and Chapter 3, Subchapter Y, of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy).

CHAPTER 11. SUBCHAPTER Z

28 TAC §§11.2501 - 11.2503

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code Chapters 541, 542, 543, 544, 547, 843, and 1273; Insurance Code §§36.001, 843.107, 843.108, 843.151, 843.403, 1201.211, 1201.212, 1201.213, 1201.214, 1201.215, 1201.216, and 1201.217.

Insurance Code Chapter 541 contains provisions regarding unfair methods of competition and unfair or deceptive acts or practices.

Insurance Code Chapter 542 regulates the processing and settlement of claims.

Insurance Code Chapter 542 regulates the processing and settlement of claims.

Insurance Code Chapter 543 contains provisions regarding prohibited practices related to policies or certificates of membership.

Insurance Code Chapter 544 contains provisions prohibiting certain forms of discrimination.

Insurance Code Chapter 547 prohibits false advertising by unauthorized insurers.

Insurance Code Chapter 843 regulates HMOs.

Insurance Code Chapter 1273 regulates Point-Of-Service Plans.

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

Insurance Code §843.107 provides that an HMO may offer: (1) indemnity benefits covering out-of-area emergency care; (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation; (3) a point-of-service plan under Chapter 1273, Subchapter A; or (4) a point-of-service rider under §843.108.

Insurance Code §843.108 defines the term "point-of-service rider," and provides the circumstances under which an HMO may offer point-of-service riders.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §843.403 provides the minimum net worth HMOs must maintain.

Insurance Code §§1201.211 – 1201.217 contain provisions relating to required policy provisions.

SUBCHAPTER Z. POINT-OF-SERVICE RIDERS

§11.2501. Definitions.

The following words and terms, when used in this subchapter, have the meaning indicated below unless the context indicates otherwise:

(1) Coinsurance--An amount in addition to the premium and copayments due from an enrollee who accesses out-of-plan covered benefits, for which the enrollee is not reimbursed.

(2) Corresponding benefits--Benefits provided under a point-of-service rider or the indemnity portion of a point-of-service plan, as defined in Insurance Code §843.108 (concerning Point-of-Service Rider) and §1273.001 (concerning Definitions), that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a point-of-service plan.

(3) Cost containment requirements--Provisions in a point-of-service rider requiring a specific action that must be taken by an enrollee or by a physician or provider on behalf of the enrollee, such as the provision of specified information to the HMO, to avoid the imposition of a specified penalty on the coverage provided under the rider for proposed service or treatment.

(4) Coverage--Any benefits available to an enrollee through an indemnity contract or rider, any services available to an enrollee under an evidence of coverage, or combination of the benefits and services available to an enrollee under a point-of-service plan.

(5) Health plan products--Any health care plan issued by an HMO under the Insurance Code or a rule adopted by the commissioner.

(6) In-plan covered services--Health care services, benefits, and supplies to which an enrollee is entitled under the evidence of coverage issued by an HMO, including emergency services, approved out-of-network services, and other authorized referrals.

(7) Nonparticipating physicians and providers--Physicians and providers who are not part of an HMO delivery network.

(8) Out-of-plan covered benefits--All covered health care services, benefits, and supplies that are not in-plan covered services. Out-of-plan covered benefits include health care services, benefits,

and supplies obtained from participating physicians and providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining in-plan covered services.

(9) Participating physicians and providers--Physicians and providers that are part of an HMO delivery network.

(10) Point-of-service blended contract plan--A point-of-service plan evidenced by a single contract, policy, certificate, or evidence of coverage that provides a combination of indemnity benefits for which an indemnity carrier is at risk and services that are provided by an HMO under a point-of-service plan.

(11) Point-of-service dual contracts plan--A point-of-service plan providing a combination of indemnity benefits and HMO services through separate contracts, one being the contract, policy, or certificate offered by an indemnity carrier for which the indemnity carrier is at risk and the other being the evidence of coverage offered by the HMO.

(12) Point-of-service rider--A rider issued by an HMO that meets the solvency requirements of §11.2502 of this title (relating to Issuance of Point-of-Service Riders) and that provides coverage for out-of-plan services, including services, benefits, and supplies obtained from participating physicians or providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining approval for in-plan covered services.

(13) Point-of-service rider plan--A point-of-service plan provided by an HMO in compliance with this subchapter under an evidence of coverage that includes a point-of-service rider.

§11.2502. Issuance of Point-of-Service Riders.

(a) Financial requirements. An HMO that issues a point-of-service rider is subject to the requirements of Insurance Code §843.403 (concerning Minimum Net Worth) and §7.402 of this title (relating to Risk-Based Capital and Surplus Requirements for Insurers and HMOs).

(b) Termination, cancellation, and renewability. An HMO must comply with all state and federal laws and rules applicable to termination, cancellation, and renewability of a point-of-service rider plan.

§11.2503. Coverage Relating to Point-of-Service Rider Plans.

(a) An HMO may not consider an in-plan covered service to be a benefit provided under the point-of-service rider.

(b) An HMO may not require an enrollee to use either the point-of-service rider benefits or in-plan covered services first.

(c) An HMO that includes limited provider networks:

(1) may not limit the access, under the point-of-service rider, of an enrollee whose in-plan covered services are restricted to the limited provider network, to either participating physicians and providers or nonparticipating physicians and providers;

(2) may not impose cost-sharing arrangements for an enrollee whose in-plan covered services are restricted to a limited provider network, and who, through the point-of-service rider, accesses a participating physician or provider outside the limited provider network, that differ from the cost-sharing arrangements for in-plan covered services obtained by the enrollee from a physician or provider in the limited provider network; and

(3) may provide for cost-sharing arrangements for benefits obtained from nonparticipating physicians and providers that are different from the cost sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50 percent of the total amount to be covered.

(d) An HMO that issues or offers to issue a point-of-service rider plan is subject, to the same extent as the HMO is subject in issuing any other health plan product, to all applicable provisions of Insurance Code Chapters 541 (concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542 (concerning Processing and Settlement of Claims), 543 (concerning Prohibited Practices Related to Policy or Certificate of Membership), 544 (concerning Prohibited Discrimination), 547 (concerning False Advertising by Unauthorized Insurers), 843 (concerning Health Maintenance Organizations), and 1273 (concerning Point-Of-Service Plans).

(e) A point-of-service rider plan offered under this subchapter must contain:

(1) a point-of-service rider that:

(A) includes coverage that corresponds to all in-plan covered services provided in the evidence of coverage as well as coverage that is provided to an enrollee as part of the enrollee's in-plan coverage through separate riders attached to the evidence of coverage;

(B) may include benefits in addition to in-plan covered services;

(C) may limit or exclude coverage for benefits that do not correspond to in-plan covered services;

(D) may not limit coverage for benefits that correspond to in-plan covered services except as provided in subparagraphs (E), (F), and (G) of this paragraph;

(E) may include reasonable out-of-pocket limits and annual and lifetime benefit allowances that differ from limits or allowances on in-plan covered services provided under other riders attached to the evidence of coverage so long as the allowances and limits comply with applicable federal and state laws;

(F) may provide for cost-sharing arrangements that are different from the cost-sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50 percent of the total amount to be covered;

(G) may be reduced by benefits obtained as in-plan covered services;

(H) may not reduce or limit in-plan covered services in any way by coverage for benefits obtained by an enrollee under the point-of-service rider;

(I) if applicable, must disclose:

(i) how the point-of-service rider cost-sharing arrangements differ from those in the evidence of coverage;

(ii) any reduction of benefits as set forth in subparagraph (G) of this paragraph;

(iii) any deductible that must be met by the enrollee under the point-of-service rider; and

(iv) whether copayments made for in-plan covered services apply toward the point-of-service rider deductible;

(J) must provide coverage for services obtained without the HMO's authorization from a participating physician or provider, but the enrollee must comply with any precertification requirements as set forth in subparagraph (L) of this paragraph that are applicable to the point-of-service rider;

(K) must include a description of how an enrollee may access out-of-plan covered benefits under the point-of-service rider, including coverage contained in other riders attached to the evidence of coverage;

(L) must disclose all precertification requirements for coverage under the point-of-service rider including any penalties for failure to comply with any precertification or cost

containment provisions, provided that the penalties will not reduce benefits more than 50 percent in the aggregate;

(M) if it is issued to a group, must contain provisions that comply with Insurance Code Chapter 1251, Subchapter C, (concerning Partnership for Long-Term Care Program); and

(N) if it is issued to an individual, must contain provisions that comply with Insurance Code §§1201.211 - 1201.217 (concerning Policy Provision: Notice of Claim, Policy Provision: Claim Forms, Policy Provision: Proof of Loss, Policy Provision: Time of Payment of Claims, Policy Provision: Payment of Claims, Policy Provision: Physical Examinations and Autopsy, Policy Provision: Legal Actions);

(2) an evidence of coverage that includes a description and reference to the point-of-service rider sufficient to notify a prospective or current enrollee that the plan provides the option of accessing participating physicians and providers as well as nonparticipating physicians and providers for out-of-plan covered benefits, and that accessing these benefits through the point-of-service rider may involve greater costs than accessing corresponding in-plan covered services; and

(3) a side-by-side summary of the schedule of the corresponding coverage for services, benefits, and supplies available under the point-of-service rider and services, benefits, and supplies available in the evidence of coverage that together constitute the point-of-service rider plan.

CHAPTER 11. SUBCHAPTER AA

28 TAC §§11.2601 - 11.2611

STATUTORY AUTHORITY. The commissioner adopts the new sections under Insurance Code Chapter 1271, Subchapters B and D; and Insurance Code §§36.001, 38.001, 843.151, 1272.001, 1272.051, 1272.052, 1272.053, 1272.056, 1272.064, 1272.102, 1272.103, 1272.202, 1272.203, 1272.205, 1272.206, 1272.207, and 1272.208.

Insurance Code Chapter 1271, Subchapter B, regulates delegation agreements.

Insurance Code Chapter 1271, Subchapter D, provides reserve requirements for delegated networks.

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

Insurance Code §38.001 provides, in relevant part, that the department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (1) the person's business condition; or (2) any matter connected with the person's transactions that the department considers necessary for the public good or for the proper discharge of the department's duties.

Insurance Code §843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to: (1) implement Insurance Code §1367.053; Chapter 843; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; Chapters 222, 251, and 258, as applicable to an HMO; and Chapters 1271 and 1272, including rules to: (A) prescribe authorized investments for an HMO for all investments not otherwise addressed in Chapter 843; (B) ensure that enrollees have adequate access to health care services; and (C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and (2) meet the requirements of federal law and regulations.

Insurance Code §1272.001 provides definitions for terms used in Insurance Code Chapter 1272.

Insurance Code §1272.051 provides that Chapter 1272, Subchapter B, does not apply to a group model HMO, as defined by §843.111.

Insurance Code §1272.052 provides, in relevant part, that: (a) an HMO that delegates a function required by Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B, must execute a written delegation agreement with the entity to which the function is delegated and (b) the HMO must file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

Insurance Code §1272.053 provides that a delegation agreement required by §1272.052 must establish a monitoring plan and sets requirements for those plans.

Insurance Code §1272.056 provides that a delegation agreement required by §1272.052 must provide that: (1) the agreement does not limit in any way the HMO's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and (2) the delegated entity must comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity.

Insurance Code §1272.064 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter B.

Insurance Code §1272.102 provides that the commissioner determine the information a HMO must provide to a delegated entity with which the HMO has entered into a delegation agreement, sets requirements for that information, and provides for the information to be provided in a standard electronic format.

Insurance Code §1272.103 provides that the commissioner may adopt rules as necessary to implement Chapter 1272, Subchapter C.

Insurance Code §1272.202 provides that if an HMO becomes aware of information that indicates a delegated entity with which the HMO has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the HMO must in writing: (1) notify the entity of those findings; and (2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition. The section provides that the HMO must provide to the commissioner a copy of each notice and request submitted to a delegated entity under the section and each response or other documentation the HMO receives or generates in response to the notice and request.

Insurance Code §1272.203 provides that a delegated entity must respond in writing to a request from an HMO under §1272.202 not later than the 30th day after the date the entity receives the request.

Insurance Code §1272.205 provides for examinations by the department of a delegated entity and reports of those examinations.

Insurance Code §1272.206 provides that the delegated entity and HMO must respond to the department's report under §1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

Insurance Code §1272.207 provides that the department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that: (1) relate to a function delegated by the HMO to the entity; or (2) are necessary to ensure the HMO's compliance with each statutory or regulatory requirement.

Insurance Code §1272.208 provides that the commissioner may order an HMO with which the entity has entered into a delegation agreement to take any action the commissioner determines is

necessary to ensure that the HMO is complying with Chapters 843, 1271, 1272, or 1367; Chapter 1452, Subchapter A; or Chapter 1507, Subchapter B.

SUBCHAPTER AA. DELEGATED ENTITIES

§11.2601. General Provisions.

(a) A delegating HMO must:

(1) identify all responsibilities relating to the function being delegated;

(2) create an agreement that enables the HMO and department to monitor both the delegated entity's financial solvency and performance or subsequent delegation of all delegated functions; and

(3) retain ultimate responsibility for ensuring that all delegated functions are performed in compliance with applicable statutes and rules.

(b) This subchapter applies to all contracts entered into or renewed on and after the effective date of these rules.

(c) This subchapter does not apply to a group model HMO, as defined in Insurance Code §843.111 (concerning Group Model Health Maintenance Organizations).

§11.2602. Definitions.

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

(1) Delegated entity--An entity, other than an HMO authorized to do business under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 (concerning to Delegation of Certain Functions by Health Maintenance Organization) and other applicable insurance laws and regulations of this state, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the HMO any function regulated by Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax

identification number and whose total claims paid to physicians and providers not employed by the group is less than 20 percent of the total collected revenue of the group calculated on a calendar-year basis.

(2) Delegated network--Any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Occupations Code §551.003 (concerning Definitions). The term does not include a delegated entity that shares risk for a category of services with an HMO.

(3) Delegated third party--A third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility to perform any function regulated by Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state.

(4) Health care--Any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, dental care, hospitalization, or incident to the furnishing of the services, care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

§11.2603. Requirements for Delegation by HMOs.

(a) Any delegation of any function under Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 (concerning Delegation of Certain Functions by Health Maintenance Organization), and other applicable insurance laws and regulations of this state by an HMO must comply with this subchapter.

(b) Oversight by the department does not relieve an HMO of responsibility for monitoring and oversight of its delegated entities.

(c) Before entering into, renewing, or amending a delegation agreement, an HMO must make a reasonable effort to evaluate the delegated entity's current and prospective ability to perform the functions to be delegated, including, but not limited to, the solvency and financial operations of the delegated entity and the projected financial effects of the agreement on the delegated entity.

(d) An HMO that delegates functions to a delegated entity must have a written contingency plan to resume any and all delegated functions, including, as applicable:

(1) quality of care;

(2) continuity of care, including a plan for transferring enrollees to new physicians and providers in the event of termination of the delegation agreement; and

(3) processing, adjudication, and payment of claims.

(e) The department may require an HMO to immediately terminate any delegation agreement to ensure that the HMO is in compliance with Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state.

(f) An HMO retains ultimate responsibility for any and all functions delegated.

(g) A delegated entity's failure to comply with applicable statutes or rules constitutes a violation of Insurance Code Chapter 843 and Chapter 1272 and other applicable insurance laws and regulations of this state by the delegating HMO.

(h) An HMO is responsible for monitoring each delegated entity with which it contracts to ensure compliance with all applicable statutes and rules, as well as for solvency.

(i) An HMO must report to the department, within a reasonable time, all penalties assessed against a delegated entity under the provisions of the delegation agreement.

(j) If an HMO cannot ensure that a delegated entity is performing all delegated functions in compliance with all applicable statutes, rules, or an order issued by the department under this subchapter, the HMO must resume all delegated functions from the delegated entity.

(k) If a license is required for any function delegated by an HMO, the HMO must ensure that the delegated entity or third party performing the function has a current appropriate license.

(l) On termination of a delegation agreement by either party, the HMO must notify the department.

§11.2604. Delegation Agreements - General Requirements and Information to be Provided to HMO.

(a) An HMO that delegates any function required by Insurance Code Chapter 843 (concerning Health Maintenance Organizations) and Chapter 1272 (concerning Delegation of Certain Functions by Health Maintenance Organization), and other applicable insurance laws and regulations of this state to a delegated entity must execute a written agreement with that delegated entity.

(b) Written agreements must include:

(1) a provision that the delegated entity and any delegated third parties must agree to comply with all statutes and rules applicable to the functions being delegated by the HMO;

(2) a provision that the HMO will monitor the acts of the delegated entity through a monitoring plan, which must be set forth in the delegation agreement, and contain, at a minimum:

(A) provisions for the review of the delegated entity's solvency status and financial operations, including, at a minimum, review of the delegated entity's financial statements, consisting of at least a balance sheet, income statement, and statement of cash flows for the current and preceding year;

(B) provisions for the review of the delegated entity's compliance with the terms of the delegation agreement as well as with all applicable statutes and rules affecting the functions delegated by the HMO under the delegation agreement;

(C) a description of the delegated entity's financial practices in sufficient detail that will ensure that the delegated entity tracks and timely reports to the HMO liabilities including incurred but not reported obligations;

(D) a method by which the delegated entity must report monthly a summary of the total amount paid by the delegated entity to physicians and providers under the delegation agreement; and

(E) a monthly log, maintained by the delegated entity, of oral and written complaints from physicians, providers, and enrollees regarding any delay in payment of claims or nonpayment of claims pertaining to the delegated function, including the status of each complaint;

(3) a statement that the HMO will use the monitoring plan on an ongoing basis; compliance with this requirement must be documented by the HMO maintaining, at a minimum:

(A) periodic signed statements from the individual identified by the HMO in paragraph (23) of this subsection that the HMO has reviewed the information required in the monitoring plan; and

(B) periodic signed statements from the chief financial officer of the HMO acknowledging that the most recent financial statements of the delegated entity have been reviewed;

(4) a provision establishing the penalties to be paid by the delegated entity for failure to provide information required by this subchapter;

(5) a provision requiring quarterly assessment and payment of penalties under the agreement, if applicable;

(6) a provision that the agreement cannot be terminated without cause by the delegated entity or the HMO without written notice provided to the other party and the department before the 90th day preceding the termination date, provided that the commissioner may order the HMO to terminate the agreement under §11.2608 of this title (relating to Department May Order Corrective Action);

(7) a provision that requires the delegated entity, and any entity or physician or provider with which it has contracted to perform a function of the HMO, to hold harmless an enrollee under any circumstance, including the insolvency of the HMO or delegated entity, for payments for covered services other than copayments and deductibles authorized under the evidence of coverage;

(8) a provision that the delegation agreement may not be construed to limit in any way the HMO's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(9) a provision that any failure by the delegated entity to comply with applicable statutes and rules or monitoring standards permits the HMO to terminate delegation of any or all delegated functions;

(10) a provision that the delegated entity must permit the commissioner to examine at any time any information the department reasonably considers is relevant to:

(A) the financial solvency of the delegated entity; or

(B) the ability of the delegated entity to meet the entity's responsibilities in connection with any function delegated to the entity by the HMO;

(11) a provision that the delegated entity, in contracting with a delegated third party directly or through a third party, will require the delegated third party to comply with the requirements of paragraph (10) of this subsection;

(12) a provision that the delegated entity must provide the license number of any delegated third party performing any function that requires a license as a third party administrator under Insurance Code Chapter 4151 (concerning Third-Party Administrators), or a license as a utilization review agent under Insurance Code Chapter 4201 (concerning Utilization Review Agents), or that requires any other license under the Insurance Code or another insurance law of this state;

(13) if utilization review is delegated, a provision stating that:

(A) enrollees will receive notification at the time of enrollment identifying the entity that will be performing utilization review;

(B) the delegated entity or delegated third party performing utilization review must do so in compliance with Insurance Code Chapter 4201 and related rules; and

(C) utilization review decisions made by the delegated entity or a delegated third party must be forwarded to the HMO on a monthly basis;

(14) a provision that any agreement in which the delegated entity directly or indirectly delegates to a delegated third party any function delegated to the delegated entity by the HMO under Insurance Code Chapter 843 and Insurance Code Chapter 1272 and other applicable insurance laws and regulations of this state, including any handling of funds, must be in writing;

(15) a provision that on any subsequent delegation of a function by a delegated entity to a delegated third party, the executed updated agreements must be filed with the department and enrollees must be notified of the change of any party performing a function for which notification of an enrollee is required by this chapter or Insurance Code Chapter 843 and Insurance Code Chapter 1272 and other applicable insurance laws and regulations of this state;

(16) an acknowledgment and agreement by the delegated entity that the HMO is not prevented from requiring that the delegated entity provide any and all evidence requested by the HMO or the department relating to the delegated entity's or delegated third party's financial viability;

(17) a provision acknowledging that any delegated third party with which the delegated entity subcontracts will be limited to performing only those functions set forth and delegated in the agreement, using standards approved by the HMO and that are in compliance with applicable statutes and rules;

(18) a provision that any delegated third party is subject to the HMO's oversight and monitoring of the delegated entity's performance and financial condition under the delegation agreement;

(19) a provision that requires the delegated entity to make available to the HMO samples of each type of contract the delegated entity executes or has executed with physicians and providers to ensure compliance with the contractual requirements described by paragraphs (6) and (7) of this subsection, except that the agreement may not require that the delegated entity make available

to the HMO contractual provisions relating to financial arrangements with the delegated entity's physicians and providers;

(20) a provision that requires the delegated entity to provide information to the HMO on a quarterly basis and in a format determined by the HMO to permit an audit of the delegated entity and to ensure compliance with the department's reporting requirements with respect to any functions delegated by the HMO to the delegated entity and to ensure that the delegated entity remains solvent to perform the delegated functions, including:

(A) a summary:

(i) describing any payment methods, including capitation or fee for services, that the delegated entity uses to pay its physicians and providers and any other third party performing a function delegated by the HMO; and

(ii) of the breakdown of the percentage of physicians and providers and any other third party paid by each payment method listed in clause (i) of this subparagraph;

(B) the period that claims and any other obligations for health care filed with the delegated entity, under this and any other delegation agreements to which the delegated entity is a party, have been pending but remain unpaid, divided into categories of 0-to-45 days, 46-to-90 days, and 91-or-more days. The summary must include aggregate information for all delegation agreements entered into by the delegated entity and information for the specific delegation agreement entered into between the parties;

(C) the aggregate dollar amount of claims and other obligations for health care owed by the delegated entity to any physician or provider, including estimates for incurred but not reported obligations;

(D) information that the HMO requires in order to file claims for reinsurance, coordination of benefits, and subrogation; and

(E) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Occupations Code, Chapter 160, Subchapter A, (concerning Requirements Relating to Medical Peer Review), that relates to:

(i) any regulatory agency's inquiry or investigation of the delegated entity or of an individual physician or provider with whom the delegated entity contracts that relates to an enrollee of the HMO; and

(ii) the final resolution of any regulatory agency's inquiry or investigation;

(21) a provision relating to enrollee complaints that requires the delegated entity to ensure that on receipt of a complaint, as defined in Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state, a copy of the complaint must be sent to the HMO within two business days, except that in a case in which a complaint involves emergency care, as defined in Insurance Code Chapter 843 and other applicable insurance laws and regulations of this state, the delegated entity must forward the complaint immediately to the HMO, provided that nothing in this paragraph prohibits the delegated entity from attempting to resolve a complaint;

(22) a provision that the HMO, the delegated entity, and any delegated third party must comply with the provisions of Chapter 22 of this title (relating to Privacy);

(23) a provision identifying an officer of the HMO as the representative of the HMO for all matters related to the delegation agreement; and

(24) a provision identifying which party to the agreement will bear the expense of compliance with each requirement set forth in this subsection, including the cost of any examinations performed under this subchapter.

§11.2605. Delegation Agreements - Information to be Provided by HMO to Delegated Entity.

(a) An HMO must provide to each delegated entity with which the HMO has a delegation agreement, at least monthly unless otherwise stated in the agreement and provided in standard electronic format agreed to by the parties, the following information:

(1) the name and either the date of birth or social security number of each enrollee of the HMO who is eligible or assigned to receive health care from the delegated entity, including the enrollees added and terminated since the previous reporting period;

(2) the age, sex, evidence of coverage, and any riders to that evidence of coverage, and, if applicable, the name of the employer, for the enrollees of the HMO who are eligible or assigned to receive health care from the delegated entity;

(3) a summary of the number and amount of claims paid by the HMO on behalf of the delegated entity during the previous reporting period; provided that an HMO is not prevented from

providing, on request, additional nonproprietary information regarding the claims if the HMO pays any claims for the delegated entity;

(4) a summary of the number and amount of pharmacy prescriptions paid for each enrollee for which the delegated entity has taken partial risk during the previous reporting period, provided that an HMO is not prevented from providing, on request, additional nonproprietary information regarding the claims, if the HMO pays any claims for the delegated entity;

(5) information that is needed by the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation; and

(6) patient complaint data that relates to the delegated entity.

(b) An HMO must provide to each delegated entity with which the HMO has a delegation agreement the following information, as applicable, provided in standard electronic format agreed to by the parties at least quarterly unless otherwise stated in the agreement:

(1) detailed risk-pool data, reported quarterly and on settlement, sufficient to allow the delegated entity to adequately monitor its position in the risk pool; and

(2) the percent of premium attributable to hospital or facility costs, if hospital or facility costs impact the delegated entity's costs and, if there are changes in hospital or facility contracts with the HMO, the projected impact of those changes on the percent of premium attributable to hospital and facility costs within 30 days of the changes.

§11.2606. Reporting Requirements.

(a) On receipt of a financial statement indicating that a delegated entity or delegated third party has an amount of total liabilities greater than its total assets, the HMO must immediately forward a copy of the financial statement to the department.

(b) An HMO that becomes aware of any information, including the information described in subsection (a) of this section, that suggests or indicates that the delegated entity or delegated third party is not operating in compliance with its written agreement or is operating in a condition that may render the continuance of its business hazardous to the enrollees, must immediately:

(1) notify the delegated entity in writing of those findings; and

(2) request, in writing, a written explanation with supporting documentation of:

(A) the delegated entity's or delegated third party's apparent noncompliance with the written agreement; or

(B) the existence of the condition that apparently renders the continuance of the delegated entity's or delegated third party's business hazardous to the enrollees.

(c) A delegated entity must respond in writing to a request from an HMO under subsection (b) of this section not later than the 30th day after the date the request is received. The response must include a corrective action plan.

(d) A copy of all written communications required by subsections (b) and (c) of this section must be sent to the department simultaneously with transmission to the HMO or delegated entity or delegated third party.

(e) The HMO must cooperate with the delegated entity to correct any failure by the delegated entity to comply with the applicable statutes and rules relating to any matters:

(1) delegated to the delegated entity by the HMO; or

(2) necessary for the HMO to ensure compliance with statutory or regulatory requirements.

§11.2607. Examinations of Delegated Entities.

(a) On receipt of complaints, a notice under §11.2606 of this title (relating to Reporting Requirements), or as otherwise permitted under the Insurance Code or related rules, the department may examine any matter relating to the financial solvency of the delegated entity or delegated third party or the delegated entity's ability to meet its responsibilities under the delegation agreement.

(b) The department may request documents, perform on-site examinations, and require any other action of the delegated entity and any delegated third party that the department determines necessary to perform an examination under this section.

(c) A delegated entity's failure to comply with a request under subsection (b) of this section may result in either or both:

(1) notification to the HMO that the delegated entity is subject to penalties under the delegation agreement; or

(2) entry of an order by the commissioner to resume or redelegate any functions delegated to the delegated entity or terminate the agreement in its entirety.

(d) The department will issue a report to the delegated entity and HMO on completion of the department's examination. The report will detail the results of the examination and any corrective actions necessary by the delegated entity or HMO.

(e) The delegated entity and the HMO must respond to the department's report and submit a corrective action plan to the department not later than the 30th day after the date of receipt of the department's report.

§11.2608. Department May Order Corrective Action.

(a) The department may require at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relates to any matters delegated by the HMO to the delegated entity;

(2) is necessary to ensure the HMO's compliance with statutory and regulatory requirements; or

(3) relates to the financial solvency and operations of the delegated entity.

(b) The commissioner may order the HMO to take any action the commissioner determines is necessary to ensure that the HMO maintains compliance with the Insurance Code, this chapter, and other applicable insurance laws and regulations of this state, including but not limited to:

(1) resumption of any or all functions delegated to the delegated entity, including claims processing, adjudication, and payments for health care previously rendered to enrollees of the HMO;

(2) temporarily or permanently ceasing assignment of new enrollees to the delegated entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive health care; or

(4) termination of the HMO's delegation agreement with the delegated entity.

§11.2609. Reserve Requirements for Delegated Networks.

In addition to any other requirements set forth in this subchapter, an HMO that contracts with a delegated network must ensure that the delegated network complies with Insurance Code Chapter 1272, Subchapter D, (concerning Reserve Requirements). The HMO's agreement with the delegated network must include a provision:

(1) that records related to the requirements of Insurance Code Chapter 1272, Subchapter D, must be accessible at all times to the HMO;

(2) requiring all financial records and related information necessary to show the delegated network's compliance with the requirements of Insurance Code Chapter 1272, Subchapter D;

(3) making the records described in paragraph (1) of this section available to the department on request; and

(4) that records be kept providing evidence that the HMO has adequately monitored the delegated network for compliance with the requirements of Insurance Code Chapter 1272, Subchapter D.

§11.2610. Penalties for Noncompliance.

(a) Failure of any party to any agreement under this subchapter to comply with any requirement of this subchapter may result in an order from the commissioner that the HMO must terminate the delegation agreement and resume or redelegate any or all delegated functions as well as the imposition of penalties provided under the Insurance Code and related rules.

(b) Any action by an HMO relating to a delegation agreement that does not comply with this subchapter or takes place under a provision of a delegation agreement not in compliance with this subchapter constitutes a violation under this subchapter.

§11.2611. Filing of Delegation Agreements.

(a) An HMO must file the written executed agreement described in this subchapter and any subsequently executed amendments to the agreement with the department as required under §11.301 of this title (relating to Filing Requirements).

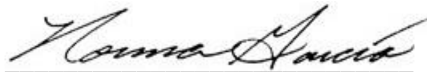
(b) Every agreement must include as an attachment a completed Delegated Entity Data form, form SN014, (rev. 02/16).

(c) Every agreement must include, as an attachment, a table of contents that allows the department to track the agreement's compliance with the requirements of §11.2604 of this title (relating to Delegation Agreements - General Requirements and Information to be Provided to HMO) and §11.2605 of this title (relating to Delegation Agreements - Information to be Provided by HMO to Delegated Entity).

(d) On notification from the department of a deficiency in a delegation agreement or filing required under this subchapter, the HMO must respond within 10 business days with a proposed correction for the defect.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on March 31, 2017



Norma Garcia
General Counsel
Texas Department of Insurance

The commissioner adopts the repeal of Chapter 11, 28 TAC §§11.1 - 11.2612 and new Chapter 11, 28 TAC §§11.1 - 11.2612.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **2017-5013**