SUBCHAPTER A. General Provisions
§§11.1 and 11.2
SUBCHAPTER B. Name Application Procedure
§11.101
SUBCHAPTER C. Application for Certificate of Authority
§§11.201 – 11.206
SUBCHAPTER D. Regulatory Requirements for an HMO Subsequent to Issuance of Certificate of Authority
§§11.301 – 11.303
SUBCHAPTER F. Evidence of Coverage
§§11.502 – 11.506, 11.508, 11.509, and 11.512
SUBCHAPTER G. Advertising and Sales Material
§§11.602 and 11.603
SUBCHAPTER I. Financial Requirements
§§11.801 – 11.803, 11.806, and 11.810
SUBCHAPTER J. Physician and Provider Contracts and Arrangements
§§11.901, 11.902, and 11.904
SUBCHAPTER K. Required Forms
§11.1001
SUBCHAPTER N. HMO Solvency Surveillance Committee Plan of Operation
§§11.1301 – 11.1306
SUBCHAPTER O. Administrative Procedures
§§11.1401 – 11.1404
SUBCHAPTER P. Prohibited Practices
§11.1500
SUBCHAPTER Q. Other Requirements
§§11.1600 – 11.1602, 11.1604 - 11.1607
SUBCHAPTER R. Approved Nonprofit Health Corporations
§§11.1702 – 11.1704
SUBCHAPTER S. Solvency Standards for Managed Care Organizations Participating in Medicaid
§§11.1801 – 11.1806
SUBCHAPTER T. Quality of Care
§§11.1901 and 11.1902
SUBCHAPTER V. Standards for Community Mental Health Centers
§§11.2101 – 11.2103
SUBCHAPTER W. Single Service HMOs
§§11.2200, 11.2201, 11.2203, 11.2204, 11.2207, and 11.2208
SUBCHAPTER X. Provider Sponsored Organizations
§§11.2303, 11.2311, and 11.2314

SUBCHAPTER Y. Limited Service HMOs
§§11.2402, 11.2405, and 11.2406
SUBCHAPTER Z. Point-of-Service Riders
§§11.2501 – 11.2503
SUBCHAPTER AA. Delegated Entities
§§11.2601 and 11.2602

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §§11.1, 11.2, 11.101, 11.201 – 11.206, 11.301 – 11.303, 11.502 – 11.506, 11.508, 11.509, 11.512, 11.602, 11.603, 11.801 – 11.803, 11.806, 11.810, 11.901, 11.904, 11.1001, 11.1301 – 11.1306, 11.1401 – 11.1404, 11.1500, 11.1600 – 11.1602, 11.1604 – 11.1607, 11.1702 – 11.1704, 11.1801 – 11.1806, 11.1901, 11.1902, 11.2101 – 11.2103, 11.2200, 11.2201, 11.2203, 11.2204, 11.2303, 11.2311, 11.2314, 11.2402, 11.2405, 11.2501 – 11.2503, 11.2601, and 11.2602, and new §§11.902, 11.2207, 11.2208, and 11.2406, concerning regulation of health maintenance organizations (HMOs). Sections 11.2, 11.205, 11.303, 11.506, 11.901, 11.1600, 11.1601, 11.1605, 11.1607, 11.1806, 11.1902, 11.2207 and 11.2208 are adopted with changes to the proposed text as published in the November 12, 2004 issue of the Texas Register (29 TexReg 10357). Sections §§11.1, 11.101, 11.201 – 11.204, 11.206, 11.301, 11.302, 11.502 – 11.505, 11.508, 11.509, 11.512, 11.602, 11.603, 11.801 – 11.803, 11.806, 11.810, 11.902, 11.904, 11.1001, 11.1301 – 11.1306, 11.1401 – 11.1404, 11.1500, 11.1602, 11.1604 – 11.1606, 11.1702 – 11.1704, 11.1801 – 11.1805, 11.1901, 11.2101 – 11.2103, 11.2200, 11.2201, 11.2203, 11.2204, 11.2303, 11.2311, 11.2314, 11.2402, 11.2405, 11.2406, 11.2501 – 11.2503, 11.2601, and 11.2602 are adopted without changes.

2. REASONED JUSTIFICATION. These amendments and new sections are necessary to implement statutory changes from prior legislative sessions and to update procedures and requirements to conform to certain nationally recognized standards. In addition, because these sections have not undergone comprehensive revision for a number of years, the department believes it is necessary to streamline and consolidate requirements to reflect more accurately acceptable HMO practices and TDI's policies and procedures, and to clarify statutory requirements. The department also believes rule revision is necessary to respond to regulatory concerns that have arisen since the last revision.

The commissioner held a public hearing on the proposed sections on December 9, 2004. Subsequently, the department received comments regarding changes within these proposed sections. In response to comments, the department has changed several of the proposed sections as published; however, none of the changes introduce new subject matter or affect additional persons than those subject to the proposal as originally published.

The department is not adopting the proposed language concerning payment for out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) in order to appropriately defer the issue pending possible action in the current legislative session. However, the department has adopted a notice requirement at §11.1600(b)(11)(D) that requires an HMO to notify an enrollee to contact the HMO upon receipt of a bill from any provider. The originally proposed language related to the issue

of payment for services received by enrollees outside of an HMO's provider network due to emergencies or the unavailability of a network provider. Comments received by the department, both written and at the hearing, placed a great deal of emphasis on this issue and generally focused on two possible effects of the proposed language. First, commenters were concerned that the proposal would have a negative effect on an HMO's ability to contract with certain types of specialty providers. These commenters noted current difficulties for HMOs attempting to contract with certain types of providers due to a variety of factors. Commenters specifically identified arrangements between hospitals and providers that make certain providers the exclusive provider of that type in a hospital. If a hospital operating under such an arrangement is a network facility, the commenters feel that the providers working within the hospital have little incentive to contract with an HMO because any steerage that commonly results from a provider's contract with an HMO already exists due to the hospital's exclusive arrangement with the provider. The commenters opined that the proposal would make it even more difficult to contract with these providers for a rate other than the provider's full billed charges.

Other commenters representing HMOs expressed concern that their ongoing efforts to negotiate with out-of-network providers for payment of necessary out-of-network services would be hindered by the proposed language because it would operate as a disincentive to accept an amount lower than the billed charge. These commenters are describing situations in which they are not seeking to contract with the

provider in order to bring the provider into the HMO's network, but rather are attempting to negotiate a price for services rendered by an out-of-network provider due to an emergency or the unavailability of a network provider.

The causes of the contracting and negotiating issues identified by commenters merit further consideration to determine adequate and appropriate solutions. Health care coverage through a managed care carrier depends upon a network of providers who have, in general, contracted with the managed care carrier for discounts in return for steerage of patients. The HMO model of managed care is especially reliant upon a provider network, as enrollees are not allowed to receive covered services from out-of-network providers unless it becomes necessary due to an emergency or the unavailability of a network provider for a specific service. If HMOs are unable to contract with providers for discounts, the cost model on which HMOs are based most likely fails or requires significant premium increases from current levels. Comments received in this rulemaking process have highlighted the increasing difficulty that HMOs are having in contracting with certain specialty providers that provide hospital-based services. This trend results in an increased likelihood that enrollees will receive out-of-network services in a network facility, which hampers the ability of an HMO to exercise cost control.

The inability of HMOs and providers to agree on a usual and customary or other acceptable payment amount for necessary out-of-network services essentially places enrollees in a position of paying a greater amount than would have been required were

services available from a network provider. The reported difficulties that HMOs are experiencing in attempting to contract with hospital-based specialty providers should not result in a shifting of costs to enrollees under the current statutory scheme. The proposal expresses the department's interpretation of the HMO Act, which prohibits enrollees from exposure to additional costs for necessary out-of-network services, despite the reported increased frequency of such services.

One aspect of the current statutory scheme appears to receive improper emphasis as a remedy for the difficulties associated with contracting with facility-based providers. With respect to the issue of enrollees that are forced to receive services outside the network, the HMO commenters look to the language in Article 20A.09(f) to limit an HMO's responsibility to a usual and customary amount as determined by the HMO. The amount determined by the HMO is often lower than the provider's billed charges, which may result in the provider looking to the enrollee for the balance. Use of Article 20A.09(f) as a solution for reported current difficulties in contracting with certain types of providers is not consistent with certain protections afforded enrollees in the HMO Act, such as requirements related to network adequacy. The commenters' interpretations create an exception to the network adequacy requirements that circumvents the rule and would allow enrollees to be routinely exposed to additional costs for services that should be available through network providers. Enrollees receiving these out-of-network services are rarely aware of the contracting status of the provider and have no opportunity to ensure that services are not received from out-of-

network providers. The department understands Article 20A.09(f) to apply more appropriately to unusual situations in which the HMO's network would not likely have the type of specialist necessary.

The issue of who is appropriately responsible for the costs of necessary out-of-network services is at the heart of the subject of balance billing. Although the department believes that the HMO Act requires enrollees to be protected from additional cost exposure for unavoidable out-of-network services, the evolving state of the market may yield cost consequences that the legislature could not have anticipated when the HMO Act was originally enacted. Deference to the legislature on this issue is therefore both appropriate and timely.

Payment for out-of-network services and balance billing have recently become the focus of legislative interest, as evidenced by the interim charge to the Senate State Affairs Committee to study payments by insurers and HMOs for out-of-network services. The Committee's report includes several recommendations for further study and consideration, stating "the issue begs for legislative action, [but] the degree of action should be fully vetted and debated." Because of the possibility of legislative attention to this matter, the department is not adopting the proposed language relating to payment of necessary out-of-network services. Should the legislature decline to take any action, the department may revisit the issue.

Despite the department's decision to defer additional action on this issue, the adopted rule includes a notice requirement so that enrollees receive proper guidance

regarding steps to take when they receive a bill from any provider. Of all the parties involved in the issue of out-of-network payments, enrollees have the least ability to exercise control over circumstances that result in out-of-network services. Consequently, the department has adopted a notice requirement at §11.1600(b)(11)(D) that requires an HMO to notify an enrollee to contact the HMO upon receipt of a bill from any provider.

In response to comments, the department has made the following changes to the language as proposed: The definition of “consumer choice health benefit plan” has been revised to restore original language regarding applicable rules. The definition of “copayment” in §11.2(b)(17) is changed to include the language: “which may be expressed in terms of a dollar amount or a percentage of the contracted rate.” The department changed the definition of “premium” in §11.2(b)(33) by replacing the reference to “small and large employer and eligible employees” with the term “contract holder” to take into account individual coverage. In §11.303(d)(1) and (3), the department restored the words “or their designee” after “key management staff,” in two places to clarify that a key manager’s designee may attend the entrance and exit conferences in the event a given key manager is not available. The department deleted the phrase “on HMO’s behalf” in §11.901(a)(1)(C) because physicians and providers do not collect copayments on behalf of the HMO. The department revised the notice in §11.1600(b)(11)(D) to require HMOs to include a notice in the plan description advising enrollees to notify the HMO of any bill received from any provider. The department

added language to §11.1600(f) requiring that internet provider directory information be easily accessible from the home page of the site. In §11.1607(g)(1)(B), the department changed back the availability requirement for urgent behavioral health care from 48 hours to 24 hours. The department changed the time frames concerning the annual reports in §11.1806(a) to be consistent with the time frames set by the Health and Human Services Commission. In §11.1902(4)(C)(iv) the department added language to clarify that the only individual providers for which site visits are required are individual behavioral health providers, as well as clarify that the provision applies to the relocation and opening of additional office sites of certain providers. The department added language in §11.2208(c) to clarify that the requirement for contracting with an inpatient facility applies only to single service HMOs that provide inpatient care. In addition to the foregoing changes, the department changed the reference in §11.1600(f) from “this paragraph” to “subsection (b)(11)” and the reference in §11.508(d) from “this section” to “this subchapter” to correct inaccurate cite references, and included a reference to Insurance Code §843.102 in §§11.204(14) and 11.301(5)(N) to more accurately reflect applicable statutory authority. The department also changed the former names of the state agencies in §11.506(10)(F)(ii) to the name of the appropriate existing state agency. The department made other changes for purposes of consistency and clarity, as well as to correct clerical and typographical errors. The department also withdrew the proposed amendments to §11.809 (29 TexReg 11945, December 24, 2004), and

instead proposed comprehensive amendments to the section in a separate proposal that was published in the same issue of the Texas Register.

3. HOW THE SECTIONS WILL FUNCTION. The amendment to §11.1 revises the section's title. Amendments to §11.2(b) add a new definition for clinical director, revise the existing titles of the definitions of consumer choice plan, referral specialists, and state-mandated plan, and revise the text of the existing definitions of agent, consumer choice plan, copayment, premium, and state-mandated plan.

Amendments to §11.101 update the contact information for obtaining forms.

The amendments to §§11.202(a), 11.203(a) and 11.204 reduce the number of additional copies required at the time of application for a certificate of authority and for revised filings to expedite review and eliminate filing of unnecessary copies. The amendment to §11.202(f) reflects a requirement for one original application, and deletes an original signature requirement to accommodate electronic filings. The amendments to §11.204(13)(B) and §11.205(a)(7) clarify that the contracts between the HMO and delegated entities and/or delegated networks be provided as part of the application process and that such agreements be available during qualifying examinations. The amendment to §11.204(14) clarifies the required quality improvement plan description. The amendments to §11.204(18) add a requirement that the HMO provide network configuration information, including maps demonstrating the location and distribution of the physician and provider network within the service area upon initial filing of an

application for a certificate of authority. Amendments to §§11.205(a)(6), 11.302(b)(3), and 11.303(c)(7) incorporate the requirement for this network configuration information. The amendments are adopted to ensure full compliance with §843.078(k), which requires network configuration information to demonstrate network adequacy. The maps, by indicating where particular providers are located, are much more demonstrative of network sufficiency and accessibility than written descriptions. In addition, the amendments also require that the HMO provide lists of physicians and individual and institutional providers, along with license type and specialization, and information concerning whether such physicians or individual providers are accepting new patients. The license type and specialization information allows TDI to more readily distinguish primary care physicians from specialists in determining network adequacy to support all types of covered services.

Section 11.204(23) clarifies that the applicant must demonstrate appropriate operational structure and adequate management and staff to operate an HMO and fully comply with all statutory and regulatory requirements applicable to the HMO and any contracting entities. The amendments to §11.205 clarify that referenced documents must be available for review at the HMO's Texas office at the time of examination, but may be physically maintained at a different site; add language about qualifications of management and staff; clarify complaints and appeals policies; and set out prescribed categories of complaints to facilitate analysis and provide for uniform categorization. These complaint categories require greater detail in, and expand on, the four categories

of complaints HMOs are currently required to maintain. These complaint categories are also referenced in Subchapter D (§11.303(c)(4)). TDI believes these amendments are necessary to facilitate review of complaints during examinations and to allow TDI and the industry to more specifically monitor problems and concerns in the face of marketplace changes that could impact enrollees. Recognizing that these changes may require additional time to implement, TDI solicited and received commenters' input on appropriate compliance dates. Based on the comments received, TDI has specified January 1, 2006, as the date by which HMOs shall comply with these requirements. The amendments also clarify and simplify the reference to health information systems records, clarify the reference to network configuration documents, and consolidate the categories of executed agreements to be available during examination. The amendments to §11.205 also change the requirement that the entire physician or provider contract be made available for review during examination; because of confidentiality concerns, the provision requires that only the first page and signature page be made available.

Section 11.205(a)(14), concerning claims systems, determines the HMO's capacity to comply with all applicable statutes and rules addressing claims payment. The amendment to §11.205(a)(16) requires the HMO, at the time of the qualifying examination, to demonstrate compliance with applicable laws, including audits or examination reports by other entities, which will provide TDI a more complete picture of

the applicant and help the agency to pinpoint any areas requiring particular attention prior to licensing.

To make departmental review and storage of documents more efficient, the amendments to §11.301 add requirements for filings; clarify that, consistent with insurance form filing requirements, each form must have a printed unique form number; reduce the number of required form filings; and add the requirement that the HMO include a cover letter with such filings. The amendments to §11.301 also add references to delegated entities and delegated networks and clarify that a filing must include a reconciliation of benefits to schedule of charges form. The amendments to §§11.301(5)(G) and 11.303(c)(8)(C) clarify that contracts between the HMO and delegated entities and/or delegated networks are included in the documents that an HMO must file pursuant to Insurance Code Article 20A.18C and 28 TAC §11.2611 for examinations, and subsequent to issuance of the certificate of authority. The amendments to §11.302 clarify that, consistent with §§843.080 and 843.078(h), a request for any modification of the service area, including a reduction, must be filed with and approved by the department. The amendments to §§11.302 and 11.303 also require the filing of network configuration information. The amendments to §11.303 clarify that: the department may conduct complaint examinations in addition to other types of examinations; quality of care examinations, except those made pursuant to Insurance Code Article 1.15, may take place off-site; examinations may be conducted by examination teams rather than single examiners; and examination teams may

conduct interviews of key management staff or their designee in connection with such examinations. Amendments to §11.303 also identify the documents that should be available for review during examinations to include those documents that have been deleted from §11.205(a) as more appropriate for review after issuance of a certificate of authority. The amendments change the timeframe for correcting serious deficiencies from 10 business days to 12 calendar days.

To expedite review and eliminate the filing of unnecessary copies, the department reduced the number of copies of documents an HMO must file relating to an evidence of coverage in §§11.502 and 11.503. Section 11.503 is changed to correct mail codes and clarify procedures for notifying HMOs of approval or disapproval. Section 11.505 clarifies that each form will have a different number, and expands the categories of variable language that can be included in form filings to include optional benefits and provisions. This flexibility will increase efficiency in form filings and facilitate greater speed to market. Section 11.506 clarifies the statutory directive in Article 20A.09(a)(1) that every enrollee residing in this state is entitled to an evidence of coverage, implements HB 1798 and HB 1800 (78th Legislature), which permit an HMO to deliver plan evidences of coverage electronically, and removes the reference to "standard language" because TDI reviews all forms for compliance. The amendments to that section also clarify that cancellation of an enrollee in a group cannot be based on health status related factors, consistent with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191.

The amendment to §11.506(2)(A) deletes the word "nominal" as an inaccurate description of a 50% copayment. Section 11.506(3)(A) is amended to conform to Insurance Code Articles 26.23 and 26.86 and to HIPAA. Section 11.506(3)(B) deletes the 60-day timeframe for prior notice to the group because there are no circumstances under which the 60-day notice would apply. Section 11.506(6)(C) clarifies that conversion coverage is an option; the continuation provision is mandatory. Section 11.506(9)(E) conforms to Insurance Code Article 20A.09H (Children and Grandchildren), which refers to "enrollee." Section 11.506(16) implements HB 508 (78th Legislature) by increasing from 30 to 60 the number of days prior notice an HMO is required to give regarding a group plan premium rate increase. Section 11.506(19) increases the age for dependent coverage for a child from 21 to 25 years as required by HB 1446 (78th Legislature). Throughout §11.506(23) the reference to an enrollee's choice of an obstetrician is changed from "designated" to "selected." Amended §11.506(25) refers to Article 21.52J rather than listing its requirements**.**

Amendments to §11.901(a)(1) add provisions from Subchapter L, §11.1102. The repeal of Subchapter L is published elsewhere in this issue of the Texas Register. Consistent with Insurance Code §843.361, the amendments require physician and provider contracts to include a hold harmless provision. Amendments to §11.901(a)(4) clarify that written notice to enrollees of termination of their physician or provider is governed by Insurance Code §§843.308 and 843.309 and the amendments to §11.901(a)(5) clarify that written notice of termination to a physician or provider is

governed by §§843.306 and 843.307. Amendments to §11.901(a)(5)(B) and (C) change the time allowed for a physician or provider to request an appeal of the termination from 60 days to 30 days from the notice of termination. This amendment will give the review panel enough time to review the termination within the 60 days mandated by Insurance Code §843.306(b). Amendments to §11.901(a)(5)(C) require the review panel to review the physician or provider's termination within 60 days of the physician or provider's request for review.

Amendments to §11.901(a)(12) add new language required by SB 781 (76th Legislature), as it amended Insurance Code Article 20A.18A (now §843.311(3)) relating to podiatrists. Amendments to §11.901(a)(13) add language from SB 418 (78th Legislature), which added Insurance Code Article 21.52Z, §2 relating to electronic health care transactions. Amendments to §11.902(a) add language from HB 606 (77th Legislature) that added new §18D to Insurance Code Article 20A (now §843.320) relating to hospitalists. Amendments to §11.902(b) and (c) add language from HB 803 (77th Legislature) that added subsection (o) to Insurance Code Article 20A.14 (now §843.3045) relating to nurse first assistants. Amendments to §11.902(d) add language from HB 1163 (78th Legislature) that added Insurance Code §843.319 (Certain Required Contracts) relating to podiatrists. Section 11.902(e) adds language that implements Insurance Code §843.312 relating to physician assistants and advance practice nurses. Where appropriate, the amendments refer to the statute rather than restating particular statutory requirements.

Amendments to §11.1001 update the contact information for obtaining forms and update form numbers.

The amendment to §11.1302(a)(1) clarifies that leaving the HMO, rather than leaving a particular plan within the HMO, triggers termination of appointment to the Solvency Surveillance Committee (SSC). The amendment to §11.1302(b) clarifies what constitutes a quorum. It also clarifies the circumstances requiring a majority vote of the total committee membership. The amendment to §11.1302(c) changes the maximum interval between SSC meetings by providing for a regular annual meeting, rather than quarterly, as presently required. This change will provide greater scheduling flexibility for better responsiveness to specific concerns regarding an HMO, while eliminating requirements for meetings that were not always necessary. The amendments to §11.1302(d) harmonize the subsection with the Open Meetings Act, remove the provision allowing meetings by telephone conference call, incorporate provisions concerning emergency meetings, and add a provision permitting a majority of members to call a special meeting. The amendment to §11.1302(e) adds the Open Meetings Act reference for notice requirements. The amendment to §11.1302(f) makes clear that SSC meetings are generally open, and adds language setting out circumstances under which a closed meeting may be held. The amendment to §11.1304(a) clarifies that the written record of SSC proceedings is subject to pertinent confidentiality laws.

The amendment to §11.1403 updates the toll-free telephone number and the agency organizational reference. The amendment to §11.1404(a) deleting certain

language relating to Article 21.52B reflects the decision in *Texas Pharmacy Assoc. v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997). The department is aware that there is uncertainty regarding the enforceability of Article 21.52B following the decision in *Texas Pharmacy Assoc.* and the subsequent U.S. Supreme Court case concerning Employee Retirement Income Security Act preemption and a Kentucky any willing provider statute similar to Article 21.52B. See *Kentucky Association of Health Plans v. Miller*, 123 S.Ct. 1471 (2003). Should the statute be determined to be enforceable without additional legislative action, the absence of this language from the rule will not prevent the department from enforcing Article 21.52B.

The amendments to §11.1500 incorporate in substance the federal standards for the term “similarly situated.” The amendments to §11.1600(a) and (b) implement HB 1800 (78th Legislature), which allows HMOs to provide plan descriptions electronically to enrollees and contract holders. Amendments to this section also consolidate notice requirements regarding current and prospective female enrollees’ choice of an obstetrician-gynecologist (OB-GYN) and clarify that female enrollees may select an OB-GYN without the requirement for formal designation. Because the OB-GYN notice requirements in §11.1600 and §11.1608 are similar, the §11.1608 requirements have been repealed. The adoption of the repeal of §11.1608 is published elsewhere in this issue of the Texas Register. The amendments also remove unnecessarily restrictive requirements for the provider directory that are not required by statute. Section 11.1600(b)(11) adds language requiring notice advising enrollees to contact the HMO if

they receive a bill from any physician or provider. The amendment to §11.1600(c) reiterates that HMOs are prohibited from making untrue or misleading statements to either current or prospective enrollees. The amendment to §11.1600(d) clarifies that an HMO may use its handbook to satisfy the plan description requirements if it discloses information adequately and in accordance with §11.1600. The amendment to §11.1600(e) requires the plan description to include a disclosure that the enrollee may receive care from a physician other than a primary care physician while in an inpatient facility. While this disclosure is already required in the Evidence of Coverage under §11.506(26), to ensure awareness of this critical provision, the department has added this requirement to the plan description. Section 11.1600(f) implements SB 494 (78th Legislature), which requires HMOs with an internet site to maintain a list of physicians and providers and to provide the same information that is required in a paper directory, and adds language requiring that the internet notices related to an HMO's current list of physicians and providers be easily accessible from the home page of the HMO's site.

Section 11.1601(b) implements SB 418 (78th Legislature) regarding identification cards that must comply with §21.2820. Section 11.1601(c) implements Insurance Code Article 21.53L regarding standards for prescription drug identification cards. Section 11.1600(d) implements SB 473 (78th Legislature), which restricts the use of social security numbers on identification cards. Section 11.1605(b), (c), (d) and (e) consolidates all pharmacy services requirements and implements HB 2382 (77th

Legislature) enacting Insurance Code Article 21.52L, which relates to health benefit plan coverage for prescription contraceptive drugs and devices.

Amendments to §11.1606(b) and (c), concerning an HMO's chief executive officer, operations officer and clinical director (formerly "medical director"), change the emphasis from full-time status and residence in the service area to detailed functional and practical requirements of the positions. The change reflects the department's understanding that executives can be responsible for operations in several states or several different service areas on less than a full-time basis in this state. The amendments to §11.1607 consolidate accessibility and availability requirements from Subchapter U, §11.2001 et. seq. The adoption of the repeal of the remaining provisions of Subchapter U is published elsewhere in this issue of the Texas Register. These provisions are repealed because some have been moved to other sections of this rule, and some were changed to comply with certain national and industry standards, as detailed herein. Subsections (a) - (h) of §11.1607, concerning accessibility and availability requirements, add standards for availability of medical care consistent with national industry standards. In accordance with the most recent National Committee on Quality Assurance (NCQA) and industry standards, §11.1607(g) changes the availability requirements for routine behavioral health care from three weeks to two weeks. Also consistent with industry standards, the requirements for availability of routine dental care were changed from three weeks to eight weeks, and the availability of preventive dental health services was changed from two or three months to four months. Section

11.1607(h) clarifies that an HMO must have a network that encompasses the entire service area, and that access radii are to be measured from providers to the boundaries of the service area, not from current enrollees to providers. This is to clarify the expectation that an HMO have a network that encompasses its entire service area, not just the current enrollee population or area in which the plan is marketing.

Section 11.1607(j) clarifies that certain health care services, such as transplants or treatment for cancer, burns, or cardiac disease, may be provided outside the service area; however, an HMO may not require an enrollee to travel outside of the service area to receive such services unless it provides the enrollee with a written explanation of the benefits and detriments of in-area and out-of-area options.

Section 11.1801(c) has been deleted as it is fully executed. Amendments to §11.1802 prescribe a more comprehensive method for assessing the minimum capital or net worth requirements of a Medicaid managed care organization (MCO) and refer to amounts established by statute for required minimum capital and surplus, rather than stating specific amounts in the rule. Obsolete language that was superseded by §11.809 is deleted from paragraph §11.1802(a)(2) and replaced by Risk Based Capital (RBC) requirements as the method, developed in coordination with the National Association of Insurance Commissioners (NAIC), for assessing capital adequacy. The method will be phased in over three years. All HMOs, including those that are MCOs, must already comply with the RBC formula currently required in §11.809. Insurance Code Article 1.61 requires TDI, in conjunction with the Texas Health and Human

Services Commission (HHSC), to establish fiscal solvency standards for MCOs, and these amendments are meant to ensure that MCOs that contract with the state operate in a fiscally sound manner. The amendment to §11.1803(b) clarifies that the deposit is used to protect the interests of the enrollees.

Section 11.1804 allows a reduction in the special statutory deposit required for MCOs, taking into account certain guarantees from sponsoring organizations. The amendment clarifies that the reduction relates only to the amount of the statutory deposit held under §11.1803 and does not relate to other requirements or unrelated non-Medicaid business. Section 11.1806(a) removes the automatic requirement for filing certain financial information with TDI and instead requires the information be filed only upon the department's request, and changes the time frames concerning the annual reports to be consistent with the time frames set by HHSC. Section 11.1806(b) clarifies that, concurrently with filing a Medicaid participation request with HHSC, Medicaid MCO candidates must file with TDI the financial projections related to that request; it also deletes the term "RFA" because it is not commonly used. Section 11.1806(c) clarifies that an MCO must notify TDI of any financial or statistical reports filed with other state agencies, but is not required to file such reports with TDI except upon TDI's request.

The amendments to the titles of §§11.1901 and 11.1902 clarify that the sections apply to both basic and limited service HMOs. The amendment to §11.1901(c)(1)(B) clarifies that the subcommittee is responsible for reporting to the quality improvement

committee (QIC), which in turn is responsible for reporting to the governing body. Amendments throughout §11.1902 implement Insurance Code Article 21.58D, as amended by HB 1095 (78th Legislature), relating to standardized forms for verification of certain credentials including those for advanced practice nurses and physician assistants; fully update credentialing requirements to comply with NCQA standards as required by Insurance Code Article 20A.39; and add requirements relating to initial credentialing site visits and tracking the opening of new offices to comply with NCQA requirements applicable to primary care physicians and individual primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers. Although the NCQA standards do not specifically address primary care dentists, the department, pursuant to the direction of Article 20A.39, has applied those standards to dentists to ensure consistent quality in all areas of health care.

The amendments to §11.1902(2) more accurately state criteria the work plan must meet. The amendments to §11.1902(2)(B) expand updating intervals for those clinical guidelines that change more or less frequently, allow practicing physicians and providers to have input into clinical practice guidelines, and in accord with NCQA requirements, delete the requirement that practice guidelines be communicated to providers in a particular way. The amendment to §11.1902(2)(B) adds clauses (xi) through (xiii) to include program areas that are essential to any quality improvement (QI) work plan. The amendments to §11.1902(4)(B) add a reference to the provider

directory to indicate which physicians and providers must be credentialed, and clarify that hospital-based physicians and providers, if they are not listed in the provider directory, and opticians would not be required to be credentialed by the HMO. Section 11.1902(4)(B)(ii) adds language to comply with NCQA standards concerning physician and practitioner rights. Section 11.1902(4)(B) requires appropriate, timely notice to applicants concerning credentialing and recredentialing to comply with NCQA standards and adds a specific timetable associated with NCQA-required monitoring of certain sanctions. The amendment to §11.1902(4)(B)(viii) provides additional discrimination prohibitions to be included in HMO credentialing and recredentialing procedures to ensure compliance with NCQA requirements and other applicable law. The amendment to §11.1902(4)(C)(iv) clarifies that site visits apply only to certain physicians and providers, more clearly states that the HMO may conduct a single visit to accomplish on-site visit requirements for multiple providers, and adds language requiring the HMO to have a process to track the relocation of and opening of additional office sites for primary care physicians and individual primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers. Section 11.1902(4)(D) provides that the items to be gathered at the time of recredentialing and the recredentialing timeframes are the same as for an original credentialing. The amendment to §11.1902(4)(F) deletes reference to clause (v) because site visits for evaluation are no longer required at the

time of recredentialing. Section 11.1902(7) restates the provisions for the delegation of credentialing functions from former §11.1902(4)(B)(vi).

Section 11.2207 is adapted from revised Subchapter T to add specific QI requirements for single service HMOs, to clarify that the same QI standards apply to all HMOs. In addition, the amendments incorporate the single health care services availability and accessibility requirements from Subchapter U, §11.2006, so that all requirements relating to single service HMOs are contained in one subchapter.

Amendments to §11.2314 add the words “opportunity for” to clarify that under §843.461(a)(1) only notice and an opportunity for a hearing must be available before the commissioner may suspend or revoke a certificate of authority.

Section 11.2406 specifies the statutory and regulatory standards for a limited service HMO providing long-term care services and benefits.

Amendments to the subchapters, including Subchapters G, I, R, Z and AA, make editorial or grammatical changes for ease of reading or for clarity; update references to statutory authority; change specific references to more general references to avoid constant updating and revisions; add consistent abbreviations; eliminate redundant or unnecessary wording; and reflect accurate terminology.

4. SUMMARY OF COMMENTS AND AGENCY’S RESPONSE TO COMMENTS.

§11.2(b)(17): Some commenters suggest that the department clarify that a copayment may be expressed either in terms of a dollar amount or a percentage.

Agency Response: The department agrees to add the language “which may be expressed in terms of a dollar amount or a percentage of the contracted rate,” to reflect the position the department has historically taken.

§11.2(b)(33): A commenter believes the modifications to the definition of "premium" do not take into account individual coverage because the definition refers to only large and small employers and large and small employer carriers.

Agency Response: The department agrees and has changed the rule to encompass individual as well as employer coverage.

§11.204(18): A commenter agrees with language requiring HMOs to submit lists of various physicians, specialties, and individual and institutional providers and whether or not they are accepting new patients. The commenter also recommends that the HMOs be required to submit lists of any specialty groups the HMO was unsuccessful in bringing into their network because having this information during the application process would allow a more comprehensive representation of the network’s adequacy or inadequacy.

Agency Response: The department declines to make the requested change. The HMO Division determines network adequacy based on an HMO’s contracted physicians and providers, not on non-contracted physicians and providers. The list of contracted physicians and providers, along with maps showing their locations, are evaluated

against TDI access requirements to ascertain whether an adequate number of physicians and providers with the appropriate skill levels are available to provide the covered services. If deficiencies are noted in the network, the HMO will be required to submit an access plan for approval unless the network deficiencies are so severe that they cannot be adequately addressed by an access plan. In such case, the network will not be approved.

§11.204(23): A commenter feels the requirement for a description of the management structure and personnel to demonstrate an applicant's capacity to meet the needs of providers and enrollees, and to meet the requirements of regulatory and contracting entities, is vague and may exceed the agency's statutory authority.

Agency Response: The department disagrees. This provision is not new but rather clarifies and expands the previous language in §11.204(23) that required applicants for an HMO certificate of authority to provide information demonstrating their ability to comply with statutory requirements. Further, §843.078(n) provides that an application for a certificate of authority must include "any other information that the commissioner requires to make the determinations required by this chapter and Chapter 20A" of the Insurance Code.

§§11.204, 11.205, 11.506, 11.901, 11.1600, 11.1601, and 11.1607: Some commenters strongly support the department's position and encourages adoption of these sections.

Agency Response: The department appreciates the comments.

§11.205: A commenter understands the department's rationale for requiring greater detail regarding complaints to facilitate monitoring problems and concerns that may impact enrollees. However, some commenters believe the proposed changes to the complaint categories will necessitate change to complaint and appeal policies and procedures and the current complaint log format. These commenters feel that substantial lead time will be required to design enhancements, re-program and test impacted databases and systems, and train coordinators. One commenter suggests an effective date of enhanced categories be January 1, 2006 or later. Another proposed nine months lead time. A commenter also asked the department for additional guidance on the use of these categories, as one complaint could fall into more than one category.

Agency Response: The department agrees with the need for a delayed compliance date. Therefore, the department has determined that compliance with this provision is required as of January 1, 2006. The department recognizes that a single complaint may fall under multiple categories, and expects that reporting will distinguish clearly between number of complaints and number of categories. For example, a report of complaints might state that there were a certain number of complaints within a time period, but the total number of complaints within the complaint categories during the same time period may be larger due to the multiple categories that apply.

§11.303(c): A commenter requests adding "or applicable sample documents" to this subsection for out of state HMOs because having all provider contracts in this state should not be necessary.

Agency Response: The department declines to make this change to subsection (c) since it reflects current department procedures. A form contract is not an adequate substitute for a copy of an executed contract because it does not contain evidence of actual agreements in effect.

§11.303(c)(5): A commenter asks whether enrollee disenrollment logs and provider termination logs are information that an HMO is currently required to maintain. If not, the commenter says that the regulations should elaborate on the form of these logs.

Agency Response: The rules do not require that provider termination logs be provided. The requirement for enrollee disenrollment and termination logs is not new, as former 28 TAC §11.205(a)(5) required HMOs to maintain such logs.

§11.303(d)(1) and (3): A commenter suggests that the rule be revised to clarify that a key manager's designee may attend the entrance and exit conferences in the event a given key manager is not available.

Agency Response: The department agrees and will restore the words "or their designee."

§11.303(d)(5): A commenter states that the department has modified the timeline in the event the exam team cites serious deficiencies. The commenter states that an HMO is required to provide the exam team with a signed plan to correct deficiencies within one business day, instead of the previous 10 business days, and to submit a plan of corrective action within 10 days instead of the previous 30 days, in accordance with the severity of the deficiency. The commenter says that one business day to provide TDI with a signed plan to correct deficiencies is extremely onerous, especially when there is no definition of what a "serious" deficiency is. The commenter recommends returning to the original language.

Agency Response: The department declines to make this change. The commenter may not be distinguishing between the requirements for “serious deficiency” and “potentially serious deficiency,” which, in the previous rules, had different time frames. The proposed and adopted rule eliminates the category of “potentially serious deficiency” but continues to give the HMO one business day to submit a plan to correct serious deficiencies. However, the proposed and adopted version allows 12 calendar days (rather than 10 business days) to correct the deficiencies. In most cases, however, this will result in identical time frames. One example of a serious deficiency is an HMO with an unlicensed medical director or no medical director.

§11.505(f): A commenter suggests that to provide plans with additional flexibility in filing of EOCs with ranges of benefits, exclusions, and other provisions, the phrase "is limited to" be replaced with "such as."

Agency Response: The department disagrees. The adopted rule expands the types of variable information that can be included in an EOC, but the department declines to make the list open-ended at this time. However, the department is receptive to suggestions regarding variability that may be appropriate for consideration in future rulemaking.

§11.506(2)(A): Some commenters suggest that the department delete the reference to the 200% of total premium limit on copayments, as this maximum came from federal minimum requirements for HMOs, and SB 541 (78th Legislature) deleted the reference to federal minimum qualifications. A commenter believes that doing so will allow for increased cost sharing and more flexibility in HMO products. To be comparable to other benefits provided in the market, a commenter suggests "the department place limitation the same as for PPOs, which do not allow a cost differential less than 30% co-insurance for an insured and the insurer must pay 70%."

Agency Response: The "federal minimum requirements" the commenter references are found in the Public Health Service Act (42 U.S.C. Section 300e et seq.). SB 541 deleted only the requirement that the basic health care services an HMO must provide include at least the services designated as basic health services under Section 1302,

Title XIII, Public Health Service Act (42 U.S.C. Section 300e-1(1)). The bill made no other change to the application of the Public Health Service Act in Texas law. SB 541 does address the commenter's concern by authorizing an HMO to offer plans generally not subject to limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts. An HMO may thus offer a consumer choice health benefit plan that is not subject to the §11.506(2)(A) limit on copayments, and the increased cost sharing and flexibility in HMO products the commenter seeks are already available pursuant to SB 541. The department thus declines to make this change.

§11.506(2)(B): A commenter suggests that consumer choice plans specifically be exempted from the general prohibition against deductibles.

Agency Response: The department declines to make this change. While this adoption revises the definition of consumer choice health benefit plans, generally it does not seek to identify provisions that may be exempt from regulation under, or otherwise subject to, SB 541. The regulations specifically applicable to consumer choice plans are located at Subchapter AA, Chapter 21 of this title.

§11.506(9)(E)

Comment: A commenter states that there are two Articles 20A.09H dealing with grandchildren, and that it would be helpful to clarify which controls.

Agency Response: The caption of the applicable statute (“Children and Grandchildren”) was included in the rule to distinguish between the two articles.

Comment: A commenter suggests that rather than changing the term from "subscriber" to "enrollee" with regard to grandchild coverage, the phrase "or subscriber's spouse" be added after “subscriber.”

Agency Response: The department declines to make this change, since Article 20A.09H uses the term “enrollee.”

§11.506(23)(F): A commenter suggests inserting “which does not allow open access to participating obstetricians/gynecologists” after “An HMO” in the first line.

Agency Response: The department disagrees, as there should be no instance where an HMO does not allow open access. In the interest of standardization, the HMO must include the space on the enrollment form for selection.

§11.901(a)(1)(A) and (C): A commenter suggests that this language confine the hold harmless provisions in these sections to services that are covered under the HMO plan. The commenter also observes that subparagraph (C) incorrectly states that providers can collect supplemental charges or copayments on behalf of the HMO. Providers collect copayments on their own behalf, not on behalf of the HMO.

Agency Response: The department disagrees that the first suggested change is necessary, as the rule already states that it applies to covered services. The

department agrees to delete language concerning the collection of copayments "on HMO's behalf."

§11.901(a)(5): A commenter says that this section could arguably eliminate the ability of HMOs to terminate the provider on less than 90 days' notice for the reasons stated in §843.306 (imminent harm, fraud, etc.). The commenter doubts that was the intent, but expressed concern that the section does not clearly permit such terminations. The commenter stressed health plans' need to terminate a provider immediately for such good cause.

Agency Response: The department understands the commenter's concerns. However, the exceptions for cases of imminent harm to a patient; action by a licensing board, or other governmental agency; and provider fraud or malfeasance are referenced in the rule by citation to §843.306 and do not need to be restated.

§11.902: A commenter requests that this section be revised to clarify that nurse first assistants must comply with the terms established by the HMO for participation in the network including, but not limited to, meeting credentialing standards and network need.

Agency Response: The department declines to make this change, as this provision mirrors the statute.

§11.1600(a): A commenter requests inserting “with the contract holder” after “By agreement” in the last sentence.

Agency Response: The department declines to make the requested change, as Article 20A.09(a) says the agreement may be between the HMO and the subscriber, or the person entitled to receive the evidence of coverage.

§11.1600(b)(11): A commenter agrees with the language, but suggests that the HMO also be required to provide a list of any non-contracted specialists in the service area that are pertinent to the provision of medical benefits to enrollees; this would provide a more comprehensive representation of the network and provide enrollees a better understanding of the circumstances under which a non-network physician or provider may be involved in their care.

Agency Response: The department declines to make the requested change. While the department understands the commenter’s interest in enrollees having a better understanding of the circumstances under which a non-network physician or provider may be involved in their care, the department disagrees that providing enrollees with a list of all non-contracted specialists in a service area would accomplish that goal. The enrollee may obtain the same information that the commenter suggests be available by reviewing the list of contracted physicians and providers that the HMO is required to provide. The enrollees can assume that any physician or provider not on the list is not

in the network. In addition, a list of all non-network physicians and providers may confuse enrollees and be difficult for HMOs to assemble and maintain.

§11.1600(b)(11)(E): A commenter states that HMO and health plan internet sites are often quite large and difficult to navigate, and suggests that internet notice must be "conspicuous," "prominent," and "no deeper than one page below the HMO main home page." Other commenters applaud the enrollee notice in this section, and feel that it ensures that enrollees have more information to make healthcare decisions, but request that the information be more easily accessed on the website, and suggest no more than three "clicks" to get to the information.

Agency Response: The department agrees that clarification would be useful, and has added clarifying language in §11.1600(f), which refers to the entire provider directory, rather than in (b)(11)(E), which is limited to the notice provisions that must be included in the provider directory.

§11.1600(d): A commenter notes that the plan description still requires the HMO to hand out paper provider directories but, along with another commenter, believes that web site directories are more accurate and up-to-date than paper directories. Consequently, the commenters believe, the department should allow HMOs to direct members to the HMO website for provider lists and to provide written hard copy directories upon request. A commenter believes Insurance Code §843.2015 gives the

department the authority to allow carriers to provide such directories in this manner and points out that allowing carriers to do so will save costs.

Agency Response: The proposal does not require issuance of a paper directory. Section 11.1600(d) concerns only situations where an HMO seeks to provide plan descriptions and provider directories along with the handbook. Subsections (a) and (b), which address an HMO's publication of a plan description, allows an HMO to furnish a plan description, including a provider directory, electronically upon agreement. Pursuant to TIC §843.2015, electronic distribution includes publishing the directory on the HMO's internet site. The electronic option may not work for all enrollees or potential enrollees, as internet access is not universal. Moreover, some electronic directories pull up only one provider at a time or a limited provider list at one time based upon search criteria such as ZIP code, which lists providers available in a certain ZIP code. Accordingly, while electronic distribution is permitted, if the enrollee does not agree to accept an electronic version, the HMO must furnish a paper copy of the plan description or directory.

§11.1605(b): A commenter suggests adding language to permit an HMO to contract with a mail order pharmacy vendor who is located outside of Texas and who may not be licensed in Texas (unless a pharmacy providing mail order services to Texas residents must be licensed under Texas State Board of Pharmacy requirements).

Agency Response: The department declines to make the requested change, as the Texas Pharmacy Act, Texas Occupations Code Subtitle J, requires a pharmacy vendor who ships medications into Texas through mail order arrangements to become licensed as a Class E Pharmacy.

§11.1606(b): A commenter believes that the department should not dictate the responsibilities of the Chief Operating Officer (COO) or Chief Executive Officer (CEO) other than general oversight and responsibility for the operations of the HMO, and notes that the list contained in this section doesn't fit all organizational structures. Another commenter asks that the CEO or COO definition not include responsibility for "marketing operations" and "medical management" because medical management decisions should be made by doctors, and recommends that the CEO or COO be responsible instead for "the general oversight of the plan."

Agency Response: The department disagrees and does not believe the recommended change is necessary. If in a particular organizational structure, an executive at an equal or higher level than the CEO or COO oversees portions of the functions, and informs the CEO or COO of the status of the functions on a regular basis, the department would take this structure into account during an examination. Oversight of medical management functions does not imply that the CEO/COO makes medical management decisions; rather, the CEO/COO oversees the administrative functions of the medical management department such as staffing, equipment and other resources,

and ensuring compliance with all applicable statutes and rules pertaining to the operations of the HMO.

§11.1606(c) and (d): A commenter supports the revised requirements for clinical director as more flexible and more reflective of the current operations of national health plans.

Agency Response: The department appreciates the comment.

§11.1606(c)(1): A commenter feels this provision should state, “shall be currently licensed in the United States or otherwise authorized to practice in the United States…”

Agency Response: The department declines to change the existing requirement because a clinical director, as a health care professional, must logically be a physician or provider. Texas Insurance Code, at §843.002(22), defines "physician" as "an individual licensed to practice medicine in this state.” Likewise, §843.002(24) defines "provider" as “a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state.”

§11.1607(g): Some commenters support changing the availability of routine behavioral health care from three to two weeks. Another commenter is concerned about this change, and asks about the disposition of the provisions in 28 TAC §11.2001. The commenter says that change from three weeks to two weeks for appointment times for

behavioral health providers is particularly troublesome in a Medicaid context, where it is difficult to find qualified providers willing to accept patients for that program at rates that are competitive, given HHSC's capitation rates to HMOs.

Agency Response: The change from three weeks to two weeks is consistent with NCQA requirements. The department clarifies that the referenced provision was formerly located at §11.2001, Subchapter U, which is being repealed simultaneously with this adoption order. Regarding Medicaid patients, the department notes that HHSC has authority over the Medicaid product, except as specifically provided for in the Texas Insurance Code and other applicable laws, and therefore the provision does not apply other than by reference, if any, in the HHSC contract with the HMO.

§11.1607(g)(1)(B): Some commenters oppose changing the availability requirements for urgent behavioral health care from 24 hours to 48 hours from time of request. They feel the change would be dangerous to patients who need urgent treatment and that unnecessary delays will cause the patient’s health to deteriorate and lead to the need for more and more expensive services.

Agency Response: The department agrees that urgent behavioral health care should be available on a timely basis and is retaining the 24 hour requirement.

§11.1607(h): A commenter feels the language change to “travel distances from any point in the service area to a point of service…” would require a change to current

software mapping programs, which measure distances from where actual enrollees live or work. Another commenter requests confirmation of its understanding that the mileage requirements of the rule refer to the given mileage radius rather than actual road mileage.

Agency Response: While changes to current software programs may be required to meet the clarified standard, the department believes the change was necessary to ensure that HMOs have networks that encompasses the entire service area. In addition, the department notes that a variety of software or manual methods of demonstrating compliance is available. The department clarifies that the mileage requirements are measured as radii from provider and physician locations within the HMO service area. This change should better demonstrate access to the particular type of provider throughout the service area.

§11.1607(j): A commenter feels the requirement to provide an enrollee with a written explanation of the out-of-area options seems onerous. The commenter says that HMOs arrange for access to providers based on the medically appropriate services needed by the member, and questions how often an HMO would "force" an enrollee to go outside the service area when in-area services are available. The criteria for going outside would be based on the need for the higher skill level.

Agency Response: Treatments or services that require a “higher level of skill or specialty” may be rare. However, these services may still be needed in such instances

and the requirement should not be onerous or burdensome for HMOs. The rule allows HMOs the flexibility to provide quality care in a cost-effective manner, while balancing the need for appropriate notice to enrollees. The department is familiar with one situation in which an HMO contracted with a network of “centers of excellence” for transplant services. In some service areas, the contracted facility was located outside the service area, although another transplant facility was also located within the service area. In this instance, the HMO filed an access plan to demonstrate that the in-area facility did not meet the quality standards for the particular transplant services, or else was inaccessible because it did not enter into a contract. In the event that an enrollee had required the transplant services in this instance but wished to stay in the service area, the department expects that the HMO will give the enrollee written information regarding the benefits and detriments of the in-area and out-of-area facilities, allowing the enrollee to make the decision after full disclosure. The HMO has the option of authorizing out-of-network services in such a situation, and may even negotiate a single-member contract with the in-area facility.

§11.1806(a): A commenter suggests that the requirement that the second (final) Medicaid Financial Statistical Report be accompanied by a CPA opinion creates issues of timing (for the report to be prepared, and then audited, before submission) and expense (the audit fees). The 30-day period between 270 and 300 days after the contract period is not only insufficient for this new requirement, but also is not consistent

with the Medicaid requirement that the report reflect data through the 334th day and be submitted by the 365th day.

Agency Response: This provision was not changed from that originally adopted in 1998, which was consistent with the requirements of the Texas Department of Health at that time. Upon consultation with the Health and Human Services Commission (HHSC), who has changed the requirement to the time period the commenter referenced, this section was changed to the time frames of the annual reports as set by HHSC**.**

§11.1902(4)(B)(i): A commenter states that this section requires each provider of a Group/Independent Physician Association to be individually credentialed by the HMO but does not make allowance for delegation, although delegation is listed in many areas.

Agency Response: The provision distinguishes between individual credentialing of members of a group, as opposed to a group credentialing process. To the extent that an HMO delegates credentialing, the same requirements would apply to the delegate. However, as set forth in 28 TAC §11.2601, the HMO remains ultimately responsible for compliance with all applicable laws, including credentialing requirements.

§11.1902(4)(B)(v): A commenter states that clause (v) should be changed so that applicants must be notified only if the credentialing or recredentialing decision is adverse. The commenter says that every plan has network management procedures

for welcoming new providers upon initial credentialing and that it would be redundant and burdensome to require separate notification of a positive decision. For recredentialing, the process for providers successfully recredentialed is seamless so that notification of a positive recredentialing decision would serve no useful purpose. The commenter also says that NCQA has eliminated this requirement for notification of positive actions and only requires notification of adverse actions.

Agency Response: The department declines to make the change because the language is consistent with NCQA standard CR1 (2004).

§11.1902(4)(C)(iv)

Comment: A commenter is concerned about the use of the term “individual provider” and asks that the department clarify that site visits are required only for primary care providers, OB/GYNs and high-volume specialists.

Agency Response: To clarify, the department will add the words “behavioral health” when referring to “individual provider,” where appropriate.

Comment: A commenter urges deletion of the language requiring HMOs to have a process to track the opening of new physician and individual provider offices, and to perform a site visit of each new office site of the stated physicians and providers. The commenter says that the language implies that the plan would have an obligation to continuously monitor the status of new office openings, which would be extremely costly and burdensome. The commenter suggests alternative language that says opening of a

new provider office is considered a material change in a provider's participation status that must be reported to the HMO, which will perform a site visit when so informed.

Agency Response: The site visit requirement is only applicable to relocation and opening of additional sites for primary care physicians, OB/GYNs, and high-volume behavioral health physicians or individual behavioral health providers. Because HMOs are already required to maintain a current provider directory, tracking should impose no additional burden. To clarify, the section has been changed as follows: "The HMO shall have a process to track the relocation and the opening of additional office sites for primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers."

§11.1902(7)(A)(iv): A commenter states that the language of this clause is not consistent with NCQA standards. The commenter could find no requirements for a procedure for termination of the delegation agreement for non-performance in the standards for NCQA accreditation.

Agency Response: The language is consistent with current NCQA standard CR12 (2004). A written delegation agreement is required for the delegation of any function required by the HMO Act, including credentialing, under Article 20A.18C. One of the required provisions of such agreement is an acknowledgment and agreement by the delegated entity that if it fails to meet standards established to ensure that delegated

functions are in full compliance with all statutory and regulatory requirements, the HMO may cancel delegation of any or all delegated functions.

§11.1902(7)(B) and (C)(iii): A commenter says it did not find any requirements for semi-annual reports received from the delegated entities in the standards for NCQA accreditation.

Agency Response: This requirement is consistent with NCQA standard CR12 (2004).

§11.2201(c): One commenter says that some single service HMOs only contract with full service HMOs and therefore would never produce an evidence of coverage (EOC). The commenter accordingly recommends adding the words “if applicable” after the term “evidence of coverage.”

Agency Response: The department disagrees that this is necessary, since the provision applies only to an HMO that issues an EOC.

§11.2207(d)(2)(B)(xiii): A commenter recommends adding “as applicable” after “pharmacy,” as not all single service HMOs cover this benefit.

Agency Response: The department disagrees that the suggested phrase is necessary, as the language would only be applicable to those HMOs that offer pharmacy benefits.

§11.2207(d)(4)(G): A commenter disagrees with linking department rules to NCQA requirements for categories of health plans that are not accredited by NCQA, and suggests that the language in this subparagraph be revised to exempt categories of health plans that NCQA does not accredit, i.e., stand-alone dental plans.

Agency Response: The department disagrees, as this requirement comes from Insurance Code Article 20A.39, which applies to all HMOs without exception.

§11.2208(b): A commenter asks that this subsection clarify the exclusion of non-emergency conditions (such as routine eye care and dental checkups).

Agency Response: The department does not believe this change is necessary. Sections 11.2203 and 11.2204 specifically address minimum standards for dental care and vision care services and benefits, and §11.2208(b) already requires an HMO to make services available only "as appropriate."

§11.2208(c): A commenter says that this requirement could severely limit the business of health plans that hold the contract with ambulatory surgical centers and hospitals and not with single service HMOs. Presently none of the commenter's business with full service HMOs carve out both provider and hospital services.

Agency Response: To clarify that this section applies only to single service HMOs that provide inpatient care, the department has changed the subsection as follows: "If a service offered by a single health care service HMO requires inpatient status…."

Payment for Out-Of-Network Services

§11.506(10)(D) and §11.1607(i)(4): A commenter generally supports the rules as published, and believes the amendments to these sections are necessary to ensure that enrollees receive covered services by paying only the deductibles and copayments stated in their contracts. The commenter agrees that this language does not address an HMO's ability to negotiate rates; instead the amendments clarify that HMOs must provide care on a pre-paid basis in accordance with accessibility and availability standards of the statute.

Agency Response: The department appreciates the comment. However, as previously noted, the department acknowledges concerns that the proposed language may have some effect on an HMO's ability to negotiate with certain providers which may not have been anticipated at the time of the original enactment of the HMO Act. As a result of the possibility of legislative action, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) in order to appropriately defer the issue during the current legislative session.

§11.506(10)(D) and §11.1600(b)(11): A commenter feels that these sections should be changed to include not only the term "network" but also "network facilities," as contained in §11.1607(i)(4), to maintain consistency and clarify the intent that enrollees are

protected from paying amounts that may be balance billed whether benefits are received from a network provider or a non-contracted physician.

Agency Response: The department is not adopting the proposed language relating to payment of necessary out-of-network services. However, the department disagrees that this change would be necessary because it is generally understood that a network would include any providers who contract with the HMO, including facilities. "Provider" is defined in Insurance Code §843.002(24) as "a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including . . . a pharmacy, hospital or other institution or organization."

§11.506 and 11.1607: Some commenters feel that the term "usual and customary," as stated in Texas Insurance Code Article 20A.09Y, refers to the fee a particular physician charges for a particular service. The commenters believe that defining the term in this manner is necessary to protect the enrollee from balance billing, as there will undoubtedly be a difference between the amount the plan is willing to pay and the physician's actual charge. A commenter believes this position is supported by Insurance Code Article 21.60 which, when referring to the amount the plan is willing to pay, does not use the phrase "usual and customary." Another commenter feels that to allow plans to define "usual and customary" as their contracted rate confuses the issue and violates the statute.

Another commenter notes that the language of the 1997 Patient Protection Act relating to ER providers came from the department's rules and asserts that the "usual and customary" language was included to address those instances when the HMO and provider could not agree on a rate. A commenter notes that §11.204(20), concerning contents of an application, continues to require that the HMO demonstrate that it will pay for emergency care services rendered by non-network providers at either a negotiated rate or the "usual and customary" rate. The commenter asserts that "usual and customary" rates are established as a means of providing fair and reasonable compensation for services rendered while protecting health plans and members from "price gouging."

Agency Response: The different approaches from the commenters on this issue demonstrate the complexity involved in payment for necessary out-of-network services. Defining "usual and customary" would likely have more far-reaching effects on other elements of the health care industry than ensuring enrollees are protected from additional charges for out-of-network services. As a result of the possibility of legislative action on the issue of payment for necessary out-of-network services, the department is not adopting the proposed language relating to payment of necessary out-of-network services and declines to define "usual and customary" as suggested.

§11.506(10)(D): Some commenters oppose the requirement that an HMO ensure enrollees are indemnified or otherwise held harmless if they receive out-of-network

emergency care services. Some commenters state that this issue is currently not addressed by statute and, as one commenter notes, there is presently no Texas law to prohibit non-contracted providers from balance billing patients. The commenters believe that the rules exceed the department's statutory authority in Article 20A.09Y, which allows HMOs to pay for emergency services through a negotiated rate or, in the event the HMO cannot negotiate a rate, a usual and customary rate.

Agency Response: While the commenters are correct that there is no law preventing out-of-network providers from balance billing an enrollee, the proper focus for these rules is the department's authority over HMOs and their payment obligations for necessary out-of-network services. Some HMOs indicate they rely upon the term "usual and customary" in the statute in order to pay an amount that is sometimes less than what a provider is willing to accept. This, in turn, creates the potential for additional cost exposure to enrollees, which is inconsistent with other provisions of the statute. As a result of the possibility of legislative action, the department is not adopting the proposed language concerning payment for necessary out-of-network services in §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

§11.506(10)(D)(ii): Some commenters are concerned that emergency care providers may terminate existing contracts in order to maximize their revenue by forcing payment of billed charges by HMOs. A commenter suggests that, as applied to consumer choice

plans that have copayments that are a percentage of the billed charges, this requirement could actually result in additional out-of-pocket liability for enrollees.

Agency Response: As discussed previously, the department received comments regarding the effects the proposed language may have on an HMO's future ability to negotiate with providers, including emergency providers, to create a network. The department also recognizes that creating a network of contracted providers is crucial to the concept of managed care, including consumer choice plans offered by an HMO. Because of the potential effects that the proposed language may have on HMOs' ability to create networks of contracted providers, as well as legislative interest in the issue of payment for necessary out-of-network services, the department is not adopting the proposed language.

§11.506(10)(D): Some commenters request that this provision be removed because the current statutory framework allows HMOs to negotiate with non-contracted emergency service providers for a rate lower than billed charges. If the provision remains, it will essentially remove the incentive for emergency care providers to negotiate and, as one commenter notes, may embolden already aggressive emergency care providers into absolute refusal to negotiate rates. Without rate negotiation, providers will be free to set exorbitant charges, which will only serve to make health plan coverage more unaffordable in Texas. They note that currently if their negotiations are unsuccessful most HMOs will make certain that their enrollees are held harmless.

Agency Response: As discussed previously, the department received comments regarding the possible effects the proposed language may have on an HMO's ability to negotiate with out-of-network emergency providers and the potential associated costs. Because of this, as well as legislative interest in the issue of payment for necessary out-of-network services, the department is not adopting the proposed language.

§§11.506, 11.1600 and 11.1607

Comment: A commenter notes that balance billing is a nationwide problem but, along with others, does not believe the rule amendments are the appropriate way to address the problem. Some commenters believe the rule seeks to treat the problem of network adequacy, especially with facility-based providers, with a solution that guarantees to increase the network adequacy problem. Because the amendments take away the HMO's ability to negotiate with providers, the commenters assert, the rule amendments make the term "usual and customary" effectively the same as billed charges. The commenters assert that if HMOs are required to fully indemnify members for use of out-of-network providers rather than to be able to negotiate or pay a reasonable and customary fee, providers will leave HMO networks so that they can be paid full billed charges. This result is contrary to the requirement that HMOs provide adequate networks. A commenter asserts that facility-based providers have no incentive to contract with health plans under current laws and believes the proposed amendments further encourage providers to not contract with HMOs or to leave the networks. A

commenter notes that those that stay in network will be able to exact increased contract rates because of the threat of going out-of-network. The result is an upward pressure on contract pricing that must inevitably be passed on to employers and employees, as well as any state plan that does not have a mandatory fee schedule and automatic hold harmless requirement, i.e., CHIP and others. The commenter believes that the rules are inconsistent with the cost-saving purpose of HMOs, and will result in an extreme cost increase to employers in the form of rate increases, which will result in higher costs ultimately paid by enrollees. Thus, the commenter concludes, the rules threaten the very existence of the fully-insured HMO market in Texas, and limit insurance availability, resulting in an increase in the number of uninsured in Texas. Some commenters recommend that the department not address the issue, as often non-contracted providers will negotiate and many times the carrier will pay billed charges if necessary to hold the member harmless.

Agency Response: The department recognizes the concern that the proposed language may hinder contract negotiation efforts, but the absence of protections for enrollees seeking services in a network facility highlights a potential network adequacy problem that the commenter is not addressing. The cost-saving aspect of HMOs, as mentioned by the commenters, depends upon the ability to contract with providers for discounted fees. However, another aspect essential to HMOs, to deliver covered services to enrollees without additional costs other than applicable copayments and deductibles, depends upon the ability of enrollees to access covered services in a

network facility. This issue was a subject of the Senate Committee on State Affairs Interim Report and, as stated in the report, “begs for legislative action.” Due to the upcoming legislative session and the expressed interest in the subject, the department is not adopting the proposed language.

Comment: Some commenters take issue with the statements in the preamble of the proposed rules which indicate that the revisions requiring indemnification of health plan members who obtain out-of-network services are necessary to comply with existing statutory requirements and are basically a restatement of Insurance Code Article 20A.09(f). The commenters feel that Article 20A.09(f) clearly states that an HMO may pay either an agreed rate or, absent an agreement, may pay a usual and customary rate. A commenter notes that the language of the 1997 Patient Protection Act came from the department’s rules and was included to address the fact that insurance companies may not be able to reach an agreement with providers on a rate. Some commenters feel that the regulation would make the statutory reference to “usual and customary” meaningless as it essentially mandates the payment of full billed charges. The commenters further note that the requirement of a hold harmless provision found in Subchapter K, § 843.361 of the Insurance Code only applies to contracted providers and would be rendered meaningless if the department’s interpretation is correct. Under the department’s interpretation, there would be no need for the hold harmless provision because all health care costs other than copayments would be borne by the HMO, regardless of whether there was a provider network contract. Rules of statutory

construction do not support this result. Thus, the commenters assert that the rule not only exceeds statutory authority but actually conflicts with existing statutes.

Agency Response: The commenter is correct that the hold harmless language found in §843.361 specifically relates to contracted providers. The provision is made a part of the provider contract and is an important enrollee protection in the HMO Act. When enrollees must receive services outside the provider network due to the unavailability of services through a network provider, the statute continues to protect enrollees by requiring HMOs to "fully" reimburse the out-of-network provider. Although unrelated to the requirement in §843.361, the department views this directive as a requirement that enrollees be held harmless when forced to receive services outside of the network. This provision, combined with the §843.361 requirement for a contractual hold harmless provision for contracted providers, protects enrollees from additional costs when attempting to access covered services.

The department disagrees with the commenters' characterization of the statute and its requirements concerning out-of-network payments by HMOs. Paying a provider at the HMO's usual and customary amount and thereby subjecting the enrollee to additional costs is inconsistent with the statutory directive to "fully" reimburse the provider. A fundamental concept of a managed care plan is that enrollees are protected from additional costs in exchange for giving up the ability to choose a provider outside the HMO's network. The commenters' interpretation would undermine that concept. Additionally, the HMO Act requires that an HMO maintain an adequate network. This

requirement would be rendered meaningless if the inability of HMOs and providers to agree on a usual and customary or other acceptable payment amount for necessary out-of-network services subjected enrollees to additional costs when they are forced to go outside of the network for covered services. Moreover, the use of Article 20A.09(f) to solve reported current difficulties in contracting with certain types of providers is not consistent with certain protections afforded enrollees in the HMO Act, such as requirements related to network adequacy. The commenters' interpretations create an exception to the network adequacy requirements that circumvents the rule and would allow enrollees to be routinely exposed to additional costs for services that should be available through network providers. The HMOs' reported difficulty contracting with facility-based providers and the resulting possibility of out-of-network services is an issue that has become more prominent since the legislature originally enacted this provision. Due to potential legislative action, as evidenced by the Senate Committee on State Affairs Interim Report, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter believes the legislature should address the balance billing problem and has asked the legislature to do so.

Agency Response: The department acknowledges that the legislature has expressed its intent to address this issue, and therefore is not adopting these provisions pending such action.

Comment: Some commenters feel that physicians will always have an incentive to contract with HMOs who negotiate in good faith, and thus will continue to contract with HMOs. A commenter disagrees that the steerage of patients is the only incentive for a physician to contract, as other incentives exist, including: application of prompt pay to contracted providers; facility-based physicians who want to maintain a relationship with a hospital; and a hospital preferring a group who will contract over one who does not.

Agency Response: The department notes that many factors may influence providers' decisions to contract with HMOs, including those mentioned by the commenter, but acknowledges the concerns regarding the potential effect of the proposed provisions on negotiations between HMOs and providers for discounted rates. The department recognizes the challenge concerning the fundamental HMO concept of providing covered services through a closed network of providers and the HMOs' stated inability to contract to provide those services. Given the expressed legislative interest in addressing this issue, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: One commenter estimates costs for a health plan under existing market participation to be about $15 million (using 2003 figures) and says costs will go up as providers leave the network. These costs will ultimately be borne by the enrollee. Another commenter estimates that 95,000 of its members will be affected and that paying billed charges would cost an additional $8.87 million. The amount will go up as providers leave the network. The commenter is concerned that there is no limit to billed charges and has seen one as high as 1800 percent of Medicare in 2002. The same commenter says the average for billed charges in West Texas in 2002 was 300 percent of Medicare and now it is 400 percent.

Agency Response: The department acknowledges the concerns regarding potential cost effects the proposed language may have on an HMO's ability to contract or negotiate with providers. Given these concerns and the competing consideration of enrollee protection, as well as the expressed legislative interest in addressing this issue, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: Some commenters assert that the proposed provisions are contrary to previous positions taken by the department.

Agency Response: Regardless of the department's previous statements on this issue, the proposal sought to clarify an HMO's out-of-network payment obligations consistent with existing statutory requirements through the rulemaking process. As a result of the

considerations regarding HMOs' ability to negotiate and contract with providers and a clear legislative interest in this subject, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter states that they currently have over 53,000 CHIP members and if the proposed rules go into effect, they will have to request a premium increase from HHSC, which will probably hurt their ability to increase CHIP membership. The commenter notes that they had paid billed charges in the past but recognized that doing so took away their ability to negotiate. They then changed to paying a usual and customary rate based on Medicaid, which increased their ability to contract and saved $2.7 million for the plan and HHSC. If a non-contracted provider balance bills a member, they try to reach agreement, but if they are unsuccessful they will sometimes pay billed charges to protect the member. Because they pay non-contracted providers at a usual and customary rate, they have the ability to negotiate with providers. To take this ability away will cost more than $2.7 million. The commenter believes things are working now and has received few complaints on this issue. A commenter believes the proposed rule amendments will have a huge impact on HHSC, and will be asking for a premium increase if the amendments are adopted.

Agency Response: The proposed language sought to clarify the issue of payment of necessary out-of-network services due to some confusion regarding HMOs'

responsibilities for payment of such services. The department is aware of the competing considerations concerning costs and enrollee protections, as well as the expressed legislative interest in addressing them. As a result, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: Some commenters note that if an HMO is meeting its statutory duty to maintain an adequate network, payment to non-network physicians is not an issue. One commenter believes that adequate provider networks actually decrease health care costs and promote continuity of care and health management, and reduce hassles for the patient, health plan, and provider. Thus, these commenters believe the department is correct in stating that the root of the balance billing issue is the failure of HMOs to have an adequate network and provide the basic health care services they promise to provide on a prepaid basis. The commenters believe HMOs should be held to their obligations. A commenter notes that only HMOs that continue to fail to meet their obligations will see increased costs, which are “currently borne on the backs of patients and non-network physicians – both of whom are innocent parties.” A commenter also feels that the cost of an inadequate network is a risk an HMO takes when it applies for a certificate of authority to offer HMO services in Texas. Some commenters applaud the department’s efforts to protect patients by monitoring network adequacy and ensuring patients do not incur additional financial liability as a result of accessing care when a

contracted provider is unavailable. The commenters note that the proposal merely states current state law, and thank the department for its continued efforts in resolving issues that plague insurance.

Agency Response: The proposal sought to clarify an HMO's out-of-network payment obligations consistent with existing statutory requirements through the rulemaking process. The department recognizes that HMOs are reporting difficulties in contracting with certain facility-based providers, which impacts network adequacy and makes balance billing or increased costs to HMOs more likely. For the reasons stated previously, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: Some commenters express concern about reimbursement of non-network providers at "usual and customary" in absence of an agreed-to rate. One commenter notes that the term "usual and customary" is "all over the board." Some commenters state that some health plans have used this as an opportunity to cap out-of-network expenses without regard to actual billed charges or market rates for the services. Although the Attorney General has made clear that a non-network physician may balance bill for the services not covered by the health plan, it is unreasonable for a health plan to determine a "usual and customary" amount from another negotiated discount. A commenter encourages patients to use mechanisms already in place through the Texas State Board of Medical Examiners (TSBME) for review to address

excessive billing. Under current antitrust law, physicians cannot survey other area physician's charges to determine appropriateness. A commenter discusses testimony at the hearing regarding overcharging and improper billing and notes that there are ample tools available to combat the very few who improperly bill. Current law states that it is illegal pursuant to Article 21.79F to charge a higher price based solely on the fact that an insurer will pay all or part of the price, and TSBME can enforce the Texas Medical Practice Act relating to improper billing.

Agency Response: The department encourages the use of all legal means to ensure that health care charges are reasonable and proper. However, as the comments reveal, the issue of "usual and customary" has been the subject of varying interpretations. The conflicting comments received on this issue demonstrate the complexity involved in payment for necessary out-of-network services. Defining "usual and customary" would likely have more far-reaching effects on elements of the health care industry other than protecting enrollees from additional charges for out-of-network services. Comments received from HMOs indicate that routine payment of out-of-network providers' billed charges, even if not excessive, will have a substantial impact on costs and, as a result, on premiums. The department acknowledges the considerations concerning costs, as well as the need for enrollee protections when forced to seek out-of-network services. Due to these competing considerations and the possibility of legislative action on the issue of payment of out-of-network services, the

department is not adopting the proposed language relating to payment of necessary out-of-network services and declines to define “usual and customary.”

Comment: A commenter is dismayed at some testimony at the hearing and feels that testimony of several health plan representatives that the proposed rule will increase premiums is untrue. The commenter asserts that TDI policy has for years provided that non-contracted providers may bill patients and notes that an AG opinion on this subject was issued over a year and a half ago. Consequently, the HMOs’ argument that costs for treatment by non-contracted physicians has not already been included in premiums is not credible. The commenter believes that costs for treatment by out-of-network providers should already be included in HMO premiums due to the inevitability of such treatment.

Agency Response: The department notes that comments concerning the proposed language highlight existing confusion regarding the issue and competing considerations concerning costs and enrollee protections. Due to these considerations, and the expressed legislative interest in addressing them, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter disagrees with the proposed rules requiring “indemnification” of all costs of out-of-network care incurred by enrollees. Some commenters believe the statutory and regulatory basis relied on in implementing the indemnification requirement

is unsupportable. The department relies on the fact that HMO insurance is purchased on a "prepaid basis" to suggest a requirement that all costs other than copayments are the responsibility of the health plan. It would follow that if all costs other than copayments are borne by the health plan, the health plans must indemnify the costs of out-of-network services that are incurred by the member. A commenter believes that the use of the phrase "prepaid basis" in the relevant statutory sections was never intended to provide a requirement of indemnification. Rather, the commenter states, it was intended to distinguish a prepaid plan from a plan that indemnified for medical costs as is made clear by Insurance Code §843.002(12), which defines a "health care plan" as a plan "that consists in part of providing or arranging for health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of health care services." The commenter believes the department is acting outside its rulemaking authority in promulgating the particular provisions relating to indemnification of out-of-network costs.

Agency Response: A fundamental element of an HMO's health plan is the requirement that an enrollee receive covered services from network providers that have agreed to hold enrollees harmless for such services. This entitles enrollees to receive basic health care services from network providers without being subject to any costs beyond applicable copayments and deductibles. However, if an enrollee is forced, due to the unavailability of a network provider, to receive services from an out-of-network provider and is subject to additional costs, this basic principle fails. The proposal placed

enrollees in the same position they would have been had they been treated by a network provider and used the term “indemnify” to ensure this outcome. The department is aware of the competing considerations concerning costs and enrollee protections and the expressed legislative interest in addressing them. Therefore, the department is not adopting the proposed language concerning payment for necessary out-of-network services at §§11.506(10)(D), 11.1600(b)(11)(D), and 11.1607(i)(4) to appropriately defer the issue during the current legislative session.

Comment: A commenter contends that the out-of-network and balance billing rules do not apply to Children’s Health Insurance Program (CHIP) HMOs by operation of Texas Health and Safety Code §62.152(3), which exempts the CHIP program from state insurance laws that require “the use of a particular policy or contract form or of particular language in a policy or contract form.” TDI’s proposed rules would require specific language in the evidence of coverage and notices to HMO enrollees. The commenter believes that these rules do not apply to CHIP by virtue of the program’s statutory exemption and requests that the rules state that they are not applicable to CHIP HMOs.

Agency Response: The department declines to adopt the suggested exclusion for CHIP HMOs. Although the department is not making the proposed changes relating to payment for necessary out-of-network services in §§11.506(10)(D), 11.1600(b)(11)(D) and 11.1607(i)(4), the insurance laws and rules of this state, in general, apply to CHIP, except as otherwise provided in the Insurance Code and Texas Health and Safety Code §62.152. The department points out that the current CHIP/Medicaid RFP requires that

"[t]he Member will not be responsible for any payment for Medically Necessary Covered Services, other than HHSC-specified co-payments for CHIP Members, where applicable."

Comment: A commenter feels language should be adopted like that contained in rules implementing the prompt payment provisions of SB 418 at 28 TAC §21.2826, and suggests: "These rules are not applicable to Medicaid and CHIP provided by an HMO or preferred provider carrier to persons enrolled in the medical assistance program established under Chapter 32, Human Resources Code, or the child health plan established under Chapter 62, Health & Safety Code."

Agency Response: The department adopted §21.2826 pursuant to Insurance Code Article 21.30, which requires the Commissioner of Insurance to exempt Medicaid if, after consulting with the Commissioner of Health and Human Services, he determines that the provisions of SB 418 would have a negative fiscal impact on the Medicaid program. Because the Commissioner of Health and Human Services indicated that the bill would have a negative fiscal impact, the Commissioner of Insurance adopted §21.2826, which exempts both traditional Medicaid and Medicaid HMO plans from the provisions of SB 418. While federal law, Health and Safety Code §62.152, and certain provisions of the Insurance Code provide certain exemptions to CHIP and Medicaid coverages, the department does not believe the law authorizes the requested blanket exemption.

Comment: A commenter states that, given the Texas Health and Human Services Commission's exclusive authority to administer Texas Medicaid contracts, the rules

should not be applicable to HMOs with whom HHSC contracts because it could result in forcing such HMOs to cover the cost of billed charges, rather than an amount substantially less than billed charges, as the commenter understands is current practice. The commenter requests that the department's rules explicitly not apply to Medicaid HMOs. Another commenter expresses concern that the rules are in conflict with HHSC's plan to limit reimbursement.

Agency Response: The department agrees that HHSC has authority over the Medicaid product, except as specifically provided in the Insurance Code, and therefore the provision does not apply other than by reference, if any, in the HHSC contract with the HMO.

§11.1600(b)(11)(D): A commenter supports this proposal but recommends requiring the HMO to inform the enrollee of the possibility that professional and ancillary services delivered in a contracted hospital or facility might be provided by non-network physicians or providers. This would give enrollees a better understanding as to when they might receive a bill for services provided by a non-network physician or provider and better understanding of their recourse under the indemnification requirements of the HMO.

Agency Response: The department agrees that a notice is appropriate, but declines to require the recommended notice. While the department recognizes the importance of informed decision-making, it notes that patients may not always be in a position to make

informed choices about which doctors may provide services in a hospital setting, nor may they be able to require that the hospital honor the enrollee's choice of doctors. Instead, the department is adopting a notice requirement that HMOs inform enrollees to contact the HMO whenever they receive a bill from a provider, whether contracted or non-contracted.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For With Changes: Office of Public Insurance Counsel, Texas Medical Association, Texas Hospital Association, Dallas County Medical Society, Texas Medical Group Management Association, Harris County Medical Society,

Against: Texas Association of Health Plans, Scott & White Health Plan, Texas Society of Psychiatric Physicians, Texas Health and Human Services Commission, Cigna Health Care, Humana, Inc., Community First Health Plans, Inc., Texas Association of Business, Unicare, Firstcare HMO, Texas Children's Health Plan, and Pacificare.

6. STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to Insurance Code §§843.080, 843.082, 843.083, 843.102, 843.151, and 843.404; Articles 20A.09N, 20A.18C, 20A.39, 21.53D (Obstetrical care), 21.53F (Children's benefits), 21.53F (Telemedicine), 21.53K, 21.53L, 21.53M, 21.58D, 26.04, and §36.001. Section 843.080 provides that the commissioner may promulgate reasonable rules that the commissioner considers necessary for the proper

administration of Chapter 843 to require a health maintenance organization, 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 health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination. Section 843.082 sets out the determinations the commissioner must make prior to granting a certificate of authority to an HMO. Section 843.083 sets out the notification and deficiency specification requirements for plan applications whose defects preclude issuance of a certificate of authority. Section 843.102 provides that the commissioner by rule may establish minimum standards and requirements for the quality assurance programs of HMOs, including standards for ensuring availability, accessibility, quality and continuity of care. Section 843.151 provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapters 843 and 20A, including rules to prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in Chapter 843; to ensure that enrollees have adequate access to health care services; to 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 to meet the requirements of federal law and regulations. Section 843.404 provides that the commissioner may adopt rules or may by rule establish guidelines requiring a health

maintenance organization to maintain a specified net worth based on the nature and kind of risks the health maintenance organization underwrites or reinsures; the premium volume of risks the health maintenance organization underwrites or reinsures; the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio; fluctuations in the market value of securities the health maintenance organization holds; the adequacy of the health maintenance organization's reserves; the number of individuals enrolled by the health maintenance organization; or other business risks. Article 20A.09N(j) provides the commissioner shall adopt rules as necessary to implement provisions of HMO choice of benefits plans. Article 20A.18C(r) provides that the commissioner shall adopt reasonable rules to implement the article as it relates to delegation of certain functions by an HMO. Article 20A.39(a) provides that rules adopted by the commissioner under §843.102 that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with provisions of Article 20A.39 and standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. Article 21.53D, §6, provides the commissioner shall adopt rules as necessary to implement obstetrical/gynecological care provisions. Article 21.53F, addressing children's benefits, provides in Section 7 the commissioner may adopt rules as necessary to implement children's benefits provisions in the article. Article 21.53F, addressing telemedicine, provides in Section 6 the commissioner may adopt rules necessary to implement the article. Article 21.53K, §2, provides the

commissioner may adopt rules to implement the article. Article 21.53L, §4, provides that the commissioner shall adopt necessary rules to implement pharmacy benefit card provisions of the article. Article 21.53M, §4, provides the commissioner may adopt rules to implement the off-label drug coverage provisions of the article. Article 21.58D provides the commissioner shall by rule adopt a standardized form for verification of credentials of professionals named in the statute and shall consider any credentialing application form widely used in the state or by the department. Article 26.04 provides that the commissioner shall adopt rules as necessary to implement Insurance Code Chapter 26 and to meet the minimum requirements of federal law and regulations which, for large and small employer health carriers, are contained in HIPAA. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

SUBCHAPTER A. General Provisions

§11.1. Purpose. This chapter implements the Texas Health Maintenance Organization Act, Texas Insurance Code, Chapters 20A and 843.

(1) Severability. Where any terms or sections of this chapter are determined by a court of competent jurisdiction to be inconsistent with the Texas Health

Maintenance Organization Act, as identified by this section, the Act will apply, but the remaining terms and provisions of this chapter will continue in effect.

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

(3) Violation of rules. A violation of the lawful rules or orders of the commissioner made pursuant to this chapter constitutes a violation of the Texas Health Maintenance Organization Act.

§11.2. Definitions.

(a) The definitions found in the Texas Health Maintenance Organization Act, Texas Insurance Code §843.002, are incorporated into this chapter.

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

(1) Act--The Texas Health Maintenance Organization Act, codified as the Texas Insurance Code Chapters 20A and 843.

(2) Admitted assets--All assets as defined by statutory accounting principles, as permitted and valued in accordance with §11.803 of this title (relating to Investments, Loans, and Other Assets).

(3) Adverse determination--A determination upon utilization review that the health care services furnished or adopted to be furnished to a patient are not medically necessary or not appropriate.

(4) Affiliate--A person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(5) Agent--A person who may act as an agent for the sale of a health benefit plan under a license issued under Insurance Code Chapter 21.

(6) ANHC or approved nonprofit health corporation--A nonprofit health corporation certified under §162.001 of the Occupations Code.

(7) Annual financial statement--The annual statement to be used by HMOs, as promulgated by the NAIC and as adopted by the commissioner under Insurance Code Article 1.11 and §§802.001, 802.003 and 843.155.

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

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

(10) Clinical director--Health professional who meets the following criteria:

(A) is appropriately licensed;

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

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

(11) Code--The Texas Insurance Code.

(12) Consumer choice health benefit plan--A health benefit plan authorized by Insurance Code Article 3.80 or Article 20A.09N, and as described in Subchapter AA of Chapter 21 of this title (relating to Consumer Choice Health Benefit Plans).

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

(14) Control--As defined in Insurance Code §§823.005 and 823.151.

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

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

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

(18) 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.

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

(20) General hospital--A licensed establishment 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.

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

(22) 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 Article 21.21-5); or

(H) disability.

(23) Individual provider--Any person, other than a physician or institutional provider, who is licensed or otherwise authorized to provide a health care service. Includes, but is not limited to, licensed doctor of chiropractic, dentist, registered nurse, advanced practice nurse, physician assistant, pharmacist, optometrist, registered optician, and acupuncturist.

(24) Institutional provider--A provider that is not an individual. Includes any medical or health related service facility caring for the sick or injured or providing care or supplies for other coverage which may be provided by the HMO. 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) Infusion services centers,

(N) Residential treatment centers,

(O) Community mental health centers,

(P) Urgent care centers, and

(Q) Pharmacies.

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

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

(27) NAIC--National Association of Insurance Commissioners.

(28) Out of area benefits--Benefits that the HMO covers when its enrollees are outside the geographical limits of the HMO service area.

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

(30) Pharmaceutical services--Services, including dispensing prescription drugs, under the Pharmacy Act, Occupations Code, Subtitle J, that are ordinarily and customarily rendered by a pharmacy or pharmacist.

(31) Pharmacist--An individual provider licensed to practice pharmacy under the Pharmacy Act, Occupations Code, Subtitle J.

(32) Pharmacy--A facility licensed under the Pharmacy Act, Occupations Code, Subtitle J.

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

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

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

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

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

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

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

(40) RBC--Risk-based capital.

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

(42) RBC Report--Health Risk-Based Capital Report including Overview and Instructions for Companies published by the NAIC and adopted by reference in §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank).

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

(A) qualifications of physicians and providers are reassessed;

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

(C) continued eligibility to provide services is determined.

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

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

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

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

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

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

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

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

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

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

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

(51) State-mandated health benefit plan--As defined in §21.3502 of this title (relating to Definitions).

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

(53) Subscriber--If conversion or individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO; or if group coverage, the individual who is the certificate holder and whose employment or other

membership status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

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

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

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

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

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

(59) Utilization review--A system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or

proposed to be provided to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.

(60) Voting security--As defined in Insurance Code §823.007, including any security convertible into or evidencing a right to acquire such security.

SUBCHAPTER B. Name Application Procedure

§11.101. How To Obtain Forms. The name application form and all other HMO forms may be obtained by contacting the Company Licensing and Registration Division, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

SUBCHAPTER C. Application for Certificate of Authority

§11.201. Filing Fee. The filing fee required by Insurance Code §843.154, as determined by §7.1301 of this title (relating to Regulatory Fees), must accompany the application. The fee is non-refundable.

§11.202. Binding, Indexing, and Numbering Requirements.

(a) An original of the application must be submitted in one or more three-ring binders, so that pages may be easily replaced when necessary.

(b) Dividers with identifying subject tabs must precede each separate exhibit.

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

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

(e) Identical items should not be used in more than one section of the application. Instead of using the same information in more than one place, refer to the page or pages on which the required form or list may be found.

(f) The original application becomes the charter file.

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

(h) 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 the application must be addressed to: Company Licensing and Registration Division, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The applicant must include an original of the transmittal letter, plus the original of any revision specified in this subchapter.

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

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

(d) Staff shall conduct qualifying examinations and notify the applicant of the need for revisions necessary to meet the requirements of the Act or this chapter. If the applicant does not make the necessary revisions, the department shall deny the application. If the time required for the revisions will exceed the time limits set out in §1.809 of this title (relating to HMO Certificate of Authority), the applicant must request additional time within which to make the revisions. The applicant must specifically set out the length of time requested, which may not exceed 90 days. The commissioner may grant or deny the request for an extension of time at his or her discretion under §1.809 of this title. Additional extensions may be requested. The request for any additional extension must set out the need for the additional time, in writing, in sufficient detail for the commissioner to determine if good cause for the extension exists. The commissioner may grant or deny any additional request for an extension of time at his or her discretion.

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

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

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

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

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

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

(A) a completed officers and directors page; and

(B) biographical data forms for all persons who are to be responsible for the day-to-day conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing body or committee, the principal officers, and controlling shareholders of the applicant if a corporation, or all partners or members in the case of partnership or association. Any relationship between the HMO and any affiliate or other organization in which a shareholder with 10% or more interest also has an interest must be clearly identified;

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

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

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

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

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

(A) A bond must be in compliance with Insurance Code §843.402, and must be either the original bond or a copy of the bond. The bonds shall not contain a deductible.

(B) A cash deposit must be held by the Comptroller of the State of Texas in the same amount and subject to the same conditions as a bond.

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

(A) An applicant licensed as an HMO in another state must furnish a copy of the certificate of authority from the domiciliary state's licensing authority, and a power of attorney executed by the applicant appointing an agent for service, other than the commissioner as the attorney of such applicant in and for the state, upon whom all

lawful processes in any legal action or proceedings against the HMO on a cause of action arising in this state may be served.

(B) All applicants 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 in accordance with Insurance Code Chapter 804.

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

(10) financial information, consisting of the following:

(A) a current financial statement, including balance sheet reflecting assets and liabilities, statement of income and expenses, and sources and application of funds;

(B) projected financial statements for the 24-month period from the start of operations using quarterly balance sheet projections based on calendar quarters, quarterly cash flow schedules reflecting capital expenditures, and monthly revenue and expense projections, such financial statements must include the identity and credentials of the person making the projections; and

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

(11) the schedule of charges as defined in §11.2 of this title (relating to Definitions) to be used through the first 12 months of operation including any charges for Medicaid products. If any HMO proposes to write Medicaid and the maximum rates allowed by contracting state agency are proposed to be charged, then the rates published by the contracting state agency must be included with an actuarial certification and supporting documentation showing these rates are adequate in relation to benefits provided. If lesser rates are to be charged, an actuarial certification and supporting documentation must be included evidencing that the rates are adequate for the benefits to be provided. If contracting state agency Medicaid rates are not available, then the anticipated rates used in determining the applicant's financial projections must be disclosed with an actuarial certification and supporting documentation showing that the anticipated rates are reasonable in relation to the expected benefits to be provided. If a provider HMO proposes to contract to provide prepaid services to a primary HMO, the provider HMO must submit an actuarial certification and supporting documentation evidencing that the anticipated prepayments to be received from the primary HMO are adequate to pay for services to be provided to the primary HMO. All actuarial certifications must meet the qualifications specified in §11.702 of this title (relating to Actuarial Certification).

(12) a description and a map of the service area, with key and scale, which shall identify the county and counties, or portions thereof, to be served. If the map is in color, the original and all four copies must also be in color;

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

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

(B) any physician, medical group, association of physicians, delegated entity, as described in Insurance Code Article 20A.18C, delegated network, as described in Insurance Code Article 20A.18D, or any other provider, plus the form of any subcontract between such entities and any physician, medical group, association of physicians, or any other provider to provide health care services. All contracts shall include a hold-harmless provision, as specified in §11.901(a)(1) of this title (relating to Required Provisions). Such clause shall be no less favorable to enrollees than that outlined in §11.901(a)(1) of this title.

(C) any exclusive agent or agency;

(D) any person who will perform management, marketing, administrative, data processing services, or claims processing services. A bond or deposit meeting the requirements of Insurance Code §843.105, is required for management contracts. If submitting a bond, the original or a copy shall be submitted. The bond shall not include a deductible;

(E) an ANHC which agrees to arrange for or provide health care services, other than medical care or services ancillary to the practice of medicine, or a provider HMO which agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of a primary HMO as part of the primary

HMO delivery network. A monitoring plan as required by §11.1604 of this title (relating to Requirements for Certain Contracts between Primary HMOs and ANHCs and Primary HMOs and Provider HMOs) must also be submitted; and

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

(14) a description of the quality improvement program that includes a process for medical peer review required by Insurance Code §§843.082 and 843.102. Arrangements for sharing pertinent medical records between physicians and/or providers contracting or subcontracting pursuant to paragraph (13)(B) of this section with the HMO and assuring the record's confidentiality must be explained;

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

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

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

(C) any other arrangements offering protection against insolvency, including guarantees, as specified in §11.806 of this title (relating to Liabilities), §11.808 of this title (relating to Guarantee from a Sponsoring Organization), and §11.1804 of this title (relating to Guarantees);

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

(17) the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO pursuant to the requirements of Insurance Code §§843.078 and 843.079 and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees);

(18) network configuration information, including maps demonstrating the location and distribution of the physician, dentist and provider network within the proposed service area by county(ies) or ZIP code(s); lists of physicians, dentists and individual providers, including license type and specialization and an indication of whether they are accepting new patients, and institutional providers;

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

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

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

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

(C) services originating in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition will be provided to covered enrollees as approved by the HMO, provided that the HMO is required to approve or deny coverage of post stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from the time of the request; the HMO must respond

to inquiries from the treating physician or provider in compliance with this provision in the HMO's plan.

(21) a description of the procedures by which:

(A) a member handbook and materials relating to the complaint and appeal process and the independent review process will be provided to enrollees in languages other than English, pursuant to Insurance Code §843.205; 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, pursuant to Insurance Code §843.205.

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

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

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

§11.205. Documents To Be Available for Qualifying Examinations.

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

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

(2) quality improvement: program description and work plan as required by §11.1902 of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs);

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

(4) complaints and appeals: policies and procedures, examples of letters and examples of complaint and appeal logs. On or after January 1, 2006, each complaint shall be categorized as one or more of the following types of complaint:

(A) quality of care or services;

(B) accessibility/availability of services;

(C) utilization review or management;

(D) complaint procedures;

(E) physician and provider contracts;

(F) group subscriber contracts;

(G) individual subscriber contracts;

(H) marketing;

(I) claims processing; and

(J) miscellaneous;

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

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

(7) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

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

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

(10) current physician manual and current provider manual which shall be provided to each contracting physician and other provider. The manuals shall contain details of the requirements by which the physicians and providers will be governed;

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

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

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

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

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

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

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

(1) financial records, including ledgers;

(2) checkbooks;

(3) inventory records;

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

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

§11.206. Review of Application.

(a) The application will be processed pursuant to §1.809 of this title (relating to HMO Certificate of Authority).

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

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

SUBCHAPTER D. Regulatory Requirements For an HMO Subsequent to Issuance of Certificate of Authority

§11.301. Filing Requirements. Subsequent to the issuance of a certificate of authority, each HMO is required to file certain information with the commissioner, either for approval prior to effectuation or for information only, as outlined in paragraphs (4) and (5) of this section and in §11.302 of this title (relating to Service Area Expansion or Reduction Applications). These requirements include filing changes necessitated by federal or state law or regulations.

(1) Completeness and format of filings.

(A) The department shall not accept a filing for review until the filing is complete. An application to modify the approved application for a certificate of authority which requires the commissioner's approval in accordance with Insurance Code §843.080 and Article 20A.09(l) is considered complete when all information required by this section, §11.302 of this title, and §§11.1901 - 11.1902 of this title (relating to Quality of Care) that is applicable and reasonably necessary for a final determination to be made by the department, has been filed.

(B) Filings shall:

(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.

(2) Identifying form numbers required. Each item required to be filed pursuant to paragraphs (4) and (5) of this section must be identified by a printed unique form number, adequate to distinguish it from other items. Such identifying form numbers shall be composed of a total of no more than 40 letters, numbers, symbols, and 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 appear on the lower left-hand corner of the first page. Page numbers should appear on subsequent pages.

(B) If an item is to be replaced or revised subsequent to issuance of a certificate of authority, a new identifying form number must be assigned. A change in address or phone number on a form will not require a new identifying form number. A new edition date added to the original identifying form number is an acceptable way of

revising the number so that it is identifiable from any previously approved item; e.g., if G-100 was the originally approved number, the revision may be numbered G-100 12/79. Changing the case of the suffix is not considered to be a change in the number, e.g., "ED" and "ed" or "REV" and "rev" are the same for form numbering purposes.

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

(A) one original of the HMO certification and transmittal form for each new, revised, or replaced item;

(B) one original of such supporting documentation as considered necessary by the commissioner for review of the filing, along with 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.

(C) except for the filings outlined in paragraphs (4)(A), (B), and (L), and (5)(C), (G), (K), (M), and (N) of this section, the applicable filing fee for other filings as required by Insurance Code §843.154, as determined by §7.1301 of this title (relating to Regulatory Fees). The filings outlined in paragraphs (4)(A), (B), and (L), and (5)(C), (G), (K), (M), and (N) of this section are subject to the fee amounts described in §7.1301(g) of this title, but such fees shall not be attached with the filing. Instead, the

submission of such fee(s) is subject to the billing provisions of §7.1302 of this title (relating to Billing System).

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

(A) the evidence of coverage and related forms, as described in §11.501 of this title (relating to Forms Which Must Be Approved Prior to Use);

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

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

(D) any change in more than 10% of control of the HMO, as specified in the definition of "control" in §11.2(b) of this title (relating to Definitions);

(E) transactions with affiliates related to the purchase, construction, or renovation of hospitals, medical facilities, administrative offices, or any

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

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

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

(H) a copy of any proposed amendment to basic organizational documents. If the approved amendment must be filed with the secretary of state, an original, or a certified copy of such document with the original file mark of the secretary of state, shall be filed with the commissioner;

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

(J) any name, or assumed name, on a form, as specified in §11.105 of this title (relating to Use of the Term "HMO," Service Mark, Trademarks, d/b/a);

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

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

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

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

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

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

(C) the formula or method for calculating the schedule of charges, as defined in §11.2(b) of this title. The filing must include the HMO reconciliation of benefits to schedule of charges form as described in §11.701 of this title (relating to Must be Filed Prior to Use);

(D) any change in the physical address of the books and records described in §11.205 of this title (relating to Documents To Be Available for Qualifying Examinations);

(E) any change of the certificate of authority for a domestic or foreign HMO. If the HMO is a foreign HMO, a certified copy of the certificate of authority and power of attorney must be submitted;

(F) any new trademark or service mark, or any changes to an existing trademark or service mark;

(G) a copy of the form of any new contract or subcontracts or any substantive changes to previously filed copies of forms of all contracts between the

HMO and any physicians, delegated entities and delegated networks as defined in §11.2602 of this title (relating to Delegated Entities), or other providers described in §11.204(13)(B) of this title, and copies of forms of all contracts between the HMO and an insurer or group hospital service corporation to offer indemnity benefits, whether utilized with all contracts or on an individual basis. If such contracts are amended, each copy of such agreement must be marked to indicate revisions. In addition, questions listed on the HMO certification and transmittal form, must be answered;

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

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

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

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

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

(M) any material change in network configuration; and

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

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

(7) Filing review procedure. Within 20 days from the department's receipt of an initial filing for commissioner's approval under this section, the department shall determine whether the filing is complete or incomplete for purposes of acceptance for review and, if found to be incomplete, the department shall issue a written or electronic

notice to the HMO of its incomplete filing. A filing under this subchapter that is subject to the billing provisions of §7.1302 of this title and which, upon receipt by the department, fails to comply with the requirements of that section, will be deemed to be incomplete for purposes of this subchapter.

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

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

(C) Pending status. Complete filings will be approved or disapproved in writing within the statutory deemer period set forth in paragraph (6) of this section unless, prior to the department's issuance of notice of proposed negative

action pursuant to §1.704(a) of this title (relating to Summary Procedure; Notice), the HMO has been contacted by the department regarding corrections or additional information necessary for commissioner's approval, and files with the department a written consent to waive the statutory deemer. The deemer shall be waived upon the department's receipt of the HMO's written consent. The filing shall be held in a pending status for 45 days from the date of the applicable statutory deemer, either on the 30th or 60th day from the date the filing is complete. If the necessary corrections or additional information have not been filed by the end of 45 days the filing shall be considered withdrawn.

§11.302. Service Area Expansion or Reduction Applications.

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

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

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

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

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

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

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

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

(7) the formula or method for calculating the schedule of charges for any new or amended evidence of coverage in accordance with Subchapter H of this chapter (relating to Schedule of Charges);

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

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

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

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

(12) a description of the method by which the complaint procedure, as specified in Insurance Code §843.251, et seq. and related regulations, will be made reasonably available in the new service area or division, including a toll free call, and the information and complaint telephone number required by the Insurance Code Article 21.71, where applicable. For HMOs subject to the Insurance Code Article 21.71, the toll free call required by this rule and the toll free information and complaint number required by the Insurance Code Article 21.71 may be the same number.

(c) The department shall not accept an application for review until the application is complete. An application to modify the certificate of authority that requires the commissioner's approval in accordance with Insurance Code §843.080 and Article 20A.09(l) is considered complete when all information required by §11.301 of this title, this section, and §§11.1901 - 11.1902 of this title (relating to Quality of Care) that is reasonably necessary for a final determination by the department, has been filed with the department.

(d) Before consideration of a service area expansion or reduction application, the HMO must be in compliance with the requirements of §§11.1901 - 11.1902 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 §§843.251 and 843.156. Such examinations may be conducted to determine the financial condition ("financial exams"), quality of health care services ("quality of care exams"), or compliance with laws affecting the conduct of business ("market conduct exams" or “complaint exams”).

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

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

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

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

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

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

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

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

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

(8) executed agreements: including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements.

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

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

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

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

(13) claims systems: policies and procedures and systems/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: including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments and debts; and

(15) other: any other records demonstrating compliance with applicable statutes and rules.

(d) Quality of care examinations shall be conducted pursuant to the following protocol:

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

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

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

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

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

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

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

SUBCHAPTER F. Evidence of Coverage

§11.502. Filing Requirements for Evidence of Coverage. Filing requirements for the evidence of coverage, when filed as part of the application for a certificate of authority, are as follows:

(1) Proposed forms must be neatly typed.

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

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

§11.503. Filing Requirements for Evidence of Coverage Subsequent to Receipt of Certificate of Authority. Subsequent to receipt of a certificate of authority, no evidence of coverage may be amended or altered in any manner, and no new evidence of coverage may be used, unless the proposed new or revised evidence of coverage has been filed for review and has received the approval of the commissioner. Filing requirements for the evidence of coverage when filed subsequent to receipt of a certificate of authority are as follows:

(1) The HMO must submit the original of the revised or new evidence of coverage, transmittal letter and the HMO transmittal and certification form, addressed to the Texas Department of Insurance, Life, Health & HMO Intake Unit, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104.

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

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

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

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

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

§11.504. Disapproval of an Evidence of Coverage.

(a) If the department disapproves any portion of any evidence of coverage, the department will specify the reason for the disapproval. The department is authorized to disapprove any form or withdraw any previous approval for any of the following reasons:

(1) it fails to meet the requirements of the Act, these sections, or other applicable statutes and rules;

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

(3) it contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate Insurance Code Articles 21.21, 21.21A, 21.21-1, 21.21-2, 21.21-5, 21.21-6, or 21.55 in accordance with Article 20A.09Z or any regulations thereunder or any other applicable law;

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

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

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

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

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

§11.505. Specifications for the Evidence of Coverage.

(a) The evidence of coverage must be printed on paper of quality suitable for file-marking (not slick-faced) and filing for permanent record.

(b) For the conversion, individual, and group agreements and group certificates and all amendments, type must be light-faced, uniform sized, common-style not less

than 10 points in height and with a lowercase unspaced alphabet length not less than 120 points. For other forms, type must be legible.

(c) The style, arrangement and overall appearance shall 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 name, address, and phone number of the HMO;

(2) the name or title of the form;

(3) the captions and subcaptions; and

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

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

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

(f) Certain language shall not be varied or changed without resubmitting a form for the commissioner's approval. Changeable language must be enclosed in brackets and shall include the range of variable information or amounts and is limited to rates, dates, addresses, phone numbers, optional provisions as set forth in §11.511 of this title (relating to Optional Provisions) and optional benefits as set forth in §11.512 of this title

(relating to Optional Benefits), and other such information, as approved by the commissioner.

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

§11.506. Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate. Each enrollee residing in this state is entitled to an evidence of coverage under a health care plan. By agreement between the issuer of the evidence of coverage and the enrollee, the evidence of coverage approved under this subchapter and required by this section may be delivered electronically. Each group, individual and conversion contract and group certificate must contain the following provisions.

(1) Name, address, and phone number of the HMO--The toll-free number referred to in Insurance Code Article 21.71, where applicable, 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 Article 21.71 in accordance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

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

(A) Copayments. An HMO may require copayments to supplement payment for health care services. Each HMO may establish one or more copayment options. A basic service HMO may not impose copayment charges that exceed fifty percent of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent of the total cost to the HMO of providing all basic health care services. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total two hundred 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. The HMO shall state the copayment in the group, individual or conversion agreement and group certificate.

(B) Deductibles. A deductible shall be for a specific dollar amount of the cost of the basic, limited, or single health care service. An HMO shall charge a deductible only 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) Immunizations. An HMO shall not charge a copayment or deductible for immunizations as described in Insurance Code Article 21.53F 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 Chapter 26, that covers such immunizations may charge a copayment or deductible.

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

(A) An HMO may cancel a subscriber in a group and subscriber's enrolled dependents under circumstances described in clauses (i) – (vii) of this subparagraph, so long as the circumstances do not include health status related factors:

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

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

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

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

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

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

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

(B) An HMO may cancel a group under circumstances described in clauses (i) – (vi) of this subparagraph:

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

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

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

(iv) For employer groups, in accordance with §26.16 and §26.309 of this title (relating to Refusal To Renew and Application To Reenter Small Employer Market and Refusal To Renew and Application To Reenter Large Employer Market), coverage may be cancelled upon 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, the HMO may cancel the coverage after 30 days written notice.

(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, the HMO may cancel the coverage after 30 days written notice.

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

(D) An HMO may cancel an individual contract under circumstances described in clauses (i) – (vi) of this subparagraph.

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

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

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

(iv) Where the subscriber neither 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 coverage is terminated uniformly without regard to any health status-related factor of enrollees, coverage may be cancelled after 30 days written notice. An HMO

shall not cancel the coverage for a child who is the subject of a medical support order because the child does not reside, live or work in the service area.

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

(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, the HMO may cancel coverage after 180 days written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance at the last coverage not renewed.

(4) Claim payment procedure--A provision that sets forth the procedure for paying claims, including any time frame for payment of claims which must be in accordance with Insurance Code Articles 21.55 and 20A.09Z and the applicable rules.

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

(6) Continuation of coverage--Group agreements must contain a provision providing for mandatory continuation of coverage for enrollees who were continuously covered under a group certificate for three months prior to termination of the group coverage, or newborn or newly adopted children of enrollees with three months prior continuous coverage, that is no less favorable than provided by Insurance Code Article 20A.09(k).

(A) An enrollee shall have the option to continue coverage as provided for by Insurance Code Article 20A.09(k), upon completion of any continuation of coverage provided under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law Number 99-272, 100 stat. 222) and any amendments thereto.

(B) A dependent, upon completion of any continuation of coverage provided under Insurance Code Article 3.51-6 §3B, shall have the privilege to continue coverage for the 6 months prescribed by Insurance Code Article 20A.09(k).

(C) If an HMO offers conversion coverage, it must be offered to the enrollee not less than 30 days prior to the expiration of the COBRA or Article 3.51-6 §3B continuation coverage period.

(D) A basic service HMO shall notify the enrollee not less than 30 days before the end of the six months from the date continuation under Article 20A.09(k) was elected that the enrollee may be eligible for coverage under the Texas

Health Insurance Risk Pool, as provided under Insurance Code Article 3.77, and shall provide the address and toll-free number of the pool.

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

(8) Effective date--A statement of the effective date requirements of various kinds of enrollees.

(9) Eligibility--A statement of the eligibility requirements for membership, including:

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

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

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of such 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 conditions under which dependent enrollees may be added to those originally covered;

(C) any limiting age for subscriber and dependents;

(D) a clear statement regarding the coverage of newborn children:

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

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

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

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

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 31 days following birth. The HMO shall 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) a clear statement regarding the coverage of the enrollee's grandchildren up to the age of 25 under the conditions under which such coverage is required by Insurance Code Article 3.70-2, subsection (L) and Article 20A.09H (Children and Grandchildren).

(10) Emergency services--A description of how to obtain services in emergency situations including:

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

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

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

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

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to such stabilization shall be provided to enrollees as approved by the HMO, provided that the HMO is required to approve or deny coverage of poststabilization care as requested by a treating physician or provider. An HMO shall approve or deny such treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case shall approval or denial exceed one hour from the time of the request.

(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 which have licensed and/or certified personnel and equipment to provide Advanced Cardiac Life Support (ACLS) consistent with American Heart Association (AHA) and American Trauma Society (ATS) standards of care;

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

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

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

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

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

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

(VI) a hospital operated by a federal agency.

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

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

(13) Grace period--A provision for a grace period of at least 30 days for the payment of any premium falling due after the first premium during which the coverage remains in effect. A charge may be added to the premium by the HMO for

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

(14) Incontestability:

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

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

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

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

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

(15) Out-of-network services--Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, upon the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and shall fully reimburse the non-network provider at the usual and customary or an agreed rate.

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

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

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

(16) Schedule of charges--A statement that discloses the HMO's right to change the rate charged with 60 days written notice pursuant to Insurance Code Article 3.51-10.

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

(18) Termination due to attaining limiting age--A provision that a child's attainment of a limiting age does not operate to terminate the coverage of the child while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent upon the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of such incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of such limiting age.

(19) Termination due to student dependent's change in status--Each group agreement and certificate that conditions dependent coverage for a child twenty-

five years of age or older on the child's being a full-time student at an educational institution shall contain a provision in accordance with Insurance Code Article 21.24-2.

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

(21) 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 Coverage Under Individual and Group Policies), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement rules and/or the long-term care rules and the HMO rules, the Medicare supplement rules or long-term care rules shall govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO shall follow both the Medicare supplement rules and/or the long-term care rules and the HMO rules where applicable.

(22) Nonprimary care physician specialist as primary care physician--A provision that allows enrollees with chronic, disabling, or life threatening illnesses to

apply to the HMO's medical director to utilize a nonprimary care physician specialist as a primary care physician as set forth in Insurance Code Article 20A.09(g).

(23) Selected obstetrician or gynecologist--Individual, conversion and group agreements and certificates, except small employer plans as defined by Insurance Code Chapter 26, 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 Article 21.53D. An HMO shall not preclude an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

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

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

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

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

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

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

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

(F) An HMO shall include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in Insurance Code Article 21.53D. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or

gynecological services from her primary care physician or primary care provider. Such enrollee shall have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee’s request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

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

(24) 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 by a physician licensed in this state pursuant to the Insurance Code Article 3.78 shall satisfy any requirement for demonstrable proof of organic disease.

(25) Drug Formulary--A group agreement and certificate, except small employer plans as defined by Insurance Code Chapter 26, that covers prescription drugs and uses one or more formularies must comply with Insurance Code Article 21.52J and Chapter 21, Subchapter V of this title (relating to Pharmacy Benefits).

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

physician other than the primary care physician may direct and oversee the enrollee's care.

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

(a) Each evidence of coverage providing basic health care services shall provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set forth in §11.506(10) or (15) 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 in Insurance Code Article 20A.09B;

(ii) immunizations for children as required in Insurance Code Article 21.53F §3;

(iii) well-child care from birth as required in Insurance Code Article 20A.09E;

(iv) cancer screenings as required in Insurance Code Article 3.70-2(H) relating to mammography;

(v) cancer screenings as required in Insurance Code Article 21.53F relating to screening for prostate cancer;

(vi) cancer screenings as required in Insurance Code Article 21.53S relating to screening for colorectal cancer;

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

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

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

(J) emergency services as required by Insurance Code Article 20A.09Y.

(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, special duty nursing when medically necessary, radiation therapy, inhalation therapy, 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.

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

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

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

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

(3) diabetes self-management training, equipment and supplies as required in Insurance Code Article 21.53G.

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

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

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

§11.509. Additional Mandatory Benefit Standards: Group Agreement Only. Group agreements must contain the following additional mandatory provisions.

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

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

(3) Chemical dependency. A provision to provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than

for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors is required for state-mandated health benefit plans defined in §11.2(b) of this title (relating to Definitions). Dollar or durational limits which are less favorable than for physical illness generally may be set only if such limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under the Insurance Code Article 3.51-9, §2A(d), including §§3.8001 - 3.8022 of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

(A) Coverage for chemical dependency may be limited to a lifetime maximum of three separate series of treatment for each covered individual as described by the Insurance Code Article 3.51-9, §2A(b).

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

(4) Osteoporosis. A provision that provides coverage to a qualified individual as defined in the Insurance Code Article 21.53C for medically accepted bone mass measurement for the detection of low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis is required for state-mandated health benefit plans defined in §11.2(b) of this title.

(5) Serious mental illness. Group agreements, except for contracts issued to small employer plans, must include a provision for the treatment of serious

mental illness, as required in the Insurance Code Article 3.51-14. Small employer plans must be offered coverage for serious mental illness as required in the Insurance Code Article 3.51-14. Serious mental illness benefits are also subject to the provisions of the Insurance Code Articles 3.70-2(F) and 3.72.

(6) Conditions affecting the temporomandibular joint. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans defined in §11.2(b) of this title must include a provision that provides coverage for a condition affecting the temporomandibular joint as required by Insurance Code Article 21.53A.

(7) Inability to undergo dental treatment. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans defined in §11.2(b) of this title, may not exclude from coverage under the plan an enrollee who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the enrollee's physician or the dentist providing the dental care. This benefit does not require an HMO to provide dental services if dental services are not otherwise scheduled or provided as part of the benefits covered by the agreement.

§11.512. Optional Benefits. An HMO may provide to its enrollees health services that §11.508 of this title (relating to Mandatory Benefit Standards: Group, Individual and Conversion Agreements) does not include as basic health care services. An HMO may

limit these optional health services as to time and cost. Group, individual and conversion certificates may contain optional benefits, including:

(1) corrective appliances and artificial aids;

(2) cosmetic surgery;

(3) ambulance services;

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

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

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

(7) vision care;

(8) custodial or domiciliary care;

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

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

(11) whole blood and blood plasma;

(12) durable medical equipment for home use (such as wheel chairs, surgical beds, respirators, dialysis machines);

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

(14) reversal of voluntary sterilization; and

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

SUBCHAPTER G. Advertising and Sales Material

§11.602. Health Maintenance Organizations Subject to the Texas Insurance Code, Articles 21.21, 21.21-1, and 21.21-2, and Related Rules. Health maintenance organizations must comply with the Texas Insurance Code Articles 21.21, 21.21-1, and 21.21-2, and rules promulgated by the Texas Department of Insurance, pursuant to the Texas Insurance Code Articles 21.21, 21.21-1, and 21.21-2, to the extent these rules may be applied in the same manner as insurance companies.

§11.603. Filings. Any HMO licensed to do business in Texas which offers coverage to Medicare beneficiaries under the provisions of Subchapter XVIII of 42 United States Code, Health Insurance for the Aged and Disabled, shall file with the department a copy of each advertisement related to such coverage which is produced by the HMO or its agents and which is an invitation to inquire or invitation to contract as defined in §21.113

of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising) no later than 45 days prior to its use. Material shall be filed in accordance with §21.120 of this title (relating to Filing for Review). Material filed under this paragraph is not to be considered approved but may be subject to review for compliance with Texas law and consistency with other documents.

SUBCHAPTER I. Financial Requirements

§11.801. Minimum Net Worth.

(a) On or after September 1, 1999, at the time of the initial qualifying examination, an applicant for a certificate of authority to operate an HMO must have unencumbered assets of the type described in subsection (b) of this section in excess of all of its liabilities equal to or greater than the required net worth established in Insurance Code §843.403. An HMO licensed before September 1, 1999, must comply with the minimum net worth requirement in Insurance Code §843.4031.

(b) The types of assets required for an applicant to possess at the time of the qualifying examination are lawful money of the United States of America, bonds of this state, bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state. Lawful money of the United States of

America includes deposits in an institution that is a member of the Federal Deposit Insurance Corporation. Demand deposits, savings deposits or time deposits, of the type that are federally insured in solvent banks and savings and loan associations and branches thereof, which are organized under the laws of the United States of America or under the laws of any state of the United States of America may not exceed the greater of:

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

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

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

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

§11.802. Statutory Deposit Requirements.

(a) Statutory deposits made pursuant to Insurance Code §843.405 must consist of funds in the form of lawful money of the United States of America, bonds of this state, bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state.

(1) Certificates of deposit must be issued by a solvent, federally insured and Texas domiciled bank. However, the amount of total deposits by the HMO in the same depository bank may not exceed the greater of:

(A) the limits of federal insurance coverage pertaining to such deposits; or

(B) 10% of the issuing depository bank's net worth, provided that such net worth is in excess of $25 million.

(2) Bonds of this state, bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America, or bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state must be valued at the lesser of current fair market value or amortized cost.

(b) Before the issuance of the certificate of authority, the HMO must submit funds as described in subsection (a) of this section in the amount required by Insurance Code §843.405, with four completed originals of security deposit report form number 120, one original pledge document on bank letterhead, and the applicable fees pursuant to §7.1301(d) of this title (relating to Regulatory Fees) to the bond and securities officer of the department.

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

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

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

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

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

(1) Specification of the pertinent provision(s) of the Insurance Code under which the release or waiver is being requested;

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

(3) If a waiver is being requested, the period of time over which the waiver is requested;

(4) Supporting documentation that justifies such release or waiver including:

(A) Reasons for requesting the release or waiver;

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

(C) Evidence that the HMO has reported net profits for the previous 12 months;

(D) Evidence that the HMO's net worth is in a positive position;

(E) If a request is based upon a guarantee:

(i) a copy of the guarantee;

(ii) a copy of the most current financial statements of the sponsoring organization;

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

(iv) disclosure of the dollar amount of all obligations guaranteed and the amounts reflected as liabilities and the amounts guaranteed that are not reflected as liabilities in the sponsoring organization's consolidated financial statements;

(5) If the request is based on projected uncovered expenses:

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

(B) An explanation as to 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.

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

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

(7) If the commissioner approves the release or waiver, the HMO must submit the forms required by subsection (c)(2) of this section.

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

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

§11.803. Investments, Loans, and Other 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 maintain assets in an amount equivalent to its required minimum net worth in accordance with Insurance Code §843.403. Demand deposits, savings deposits or time deposits, of the type that are federally insured in solvent banks and savings and loan associations and branches

thereof, which are organized under the laws of the United States of America or under the laws of any state of the United States of America may not exceed the greater of:

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

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

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

(A) any investments allowed in paragraph (1) of this section;

(B) direct general obligations of any state of the United States of America for the payment of money, or obligations for the payment of money, to the extent guaranteed or insured as to the payment of principal and interest by any state of the United States of America, provided:

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

(ii) such state shall not be in default in the payment of principal or interest on any of its direct, guaranteed, or insured general obligations at the date of such investment;

(C) bonds, interest-bearing warrants, or other obligations issued by authority of law by any county, city, town, school district, or other municipality or political

subdivision which is now or hereafter may be construed or organized under the laws of any state in the United States of America and which is authorized to issue such bonds, warrants, or other obligations under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet said obligations or a special revenue or income to meet the principal and interest payments as they accrue upon such obligations has been appropriated, pledged, or otherwise provided; and

(ii) such county, city, town, school district, or other municipality or political subdivision shall not be in default in the payment of principal or interest on any of its obligations at the date of such investment;

(D) bonds, interest-bearing warrants, or other obligations issued by authority of law by any educational institution which is now or hereafter may be construed or organized under the laws of any state in the United States, and which is authorized to issue such bonds and warrants under the constitution and laws of the state in which it is situated, provided:

(i) legal provision has been made by a tax to meet said obligations or a special revenue or income to meet the principal and interest payments as they accrue upon such obligations shall have been appropriated, pledged, or otherwise provided; and

(ii) such educational institution shall not be in default in the payment of principal or interest on any of its obligations at the date of such investment;

(E) investments issued by insurers or HMOs subject to the following conditions:

(i) an HMO may not make an investment under this subparagraph in any other HMO or insurer unless such other HMO or insurer is duly licensed to do business in its domestic state and at the time of such investment is in compliance with the minimum capital and surplus requirements then applicable under the provisions of that state's statutes and regulations; provided, however, an HMO may make an investment pursuant to this paragraph in another HMO which has not yet received its certificate of authority to conduct the business of an HMO in its domestic state or which does not yet possess the minimum capital and surplus required by its domestic state if such investment will be sufficient to give the investing HMO at least 50% control in such other HMO, as the term "control" is defined in §11.2 of this title (relating to Definitions);

(ii) an HMO may not invest, except as provided in subparagraphs (F) and (G) of this paragraph, in any other HMO or insurer unless such investment with subsequent investments shall result within 180 days of the first investment in the investing HMO having control in such other HMO or insurer, as the term "control" is defined in §11.2 of this title;

(iii) in no event may an HMO invest more than 50% of its net worth in excess of minimum net worth in any one other HMO or insurer;

(iv) in no event may the total investments made by an HMO in all other HMOs or insurers pursuant to this subparagraph exceed 75% of the investing HMO's net worth in excess of minimum net worth;

(v) the restrictions of clauses (iii) and (iv) of this subparagraph shall not apply if the HMO is purchasing 100% of the stock of another HMO for the purpose of merger, which is anticipated to take place no later than three months from the purchase date, unless said 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 said merger, unless said period of time is extended by the commissioner;

(F) bonds, debentures, bills of exchange, commercial notes, or any other bills and obligations of any corporation incorporated under the laws of any state of the United States of America or of the United States of America, which issuing corporation is designated highest quality (NAIC designation 1) or high quality (NAIC designation 2) in 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:

(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 shall not be permitted to invest in a partnership, as a general partner, except through a wholly owned subsidiary;

(iv) the restrictions of clauses (i) and (ii) of this subparagraph shall not apply if the business entity of which the HMO wishes to purchase the equity interest is, or is to be, a contracted provider of services;

(H) shares of mutual funds doing business under the Investment Company Act of 1940 (15 U.S.C. §80a-1, et seq.) and shares in real estate investment trusts as defined in the Internal Revenue Code of 1986 (26 U.S.C. §856), provided that such mutual funds and real estate investment trusts be solvent with at least $1 million of net worth as of the date of its latest annual, or more recent, certified audited financial statement;

(I) mortgage loans by an HMO that are secured by valid first liens on improved real estate, provided that:

(i) there is a title insurance policy or attorney's opinion evidencing that the borrower owns the real estate;

(ii) there is an appraisal of the real estate and its improvements and the loan does not exceed 75% of such appraised value;

(iii) there is an executed note evidencing the loan;

(iv) there is a recorded deed of trust;

(v) the value of such improvements is adequately insured by a company authorized to do business in Texas or in the state in which the real estate is located; and the insurance policy must be made payable to the HMO in an amount equal to at least 50% of the value of such building, provided that such insurance coverage need not exceed the outstanding balance owed to the HMO when the outstanding balance falls below 50% of the value of such building;

(vi) the commissioner has the right to obtain an independent appraisal, at the HMO's expense, of real estate securing any loan;

(J) loans to persons secured by collateral, specified in paragraph (1) of this section and subparagraphs (A) - (D) of this paragraph, but the amount loaned may not exceed the value of the securities held as collateral;

(K) loans, whether secured or unsecured, that are not in default, to medical and other health care providers under contract with the HMO for the provision of health care services, but in no event shall the value of any such loan or loans made under this subparagraph exceed the maker's ability to repay the loan or loans; the maker's ability to repay the loan or loans shall be determined by allowing only assets that an HMO may hold to be considered toward determining any excess of assets over all liabilities of the maker;

(L) real estate acquired in satisfaction of debt; all such real property not qualifying under any other provisions of this section shall be sold and disposed of within five years after the HMO has acquired title to same unless the time for disposal is extended by the commissioner;

(M) investments in improved, income-producing real estate;

(N) additional investments which are not otherwise specified by this section, provided:

(i) the amount of any one such investment shall not exceed 10% of the net worth in excess of the minimum net worth of the HMO; and

(ii) the total amount of investments authorized by this paragraph shall not exceed the HMO's net worth in excess of its minimum net worth.

(3) Other assets. An HMO may have assets beyond those required to be held for its minimum net worth and uncovered liabilities which are either necessary for its operations or invested as permitted by this section. Assets an HMO may find necessary in its operations include, but are not limited to, the following:

(A) uncollected premiums or subscriptions with an adequate provision for uncollectable premiums or subscriptions;

(B) advances of capitation or other fees expected to be paid for the next month to medical and other health care service providers under contract with the HMO; provided that no termination of the contract may take place prior to the end of the period for which advances were paid;

(C) the following assets may be admitted provided a detailed inventory is maintained with each item marked by any identifying number and the proof of cost maintained:

(i) Furniture, labor-saving devices, machines and all other office equipment used in the administration of the HMO may be admitted as an asset and for such property acquired after December 31, 2000, amortized in full over a period not to exceed five years. All such property acquired prior to January 1, 2001, may be admitted and shall be amortized in full over a period not to exceed ten years.

(ii) Furniture, medical equipment and vehicles used in connection with the direct provision of health care services may be admitted as an asset and for such property acquired after December 31, 2000, amortized in full over a period not to exceed five years. All such property acquired prior to January 1, 2001, may be admitted and shall be amortized in full over a period not to exceed ten years.

(iii) Electronic machines, constituting a data processing system or systems and operating systems software used directly for the provision of medical services and the administration of the HMO may be admitted as an asset and for such property acquired after December 31, 2000, amortized as provided by the March 2000 version of the Accounting Practices and Procedures Manual. All such property acquired prior to January 1, 2001 may be admitted and shall be amortized in full over a period not to exceed ten years;

(D) inventories of necessary pharmaceutical and surgical supplies used directly in the treatment of medical conditions, it being the duty of the HMO to sufficiently prove the value of such inventories; and

(E) real estate and leasehold estates, including buildings and improvements, and leasehold improvements on rented space, for the accommodation of the HMO's current or expected business operations used in the provision or support of health care services, including space for rent to any health care provider under contract with the HMO which property shall be used in the provision of health care services to members of the HMO by that provider.

(F) Claims overpayments, with the right of offset supported by a contractual agreement, that are specifically identifiable payments, may be admitted to the extent a liability to that provider exists.

(4) Valuation. Except where elsewhere specifically provided, investments, loans and assets are valued in accordance with the Purposes and Procedures of the Securities Valuation Office of the National Association of Insurance Commissioners as it applies to entities not required to maintain an asset valuation reserve. If no such standard applies, then the valuation shall be their fair value.

(5) Evidence of ownership. A domestic HMO may demonstrate ownership of its securities by complying with §7.86 of this title (relating to Custodied Securities.)

(6) Sale of investment. Section 7.4 of this title (relating to Admissible Assets) shall apply to investments not specifically allowed under this subchapter. The commissioner may require any investment to be sold which would otherwise be authorized under the provisions of this section if the commissioner finds that such investment would cause the investing HMO to operate in a condition which is hazardous to its enrollees, creditors, or the general public.

§11.806. Liabilities.

(a) Each HMO must establish and maintain records identifying and supporting each liability the HMO incurs. Each liability incurred by an HMO shall be reported on all financial statements filed with the department. A liability shall be incurred from the date a service was performed, a product was delivered, a title was transferred, or a contractual obligation entered into for an amount that is specified and unconditionally owed. Each HMO must segregate its liabilities into classification of "covered" or "uncovered." Agreements to loan money or to make future capital or surplus contributions do not, in themselves, cause liabilities to be covered. Any guarantee of future contributions to surplus which 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:

(1) is based on a provider contract with a hold-harmless clause as provided in §11.901(a)(1) of this title (relating to Required Provisions);

(2) is subordinated in writing to the uncovered health care liabilities of the HMO; or

(3) is unconditionally guaranteed and the guarantee is without monetary limit, as specified in §11.808 of this title (relating to Guarantee from a Sponsoring Organization), by a sponsoring organization which has a tangible net worth of at least $10 million in excess of all amounts that the sponsoring organization has guaranteed.

(b) Liabilities shall include, but are not limited to, the following:

(1) gross premiums received in payment for all or any part of medical and other health care services to be provided by the HMO subsequent to that financial reporting period (unearned premiums);

(2) the unpaid balance under any promissory note or other obligation evidencing amounts owed by the HMO without any adjustment for unrealized gains or losses due to an assumption of a loan or note payable at interest rates different from the prevailing rate at the time of assumption;

(3) capital leases in an amount equal to the value of the admitted assets hypothecated by the lease or the present value of the total amounts owed under the remaining term of the lease in accordance with generally accepted accounting principles; in determining the present value of the lease payments, the rate of interest

should be equivalent to the rate of interest on United States of America Treasury Notes as of December 31st of the preceding calendar year; and

(4) incurred claim liabilities, including all liabilities and expenses relating to medical and health care services provided by HMO delivery network and non-network physicians and providers.

(c) An HMO shall 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. Hazardous Conditions for HMOs.

(a) Purpose. The purpose of this section is to enumerate conditions which may indicate an HMO is in hazardous condition and which authorize the commissioner of insurance to initiate an action against an HMO under Insurance Code §843.461 or §843.157. In evaluating any of the conditions in this section, the commissioner must evaluate all circumstances concerning the HMO's operation in making an ultimate conclusion that an HMO is in hazardous condition. The evaluation of the information relating to these conditions is a part of the examination process. The conditions

enumerated in this section do not conclusively indicate that an HMO is in hazardous condition. One or more of the conditions can exist in an HMO which is in satisfactory condition; however, one or more of these conditions has often been found in an HMO which was unable to perform its obligations to enrollees, creditors or the general public, or has required the commissioner to initiate regulatory action to protect enrollees, creditors and the general public.

(b) An HMO may be found to be in hazardous condition, after notice and opportunity for hearing, when the commissioner finds one or more of the following conditions to exist:

(1) an HMO's federal qualification designation and/or National Committee on Quality Assurance accreditation is revoked or discontinued;

(2) an HMO's reported claims in process exceed 12% of annualized medical and hospital expenses (12% is approximately a 45 day backlog);

(3) an HMO's parent or sponsoring organization is operating in a hazardous condition;

(4) an HMO's annual CPA report or actuarial opinion contains a material adverse finding or findings;

(5) an HMO fails to comply with the Texas Health Maintenance Organization Act (Insurance Code Chapters 20A and 843) or Title 28, Texas Administrative Code, Chapter 11;

(6) an HMO has an inadequate provider network;

(7) an HMO contracts with a management or administrative company on a capitated or percentage of premium basis and such administrative or management company refuses to submit financial statements to the HMO;

(8) an HMO does not file a financial statement with the department within the time required by the Insurance Code, or as requested by the department;

(9) a health care provider that is under contract, directly or indirectly, with an HMO, has a pattern of balance billing;

(10) an HMO files financial information with the department which is false or misleading;

(11) an HMO does not amend its financial statement when requested by the department;

(12) an HMO overstates its net worth by 25% or more;

(13) an HMO relies on its parent's forgiveness of debt or frequent surplus contributions to finance its operations or to maintain its minimum net worth or risk based capital;

(14) an HMO does not maintain books and records sufficient to permit examiners to determine the financial condition of the HMO, examples of which include:

(A) a domestic HMO maintains books and records outside the State of Texas in violation of Insurance Code Chapter 803; or

(B) an HMO moves, or maintains, the location of the books and records necessary to conduct an examination without notifying the department of such location;

(15) an HMO's management does not have the experience, competence, or trustworthiness to operate the HMO in a safe and sound manner;

(16) an HMO's management has been found to have engaged in unlawful transactions;

(17) an HMO has a pattern of denial or nonpayment of emergency care;

(18) an HMO does not follow its policy on rating and underwriting standards appropriate to the risk;

(19) an administrative or judicial order, initiated by an insurance regulatory agency of another state, is issued against an HMO, its parent or affiliate, or a regulatory action is initiated by another agency within the state of domicile;

(20) an HMO does not have the minimum net worth required by Insurance Code §843.403 or §843.4031;

(21) an HMO does not meet the requirements of §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank); or

(22) an HMO is in any condition that the commissioner finds may present a hazard to enrollees, creditors, or the general public.

SUBCHAPTER J. Physician and Provider Contracts and Arrangements

§11.901. Required Provisions.

(a) Physician and provider contracts and arrangements shall include provisions:

(1) regarding a hold harmless clause as described in Insurance Code §843.361:

(A) A hold harmless clause is a provision, as required by Insurance Code §843.361, in a physician or health care provider agreement that obligates the physician or provider to look only to the HMO and not its enrollees for payment for covered services (except as described in the evidence of coverage issued to the enrollee).

(B) In accordance with Insurance Code §843.002 relating to an "uncovered expense," if a physician or health care provider agreement contains a hold harmless clause, then the costs of the services will not be considered uncovered health care expenses in determining amounts of deposits necessary for insolvency protection under Insurance Code §843.405.

(C) The following language is an example of an approvable hold-harmless clause: (Physician/Provider) hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency, or breach of this agreement, shall (physician/provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than HMO acting on their behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental

charges or copayments made in accordance with the terms of (applicable agreement) between HMO and subscriber/enrollee. (Physician/Provider) further agrees that:

(i) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee; and

(ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (physician/provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than 15 days after the commissioner has received written notice of such proposed changes;

(2) regarding retaliation as described in Insurance Code §843.281;

(3) regarding continuity of treatment, if applicable, as described in Insurance Code §843.309 and §843.362;

(4) regarding written notification to enrollees receiving care from a physician or provider of the HMO's termination of that physician or provider in accordance with Insurance Code §843.308 and §843.309;

(5) regarding written notification of termination to a physician or provider in accordance with Insurance Code §843.306 and §843.307:

(A) the HMO must provide notice of termination by the HMO to the physician or provider at least 90 days prior to the effective date of the termination;

(B) 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;

(C) within 60 days following receipt of the provider's request for review, the advisory review panel must make its formal recommendation and the HMO must communicate its decision to the physician or provider;

(6) regarding posting of complaints notice in physician/provider offices as described in Insurance Code §843.283. A representative notice that complies with this requirement may be obtained from the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104;

(7) regarding indemnification of the HMO as described in Insurance Code §843.310;

(8) regarding prompt payment of claims as described in Insurance Code Article 20A.09Z and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J (Payment of Claims to Physicians and Providers) and Chapter 21, Subchapter T of this title (relating to Submission of Clean Claims) with respect to the payment to the physician or provider for covered services that are rendered to enrollees;

(9) regarding capitation, if applicable, as described in Insurance Code §§843.315 and 843.316;

(10) regarding selection of a primary physician or provider, if applicable, as described in Insurance Code §843.315;

(11) entitling the physician or provider upon request to all information necessary to determine that the physician or provider is being compensated in accordance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including e-mail, computer disks, paper or access to an electronic database. Amendments, revisions or substitutions of any information provided pursuant to this paragraph must be made in accordance with subparagraph (D) of this paragraph. The HMO shall provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(A) This information must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider. At a minimum, the information must include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM codes and modifiers:

(I) by which the HMO will calculate and pay all claims for covered services submitted by or on behalf of the contracting physician or provider; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that contracting physician or provider on a routine basis along with a toll-free number or electronic address through which the contracting physician or provider may request the fee schedules applicable to any covered services that the physician or provider intends to provide to an enrollee and any other information required by this paragraph, that pertains to the service for which the fee schedule is being requested if the HMO has not previously provided that information to the physician or provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which must be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the HMO may use that affects the payment of specific claims submitted by or on behalf of the contracting physician or provider, including recoupment;

(vi) any addenda, schedules, exhibits or policies used by the HMO in carrying out the payment of claims submitted by or on behalf of the contracting physician or provider that are necessary to provide a reasonable understanding of the information provided pursuant to this paragraph; and

(vii) the published, product name and version of any software the HMO uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the HMO, such as state Medicaid or federal Medicare fee schedules, the information the HMO provides shall clearly identify the source and explain the procedure by which the physician or provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph shall be construed to require an HMO to provide specific information that would violate any applicable copyright law or licensing agreement. However, the HMO must supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this paragraph shall be effective as to the contracting physician or provider, unless the HMO provides at least 90 calendar days written notice to the contracting physician or provider identifying with specificity the amendment, revision or substitution. An HMO may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation of Insurance Code Chapters 843 and 20A (Texas Health Maintenance Organization Act).

(F) Upon receipt of a request, the HMO must provide the information required by subparagraphs (A) - (D) of this paragraph to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.

(G) A physician or provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the physician's or provider's practice management,

(II) billing activities,

(III) other business operations, or

(IV) communications with a governmental agency involved in the regulation of health care or insurance;

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(H) A physician or provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider shall provide for reasonable advance notice to enrollees being treated by the physician or provider prior to the termination consistent with Insurance Code §843.309.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract;

(12) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish x-rays and nonprefabricated orthotics covered by the evidence of coverage; and

(13) regarding electronic health care transactions as set forth in §21.3701 of this title (relating to Electronic Health Care Transactions) if the contract requires electronic submission of any information described by that section.

(b) An HMO may require a contracting physician or provider to retain in the contracting physician or provider's records updated information concerning a patient's other health benefit plan coverage.

§11.902. Prohibited Actions.

(a) Pursuant to Insurance Code §843.320, a contract between an HMO and a physician may not require the physician to use a hospitalist for a hospitalized patient.

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

(c) An HMO may not by contract or any other method require a physician to use the services of a nurse first assistant as defined by §301.1525, Occupations Code.

(d) Pursuant to Insurance Code §843.319 (Certain Required Contracts), 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 HMO's application procedures and meets the HMO's qualification and credentialing requirements for contracting.

(e) Pursuant to Insurance Code §843.312, an HMO may not refuse a request by a contracted physician and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code, to identify a physician assistant or advanced practice nurse as a provider in the HMO's network, provided the physician assistant or advanced practice nurse meets the quality of care standards for participation in the HMO's network.

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

(a) Pursuant to Insurance Code Article 21.53K, an HMO shall not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee by a pharmacist.

(b) No contract between an HMO and a pharmacy or pharmacist shall prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act, (Subtitle J, Occupations Code) and rules promulgated thereunder.

SUBCHAPTER K. Required Forms

§11.1001. Required Forms. The following forms are to be used in conjunction with the rules adopted under this chapter. Copies of these forms may be obtained by contacting the Company Licensing and Registration Division, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Each HMO or other person or entity shall use such form or forms as are required by this title and as are appropriate to its particular activities. The forms are listed as follows:

(1) Name Application Form Rev. 02/99;

(2) Application for a Certificate of Authority to do business in the State of Texas, Rev. 02/99;

(3) State of Texas Officers and Directors Page, Rev. 06/2000;

(4) State of Texas Biographical Affidavit, Rev. 01/2002;

(5) HMO Certification and Transmittal Form Rev. 02/99;

(6) Reconciliation of Benefits to Schedule of Charges Form, Rev. 04/92 ;

(7) Deposit Report Form, No. 120; and

(8) Withdrawal Form, No. 121.

SUBCHAPTER N. HMO Solvency Surveillance Committee Plan of Operation

§11.1301. Plan of Operation. This plan of operation, hereinafter referred to as the plan, shall become effective upon written approval of the Texas Department of Insurance, hereinafter referred to as the department, as provided by the Texas Health Maintenance Organization Act, Insurance Code Chapters 20A and 843, hereinafter

referred to as the Act. As used in this subchapter, the committee shall be the solvency surveillance committee as provided for and defined in the Act, and the members shall be the members of the committee as provided for and defined in the Act.

§11.1302. Solvency Surveillance Committee.

(a) Members. The composition of the committee shall be in accordance with Insurance Code §843.436.

(1) The HMO members' terms shall last for three years unless otherwise appointed by the commissioner and shall be staggered with three appointments expiring each year. A member's term shall terminate if the member leaves the HMO whose characteristics were the basis for appointment. The HMO shall not automatically continue as a member.

(2) Members may serve multiple terms.

(3) A member shall serve until a successor is appointed unless such member's term is in conflict with the Act, or unless a member misses two or more consecutive meetings or engages in willful misconduct, in which case the commissioner may remove the member. The committee shall make recommendations to the commissioner and the department to fill vacancies. Members shall not receive any remuneration or emolument of office.

(4) The members shall elect a chairman, a vice chairman, a secretary-treasurer, and such other officers as they deem necessary. The term of office shall be

one year or until a successor is elected and qualified. Vacancies occurring in elective office shall be filled by vote of the members.

(b) Voting. A majority of the members shall constitute a quorum for the transaction of business, and the acts of a majority of the members at a meeting at which a quorum is present shall be the acts of the committee. An affirmative vote of a majority of the total membership of the committee shall be required:

(1) to propose amendments to the plan;

(2) to approve any contract or service agreement;

(3) to levy an assessment or provide for a refund;

(4) to borrow money; or

(5) to extend funding of expenses of supervision, conservation, rehabilitation, or liquidation of an HMO as provided in Insurance Code §843.441 unless special notice of the desire to take action on this item is part of the notice of the meeting, in which case the acts of a majority of the members voting in person at a meeting at which a quorum is present shall be the acts of the committee.

(c) Meetings. On a day determined by the members, the committee shall hold a regular annual meeting. At its annual meeting, the committee may schedule additional regular meetings to be held during the period between annual meetings. Meetings shall be held at the department's offices unless the commissioner, chairman of the committee, or other officer acting on the chairman’s behalf, designates some other place. At each such meeting the committee may:

(1) review the plan and submit to the department for approval any proposed amendment to the plan;

(2) review outstanding contracts or service agreements, if any, and, to the extent possible, make necessary or desirable corrections, improvements, or additions;

(3) consider and provide for collection of assessments for operating expenses of the committee;

(4) consider facts relevant to, and provide for, the collection of assessments as determined by the commissioner;

(5) consider any extension of funding for the expenses of supervision, conservation, rehabilitation, or liquidation of an HMO as provided in Insurance Code §843.441;

(6) review financial information relating to each HMO. Committee members shall be provided with reports regarding the financial condition of Texas licensed HMOs and regarding the financial condition, administration, and status of HMOs in supervision, conservation, rehabilitation, or liquidation at meetings. Committee members shall not reveal the condition of nor any information secured in the course of any meeting of the committee with regard to any corporation, form, or person examined by the committee;

(7) advise the commissioner on actions necessary to prevent financial impairment;

(8) receive reports and advise the commissioner regarding management of HMO impairments and insolvencies;

(9) authorize appropriate legal action to recover unpaid assessments;

(10) review, consider, and act on the powers given the committee for a special or emergency meeting as outlined in subsection (d)(1) - (3) of this section; and

(11) review, consider, and act on other matters deemed by it to be necessary and proper for the administration of the committee.

(d) Special or emergency meetings. The committee shall hold a special or emergency meeting promptly after receiving notice from the commissioner of the need for such meeting. In addition, a special meeting of the committee may be held at the request of a majority of the membership, which shall be polled by the chairman at the request of any two members seeking a special meeting. At such meetings, the committee, if appropriate, shall perform the following functions.

(1) The committee shall receive and consider the report of the commissioner regarding HMO impairments or insolvencies within the meaning of Insurance Code Articles 21.28 and 21.28-A. Such reports may include progress and developments on management of such impairments or insolvencies.

(2) In consultation with the commissioner, the committee shall consider what assessment, if any, shall be levied, decide whether any refund should be made to an HMO, and consider and decide whether any assessment for expenses of supervision, conservation, rehabilitation, or liquidation shall be extended as provided in

Insurance Code §843.441. Assessments shall conform to Insurance Code §843.441. Any HMO failing to pay an assessment after 30 days' written notice that payment is due, shall be reported to the commissioner, and the committee shall consider what other action, if any, shall be taken.

(3) The committee shall take all steps permitted by law, and deemed necessary, to protect the committee's rights as pertaining to the impaired or insolvent HMO or its enrollees.

(4) In addition to the powers described in paragraphs (1) - (3) of this subsection, the committee shall have and exercise such other powers as may be reasonably necessary to implement its powers and responsibilities under the Act.

(e) Notice. Notice of meetings of the committee shall be in accordance with Chapter 551 of the Government Code.

(f) Attendance at meeting. Committee meetings shall be open to the public, but the committee may hold a closed meeting under the provisions of Subchapter D of Chapter 551, Government Code, in which only committee members, the commissioner, and persons authorized by the commissioner shall be in attendance at such meeting.

§11.1303. Operations.

(a) Official address. The official address of the committee shall be the address of the office of the commissioner unless otherwise designated by the committee.

(b) Record maintenance. The committee shall keep and maintain a record of the affairs and financial transactions of the committee and its agents.

(c) Custodian of accounts.

(1) The committee appoints the director of liquidation oversight as the custodian of the administrative account and as its agent for collecting assessments from HMOs. In the name of the committee, the custodian shall maintain such funds in depositories as provided by Insurance Code Article 21.28, §(2)(h). The committee may authorize the investment of some or all of these funds in other types of investments.

(2) The director of liquidation oversight shall maintain suitable account records and shall furnish the committee at each regular meeting a statement of the financial condition of the committee and a statement of income and disbursements since the last report. The director of liquidation oversight shall be entitled to reimbursement for actual expenses in performing the custodian's duties under this subsection and is authorized to hire a certified public accountant to audit the annual statement required by Insurance Code Chapters 20A and 843.

(3) Disbursement of any of the funds of the committee specifically authorized by this plan or subsequently authorized by resolution of the committee may be made by the custodian upon receipt of a statement or voucher describing the proposed expenditure that has been approved in writing by an officer of the committee.

(d) Additional procedures. The committee shall establish any additional procedures for handling any assets of the committee as deemed appropriate.

§11.1304. Records and Reports.

(a) Written record. A written record of the proceedings of each committee meeting shall be made. The original of this record shall be retained by the commissioner with copies furnished to each member and to the department. The record shall be subject to the pertinent provisions of the law, including confidentiality laws.

(b) Annual report. Not later than May 1st of each year, the committee shall make an annual report to the commissioner. Such report shall include a financial report for the preceding calendar year in a form approved by the commissioner during the preceding calendar year.

§11.1305. Appeals.

(a) Appeal to commissioner. Any HMO or HMO agent aggrieved by an act of the committee may appeal to the committee. If such HMO or HMO agent is aggrieved by the final action or decision of the committee, or if the committee does not act on such appeal within 30 days, then the HMO or HMO agent may appeal to the commissioner within 30 days after the action or decision of the committee or the expiration of the 30-day period in which the committee failed to act on such appeal.

(b) Appeal to district court. Any HMO or HMO agent which is affected by any ruling or action of the commissioner may file a petition in the District Court of Travis

County, Texas to have any ruling or action reviewed by the court pursuant to Insurance Code §§36.201 - 36.205.

§11.1306. Conformity of Statute. Sections 843.435 – 843.441 of the Texas Insurance Code are incorporated as a part of this plan.

SUBCHAPTER O. Administrative Procedures

§11.1401. Commissioner's Authority to Require Additional Information. The commissioner may require additional information as needed to make any determination required by Insurance Code, Chapters 20A and 843, or this chapter.

§11.1402. Notification to Providers.

(a) A health maintenance organization that provides coverage for health care services or medical care through one or more providers or physicians is required by the provisions of Insurance Code §843.305 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 providing health care services or medical care under the terms and conditions established by the health maintenance organization for the provision of such services and the designation of such providers and physicians. Section 843.305 may not be construed to:

(1) require that a health maintenance organization utilize a particular type of provider or physician in its operation;

(2) require that a health maintenance organization accept a provider or physician of a category or type that does not meet the practice standards and qualifications established by the health maintenance organization; or

(3) require that a health maintenance organization contract directly with such providers or physicians.

(b) An HMO which is covered by Insurance Code §843.305 must publish a notice of an application period to physicians and providers in the public notice section of at least one major newspaper with general circulation in each of its service areas. The notice must be published for five consecutive days during the period of January 2 through January 23 of each calendar year and must include this caption in bold type: Notice to Physicians and Providers, the name and address of the HMO, what type of services 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.

(c) A health maintenance organization must notify a physician or provider of acceptance or non-acceptance, in writing, no later than 90 days from receipt of an application for participation by that physician or provider.

(d) A health maintenance organization must file a copy of the published notice with the HMO Division, for information, within 15 days of publication. The filing must include the following:

(1) the name of the newspaper; and

(2) the beginning and ending date of the publication.

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers. Health Maintenance Organizations shall include in their next available newsletter or other general mailing to all enrollees following the effective date of this section, and shall include in information provided to new subscribers, the following notice:

FIGURE: 28 TAC §11.1403:

NOTICE OF SPECIAL TOLL-FREE COMPAINT 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:

1-800-832-0623

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

The entire notice shall be in at least 10-point type. If the newsletter or other mailing is in larger than 10-point type, the notice shall be in the same type as the rest of the newsletter or mailing. Paragraphs 1-3 of the English notice and paragraphs 1-3 of the Spanish notice must be in boldface type. Paragraphs 1 and 2 of the English and Spanish notices must be in capital letters. A final print of the mailing shall be submitted to the HMO Division of the Texas Department of Insurance for filing within 30 days following distribution to enrollees.

§11.1404. Pharmacy Application and Recertification.

(a) An HMO may establish reasonable application and recertification fees for each licensed pharmacy that participates or applies to participate as a contract provider in an HMO delivery network.

(b) An application or recertification fee charged under this section shall be considered reasonable provided:

(1) the fee does not exceed $50 per licensed pharmacy;

(2) the fee shall be uniformly charged per application or recertification to each pharmacy holding a license issued by the Texas State Board of Pharmacy;

(3) an HMO that contracts for the pharmaceutical services of more than one licensed pharmacy under common ownership or affiliation shall charge a separate fee for each licensed pharmacy;

(4) no more than one fee per licensed pharmacy is charged by an HMO for processing an application or recertification for participation as a contracted provider under more than one group or individual contract or in more than one HMO delivery network; and

(5) no more than one fee per licensed pharmacy is charged by any HMO or insurer within the same insurance holding company system, as defined in Insurance Code §843.002, utilizing common networks.

(c) An HMO shall not require any pharmacy or pharmacist participating or applying to participate as a contracted provider in an HMO delivery network:

(1) to provide financial statements to the HMO; and

(2) to deposit with the HMO any monies or other form of consideration, except for reasonable application and recertification fees.

SUBCHAPTER P. Prohibited Practices

§11.1500. Discrimination Based on Health Status-Related Factors. An HMO may not require an enrollee in a group health plan to pay a premium or contribution that is different from the premium or contribution for a similarly situated enrollee based on a health status-related factor. For purposes of this section, the term "similarly situated" has the meaning assigned to it in 45 CFR §146.121, relating to prohibiting discrimination against participants 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.

SUBCHAPTER Q. Other Requirements

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

(a) An HMO shall provide an accurate written description of health care plan terms and conditions to allow any prospective contract holder or enrollee or current contract holder or enrollee to make comparisons and informed decisions before selecting among health care plans. By agreement, the HMO may deliver the required description of health care plan terms required by this section electronically.

(b) The written or electronic plan description must be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to

Plain Language Requirements), by category, and must include a clear, complete and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an HMO;

(2) a toll-free number, unless exempted by statute or rule, and address for obtaining additional information, including provider information;

(3) all covered services and benefits, including a description of the options (if any) for prescription drug coverage, both generic and brand name;

(4) emergency care services and benefits, including coverage for out-of-area emergency care services and information on access to after-hours care;

(5) out-of-area services and benefits (if any);

(6) an explanation of enrollee financial responsibility for payment of premiums, copayments, deductibles, and any other out-of-pocket expenses for noncovered or out-of-plan services, and an explanation that network physicians and providers have agreed to look only to the HMO and not to its enrollees for payment of covered services, except as set forth in this description of the plan;

(7) any limitations or exclusions, including the existence of any drug formulary limitations;

(8) any prior authorization requirements, including limitations or restrictions thereon, and a summary of procedures to obtain approval for, referrals to 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;

(9) provision for continuity of treatment in the event of the termination of a primary care physician or dentist;

(10) a summary of the complaint and appeal procedures of the HMO, a statement of the availability of the independent review process, and a statement that the HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO;

(11) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, updated on at least a quarterly basis. The list shall include the information necessary to fully inform prospective or current enrollees about the network, including names and locations of physicians and providers, a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network, and a disclosure of which physicians and providers will not accept new enrollees or participate in closed provider networks serving only certain enrollees.

(A) If an HMO limits enrollees' access to a limited provider network, it shall provide to prospective and current group contract holders and enrollees a notice

in substantially the following form: "Choosing Your Physician--Now that you have chosen XYZ Health Plan, 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."

(B) 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, it shall provide to current or prospective enrollees a notice in compliance with Insurance Code Article 21.53D in substantially the following form: "ATTENTION FEMALE ENROLLEES: You have the right to select an OB-GYN to whom you have access without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's

network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

(C) An HMO shall clearly differentiate limited provider networks and open networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. An HMO shall 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 shall indicate the limited provider network(s) to which the physician or provider belongs, and the page number where the physician or provider's name can be found.

(D) An HMO shall provide notice to enrollees informing them to contact the HMO upon receipt of a bill for covered services from any physician or provider. The notice shall inform enrollees of the method(s) for contacting the HMO for this purpose.

(E) An HMO that maintains an internet site shall include on its internet site the information as required in subparagraphs (A) - (D) of this paragraph.

(12) the service area.

(c) No HMO, or representatives thereof, may cause or knowingly permit the use or distribution of enrollee information which is untrue or misleading.

(d) An HMO may utilize its handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure as the written or electronic description prescribed by the commissioner and contains all the information required under subsection (b) of this section.

(e) If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (e.g., hospital or skilled nursing facility), the plan description must disclose that upon admission to the inpatient facility, a physician other than the primary care physician may direct and oversee the enrollee's care.

(f) An HMO that maintains an internet site shall list the information as required by subsection (b)(11) of this section and Insurance Code §843.2015 on its internet site. Such information shall be easily accessible from the home page of the site.

§11.1601. Enrollee Identification Cards.

(a) If an HMO issues identification (ID) cards to enrollees, the HMO shall issue the ID cards within 30 calendar days of receiving notice of the enrollee’s selection of a primary care physician. The enrollee ID card will include, at a minimum, all necessary information to allow an enrollee to access all services under the certificate or evidence of coverage which require presentation of the card.

(b) All ID cards an HMO issues shall comply with the requirements of §21.2820 of this title (relating to Identification Cards).

(c) If an evidence of coverage provides benefits for prescription drugs, an HMO shall issue an ID card in compliance with §§21.3002 - 21.3004 of this title (relating to Definitions; Pharmacy Identification Cards, and Issuance of Standard Identification Cards).

(d) All ID cards issued by an HMO shall comply with the requirements of Business and Commerce Code Section 35.58, which restricts the display of social security numbers on ID cards.

§11.1602. Access to Certain Information.

(a) An HMO shall include on its enrollment form a space in which an enrollee may indicate:

(1) his or her primary language; and

(2) whether the enrollee has a disability affecting the enrollee's ability to communicate or read.

(b) The HMO shall provide, at its own expense, an enrollee handbook and materials relating to the complaint and appeal process and the availability of the independent review process in the language of the major population of the HMO’s enrolled population pursuant to Insurance Code §843.205.

(c) If an enrollee has a disability affecting the enrollee's ability to communicate or read, the HMO shall provide, at its own expense, an enrollee handbook and materials

relating to the complaint and appeal process and the availability of the independent review process in the appropriate format, including but not limited to, the following:

(1) Braille;

(2) large print, no smaller than seventeen point;

(3) audio tape;

(4) TDD access; and/or

(5) an interpreter.

§11.1604. Requirements for Certain Contracts between Primary HMOs and ANHCs and 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 a provider HMO in which the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the primary HMO as part of the primary HMO delivery network shall:

(1) submit to the Texas Department of Insurance a monitoring plan setting out:

(A) how the primary HMO will ensure that the ANHC or provider HMO has an effective administrative system for providing timely and accurate reimbursement to all physicians and providers under contract with the ANHC or provider HMO; and

(B) how the primary HMO will ensure that all HMO functions which are delegated or assigned under contract with the ANHC or provider HMO are consistent with full compliance by the primary HMO with all regulatory requirements of the Texas Department of Insurance;

(2) file with the Texas Department of Insurance, pursuant to §11.301(5) of this title (relating to Filing Requirements), a copy of the form of the written agreement with an ANHC or provider HMO that:

(A) requires that the ANHC or provider HMO cannot terminate the agreement without 90 days written notice;

(B) contains a hold-harmless provision that prohibits the ANHC or provider HMO and its contracted physicians and providers from billing for or attempting to collect from HMO members (except for authorized co-payments and deductibles) charges for covered services under any circumstance, including the insolvency of the primary HMO, ANHC or provider HMO;

(C) contains a provision stating that nothing in the primary HMO-ANHC or primary HMO-provider HMO contract shall be construed to in any way limit the HMO's authority or responsibility to comply with all regulatory requirements of the Texas Department of Insurance;

(D) includes the ANHC's or provider HMO's acknowledgment and agreement that:

(i) the primary HMO is required to establish, operate and maintain a health care delivery system, quality assurance system, provider credentialing system and other systems and programs meeting Texas Department of Insurance and Texas Health Care Council standards and is directly accountable for compliance with such standards;

(ii) the role of the ANHC or provider HMO in contracting with the primary HMO is limited to implementing certain systems of the primary HMO, utilizing standards approved by the primary HMO and subject to the primary HMO's oversight and monitoring of the ANHC's or provider HMO's performance; and

(iii) the primary HMO may take necessary action to assure that all HMO systems and functions which are delegated or assigned under the contract with the ANHC or provider HMO are in full compliance with all regulatory requirements of the Texas Department of Insurance;

(E) requires the ANHC to make available to the primary HMO the ANHC's contracts with physicians and providers so as to ensure compliance with contractual requirements set out in subparagraphs (B) and (C) of this paragraph; and

(F) requires the ANHC to provide the primary HMO with evidence of both financial solvency and financial ability to perform, such as a certified financial audit of the ANHC conducted by independent certified public accountants, utilizing generally accepted accounting and auditing principles;

(G) requires the ANHC or provider HMO to provide the primary HMO on at least a monthly basis, in a usable form necessary for audit purposes, the data necessary for the HMO to comply with the Texas Department of Insurance, and Texas Health Care Council reporting requirements with respect to any services provided pursuant to 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 number added and terminated since the last reporting period);

(ii) form of the contracts and subcontracts between the ANHC and physicians and providers who will be providing services to enrollees of the primary HMO and any material changes to the contracts and subcontracts;

(iii) co-payments 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 (capitation, fee-for-services, 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) time period that claims and debts related to claims owed by the ANHC or provider HMO have been pending;

(ix) information required for the primary HMO to be able to file claims for reinsurance, coordination of benefits and subrogation;

(x) provider-enrollee satisfaction data;

(xi) complaint data;

(xii) documentation of any inquiry and/or investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider, made by regulatory agencies, and documentation of the final resolution of such an inquiry and/or investigation; and

(xiii) any other data necessary to assure proper monitoring and control of the primary HMO delivery network by the primary HMO;

(3) conduct an on-site audit of the ANHC or provider HMO no less frequently than annually, or more frequently upon indication of material non-compliance, to obtain information necessary to verify compliance with all regulatory requirements of the Texas Department of Insurance. Written documentation of each audit required by this paragraph shall be made available to the Texas Department of Insurance upon request; and

(4) take prompt action to correct any failure by the ANHC to comply with regulatory requirements of the Texas Department of Insurance relating to any matters

delegated by the primary HMO to the ANHC and necessary to ensure the primary HMO's compliance with the regulatory requirements.

§11.1605. Pharmaceutical Services.

(a) Should an HMO provide prescription drug coverage, such coverage shall be subject to copayments for both generic drugs and name brand drugs. If the negotiated or usual or customary cost of the drug is less than the copayment, the enrollee shall pay the lower cost. The copayments may be the same, or if different, shall be applied as follows:

(1) if the prescription is for a generic drug, the enrollee shall pay no more than the generic copayment;

(2) if the prescription is for a name brand drug, the enrollee shall 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, the enrollee shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name brand drug.

(4) if the enrollee’s prescription benefit requires the use of generic equivalent drugs (“required generic”) and the enrollee receives a name brand drug

when a generic equivalent is available, the enrollee shall pay no more than the generic copayment plus the difference between the cost of the generic drug and the cost of the name brand drug, even when the prescription is written “dispense as written.”

(b) Pharmacy services, if offered, shall be available and accessible within the service area for the enrolled population through pharmacies licensed by the Texas State Board of Pharmacy. The HMO shall offer such pharmacy services directly or through contracts.

(c) An HMO that provides coverage for prescription drugs under an individual or group health benefit plan shall comply with the requirements of Insurance Code Article 21.53M, and §21.3010 and §21.3011 of this title (relating to Definitions; Coverage of Off-Label Drugs and Minimum Standards of Coverage for Off-Label Drug Use).

(d) An HMO that provides coverage for prescription drugs or devices under an individual or group state-mandated health benefit plan shall comply with the requirements of Insurance Code Article 21.52L (Health Benefit Plan Coverage for Prescription Contraceptive Drugs and Devices and Related Services).

(e) An HMO that provides coverage for prescription drugs under a group state-mandated health benefit plan and that utilizes one or more drug formularies to specify which prescription drugs the plan will cover shall comply with the requirements of Insurance Code Article 21.52J and §§21.3020 - 21.3023 of this title (relating to Definitions; Prescription Drug Formulary, Required Disclosure of Drug Formulary, Continuation of Benefits, and Nonformulary Prescription Drugs; Adverse Determination).

§11.1606. Organization of an HMO.

(a) The governing body as described in Insurance Code §843.004, shall have ultimate responsibility for the development, approval, implementation and enforcement of administrative, operational, personnel and patient care policies and procedures related to the operation of the HMO.

(b) The HMO shall have a chief executive officer or operations officer who shall be accountable for the administration of the health plan, including:

(1) developing corporate strategy;

(2) overseeing marketing programs;

(3) overseeing medical management functions; and

(4) ensuring compliance with all applicable statutes and rules pertaining to the operations of the HMO.

(c) The HMO shall have a clinical director who:

(1) shall be currently licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HMO. For example:

(A) a basic HMO shall have a physician;

(B) a dental HMO shall have a dentist or physician;

(C) a vision HMO shall have an optometrist or physician; and

(D) a limited services HMO shall have a physician.

(2) shall reside in the state of Texas;

(3) shall be available at all times to address complaints, clinical issues, utilization review and any quality of care issues on behalf of the HMO;

(4) shall demonstrate active involvement in all quality management activities; and

(5) shall be subject to the HMO's credentialing requirements, as appropriate.

(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 and zip codes, or any portions thereof, included in the service area;

(3) provide a complete physician and provider listing for all enrollees residing, living or working in the service area; and

(4) maintain separate cost center accounting for each service area to facilitate the reporting of divisional operations as required for HMO financial reporting.

§11.1607. Accessibility and Availability Requirements.

(a) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network which is adequate and complies with Insurance Code §843.082.

(b) There shall be a sufficient number of primary care physicians and specialists with hospital admitting privileges to participating facilities who are available and accessible 24 hours per day, seven days per week, within the HMO’s service area to meet the health care needs of the HMO’s enrollees.

(c) An HMO shall make general, special, and psychiatric hospital care available and accessible 24 hours per day, seven days per week, within the HMO's service area.

(d) If an HMO limits enrollees' access to a limited provider network, it must ensure that such limited provider network complies with the provisions of this section.

(e) An HMO shall make emergency care available and accessible 24 hours per day, seven days per week, without restrictions as to where the services are rendered.

(f) All covered services that are offered by the HMO shall be sufficient in number and location to be readily available and accessible within the service area to all enrollees.

(g) HMOs must arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis upon request and consistent with guidelines set out in paragraphs (1) - (3) of this subsection:

(1) Urgent care shall be available:

(A) within 24 hours for medical and dental conditions; and

(B) within 24 hours for behavioral health conditions.

(2) Routine care shall be available:

(A) within three weeks for medical conditions;

(B) within eight weeks for dental conditions; and

(C) within two weeks for behavioral health conditions.

(3) Preventive health services shall be available:

(A) within two months for a child;

(B) within three months for an adult; and

(C) within four months for dental services.

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) 30 miles for primary care and general hospital care; and

(2) 75 miles for specialty care.

(i) If any covered health care service or a participating physician and provider is not available to an enrollee within the mileage radii specified in subsection (h)(1) and (2) of this section because physicians and providers are not located within such mileage radii, or if the HMO is unable to obtain contracts after good faith attempts, or physicians and providers meeting the minimum quality of care and credentialing requirements of the HMO are not located within the mileage radii, the HMO shall submit an access plan to the department for approval, at least 30 days before implementation in accordance with the filing requirements in §11.301 of this title (relating to Filing Requirements). The access plan shall include the following:

(1) the geographic area identified by county, city, ZIP code, mileage, or other identifying data in which services and/or physicians and providers are not available;

(2) for each geographic area identified as not having covered health care services and/or physicians or providers available, the reason or reasons that covered health care services and/or physicians and providers cannot be made available;

(3) a map, with key and scale, which identifies the areas in which such covered health care services and/or physicians and providers are not available;

(4) the HMO's plan for making covered health care services and/or physicians and providers available to enrollees in each geographic area identified;

(5) the names and addresses of the participating physicians and providers and a listing of the covered health care services to be provided through the HMO delivery network to meet the medical needs of the enrollees covered under the HMO's plan required under paragraph (4) of this subsection;

(6) the names and address of other physicians and providers and a listing of the specialties for any other health care services or physicians and providers to be made available in the geographic area in addition to those physicians and providers participating in the HMO delivery network listed under paragraph (5) of this subsection;

(7) the procedures to be followed by the HMO to assure that primary care physicians, general hospitals, specialists, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, or single or limited health care service providers

and all other mandated health care services are made available and accessible to enrollees in the geographic areas identified as being areas in which such covered health care services and/or physicians and providers are not available and accessible, and any plans of the HMO for attempting to develop an HMO delivery network through which covered health care services are available and accessible to enrollees in these geographic areas in the future; and

(8) any other information which is necessary to assess the HMO's plan.

(j) The HMO may make arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level which is available within the HMO service area such as, but not limited to, transplants, treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive such services, unless the HMO provides the enrollee with a written explanation of the benefits and detriments of in-area and out-of-area options.

(k) The HMO shall not be required to expand services outside its service area to accommodate enrollees who live outside the service area, but work within the service area.

(l) In accordance with Insurance Code Article 21.53F (Telemedicine), each evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or a telemedicine medical service.

SUBCHAPTER R. Approved Nonprofit Health Corporations

§11.1702. Requirements for Issuance of Certificate of Authority to ANHC.

(a) Prior to 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, Chapters 20A and 843; this chapter; and applicable insurance laws and regulations of this state; and

(2) demonstrate by appropriate documentation that the applicant ANHC has established and maintains accreditation by:

(A) the National Committee on Quality Assurance; or

(B) the Joint Commission on Accreditation of Health Care Organizations-network accreditation program.

(b) The commissioner shall grant a provisional certificate of authority to an applicant ANHC under Insurance Code, Chapter 844, if:

(1) the applicant ANHC complies with each requirement for the issuance of a certificate of authority imposed on an HMO under Insurance Code, Chapters 20A and 843; this chapter; and applicable insurance laws and regulations of this state;

(2) the applicant ANHC demonstrates that it has applied for accreditation;

(3) the applicant ANHC is diligently pursuing accreditation as determined by the commissioner; and

(4) the accrediting organization has not denied the accreditation.

(c) An ANHC with a certificate of authority or a provisional certificate of authority must comply with all the appropriate requirements that an HMO must comply with under Insurance Code, Chapters 20A and 843; this chapter; and 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.

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder. Any agent for an ANHC with a certificate of authority or a provisional certificate of authority shall be considered an HMO agent and shall comply with the requirements of Insurance Code Article 21.07-1 and Chapter 19 of this title (relating to Agent's Licensing), as applicable.

§11.1704. Statutes and Rules Applicable to ANHC with a Certificate of Authority. An ANHC with a certificate of authority or provisional certificate of authority under Insurance Code, Chapter 844, and this subchapter shall be subject to the same statutes

and rules as an HMO and considered an HMO for purposes of regulation and regulatory enforcement.

SUBCHAPTER S. Solvency Standards for Managed Care Organizations Participating in Medicaid

§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 Chapters 20A and 843 of the Texas Insurance Code or as an approved nonprofit health corporation under Chapter 844 of the Texas Insurance Code.

(b) Any managed care organization or other entity providing the services specified in 42 United States Code §1396b(m)(2)(A) and participating in the State Medicaid Program (all hereinafter referred to as an "MCO") must first comply with the requirements and solvency standards set forth in this subchapter, and must not be in a hazardous financial condition as defined in §843.406 of the Texas Insurance Code, §11.810 of this title (relating to Hazardous Conditions for HMOs), or Chapter 8 of this title (relating to Early Warning System for Insurers in Hazardous Condition) where pertinent to managed care organizations. In addition, any MCO already subject to regulation of any kind, must be in compliance with any solvency standard and/or requirement pertinent to its regulation, as well as all applicable licensing laws and regulations.

§11.1802. Minimum Surplus or Net Worth.

(a) An MCO must possess the greater of:

(1) the statutory minimum capital and surplus (net worth) required of an MCO in accordance with the types of business that the MCO is authorized to write; or

(2) a minimum surplus or net worth equal to no less than the regulatory action level of risk based capital (150% of its authorized control level risk based capital) in accordance with the formula adopted by the commissioner pertaining to the MCO subject to the following phase-in:

(A) at December 31, 2005, the minimum net worth shall be equal to no less than 100% of the authorized control level risk based capital,

(B) at December 31, 2006, the minimum net worth shall be equal to no less than 125% of the authorized control level risk based capital, and

(C) at December 31, 2007, the minimum net worth shall be equal to no less than 150% of the authorized control level risk based capital.

(b) If at any time the MCO discovers that it does not meet its minimum net worth requirement, the MCO shall immediately fund capital sufficient to cure the impairment.

§11.1803. Statutory Deposits.

(a) In addition to amounts already deposited in accordance with other statutory and regulatory provisions, and subject to the reduction specified in §11.1804 of this title

(relating to Guarantees), an MCO must deposit with the Office of the Comptroller of Public Accounts of Texas:

(1) $400,000 if a basic service MCO;

(2) $275,000 if a limited service MCO; or

(3) $200,000 if a single service MCO.

(b) This deposit may be used to protect the interests of the enrollees of the MCO, including but not limited to the payment of the costs delineated in §11.1805(a)(2)(C) of this title (relating to Performance and Fidelity Bonds). Any deposit is subject to the procedures set forth in §11.802 of this title (relating to Statutory Deposit Requirements).

§11.1804. Guarantees.

(a) As used in this section, the phrase "certified audited financial statements" means financial statements audited by a CPA utilizing generally accepted auditing standards that attest that the financial condition of the MCO is fairly represented in accordance with generally accepted accounting principles; and the phrase "section 1115 waiver expansion program" means the Medicaid program involving children of the ages 6 - 18 years in a socio-economic level of up to 133% over the federal poverty level and who are not eligible under the regular Medicaid program.

(b) If a guarantee issued for the benefit of an MCO satisfies the conditions and requirements set forth in this section, then the additional deposit amounts specified in

§11.1803(a)(1) of this title (relating to Statutory Deposits) shall be reduced to the following amounts:

FIGURE: 28 TAC §11.1804(b):

Additional Statutory Deposit Required

Type of HMO	
Basic Service MCO	$150,000
Limited Service MCO	$100,000
Single Service MCO	$ 75,000

If and only if a guarantee issued for the benefit of an MCO satisfies the conditions and requirements set forth in subsection (c)(2)(B) in this section and if the MCO participates solely in the section 1115 waiver expansion program controlled and as defined by the State Medicaid Office for Texas, and is determined by the commissioner to be such an MCO, then the $400,000 figure required by §11.1803(a)(1) of this title (relating to Statutory Deposits) is reduced to $100,000.

(c) A guarantee must:

(1) be unconditional, monetarily unlimited, cover all expenses and liabilities, and approved by the department, filed with the contracting state agency, and provide for 6 months advance notice to the department and the contracting state agency prior to its cancellation; and

(2) be executed by a sponsoring organization with:

(A) a minimum tangible worth equal to $10 million for each guarantee it has issued, and be supported by board resolutions which are properly created, certified, and filed with the department and the contracting state agency. In addition, the sponsoring organization must timely provide to the department and the contracting state agency certified audited financial statements for the most recent fiscal year, a report identifying in detail all guarantees issued or made, and notification in detail of any guarantees issued or made while a guarantee described in paragraph (1) of this subsection is in force or exists; or

(B) taxing authority over a portion of the population of Texas for the purpose of funding medical care. For the MCO to qualify for this reduction, its sponsoring organization must submit satisfactory and verifiable evidence to the Texas Health and Human Services Commission and the department that it actually has the ability to tax a portion of the population of Texas.

(d) If at any time a guarantee issued for the benefit of an MCO does not comply with every requirement of this section, then the reductions provided for in this section terminate and the amounts stated in §11.1803 of this title immediately apply to the MCO.

§11.1805. Performance and Fidelity Bonds.

(a) An MCO must provide a performance bond to the contracting state agency, and file a copy with the department, which:

(1) names the contracting state agency as the obligee;

(2) provides for the faithful performance of the MCO in accordance with the contract and all specifications related to the Medicaid Program, and covers:

(A) any expenses (including, but not limited to, administrative, personnel and legal expenses) incurred by the contracting state agency resulting from an MCO's non-performance;

(B) the additional costs for services rendered after the termination of a contract for non-performance until other arrangements for services are made; and

(C) any costs for services not paid by the MCO under its contract that ultimately may be the responsibility of the contracting state agency or State of Texas;

(3) is in an amount of at least $100,000 with no deductible; and

(4) is issued by an insurance company licensed by the department.

(b) In addition, an MCO must maintain the fidelity bonds required by and comply with Insurance Code §843.402.

§11.1806. Additional Information That May be Requested From an MCO Participating in Medicaid.

(a) Whenever requested by the department, the MCO shall file a complete set of financial exhibits pertaining to the state Medicaid program, in the format of the Managed Care Financial Statistical Report, as may be modified or amended by the Texas Health

and Human Services Commission. When a request is received, the MCO shall then file, on two separate occasions, an original Managed Care Financial Statistical Report reflecting the state Medicaid program operations for each contract year in the same format as the monthly Managed Care Financial Statistical Report. These reports shall be in accordance with the instructions promulgated by the 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 are also required to be submitted to the Texas Department of Insurance. The MCO shall submit the same financial projections, including a cash flow statement, submitted to the Texas Health and Human Services Commission with the request to participate in the Medicaid program. This information shall be submitted with the certificate of authority if the MCO is not already a licensed MCO. If the MCO is a licensed operation, then the financial projections must be sent with the next financial statement due to the department.

(c) The MCO shall notify the department of any similar financial or statistical reports required by other contracting state agencies and shall submit copies of these reports, when requested by the department.

(d) Information submitted pursuant to this section shall be sent to the Texas Department of Insurance, Financial Analysis & Examinations, Mail Code 303-1A, P.O. Box 149104, Austin, Texas 78714-9104.

SUBCHAPTER T. Quality of Care

§11.1901. Quality Improvement Structure for Basic and Limited Services HMOs.

(a) A basic or limited services HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a quality improvement committee (QIC) that shall include practicing physicians, individual providers and at least one enrollee from throughout the HMO's service area. For purposes of this section, the enrollee appointed to the committee may not be an employee of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet no less than annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC shall evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual providers, and enrollees from the service area.

(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

(B) All committees shall meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.

§11.1902. Quality Improvement Program for Basic and Limited Services HMOs. The QI program for basic and limited services HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program shall include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program shall include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status. The work plan shall include:

(A) Objective and measurable goals; planned activities to accomplish the goals; time frames for implementation; responsible individuals; and evaluation methodology.

(B) The work plan shall address each program area, including:

(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;

(ii) Continuity of health care and related services;

(iii) Clinical studies;

(iv) The adoption and periodic updating of clinical practice guidelines or clinical care standards; the QI program shall assure the practice guidelines:

(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 shall include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers, which includes the following elements, as applicable:

(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.

(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.

(i) The HMO shall credential all physicians and providers, including advanced practice nurses, and physician assistants, if they are listed in the provider directory. An HMO shall credential each physician or individual provider who is a member of a contracting group, such as an independent physician association or medical group.

(ii) Policies and procedures must include the following physicians' and providers' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) An HMO is not required to credential:

(I) hospital-based physicians or individual providers, including advanced practice nurses and physician assistants unless listed in the provider directory;

(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;

(III) students, residents, or fellows;

(IV) pharmacists; or

(V) opticians.

(iv) An HMO must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the physician or provider.

(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee's decision.

(vi) An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to Insurance Code §§843.306 - 843.309.

(vii) The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:

(I) Medicare and Medicaid sanctions: the HMO must determine the publication schedule or release dates applicable to its physician and

provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;

(II) Information from state licensing boards regarding sanctions or licensure limitations; and

(III) Complaints.

(viii) The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients.

(ix) The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician's or provider's affiliation is suspended or terminated due to quality of care concerns.

(C) Initial credentialing process for physicians and individual providers shall include the following:

(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least

five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients from the HMO. This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.

(ii) The HMO shall verify the following from primary sources and shall include evidence of verification in the credentialing files:

(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.

(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the

appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the physician's or individual provider's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the HMO must use the most recent available source.

(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them by any one of the following means:

(-a-) copy of the DEA or DPS certificate;

(-b-) visual inspection of the original certificate;

(-c-) confirmation with DEA or DPS;

(-d-) entry in the National Technical Information Service database; or

(-e-) entry in the American Medical Association Physician MasterFile.

(iii) The HMO shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the physician's or individual provider's credentialing file the following:

(I) Past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain from the professional liability carrier or the National Practitioner Data Bank;

(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain from one of the following:

(-a-) National Practitioner Data Bank;

(-b-) Cumulative Sanctions Report available over the internet;

(-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting HMOs;

(-d-) state Medicaid agency or intermediary and the Medicare intermediary;

(-e-) Federation of State Medical Boards;

(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General; or

(-g-) entry in the American Medical Association Physician MasterFile.

(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual primary care provider, obstetrician-gynecologist, primary care dentist, and high-volume behavioral health physician or individual behavioral health provider as part of the initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume behavioral health physicians or individual behavioral health providers. If physicians or individual providers are part of a group practice that shares the same office, the HMO may perform one visit to the site for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment available to the department for review. The HMO shall have a process to track the relocation of and the opening of additional office sites for primary care physicians and individual primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards

approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO shall determine whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing.

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current illegal drug use;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include the following processes:

(I) Reverification of the following from the primary sources:

(-a-) Licensure and information on sanctions or limitations on licensure;

(-b-) Board certification:

(-1-) if the physician or individual provider was due to be recertified; or

(-2-) if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and

(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:

(-1-) copy of the DEA or DPS certificate;

(-2-) visual inspection of the original certificate;

(-3-) confirmation with DEA or DPS;

(-4-) entry in the National Technical Information Service database; or

(-5-) entry in the American Medical Association Physician MasterFile.

(II) Review of updated history of professional liability claims in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for institutional providers shall include the following:

(i) Evidence of state licensure;

(ii) Evidence of Medicare certification;

(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from the Texas Department of Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are

appropriate for different types of institutional providers. The HMO's written policies and procedures must state which national accrediting bodies it accepts; and

(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.

(F) The HMO procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (iv) of this paragraph.

(G) Under Insurance Code Article 20A.39, the standards adopted in this paragraph must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA) to the extent that those standards do not conflict with other laws of the state. Therefore, if the NCQA standards change and there is a difference between the standards specified in this paragraph and the NCQA standards, the NCQA standards shall prevail to the extent that those standards do not conflict with the other laws of this state.

(5) Site visits for cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing.

(A) If the HMO delegates credentialing functions to other entities, it shall have:

(i) a process for developing delegation criteria and for performing pre-delegation and annual audits;

(ii) a delegation agreement;

(iii) a monitoring plan; and

(iv) a procedure for termination of the delegation agreement for non-performance.

(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.

(C) The HMO shall maintain:

(i) documentation of pre-delegation and annual audits;

(ii) executed delegation agreements;

(iii) semi-annual reports received from the delegated entities;

(iv) evidence of evaluation of the reports;

(v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and

(vi) documentation of ongoing monitoring and shall make it available to the department for review.

(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.

(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.

SUBCHAPTER V. Standards for Community Mental Health Centers

§11.2101. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise. Community Health Maintenance Organization (CHMO)--An entity created under the authority of Section 534.101, Health and Safety Code, by one or more community centers as defined by Section 534.001, Health and Safety Code, and authorized by the Texas Department of Insurance to provide a limited health care service plan as defined in Insurance Code §843.002(18).

§11.2102. General Provisions.

(a) Each CHMO must comply with all requirements for a limited health care service plan specified in this subchapter.

(b) Each CHMO shall provide coverage for work in progress and must clearly specify that the enrollee must agree to have the work completed by a participating provider in the HMO delivery network, as defined under Insurance Code §843.002(15), or as otherwise arranged by the limited service HMO.

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

(a) Prior to obtaining a certificate of authority under Section 534.101, Health and Safety Code (concerning Health Maintenance Organizations Certificate of Authority), an applicant CHMO must comply with each requirement for the issuance of a certificate of

authority imposed on a limited health care service plan under Insurance Code Chapters 20A and 843; this chapter; and 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 20A and 843; this chapter; and applicable insurance laws and regulations of this state to maintain a certificate of authority. A CHMO shall be subject to the same statutes and rules as a limited service HMO and considered a limited service HMO for purposes of regulation and regulatory enforcement.

(c) Nothing in this subchapter precludes one or more community centers from forming a nonprofit corporation under §162.001, Medical Practice Act, Chapters 151 – 164, Occupations Code, to provide services on a risk-sharing or capitated basis as permitted under Insurance Code Chapter 844.

(d) This subchapter does not apply to an activity exempt from regulation under Insurance Code §§843.051, 843.053, 843.073, and 843.318.

SUBCHAPTER W. Single Service HMOs

§11.2200. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, 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 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, or other such facility.

(5) Emergency Dental Services--Under a single health care service plan providing dental care services and benefits, emergency dental services are limited to procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

(6) Insurer--An insurance company, a group hospital service corporation operating under Chapter 842 of the Texas Insurance Code, a fraternal benefit society operating under Chapter 885 of the Code, or a stipulated premium insurance company operating under Chapter 884 of the Code.

(7) Point-of-service group disclosure statement--A written statement containing information about dental benefits which statement the HMO must provide to:

(A) an employer, an association or other private group arrangement to whom the HMO must offer a dental point-of-service plan; and

(B) any prospective enrollees in a dental point-of service plan, if the employer, association or private group arrangement accepts the dental point-of service plan.

(8) Point-of-service plan--A plan provided through a contractual arrangement under which indemnity benefits for the cost of dental care services other than emergency care or emergency dental care are provided by an insurer in conjunction with corresponding benefits arranged or provided by an HMO that provides dental benefits and under which an enrollee may choose to obtain benefits or services under either the indemnity plan or the HMO plan in accordance with specific provisions of Insurance Code §843.112.

(9) Qualified actuary--An actuary who is either:

(A) a Fellow of the Society of Actuaries, or

(B) a Member of the American Academy of Actuaries.

§11.2201. General Provisions.

(a) Each single service HMO shall provide uniquely described services with any corresponding copayments for each covered service and benefit and shall provide a single health care service plan as defined under Insurance Code §843.002(26). Each single service HMO must comply with all requirements for a single health care service plan specified in this subchapter.

(b) Each single service HMO schedule of enrollee copayments shall specify an appropriate description of covered services and benefits and may specify recognized procedure codes or other information which is used for the purpose of maintaining a statistical reporting system, as required under §11.1606 of this title (relating to Organization of an HMO).

(c) Each single service HMO evidence of coverage shall include a glossary of terminology, including such terms used in the evidence of coverage required by §11.501 of this title (relating to Forms Which Must be Approved Prior to Use). Such glossary shall be included in the information to prospective and current group contract holders and enrollees, as required under Insurance Code §843.201.

(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.

§11.2203. Minimum Standards, Dental Care Services and Benefits.

(a) Each single service HMO evidence of coverage which uses any dental procedure codes must use such codes as specified in the current version of CDT, as defined in §11.2200 of this title (relating to Definitions).

(b) Each single service HMO evidence of coverage providing coverage for dental care services shall provide benefits for covered dental treatment in progress and may, if

clearly disclosed, require the enrollee to have such treatment completed by a participating provider in the Health Maintenance Organization Delivery Network, as defined under Insurance Code §843.002(15), or as otherwise arranged by the single service HMO.

(c) Each single service HMO evidence of coverage providing coverage for dental care services and benefits shall offer services for the purposes of preventing, alleviating, curing, or healing dental disease, including dental caries and periodontal disease. Such services may include an infection control (sterilization) fee. Single service HMOs providing coverage for dental care services shall offer coverage for the following primary and preventive services provided by a general dentist or hygienist, as applicable: office visit-during and after regularly scheduled hours; oral evaluations; x-rays; bitewings; panoramic film; dental prophylaxis (adult and child); topical fluoride treatment for children; dental sealants for children; amalgam fillings (one, two, three and four or more surface, primary and permanent-including polishing); anterior resin fillings (one, two, three and four or more surface or involving incisal angle, primary and permanent-including polishing); simple oral extractions; surgical incision and drainage of abscess-intraoral soft tissue; and palliative (emergency) treatment of dental pain.

(d) 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 posterior resin restorations, one, two, three and four or more surface (to include polishing); crowns and

crown recementation; composite resin crowns, anterior-primary; sedative fillings; core buildup, including any pins, and pin retention; pulp cap (direct and indirect); therapeutic pulpotomy; root canal therapy, anterior, bicuspid and molar; gingival curettage; osseous surgery; periodontal scaling and root planing; periodontal maintenance procedures; complete denture (maxillary and mandibular); partial denture (maxillary and mandibular); root removal-exposed roots; surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth; removal of impacted tooth (soft tissue and completely bony); tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus; alveoplasty; occlusal guard (bruxism appliance); or orthodontia.

(e) Each single service HMO providing coverage for dental care services and benefits may also offer a preventive services plan as a supplement to a basic health care service plan offered by an affiliate or another carrier, as long as a plan described in section (c) of this section has first been offered to and rejected in writing by the group contract holder. Such a preventive plan shall include oral evaluations, X-rays, bitewings, panoramic film, and prophylaxis.

§11.2204. Minimum Standards, Vision Care Services and Benefits.

(a) Each single service HMO evidence of coverage providing vision care services and benefits shall provide the following as covered primary and preventive vision services: comprehensive eye examination to include medical history; visual

acuities, with correction (distance and near), without correction (distance and near); cover test at 20 feet and at 16 inches; versions; external examination of the eye lids, cornea, conjunctiva, pupillary reaction (neurological integrity) and muscle function; binocular measurements for far and near; internal eye examination (ophthalmoscopy); autorefraction/refraction (far point and near point); tonometry (reasonable attempt or equivalent testing if contraindicated); retinoscopy; biomicroscopy; intraocular pressure-glaucoma test; slit lamp examination; and urgent care as defined in §11.2 of this title (relating to Definitions).

(b) A single service HMO evidence of coverage providing vision care services and benefits may provide coverage for secondary vision care services which include contact lens examination; fitting; training; follow-up visits, or eye glasses.

§11.2207. Quality Improvement Structure and Program for Single Service HMOs.

(a) A single service HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a QI committee (QIC) that shall include practicing physicians, individual providers and at least one enrollee from throughout the HMO's service area.

For purposes of this section, the enrollee appointed to the committee may not be an employee of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet no less than annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC shall evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual providers, and enrollees from the service area.

(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services .

(B) All committees shall meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.

(d) The QI program for single service HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services.

The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program shall include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program shall include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms of age groups, disease categories, and special risk status, as applicable. The work plan shall include:

(A) Objective and measurable goals; planned activities to accomplish the goals; time frames for implementation; responsible individuals; and evaluation methodology.

(B) The work plan shall address each program area, including:

(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;

(ii) Continuity of health care and related services, as applicable;

(iii) Clinical studies;

(iv) The adoption and use of current professionally-recognized clinical practice guidelines, or, in the absence of current professionally-

recognized clinical practice guidelines for particular practice areas or conditions, those developed by the health plan that:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services.

(v) Enrollee**,** physician, and individual provider satisfaction;

(vi) The complaint and appeal process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians and providers from effectively making complaints against the HMO;

(vii) Preventive health care through health promotion and outreach activities:

(viii) Claims payment processes, as applicable;

(ix) Contract monitoring, including delegation oversight and compliance with filing requirements;

(x) Utilization review processes, as applicable;

(xi) Credentialing;

(xii) Member services; and;

(xiii) Pharmacy services, including drug utilization.

(3) Evaluation. The QI program shall include an annual report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers, which includes the following elements, as applicable:

(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.

(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.

(i) The HMO shall credential all physicians and providers including advanced practice nurses and physician assistants, if they are listed in the provider directory. An HMO shall credential each physician and individual provider who is a member of a contracting group, such as an independent practice association or medical group.

(ii) Policies and procedures must include the following physicians' and providers' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) An HMO is not required to credential:

(I) hospital-based physicians or individual providers, including advanced practice nurses and physician assistants unless listed in the provider directory;

(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;

(III) students, residents, or fellows;

(IV) pharmacists; or

(V) opticians.

(iv) An HMO must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the physician or provider.

(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee’s decision.

(vi) An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to Insurance Code §§843.306 - 843.309.

(vii) The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:

(I) Medicare and Medicaid sanctions: the HMO must determine the publication schedule or release dates applicable to its physician and provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;

(II) Information from state licensing boards regarding sanctions or licensure limitations; and

(III) Complaints.

(viii) The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients.

(ix) The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician’s or provider's affiliation is suspended or terminated due to quality of care concerns.

(C) Initial credentialing process for physicians and individual providers shall include the following:

(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients from the HMO. This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.

(ii) The HMO shall verify the following from primary sources and shall include evidence of verification in the credentialing files:

(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.

(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the physician’s or individual provider's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association

MasterFile, or from the specialty boards, and the HMO must use the most recent available source.

(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them by any one of the following means:

(-a-) copy of the DEA or DPS certificate;

(-b-) visual inspection of the original certificate;

(-c-) confirmation with DEA or DPS;

(-d-) entry in the National Technical Information Service database; or

(-e-) entry in the American Medical Association Physician MasterFile.

(iii) The HMO shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the physician’s or individual provider's credentialing file the following:

(I) Past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain from the professional liability carrier or the National Practitioner Data Bank;

(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain from one of the following:

(-a-) National Practitioner Data Bank;

(-b-) Cumulative Sanctions Report available over the internet;

(-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting HMOs;

(-d-) state Medicaid agency or intermediary and the Medicare intermediary;

(-e-) Federation of State Medical Boards;

(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General;

(-g-) entry in the American Medical Association Physician MasterFile.

(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual provider, obstetrician-gynecologist, primary care dentist, and high-volume behavioral health physician or individual provider as part of the initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume behavioral health physicians and individual providers. If physicians or individual providers are part of a group practice that shares the same

office, the HMO may perform one visit to the site for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment available to the department for review. The HMO shall have a process to track the opening of new physician or individual provider offices. The HMO shall perform a site visit of each new office site of primary care physicians and individual providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual providers as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO shall determine whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing.

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current illegal drug use;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include the following processes:

(I) Reverification of the following from the primary sources:

(-a-) Licensure and information on sanctions or limitations on licensure;

(-b-) Board certification:

(-1-) if the physician or individual provider was due to be recertified; or

(-2-) if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and

(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:

(-1-) copy of the DEA or DPS certificate;

(-2-) visual inspection of the original certificate;

(-3-) confirmation with DEA or DPS;

(-4-) entry in the National Technical Information Service database; or

(-5-) entry in the American Medical Association Physician MasterFile.

(II) Review of updated history of professional liability claims, and sanction and restriction information from Medicare and Medicaid in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for institutional providers shall include the following:

(i) Evidence of state licensure;

(ii) Evidence of Medicare certification;

(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from Texas Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are appropriate for different types of institutional providers. The HMO's written policies and procedures must state which national accrediting bodies it accepts;

(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.

(F) The HMO's procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (iv) of this paragraph.

(G) Under Insurance Code Article 20A.39, the standards adopted in this paragraph must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA) to the extent that those standards do not conflict with other laws of the state. Therefore, if the NCQA standards change and there is a difference between the standards specified in this paragraph and the NCQA standards, the NCQA standards shall prevail to the extent that those standards do not conflict with the other laws of this state.

(5) Site Visits for Cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing

committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing.

(A) If the HMO delegates credentialing functions to other entities, it shall have:

(i) a process for developing delegation criteria and for performing pre-delegation and annual audits;

(ii) a delegation agreement;

(iii) a monitoring plan; and

(iv) a procedure for termination of the delegation agreement for non-performance.

(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.

(C) The HMO shall maintain:

(i) documentation of pre-delegation and annual audits;

(ii) executed delegation agreements;

(iii) semi-annual reports received from the delegated entities;

(iv) evidence of evaluation of the reports;

(v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and

(vi) documentation of ongoing monitoring and shall make it available to the department for review.

(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.

(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.

§11.2208. Single Health Care Services Accessibility and Availability.

(a) A single health care service HMO that chooses to offer to an enrolled population a particular service shall comply with §11.1607(a) and (e) - (j) of this title (relating to Accessibility and Availability Requirements). Any single health care service shall be offered directly by the HMO or by contract.

(b) A sufficient number of participating single health care physicians or dentists or other individual providers with appropriate hospital or inpatient facility admitting privileges shall be available and accessible 24 hours per day, seven days per week, within the HMO's service area, to ensure availability and accessibility of care, including inpatient admissions and care, as appropriate.

(c) If a service offered by a single health care service HMO requires inpatient status for the management of a single health care condition the HMO shall provide for the appropriate inpatient facility according to the need by contracting with one or more general, or special hospitals; or home and community support services agencies for outpatient services.

SUBCHAPTER X. Provider Sponsored Organizations

§11.2303. Application for Certificate of Authority.

(a) Any health care provider may apply to the commissioner for and obtain a certificate of authority to establish and operate a PSO for the purpose of providing health care to Medicare enrollees in accordance with this subchapter.

(b) Prior to obtaining a certificate of authority under Insurance Code, Chapter 20A, an applicant PSO must comply with each requirement for the issuance of a certificate of authority imposed on an HMO under Insurance Code, Chapters 20A and 843, 28 Texas Administrative Code Chapter 11 and other applicable insurance laws and regulations of this state except where preempted by federal law.

(c) An applicant for a certificate of authority for a PSO shall complete and file with the department the application form for a health maintenance organization adopted by reference under §11.1001 of this title (relating to Required Forms) and the Financial Plan required by §11.2304 of this title (relating to Financial Plan Requirement).

§11.2311. Dissolution; Liquidation; Rehabilitation. Any dissolution, liquidation, rehabilitation, supervision or conservation of an entity licensed under this subchapter shall be handled as provided in Insurance Code Articles 21.28 and 21.28-A and §§843.463 and 843.407.

§11.2314. Suspension or Revocation of Certificate of Authority. The commissioner, after notice and opportunity for hearing, may suspend or revoke any certificate of authority issued to a PSO, if the commissioner finds that the PSO is insolvent or that any of the conditions described in Insurance Code §843.461 exist.

SUBCHAPTER Y. Limited Service HMOs

§11.2402. General Provisions.

(a) Each limited service HMO shall provide uniquely-described services with any corresponding copayments for each covered service and benefit and shall provide a limited health care service plan as defined under Insurance Code §843.002. Each limited service HMO must comply with all requirements for a limited health care service plan specified in this subchapter.

(b) Each limited service HMO schedule of enrollee copayments shall specify an appropriate description of covered services and benefits and may specify recognized procedure codes or other information used for maintaining a statistical reporting system,

as required under §11.1902 of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs).

(c) Each limited HMO evidence of coverage shall include a glossary of terminology, including such terms used in the evidence of coverage required by §11.501 of this title (relating to Forms Which Must be Approved Prior to Use). Such glossary shall be included in the information to prospective and current group contract holders and enrollees, as required under Insurance Code §843.201.

(d) In the event of a conflict between the provisions of this subchapter and other provisions of Chapter 11 of this title (relating to Health Maintenance Organizations), this subchapter prevails with regard to limited service HMOs. It is not considered a conflict if a topic that is not addressed in this subchapter appears elsewhere in Chapter 11 of this title.

§11.2405. Minimum Standards, Mental Health and Chemical Dependency Services and Benefits.

(a) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall cover, in accord with the limited service HMO's standards of medical necessity, court ordered mental health/chemical dependency treatment and may, if clearly disclosed, require the enrollee to have such treatment completed by a participating provider in the Health

Maintenance Organization Delivery Network, as defined under Insurance Code §843.002, or as otherwise arranged by the limited service HMO.

(b) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall provide primary mental health/chemical dependency services and benefits, including:

(1) For treatment of serious mental illness (as defined in Texas Insurance Code Article 3.51-14), up to 45 inpatient days per year, up to 60 outpatient visits per year, which include assessment/screening, treatment planning, and crisis services.

(2) For treatment of non-serious mental illness, up to 30 inpatient days per year, up to 30 outpatient visits per year, which include assessment/screening, treatment planning, and crisis services.

(3) Treatment of chemical dependency in accord with the levels of care and clinical criteria specified in §§3.8001, et seq. of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

(4) Any other services necessary and appropriate to treat mental health/chemical dependency or required by the Insurance Code, Health and Safety Code, and other applicable laws and regulations of this State.

(c) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall demonstrate the capacity to provide, and may provide, secondary intensive rehabilitative and community

support services for mental illness/chemical dependency, including, but not limited to, case management, partial hospitalization, residential, acute day treatment, intensive outpatient, ACT teams, and habilitative/rehabilitative services for pervasive developmental disorders.

§11.2406. Minimum Standards, Long Term Care Services and Benefits. Each limited service HMO evidence of coverage providing long-term care services and benefits shall comply with Insurance Code Article 3.70-12 and §§3.3801, et seq. of this title (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies).

SUBCHAPTER Z. Point-of-Service Riders

§11.2501. Definitions. The following words and terms, when used in this subchapter, shall have the following meaning, unless the context indicates otherwise.

(1) Coinsurance--An amount in addition to the premium and copayments due from an enrollee who accesses out-of-plan covered benefits, for which the enrollee is not reimbursed.

(2) Corresponding benefits--Benefits provided under a point-of-service (POS) rider or the indemnity portion of a point-of-service (POS) plan, as defined in Article 3.64(a)(4) and §843.108 of the Code, that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a point-of-service plan.

(3) Cost containment requirements--Provisions in a POS rider requiring a specific action, such as the provision of specified information to the HMO, that must be taken by an enrollee or by a physician or a provider on behalf of the enrollee to avoid the imposition of a specified penalty on the coverage provided under the rider for proposed service or treatment.

(4) Coverage--Any benefits available to an enrollee through an indemnity contract or rider, any services available to an enrollee under an evidence of coverage, or combination of the benefits and services available to an enrollee under a POS plan.

(5) Health plan products--Any health care plan issued by an HMO pursuant to the Code or a rule adopted by the commissioner.

(6) In-plan covered services--Health care services, benefits, and supplies to which an enrollee is entitled under the evidence of coverage issued by an HMO, including emergency services, approved out-of-network services and other authorized referrals.

(7) Non-participating physicians and providers--Physicians and providers that are not part of an HMO delivery network.

(8) Out-of-plan covered benefits--All covered health care services, benefits, and supplies that are not in-plan covered services. Out-of-plan covered benefits include health care services, benefits and supplies obtained from participating physicians and providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining in-plan covered services.

(9) Participating physicians and providers--Physicians and providers that are part of an HMO delivery network.

(10) Point-of-service blended contract plan (POS blended contract plan)--A POS plan evidenced by a single contract, policy, certificate or evidence of coverage that provides a combination of indemnity benefits for which an indemnity carrier is at risk and services that are provided by an HMO under a POS plan.

(11) Point-of-service dual contracts plan (POS dual contracts plan)--A POS plan providing a combination of indemnity benefits and HMO services through separate contracts, one being the contract, policy or certificate offered by an indemnity carrier for which the indemnity carrier is at risk and the other being the evidence of coverage offered by the HMO.

(12) Point-of-service rider (POS rider)--A rider issued by an HMO that meets the solvency requirements of §11.2502 of this title (relating to Issuance of Point-of-service Riders) and that provides coverage for out-of-plan services, including services, benefits, and supplies obtained from participating physicians or providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining approval for in-plan covered services.

(13) Point-of-service rider plan (POS rider plan)--A POS plan provided by an HMO pursuant to this subchapter under an evidence of coverage that includes a POS rider.

§11.2502. Issuance of Point-of-service Riders. An HMO may issue a POS rider plan only if the HMO meets all of the applicable requirements set forth in this section.

(1) Solvency of HMOs Issuing Point-of-service Rider Plans.

(A) For HMOs that have been licensed for at least one calendar year, the HMO shall maintain a net worth of at least the sum of:

(i) the greater of:

(I) the minimum net worth required by the Code for that HMO; or

(II) 100% of the authorized control level of risk-based capital as set forth in §11.809 of this title (relating to Risk-Based Capital for HMOs and Insurers Filing the NAIC Health Blank); and

(ii) twenty-five percent of total gross point-of-service premium revenue reported in the preceding calendar year.

(B) For HMOs that have been licensed for less than one calendar year, the HMO shall maintain a net worth of at least the sum of:

(i) the minimum net worth required by the Code for that HMO; and

(ii) fifty percent of the yearly average of the two-year annual premium gross point-of-service premium revenue as projected in its application for a certificate of authority.

(C) Assets of the HMO shall be of a sufficient amount to cover reserve liabilities for the POS riders and shall be limited to those allowable assets listed under §11.803(1) of this title (relating to Investments, Loans and Other Assets).

(D) Reserves held by an HMO for POS riders shall be calculated in accordance with Chapter 3, Subchapter GG of this title (relating to Minimum Reserve Standards for Individual and Group Accident and Health Insurance).

(E) An HMO that has issued a POS rider plan under this section and whose net worth or assets subsequently fall below the requirements of subparagraphs (A), (B) or (C) of this paragraph shall cease issuing additional new POS rider plans to groups or individuals, except as provided in paragraphs (4) and (5) of this section, until it comes into compliance with the requirements of this paragraph.

(2) Limitations on POS Rider Expenses. An HMO's POS rider expenses must not exceed 10% of medical and hospital expenses on an annual basis for all health plan products sold by the HMO.

(A) An HMO may issue a POS rider plan under this section only if the total medical and hospital expenses incurred by the HMO for the preceding four calendar quarters for all POS riders issued by the HMO under this section do not exceed 10% of the annual medical and hospital expenses incurred by the HMO for all health plan products sold during the preceding four calendar quarters.

(B) An HMO that has issued any POS rider plans under this subchapter is responsible for compiling, maintaining, and reporting to the department

the total medical and hospital expenses incurred by the HMO on an annual basis for all POS riders as well as the total medical and hospital expenses incurred by the HMO on an annual basis for all health plan products sold to ensure that the HMO is in compliance with the requirements of this subchapter.

(C) An HMO that has issued any POS rider plans under this subchapter and whose total medical and hospital expenses incurred for the preceding four calendar quarters for all POS riders issued under this subchapter has exceeded 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the preceding four calendar quarters shall:

(i) immediately cease issuance of additional new POS rider plans to groups or individuals, except as provided in paragraphs (4) and (5) of this section;

(ii) offer all subsequent new POS plans through POS blended contracts or POS dual contracts in accordance with Chapter 21, Subchapter U of this title (relating to Arrangements between Indemnity Carriers and HMOs for Point-of-service Coverage); and

(iii) not issue any additional new POS rider plans until it has either:

(I) established to the satisfaction of the commissioner that:

(-a-) its total medical and hospital expenses incurred for the preceding four calendar quarters for all POS riders issued under this section have not exceeded 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the preceding four calendar quarters; and

(-b-) its total medical and hospital expenses incurred for all POS riders issued under this section for the next four calendar quarters will not exceed 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the next four calendar quarters; or

(II) become an indemnity carrier licensed under the Code.

(D) Notwithstanding subparagraph (C)(iii) of this subsection, an HMO that has issued POS riders for which the HMO's annual medical and hospital expenses incurred by the HMO for the POS riders have exceeded 10% of the HMO's total annual medical and hospital expenses incurred by the HMO for all health plan products that can establish, to the satisfaction of the commissioner, that its total medical and hospital expenses incurred on an annual basis for all POS riders issued under this section will not exceed 10% of the total annual medical and hospital expenses incurred by the HMO for all health plan products for the following one year period, may offer new POS rider plans under this section during that following year.

(3) Renewability and discontinuance of POS rider plans.

(A) POS rider plans issued under this subchapter are guaranteed renewable if the plan is:

(i) a small employer plan, pursuant to Article 26.23 of the Code;

(ii) a large employer plan, pursuant to Article 26.86 of the Code;

(iii) an individual plan, pursuant to §11.506(3)(D) of this chapter (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate); or

(iv) an association plan, pursuant to §21.2704 of this title (relating to Mandatory Guaranteed Renewability Provisions for Health Benefit Plans Issued to Members of an Association or Bona Fide Association).

(B) An HMO that discontinues a POS rider plan must comply with all laws and rules applicable to that plan.

(C) An HMO that discontinues existing POS rider plans in order to bring the HMO into compliance with the 10% cap:

(i) shall offer, if the discontinued plan is issued to:

(I) a small employer group, to each employer, the option to purchase other small employer coverage offered by the small employer carrier at the time of the discontinuation, pursuant to Article 26.24(d) of the Code;

(II) a large employer group, to each employer, the option to purchase any other large employer coverage offered by the large employer carrier at the time of the discontinuation, pursuant to Article 26.87(d) of the Code;

(III) an individual, the option to purchase to each enrollee any other individual basic health care coverage offered by the HMO pursuant to §11.506(3)(D)(v) of this title;

(IV) an association, the option to purchase any other health benefit plan being offered by the HMO pursuant to §21.2704(d)(1)(B) of this title.

(ii) shall not issue any additional new POS rider plans:

(I) for at least one calendar year after the date on which it last discontinued any of its existing POS rider business and then only if it can establish to the satisfaction of the commissioner that:

(-a-) its total medical and hospital expenses incurred for the preceding four calendar quarters for all POS riders issued under this subchapter will not have exceeded 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the preceding four calendar quarters; and

(-b-) its total medical and hospital expenses incurred for all POS riders issued under this subchapter for the next four calendar quarters will not exceed 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the next four calendar quarters; or

(II) until it has become licensed as an indemnity carrier under the Code.

(4) An HMO that ceases to issue a POS rider plan in order to comply with the 10% cap required under paragraph (2) of this section shall continue to offer the plan to each new member of a group to which the POS rider plan has been issued unless and until the HMO divests itself of the group's business by discontinuing the plan as set forth in paragraph (3) of this section.

(5) An HMO that ceases to issue a POS rider plan in order to comply with the 10% cap required under paragraph (2) of this section must continue to offer the plan to each new individual entitled to coverage under an existing individual plan for which a POS rider has been issued unless and until the HMO divests itself of the individual plan by discontinuing the plan as set forth in paragraph (3) of this section.

§11.2503. Coverage Relating to POS Rider Plans.

(a) An HMO may not consider an in-plan covered service to be a benefit provided under the POS rider.

(b) An HMO shall not require an enrollee to use either the POS rider benefits or in-plan covered services first.

(c) An HMO that includes limited provider networks:

(1) shall not limit the access, under the POS rider, of an enrollee whose in-plan covered services are restricted to the limited provider network, either to participating physicians and providers or to non-participating physicians and providers;

(2) shall not impose cost-sharing arrangements for an enrollee whose in-plan covered services are restricted to a limited provider network, and who, through the POS 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;

(3) may provide for cost-sharing arrangements for benefits obtained from non-participating physicians and providers that are different from the cost sharing arrangements for in-plan covered services, provided that coinsurance required under a POS rider shall never exceed 50% of the total amount to be covered.

(d) An HMO that issues or offers to issue a POS 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 Chapters 20A and 843, and Articles 21.21, 21.21A, 21.21-1, 21.21-2, 21.21-5 and 21.21-6 of the Code.

(e) A POS rider plan offered under this subchapter must contain:

(1) a POS rider that:

(A) shall contain coverage that corresponds to all in-plan covered services provided in the evidence of coverage as well as coverage that is provided to an

enrollee as part of the enrollee's in-plan coverage through separate riders attached to the evidence of coverage;

(B) may include benefits in addition to in-plan covered services;

(C) may limit or exclude coverage for benefits that do not correspond to in-plan covered services;

(D) shall not limit coverage for benefits that correspond to in-plan covered services except as provided in subparagraphs (E), (F) and (G) of this paragraph;

(E) may include reasonable out-of-pocket limits and annual and lifetime benefit allowances which differ from limits or allowances on in-plan covered services provided under other riders attached to the evidence of coverage so long as the allowances and limits comply with applicable federal and state laws;

(F) may provide for cost-sharing arrangements that are different from the cost sharing arrangements for in-plan covered services, provided that coinsurance required under a POS rider shall never exceed 50% of the total amount to be covered;

(G) may be reduced by benefits obtained as in-plan covered services;

(H) shall not reduce or limit in-plan covered services in any way by coverage for benefits obtained by an enrollee under the POS rider;

(I) if applicable, shall disclose how the POS rider cost-sharing arrangements differ from those in the evidence of coverage, any reduction of benefits as set forth in subparagraph (G) of this paragraph, any deductible that must be met by the enrollee under the POS rider, and whether copayments made for in-plan covered services apply toward the POS rider deductible;

(J) shall provide coverage for services obtained without the HMO's authorization from a participating physician or provider. However, the enrollee must comply with any precertification requirements as set forth in subparagraph (L) of this paragraph that are applicable to the POS rider;

(K) shall include a description of how an enrollee may access out-of-plan covered benefits under the POS rider, including coverage contained in other riders attached to the evidence of coverage;

(L) shall disclose all precertification requirements for coverage under the POS rider including any penalties for failure to comply with any precertification or cost containment provisions, provided that any such penalties shall not reduce benefits more than 50% in the aggregate;

(M) if it is issued to a group, shall contain provisions that comply with Article 3.51-6 Sec. 1(d)(2)(vii) - (xiii) of the Code; and

(N) if it is issued to an individual, shall contain provisions that comply with Article 3.70-3(A)(5) - (11) of the Code;

(2) an evidence of coverage that includes a description and reference to the POS rider sufficient to notify a prospective or current enrollee that the plan provides the option of accessing participating physicians and providers as well as non-participating physicians and providers for out-of-plan covered benefits and that accessing these benefits through the POS rider may involve greater costs than accessing corresponding in-plan covered services; and

(3) a side-by-side summary of the schedule of the corresponding coverage for services, benefits, and supplies available under the POS rider and services, benefits, and supplies available in the evidence of coverage that together constitute the POS rider plan.

SUBCHAPTER AA. Delegated Entities

§11.2601. General Provisions.

(a) Purpose. The purpose of this subchapter is to set forth the requirements that must be met by any HMO that delegates any function as described in Texas Insurance Code Art. 20A.18C. These requirements are designed to ensure that a delegating HMO:

(1) identifies all responsibilities relating to the function being delegated;

(2) creates an agreement that enables the HMO and department to monitor both the delegated entity's financial solvency and performance or subsequent delegation of all delegated functions; and

(3) retains ultimate responsibility for ensuring that all delegated functions are performed in accordance with applicable statutes and rules.

(b) Severability. Where any terms or sections of this subchapter are determined by a court of competent jurisdiction to be inconsistent with the Act, as identified by this subchapter, the Act will apply and the remaining terms and provisions of this subchapter shall continue in effect.

(c) Applicability to Group Model HMO. This subchapter does not apply to a group model HMO, as defined by Insurance Code §843.111.

§11.2602. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The HMO Act, Insurance Code, Chapters 20A and 843.

(2) Delegated entity--An entity, other than an HMO authorized to do business under the Act, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the HMO any function regulated by the Act. 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 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.

(3) Delegated network--Any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with an HMO.

(4) Delegated third party--A third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility to perform any function regulated by the Act; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by the Act.

(5) Health care--Any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, or dental care, or hospitalization, or incident to the furnishing of such 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.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2005.

_____
Brenda Caldwell
Special Regulatory Counsel
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§11.1, 11.2, 11.101, 11.201 – 11.206, 11.301 – 11.303, 11.502 – 11.506, 11.508, 11.509, 11.512, 11.602, 11.603, 11.801 – 11.803, 11.806, 11.810, 11.901, 11.904, 11.1001, 11.1301 – 11.1306, 11.1401 – 11.1404, 11.1500, 11.1600 – 11.1602, 11.1604 – 11.1607, 11.1702 – 11.1704, 11.1801 – 11.1806, 11.1901, 11.1902, 11.2101 – 11.2103, 11.2200, 11.2201, 11.2203, 11.2204, 11.2303, 11.2311, 11.2314, 11.2402, 11.2405, 11.2501 – 11.2503, 11.2601, and 11.2602, and new §§11.902, 11.2207, 11.2208, and 11.2406, concerning regulation of health maintenance organizations (HMOs), are adopted.

AND IT IS SO ORDERED.

_____
JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

ATTEST:

_____
Brenda Caldwell
Special Regulatory Counsel

COMMISSIONER'S ORDER NO._____