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28 TAC §§11.2402, 11.2405, 11.2406

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28 TAC §§11.2501 – 11.2503

SUBCHAPTER AA. Delegated Entities
28 TAC §§11.2601 - 11.2604, 11.2608, 11.2609

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §§11.1, 11.2, 11.203, 11.204, 11.301, 11.302, 11.501, 11.503, 11.504 - 11.506, 11.508 -11.511, 11.602 ,11.706, 11.801, 11.804, 11.810, 11.901, 11.902, 11.904, 11.1201, 11.1206, 11.1301, 11.1302, 11.1401, 11.1403, 11.1600, 11.1605, 11.1607, 11.1702, 11.1703, 11.1801, 11.1901, 11.1902, 11.2103, 11.2201, 11.2207, 11.2303, 11.2315, 11.2402, 11.2405, 11.2406, 11.2501 – 11.2503, 11.2601 - 11.2604, 11.2608, and 11.2609, concerning the regulation of health maintenance organizations (HMOs).

All of these sections are adopted without changes to the proposed text published in the August 18, 2006 issue of the *Texas Register* (31 TexReg 6465), except for §11.506, which is adopted with changes.

2. REASONED JUSTIFICATION. The adopted amendments are necessary to implement changes requested by the Commissioner of the Health and Human Services Commission, pursuant to statute, related to the waiver of access requirements for certain HMOs providing covered services to participants in the CHIP Perinatal Program; to amend the definitions of *adverse determination* and *institutional provider;* to provide for the use of *matrix filings;* to clarify fee amounts for evidence of coverage filings; to remove restrictions on variable language in evidence of coverage documentation; to delete certain minimum worth requirements; to amend certain copayment requirements; to clarify enrollee participation in quality improvement programs; to require compliance with nationally recognized standards for physician and provider credentialing; to amend *specialty care* to include specialty hospitals and single healthcare service plan physicians and providers*;* to update statutory references; to correct typographical errors and incorrect cross references within Chapter 11; and to replace references to the "Texas Health Maintenance Organization Act" with references to Insurance Code chapters and other applicable insurance laws and regulations of this state that apply to HMOs*.*

The Health and Human Services Commission recently implemented a new program, the CHIP Perinatal Program. Eligible participants in this program will receive health care from HMOs for certain covered services. Pursuant to the Health and Safety Code §62.051(c) and (d), the Commissioner of the Health and Human Services Commission requested that the access of care requirements for HMOs participating in

this program be waived. The Health and Safety Code §62.051(c) provides that the Health and Human Services Commission oversee the implementation of a child health plan program and coordinate the activities of each agency necessary to the implementation of the program, including the Texas Department of Insurance. Additionally, the Health and Safety Code §62.051(d) provides that the Health and Human Services Commission may, with the consent of the Texas Department of Insurance, delegate to the Texas Department of Insurance the authority to adopt, with the approval of the Health and Human Services Commission, any rules necessary to implement the program. The adopted new §11.1607(i), which has been approved by the Health and Human Services Commission, is necessary to allow the waiver of access of care requirements for an HMO that has a contract with the Health and Human Services Commission and provides covered services to participants in the CHIP Perinatal Program.

The Legislature amended the definition of *adverse determination* in the Insurance Code §843.002(1) by Acts 2001, 77th Legislature, Regular Session, Chapter 1419 §1, effective April 1, 2003. Accordingly, the adopted amendment to §11.2(b)(2) is necessary for consistency with the statutory definition of *adverse determination*.

The adopted amendment to §11.2(b)(23) deletes the terms *infusion services centers* and *urgent care centers* from the definition of *institutional provider*. Sections 11.1902(4) and (7) and 11.2207(d)(4) and (d)(7) as adopted require compliance with the National Committee for Quality Assurance (NCQA) credentialing standards. The NCQA

credentialing standards require providers to meet all state and federal licensing and regulatory requirements. Consequently, if a state's regulatory law does not require an entity to be licensed or authorized to provide a health care service in the state, those portions of the NCQA credentialing standards will not apply to that entity. Under the Insurance Code §843.002(24), a "provider" must be either licensed or authorized to provide a health care service in this state. Infusion services centers and urgent care centers are not licensed entities under Texas law and are not otherwise authorized under Texas law to provide a health care service in this state. Therefore, the amended definition of the term *institutional provider* is necessary for consistency with the adopted credentialing requirements and with the Insurance Code §843.002(24).

The adopted amendment to §11.2(b)(26) adds a definition for the term *matrix filing*, which is necessary for internal consistency and implementation of the adopted amendment to §11.501(a) and the adopted new subsections §11.501(b) and (c), which for the first time, provide for the use of matrix filings in conjunction with HMO evidence of coverage filings.

The adopted amendment to §11.301(4)(A) is necessary for consistency with adopted §§11.501 and 11.503 regarding the use of the term *evidence of coverage filings*.

The adopted amendment to §11.501(a) and new subsection (c) are necessary because the existing rule does not address matrix filings, and this adoption is the first formal recognition of their acceptability for HMO evidence of coverage filings. Unlike the current structure for single evidence of coverage filings that require an HMO to refile

the entire document whenever any provision within the document must be changed to accommodate new business needs, *matrix filings* will allow HMOs to file various individual provisions at one time that may be combined in a variety of ways to create new evidences of coverage. Once the various provisions are approved by the Department, an HMO has much more flexibility to create new evidences of coverage by combining the approved provisions into new documents, and this flexibility will contribute to increased speed to market for new products.

An additional benefit of the Department's authorization of matrix filings is the potential cost savings to HMOs. Currently, the Department only accepts single evidence of coverage filings and assesses a fee of $100 per filing. Therefore, an HMO filing 12 single evidence of coverage filings will be assessed filing fees totaling $1,200. However, under the matrix filing approach, if the HMO files more than 10 evidence of coverage provisions in its *matrix filing*, it will only be assessed $500, since the maximum fee allowed for a matrix filing is $500. The adopted amendment actually allows an HMO to better manage its filing costs by taking advantage of filing multiple evidence of coverage provisions in a matrix filing for a single maximum fee of $500, resulting in potential savings. In addition, the Department anticipates that the use of *matrix filings* will streamline and expedite the Department's overall review process.

Newly adopted §11.501(b) is also necessary to provide clarification, fairness, and consistency regarding the amount of the filing fees that will be charged for the filing of evidence of coverage form filings. A review of all evidence of coverage form filings received by the Department from five major HMOs during the past year reveals that all

of the evidence of coverage filings were received as individual filings, rather than as one filing containing multiple evidence of coverage form filings linked together under one form number. While some HMOs may have filed a small number of their evidence of coverage filings as one document linked together under a single form number in order to pay one fee for the entire filing, this does not appear to be the standard practice. Therefore, the adopted amendment does not substantially alter the current practice of the Department or the industry. Additionally, adopted §11.501(b) provides for a reduced filing fee of $50 per filing for HMOs that re-submit an evidence of coverage filing after withdrawal or disapproval of the filing. Initial evidence of coverage filings are subject to a $100 filing fee per filing. In situations in which an HMO has paid the initial filing fee of $100 for an evidence of coverage filing, but the filing has been disapproved by the Department or has been withdrawn by the HMO, the HMO is allowed to resubmit the filing for the reduced fee. This amendment provides a filing fee cost reduction for every resubmitted evidence of coverage filing.

The adopted amendment to §11.503 is necessary for consistency with adopted §§11.301(4)(A) and 11.501 regarding the use of the term *evidence of coverage filings.*

The adopted amendment to §11.505(f) is necessary to eliminate the restrictions on variable language in evidence of coverage filings so that an HMO may utilize the benefits of matrix filings. Because matrix filings will always include variable language, and because the adopted amendments specifically authorize the use of matrix filings, it is necessary to remove the current restrictions regarding the use of variable language in evidence of coverage filings.

The adopted new subsection (h)(1) and (2) in §11.505 is necessary to specify what items must be included in a matrix filing.

The adopted amendment to §11.801(a) is necessary to reflect the fact that Insurance Code §843.4031 is no longer law. Insurance Code §843.4031 was enacted by the 76th Texas Legislature as a temporary provision and expired on January 1, 2003. In addition, the adopted amendment to §11.810(b)(20) deletes the reference to the Insurance Code §843.4031 for the same reason.

The adopted amendments to §11.1206(b) are necessary for consistency with the Insurance Code §843.105, which provides for the use of management and exclusive agency contracts, but does not define these terms. Accordingly, the adopted amendment to §11.1206(b) replaces the phrase *defined* with the phrase *provided for* and replaces a general statutory reference with a more specific statutory reference to the Insurance Code §843.105.

The adopted amendment to §11.1605(c) is necessary to clarify that small employer plans, as defined by the Insurance Code §1501.002, are exempt from the requirement that HMOs that provide coverage for prescription drugs under an individual or group health benefit plan must comply with the Insurance Code Chapter 1369 Subchapter A and Department rules.

The adopted amendment to §11.1607(h)(2) is necessary to clarify that the term *specialty care* includes specialty hospitals and single healthcare service plan physicians and providers, such as vision and dental care. In the past, there has been some industry confusion and Department inconsistency in the treatment of vision and dental

care providers regarding access of care requirements. The adopted amendment is necessary to make clear that vision and dental care providers are subject to the access of care requirements prescribed in §11.1607(h)(2), and not those access of care requirements prescribed in (h)(1).

The adopted amendments to §11.1901(a) and (b)(1) are necessary to allow for flexibility in enrollee participation in an HMO's quality improvement program. Because the amendments allow an enrollee to participate in the HMO's program in other ways besides being included in the quality improvement committee, there is better flexibility for both the enrollee and the HMO. Additionally, the amendments still require an enrollee's active participation in the HMO's quality improvement program to ensure better service for all enrollees in the plan.

The adopted amendments to §11.1902(4) and (7) are necessary to eliminate the current requirements relating to the credentialing process for contracted physicians and providers. In lieu of these requirements, the Department is requiring that the credentialing process required by §11.1902 comply with the standards promulgated by the NCQA to the extent that those standards do not conflict with other laws of this state. Section 1452.006 of the Insurance Code requires rules adopted by the Commissioner under the Insurance Code §843.102 and related to the implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians and providers to comply with the Insurance Code Chapter 1452 Subchapter A and standards adopted by the NCQA, to the extent those standards do not conflict with other laws of this state. The Department has determined that at this time the NCQA

standards do not conflict with the laws of this state. Additionally, as a result of the Department requiring compliance with the NCQA credentialing standards, the Department will not need to update its regulations each time the NCQA amends its standards, which is approximately once a year. This will ensure that the Department's credentialing regulations for contracted physicians and providers are current and accurate, resulting in more efficient industry regulation and better service to plan enrollees. In addition, the adopted amendments will ensure continued plan accountability.

The adopted amendments to §11.2207(a) and (b)(1) are necessary for consistency with the adopted amendments to §11.1901(a) and (b)(1) and to provide flexibility in enrollee participation in an HMO's quality improvement program.

The adopted amendments to §11.2207(d)(4) and (d)(7) are necessary for consistency with the adopted amendment to §11.1902(4) and (7) and to eliminate the current credentialing requirements relating to contracted physicians and providers, and in lieu of those requirements, to require that the credentialing process required by §11.1902 comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of this state.

The adopted amendments also delete references to the terms "Texas Health Maintenance Organization Act" and "Act" as a result of the enactment of the non-substantive Insurance Code revisions, Acts 2001, 77th Legislature, Regular Session, Chapter 1419 §1, effective April 1, 2003, and Acts 2003, 78th Legislature, Regular Session, Chapter 1274 §3, effective April 1, 2005, which reorganized the regulatory

statutes that apply to HMOs into multiple statutes that are no longer organized as a single "Act." In order to address this issue, the adopted amendments replace the terms "Texas Health Maintenance Organization Act" and "Act" with references to the applicable chapters of the Insurance Code, including Chapters 843 (Health Maintenance Organizations), 1271 (Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), 1272 (Delegation of Certain Functions by Health Maintenance Organizations), 1367 (Coverage of Children), 1452 (Physician and Provider Credentials), and other applicable insurance laws and regulations of this state that apply to HMOs. Since all statutory references to the "Act" no longer accurately identify all of the statutory regulations that apply to HMOs, this deletion and replacement is being made throughout Chapter 11, including those references in §§11.1, 11.2(a) and (b)(1), 11.203(d), 11.204, 11.301, 11.302, 11.504, 11.506, 11.508 - 11.511, 11.602, 11.706, 11.804, 11.810(b)(5), 11.901, 11.902, 11.904, 11.1201, 11.1301, 1302(a)(3) and (d)(4), 11.1401, 11.1600, 11.1605(c), (d), and (e), 11.1607, 11.1702, 11.1703, 11.1801, 11.2103, 11.2303, 11.2315, 11.2405, 11.2406, 11.2501 – 11.2503, 11.2601(a) and (b), 11.2602(1) and (2), (4)(A), and (B), 11.2603(a), (e), and (g), 11.2604, 11.2608(b), and 11.2609.

The Department is making two separate changes to the proposed language in §11.506(2)(A) of the rule as adopted. Neither change, however, introduces new subject matter or affects persons in addition to those subject to the proposal as published. The first change to the proposed language in §11.506(2)(A) of the rule as adopted is made in response to a written comment received from an interested party. The Department

proposed to amend §11.506(2)(A) to remove the prohibition that a basic service HMO may not impose copayment charges that exceed 50 percent of the total cost of providing any single service to its enrollees, nor in the aggregate more than 20 percent of the total cost to the HMO of providing all basic health care services. The proposed amendment to §11.506(2)(A) also removed the prohibition that 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 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. The proposed amendment to §11.506(2)(A) also removed the provision that this limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year. In lieu of these prohibitions, the Department proposed that an HMO could continue to establish one or more copayment options but that the option had to be "reasonable" and specified that a reasonable copayment option may not exceed 50 percent of the total covered amount applicable to the medical or health care services.

The commenter objected to the deletion of the limitation on an enrollee's yearly out-of-pocket copayment expenditures. Additionally, the commenter suggested setting the maximum copayment for HMO enrollees at 20 percent and setting a reasonable maximum out-of-pocket amount for HMO enrollees, such as $500 to $1,000 for an individual and $1,500 to $2,500 for a family. The Department does not agree with the commenter's proposed specific dollar limits for an individual and a family but does agree that it is necessary to have a limitation on an enrollee's yearly out-of-pocket copayment expenditures. However, the Department has determined that any new maximum out-of-

pocket copayment expenditure limit for HMO enrollees must be addressed through a separate rulemaking process. The Department will publish a notice of proposal with a 30-day comment period before proceeding further on this matter. Therefore, §11.506(2)(A) as adopted restores the provision, which was proposed for deletion, relating to a basic service HMO not being allowed to impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. The adoption also restores the provision that was proposed for deletion that specifies that this limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

Additionally, because the proposal removed the prohibitions in §11.506(2)(A) relating to a basic service HMO not imposing copayment charges under the specified circumstances and not imposing copayment charges on any enrollee in any calendar year under the specified circumstances, the Department's proposal did not include the term *basic service HMO* in the second sentence of .§11.506(2)(A). As proposed, this second sentence provided that *each HMO* may establish one or more reasonable copayment options. However, because the adoption restores the prohibition in §11.506(2)(A) relating to a *basic service HMO* not imposing copayment charges on any enrollee in any calendar year under the specified circumstances, it is necessary for purposes of clarification and consistency to change the second sentence of §11.506(2)(A) as proposed to provide in the adoption that each *basic service HMO* may establish one or more reasonable copayment options. This change does not alter the

meaning or the intent of the proposed language in the second sentence of §11.506(2)(A).

The second change to the proposed language in §11.506(2)(A) results from the Department's determination that the proposed language in the third sentence of §11.506(2)(A), which provides that a reasonable copayment option may not exceed 50 percent of the *total covered amount applicable to the medical or health care services*, could cause confusion. For consistency with the fact that an HMO provides enrollees with access to covered services on a prepaid basis, as distinguished from a preferred provider benefit plan which provides access for insureds to contracted physicians and health care providers and reimburses the insured a particular amount of a particular billed charge, the proposed language is changed in the adoption to provide that a reasonable copayment option may not exceed 50 percent of the *total cost of services provided.* This change is for purposes of clarification only and does not alter the meaning or intent of the proposed language.

In its entirety, as adopted, §11.506(2)(A) provides that an HMO may require copayments to supplement payment for health care services; that each basic service HMO may establish one or more reasonable copayment options; that a reasonable copayment option may not exceed 50 percent of the total cost of services provided; that 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 200 percent of the total annual premium cost which is required to be paid by or on

behalf of that enrollee, and that this limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

3. HOW THE SECTIONS WILL FUNCTION. The adopted amendment to §11.2(b)(2) modifies the definition of *adverse determination* by replacing the term *furnished* with the term *provided*, by replacing the term *adopted* with the term *proposed*, by substituting the term *enrollee* for the term *patient*, and by adding the phrase *by a health maintenance organization*. The adopted amendment to §11.2(b)(23) deletes the terms *infusion services centers* and *urgent care centers* from the definition of *institutional providers*. Adopted §11.2(b)(26) adds a definition for the term *matrix filing*. The adopted amendment also re-numbers the remaining definitions accordingly.

The adopted amendments to §§11.301(4)(A) and 11.503 revise the term *evidence of coverage* to *evidence of coverage filings*.

The adopted amendment to §11.501 designates the current text as subsection (a) and adds new subsections (b) and (c). Additionally, the adopted amendment to newly designated §11.501(a) adds *matrix filings* to the list of forms that are considered part of an evidence of coverage. New §11.501(b) requires that each of the listed forms in subsection (a) of the section be identified with a unique form number and be individually approved by the Commissioner before being issued, delivered, or used in Texas. Additionally, new §11.501(b) provides that each of the forms listed in subsection (a) of the section, except for *matrix filings*, are considered individual evidence of coverage filings and are subject to the filing fees prescribed in 28 Texas Administrative

Code §7.1301(g)(4) (relating to Regulatory fees). New §11.501(b) also makes clear that a fee of $100, as prescribed in §7.1301(g)(4), will be assessed for each form listed in subsection (a) of the section, except for a *matrix filing*, that is filed with the Department, and that a fee of $50 will be assessed for each form that is resubmitted to the Department after withdrawal or disapproval. New §11.501(c) prescribes the fees for *matrix filings* as $50 per individual evidence of coverage provision, with a maximum fee of $500, whether the filing be an initial filing or a resubmission.

While variable language must still be enclosed in brackets and must include the range of variable information or amounts, the adopted amendment to §11.505(f) eliminates the remaining restrictions on variable language allowed in evidence of coverage filings. Adopted new §11.505(h)(1) and (2) specify what items must be included in a *matrix filing*.

The adopted amendment to §11.506(2)(A) removes the prohibition that a basic service HMO may not impose copayment charges that exceed 50 percent of the total cost of providing any single service to its enrollees, nor in the aggregate more than 20 percent of the total cost to the HMO of providing all basic health care services. Instead, the amendment to §11.506(2)(A) provides that each basic service HMO may establish one or more reasonable copayment options and specifies that a reasonable copayment option may not exceed 50 percent of the total cost of services provided. Section 11.506(2)(A) as adopted also provides that 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. Lastly, §11.506(2)(A) as adopted provides that this limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

The adopted amendment to §11.801(a) eliminates the requirement that an HMO licensed before September 1, 1999, must comply with the minimum net worth requirements specified in the Insurance Code §843.4031.

The adopted amendment to §11.810(b)(20) deletes the reference to the Insurance Code §843.4031.

The adopted amendment to §11.1206(b) replaces a reference to the term "Act" with a more specific reference to the Insurance Code §843.105 and replaces the phrase *defined* with the phrase *provided for*.

The adopted amendment to §11.1403 corrects a typographical error in the toll-free complaint number in the Spanish language notice and corrects the misspelling of the term *complaint*.

The adopted amendment to §11.1605(c) clarifies that small employer plans, as defined by the Insurance Code §1501.002, are exempt from the requirement that HMOs that provide coverage for prescription drugs under an individual or group health benefit plan must comply with the Insurance Code Chapter 1369 Subchapter A and Department rules.

The adopted amendment to §11.1607(h)(2) clarifies that the term *specialty care* includes specialty hospitals and single healthcare service plan physicians and providers, such as vision and dental care. Adopted new §11.1607(i) waives the access

of care requirements for an HMO that has a contract with the Health and Human Services Commission and provides covered services to participants in the CHIP Perinatal Program. The adopted amendment to §11.1607 also re-designates remaining subsections.

The adopted amendments to §11.1901(a) and (b)(1) specify that an enrollee, unless the HMO has no enrollees, must be actively involved in an HMO's quality improvement program, but eliminate the requirement that an enrollee must be appointed to the HMO's quality improvement committee.

The adopted amendments to §11.1902(4) and (7) eliminate the current credentialing requirements for contracted physicians and providers, and in lieu of those requirements, require that the credentialing process comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of this state.

The adopted amendments to §§11.2201(b) and 11.2402(b) correct cross references to other rule provisions within Chapter 11.

The adopted amendments to §11.2207(a) and (b)(1) mirror the adopted amendments to §11.1901(a) and (b)(1) specifying that an enrollee, unless the HMO has no enrollees, must be actively involved in an HMO's quality improvement program but does not have to be appointed to the HMO's quality improvement committee.

The adopted amendments to §11.2207(d)(4) and (d)(7) mirror the adopted amendments to §11.1902(4) and (7) and eliminate the current credentialing requirements relating to contracted physicians and providers, and in lieu of those

requirements, require that the credentialing process comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of this state

The definitions in §11.2602 as adopted are renumbered as necessary in accordance with the adopted amendments that delete and add terms to the definitions.

The adopted amendments to §§11.1, 11.2(a) and (b)(1), 11.203(d), 11.204, 11.301, 11.302, 11.504, 11.506, 11.508 - 11.511, 11.602, 11.706, 11.804, 11.810(b)(5), 11.901, 11.902, 11.904, 11.1201, 11.1301, 1302(a)(3) and (d)(4), 11.1401, 11.1600, 11.1605(c), (d), and (e), 11.1607, 11.1702, 11.1703, 11.1801, 11.2103, 11.2303, 11.2315, 11.2405, 11.2406, 11.2501 – 11.2503, 11.2601(a) and (b), 11.2602(1) and (2), (4)(A), and (B), 11.2603(a), (e), and (g), 11.2604, 11.2608(b), and 11.2609 replace the terms "Texas Health Maintenance Organization Act" and “Act” with references to applicable chapters of the Insurance Code and other applicable insurance laws and regulations of this state that apply to HMOs.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

§11.506(2)(A)

Comment: A commenter expressed concern that, while the current regulations limit an enrollee’s copayments to 200 percent of the enrollee’s annual premium, the proposed amendment would allow for copayments up to 50 percent of the cost of the health care provided with no maximum limit on out-of-pocket costs for the enrollee. Additionally, the commenter states that staff’s explanation for the proposed amendment indicates that

the proposed language is modeled after Preferred Provider Organization (PPO) legislation contained in HB 1030 passed by the 79th Texas Legislature. The commenter suggests that, while an argument can be made that HMOs should be allowed to compete on a level playing field with PPOs, it would be more equitable to require HMOs to pay benefits at a rate that is comparable to PPO in-network rates. The commenter suggests setting an HMO enrollee's maximum copayment amount at 20 percent and establishing a reasonable maximum out-of-pocket limit, such as $500 to $1,000 for an individual and $1,500 to $2,500 for a family.

Agency Response: The Department agrees in part and disagrees in part. The Department has retained the limitation of 50 percent copayment charges as it has been determined to be a reasonable limitation. The Department does not agree with the commenter's proposed specific dollar limits for an individual and a family but does agree that it is necessary to have a limitation on an enrollee's yearly out-of-pocket copayment expenditures. However, the Department has determined that any new maximum out-of-pocket copayment expenditure limit for HMO enrollees must be addressed through a separate rulemaking process. The Department will publish a notice of proposal with a 30-day comment period before proceeding further on setting any new maximum out-of-pocket copayment expenditure limit for HMO enrollees. Therefore, the adoption restores the provision, which was proposed for deletion, relating to a basic service HMO not being allowed to impose copayment charges on any enrollee in any calendar year, when the copayment made by the enrollee in that calendar year totals 200 percent of the total annual premium cost which is required to be paid by or on behalf of that

enrollee. The adoption also restores the provision that was proposed for deletion that specifies that this limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year. As a result of the restoration of this prohibition, which has been made to the proposal in response to the commenter, the Department has determined that it is necessary to make another change to §11.506(2)(A) as proposed for purposes of clarification and consistency. In the second sentence of §11.506(2)(A) as adopted, the terminology "Each HMO" has been changed to "Each *basic service HMO".* Therefore, as a result of these changes, as well as a minor editorial change identified by the Department, §11.506(2)(A) as adopted provides that an HMO may require copayments to supplement payment for health care services; that each basic service HMO may establish one or more reasonable copayment options; that a reasonable copayment option may not exceed 50 percent of the total cost of services provided; that 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 totals 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee, and that this limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

Lastly, it is the Department's understanding that the commenter interpreted the term *modeled*, as used in the notice of the proposed rule, to indicate that the Department intended to base its amendments to this section on the intent and applicability of certain preferred provider organization legislation. This was not the

Department's intent. Rather, the Department's intent was more narrow, i.e., consistency in the wording of the amendment to §11.506(2)(A) with the wording in the Insurance Code §1301.0046, to the extent possible. The Department considered this consistency desirable because the wording in §1301.0046 accurately reflects the proposed amendment. The Department regrets any confusion resulting from the use of the term *modeled* in the notice of the proposed rule.

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

For with changes: Office of Public Insurance Counsel**.**

Against: None.

6. STATUTORY AUTHORITY. The amendments are adopted pursuant to the Insurance Code §§843.002(1), 843.002(24), 843.008, 843.102, 843.151, 843.154, 1271.101, 1271.104, 1369.003, 1452.006, 36.001, and the Health and Safety Code §62.051(c) and (d). The Insurance Code §843.002(1) defines the term *adverse determination*. The Insurance Code §843.002(24) defines the term *provider.* The Insurance Code §843.008 provides that the money collected under the Insurance Code Chapter 843 must be sufficient to administer the Insurance Code Chapters 843 and Chapter 20A, re-adopted as a result of the enactment of the non-substantive Insurance Code revisions, Acts 2001, 77th Legislature, Regular Session, Chapter 1419 §1, effective April 1, 2003, and Acts 2003, 78th Legislature, Regular Session, Chapter 1274 §3, effective April 1, 2005, as Insurance Code Chapters 1271 (Benefits Provided by

Health Maintenance Organizations; Evidence of Coverage; Charges), 1272 (Delegation of Certain Functions by Health Maintenance Organizations), 1367 (Coverage of Children), and 1452 (Physician and Provider Credentials) and other applicable insurance laws of this state that apply to HMO regulation. The Insurance Code §843.102 authorizes the Commissioner to establish by rule minimum standards and requirements for the quality assurance programs of health maintenance organizations, including standards for ensuring availability, accessibility, quality, and continuity of care. The Insurance Code §843.154 requires the Commissioner to prescribe a filing fee for an evidence of coverage that requires approval in an amount not to exceed $200. The Insurance Code §1271.101 provides that an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the Commissioner. The Insurance Code §1271.104 provides that the Commissioner may require the submission of any relevant information the Commissioner considers necessary in determining whether to approve or disapprove the form of the evidence of coverage. The Insurance Code §1369.003 excepts small employer health benefit plans from providing coverage of prescription drugs pursuant to the provisions of the Insurance Code Chapter 1369 Subchapter A. The Insurance Code §1452.006 provides that a rule adopted by the Commissioner under the Insurance Code §843.102, which regulates HMO quality assurance, relating to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with standards adopted by the National

Committee for Quality Assurance (NCQA), to the extent those standards do not conflict with other laws of this state. The Insurance Code §843.151 provides that the Commissioner may adopt rules necessary to implement the Insurance Code Chapter 843 and Chapter 20A, including rules to ensure that enrollees have adequate access to health care services and rules to establish minimum physician-to-patient rations, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment. As stated previously, Insurance Code Chapter 20A was re-adopted as part of the enactment of the non-substantive Insurance Code revisions by the 77th Legislature, Regular Session, effective April 1, 2003, and by the 78th Legislature, Regular Session, effective April 1, 2005, as Insurance Code Chapters 1271, 1272, 1367, 1452, and other applicable insurance laws of this state that apply to HMO regulation. The Health and Safety Code §62.051(c) provides that the Health and Human Services Commission shall oversee the implementation of the child health plan program and coordinate the activities of each agency necessary to the implementation of the program, including the Texas Department of Health, Texas Department of Human Services, and Texas Department of Insurance. The Health and Safety Code §62.051(d) provides that the Health and Human Services Commission may, with the consent of another agency, including the Texas Department of Insurance, delegate to that agency the authority to adopt, with the approval of the commission, any rules that may be necessary to implement the child health plan program. The Insurance Code §36.001 authorizes the Commissioner of

Insurance to adopt rules to implement the powers and duties of the Department under the Insurance Code and other laws of this state.

7. TEXT.

SUBCHAPTER A. General Provisions

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

(1) Severability. Where any terms or sections of this chapter are determined by a court of competent jurisdiction to be inconsistent with the Insurance Code Chapters 843, 1271, 1272, 1367, or 1452, or other applicable insurance laws of this state that apply to HMOs, the applicable chapters of the Insurance Code 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 Insurance Code Chapters 843, 1271, 1272, 1367, and 1452 and other applicable insurance laws of this state that apply to HMOs.

§11.2. Definitions.

(a) The definitions found in the 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) 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).

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

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

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

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

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

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

(8) 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).

(9) 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.

(10) Code--The Texas Insurance Code.

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

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

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

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

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

(16) 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.

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

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

(19) 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.

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

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

(A) health status;

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

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

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

(H) disability.

(22) 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.

(23) 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) Residential treatment centers,

(N) Community mental health centers, and

(O) Pharmacies.

(24) 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.

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

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

(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 Texas Pharmacy Act, Occupations Code, Subtitle J, as amended, that are ordinarily and customarily rendered by a pharmacy or pharmacist.

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

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

(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 the Insurance Code §823.007, including any security convertible into or evidencing a right to acquire such security.

SUBCHAPTER C. Application for Certificate of Authority

§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 Insurance Code Chapter

843, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs. 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 the Insurance Code Chapter 1272, delegated network, as described in the Insurance Code Chapter 1272, 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.

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 the Insurance Code §843.080 and Chapter 1271 Subchapter C 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 filings, 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 the Insurance Code §843.251, et seq. and related regulations, will be made reasonably available in the new service area or division, including a toll free call, and the information and complaint telephone number required by the Insurance Code §521.102, where applicable. For HMOs subject to the Insurance Code §521.102, the toll free call required by this rule and the toll free information and complaint number required by the Insurance Code §521.102 may be the same number.

(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 the Insurance Code §843.080 and Chapter 1271 Subchapter C 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.

SUBCHAPTER F. Evidence of Coverage

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

(a) No evidence of coverage or amendment thereto may be issued, delivered, or used in Texas unless it has been filed for review and has received the approval of the commissioner. The following forms are always considered to be part of the evidence of coverage:

(1) group agreement;

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

(3) conversion and individual agreements;

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

(5) group subscriber enrollment form;

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

(7) matrix filings; and

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

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

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

§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 filing may be amended or altered in any manner, and no new evidence of coverage filing may be used, unless the proposed new or revised evidence

of coverage filing has been filed for review and has received the approval of the commissioner. Filing requirements for the evidence of coverage filing when filed subsequent to receipt of a certificate of authority are as follows:

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

(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 filing 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 filing 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 Insurance Code Chapter 1271, these sections, or other applicable statutes and regulations;

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

(3) it contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate the Insurance Code Chapters 541, 542, 543, 544, and 547, in accordance with the Insurance Code §1271.005 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 and Matrix Filings.

(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.

(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).

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

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

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

§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 the Insurance Code §521.102 , 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 the Insurance Code Chapter 521 Subchapter C, 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 basic service HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50 percent of the total cost of services provided. 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 the Insurance Code Chapter 1367 Subchapter B for a child from birth through the date the child is six years of age, except that a small employer health benefit plan, as defined by the Insurance Code §1501.002, 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 the Insurance Code Chapter 542 Subchapter B and §1271.005 and the applicable rules.

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

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

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

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

(C) If an HMO offers conversion coverage, it must be offered to the enrollee not less than 30 days prior to the expiration of the COBRA or the Insurance Code Chapter 1251 Subchapter G continuation coverage period.

(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 the Insurance Code Chapter 1271 Subchapter G was elected that the enrollee may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under the Insurance Code Chapter 1506, and shall provide the address and toll-free number of the pool.

(7) 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 the Insurance Code §§1201.062 and 1271.006.

(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 the Insurance Code Chapter 1254.

(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 the Insurance Code Chapter 1503.

(20) Conformity with state law--A provision that if the agreement or certificate contains any provision not in conformity with the Insurance Code Chapter

1271 or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws.

(21) Conformity with Medicare supplement minimum standards and long-term care minimum 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 the Insurance Code §1271.201.

(23) Selected obstetrician or gynecologist--Individual, conversion and group agreements and certificates, except small employer plans as defined by the Insurance Code §1501.002, must contain a provision that permits an enrollee to select,

in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of the Insurance Code Chapter 1451 Subchapter F. 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 the Insurance Code Chapter 1451 Subchapter F. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from her 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 Chapter 1354 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 the Insurance Code §1501.002, that covers prescription drugs and uses one or more formularies must comply with the Insurance Code Chapter 1369 Subchapter B 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 the Insurance Code §1271.153;

(ii) immunizations for children as required in the Insurance Code §1367.053;

(iii) well-child care from birth as required in the Insurance Code §1271.154;

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

(v) cancer screenings as required in the Insurance Code Chapter 1362 relating to screening for prostate cancer;

(vi) cancer screenings as required in the Insurance Code Chapter 1363 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 the Insurance Code §1271.155.

(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 the Insurance Code Chapter 1358 Subchapter B.

(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 Chapter 1368, including §§3.8001 - 3.8022 of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

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

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

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

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

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

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

require an HMO to provide dental services if dental services are not otherwise scheduled or provided as part of the benefits covered by the agreement.

§11.510. Mandatory Offers. Group agreements must offer the following provisions:

(1) Coverage for services and benefits on an expense incurred, service, or prepaid basis for out-patient expenses that may arise from in-vitro fertilization procedures. Benefits for in-vitro fertilization procedures must be provided to the same extent as the benefits provided for other pregnancy-related procedures under the plan. The offer to make such coverage available is required only under the conditions set out in the Insurance Code §1366.005.

(2) Hospital and medical coverage benefits for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and copayment factors, pursuant to the Insurance Code Chapter 1365.

(3) Benefits for mental and emotional illness and disorders when confined in a hospital, with corresponding alternative treatment facility benefits pursuant to the Insurance Code Chapter 1355 Subchapter C, to the extent that such benefits are not mandated as serious mental illness under §11.509(5) of this title (relating to Additional Mandatory Benefit Standards: Group Agreement Only).

(4) For small employer groups, serious mental health benefits pursuant to the Insurance Code Chapter 1355 Subchapter C.

§11.511. Optional Provisions. Group, individual and conversion certificates may contain optional provisions, including, but not limited to, the following:

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

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

(B) Group plans may not coordinate benefits with any type of individual or conversion plan.

(C) Requirements of the Insurance Code Chapter 1203 and §§3.3501 - 3.3511 of this title (relating to Group Coordination of Benefits) relating to coordination of benefits by insurers should be followed by HMOs that include a coordination of benefits provision in their plan.

(2) Subrogation. A provision that the HMO receives any rights of recovery allowed by Texas law acquired by an enrollee against any person or organization for negligence or any willful act resulting in illness or injury covered by HMO benefits, but only to the extent of the cost to the HMO of providing such covered services. Upon receiving such services from the HMO, the enrollee is considered to

have assigned such rights of recovery to the HMO and to have agreed to give the HMO any reasonable help required to secure the recovery. The provision may include a statement that the HMO may recover its share of attorney's fees and court costs only if the HMO aids in the collection of damages from a third party.

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

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

(5) Arbitration. A statement of any required arbitration procedure. If enrollee complaints and grievances are resolved through a specified arbitration

agreement, the arbitration must be conducted pursuant to the Texas Arbitration Act, Texas Civil Practice and Remedies Code §171.001 et seq.

SUBCHAPTER G. Advertising and Sales Material

§11.602. Health Maintenance Organizations Subject to the Insurance Code Chapters 541, 542, and 547 and Related Rules. Health maintenance organizations must comply with the Insurance Code Chapters 541, 542, and 547 and rules promulgated by the Texas Department of Insurance, pursuant to the Insurance Code Chapters 541, 542, and 547, to the extent these rules may be applied in the same manner as insurance companies.

SUBCHAPTER H. Schedule of Charges

§11.706. Determination of Reasonability of Rates.

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

for enrollment and expenses shall be based upon the current experience of the HMO. A deficiency reserve liability must be funded with cash or other admitted assets in an amount equal to or greater than the deficiency reserve liability. Such funding must take place prior to implementation of the proposed rates. Any HMO required to establish a deficiency reserve liability under this subsection shall provide a plan whereby the rates actually charged by the HMO would be increased over a 24-month period to a level adequate to support benefits and the expenses of the HMO. Such a plan and any deficiency reserve liability must be developed and certified annually as actuarially sound by a qualified actuary in conjunction with the actuarial certification regulation under §11.702 of this title (relating to Actuarial Certification). An HMO may apply to the commissioner for relief from the requirement to establish and fund a deficiency reserve by specifying unusual or extraordinary circumstances by which the above provisions are not appropriate. In no circumstances shall such relief result in the lowering of existing rates.

(b) The following factors shall be considered in any review of rates under the Insurance Code Chapter 1271 Subchapter F:

(1) the cost of the health care services and benefits provided by the coverage if the same coverage were provided on a private pay basis, considering community average rates for such services and benefits within the service area of the plan;

(2) the expenses of initial enrollment. This can be expressed as the one-time enrollment fee under §11.705 of this title (relating to Enrollment Fees);

(3) administrative expenses;

(4) assumed or actual utilization levels;

(5) group demographics;

(6) other factors as appropriate.

(c) In the event the commissioner considers an HMO's rates to be in potential violation of the standards set out by this section, the commissioner shall notify the HMO of the potential violation. It will be the responsibility of the HMO to demonstrate that the rates in question are not excessive, inadequate, or unfairly discriminatory using the factors reflected in subsection (b) of this section and other factors which the HMO deems pertinent.

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.

(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.

§11.804. Investment Management by Affiliate Companies. Subject to compliance with the provisions of the Insurance Code Chapter 843, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs, nothing in this section shall prevent a domestic HMO, which is a member of an HMO holding company system with assets in an aggregate amount in excess of $1 billion and a tangible net worth of at least $100 million and having affiliates licensed in this state, from authorizing an affiliated corporation which, if other than the ultimate parent holding company, is solvent with at least $10 million tangible net worth and its performance and obligations under a written agreement with the HMO are guaranteed by the ultimate holding company, to invest, hold and administer as agent or nominee on behalf of such domestic HMO those bonds, notes, or other evidences of indebtedness and repurchase agreements that are authorized and permissible investments under the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, and which mature within one year of the date of acquisition thereof; provided that such securities are invested, held, and administered pursuant to a written agreement authorized by the board of directors of the HMO or an authorized committee thereof, and which is submitted to the commissioner for prior approval, such approval to be based upon satisfactory evidence that such agreement will facilitate the operations of the domestic HMO and will not unreasonably diminish the service to or protection of the domestic

HMO's enrollees within this state. The agreement must comply with the provisions of paragraphs (1) - (8) of this section.

(1) The affiliate shall specify in which office location it shall maintain records adequate to identify and verify the securities (or proportionate interest therein) belonging to the HMO organization.

(2) The affiliate shall allow the commissioner or the commissioner's designee to examine all records relating to those securities held subject to the agreement and shall agree to furnish these records at the principal office of the HMO within 10 business days of a request by the commissioner or any one of his or her commissioned examiners.

(3) The HMO may authorize the affiliate to:

(A) hold the securities of the HMO in bulk, in certificates issued in the name of the affiliate or its nominee, and to commingle them with securities owned by other affiliates of the affiliate;

(B) provide for such securities to be held by a custodian, including the custodian of securities of the affiliate, or in a clearing corporation or the Federal Reserve Book Entry System as provided in this subchapter; and

(C) purchase, sell, or otherwise dispose of the securities in accordance with instructions received from the HMO.

(4) The HMO shall report annually, if required by the commissioner, to the department:

(A) all investments with the affiliate pursuant to this section;

(B) the market value of all securities held by the affiliate on behalf of the HMO as of December 31 of the year next preceding (or other date as the commissioner may require); and

(C) the financial condition of the affiliate which may include, at the commissioner's discretion, balance sheets, income statements, and supporting schedules with an opinion as to those financial statements by an independent certified public accountant for the most recent fiscal year.

(5) All of such investments and transactions between or among affiliates and the HMO must otherwise comply with all other applicable provisions of the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs.

(6) If the HMO or the affiliate does not comply with the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs or does not comply with the written agreement governing such investing, holding, and administering of securities, then the commissioner's approval will be withdrawn after reasonable notice and ample opportunity to cure the noncompliance, and any further desire to continue such arrangement must be submitted for approval.

(7) At the instance of withdrawal of approval of the agreement, the HMO shall undertake to obtain, and the affiliated corporation shall undertake to return, those investments or funds resulting from the sale or maturity of those investments which the affiliated corporation invested, held, and administered on behalf of the HMO and which return shall be accomplished within 90 days unless:

(A) the commissioner determines that such period of time creates a hazard to the public, in which case the commissioner may designate that the period may not exceed 30 days from the date of determination; or

(B) the commissioner extends the period of time with regard to specific investments upon request by the HMO and affiliated corporation, but in no event to exceed one year from the date of the withdrawal of approval.

(8) The affiliate or affiliated corporation must be organized under the laws of one of the states of the United States of America or of the District of Columbia.

§11.810. 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 Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs 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 the Insurance Code §843.403;

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

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

SUBCHAPTER 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 the Insurance Code Chapter 542 Subchapter B and §1271.005 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 the Insurance Code Chapter 843, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs.

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

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

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

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

(II) billing activities,

(III) other business operations, or

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

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to an enrollee or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(H) A physician or provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the physician or provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider shall provide for reasonable advance notice to enrollees being treated by the physician or provider prior to the termination consistent with Insurance Code §843.309.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract;

(12) 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.

(c) Upon request by a participating physician or provider, an HMO shall include a provision in the physician's or provider's contract providing that the HMO and the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term batch submission is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This subsection applies to a contract entered into or renewed on or after January 1, 2006.

§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 the Insurance Code §843.3045, an HMO may not refuse to contract with a nurse first assistant as defined by the Occupations Code §301.353, as added by Acts 2005, 79th Leg. R.S., ch. 966, sec. 1, as amended, to be included in the HMO's 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 the Occupations Code §301.353, as added by Acts 2005, 79th Leg. R.S., ch. 966, sec. 1, as amended.

(d) Pursuant to Insurance Code §843.319 (Certain Required Contracts), an HMO may not deny a contract to 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 the Insurance Code Chapter 1353, 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 M. Acquisition of, Control of, or Merger of, A Domestic HMO

§11.1201. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Control (including the terms "controlling," "controlled by," and "under common control with")--The possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporation office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds irrevocable proxies representing, 10% or more of the voting securities or authority of any other person. This presumption may be rebutted by a showing made in the manner provided by the Insurance Code §823.010 that control does not exist in fact.

The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect, where a person exercises directly or indirectly, either alone or pursuant to an agreement with one or more other persons, such a controlling influence over the management or policies of an authorized health maintenance organization as to make it necessary or appropriate in the public interest or for the protection of the enrollees or shareholders of the health maintenance organization that the person be deemed to control the health maintenance organization.

(2) Controlled health maintenance organization--A health maintenance organization controlled directly or indirectly by a health maintenance organization holding company.

(3) Controlled person--Any person, other than a controlled health maintenance organization, who is controlled directly or indirectly by a health maintenance organization holding company.

(4) Health maintenance organization holding company--Any person who directly or indirectly controls any health maintenance organization, except that it shall not be deemed to include: the United States, a state or any political subdivision, agency, or instrumentality thereof, or any corporation which is wholly owned directly or indirectly by one or more of the foregoing.

(5) Person--Any natural or artificial person, including, but not limited to, individuals, partnerships, associations, organizations, trusts, or corporations, but shall

not include any securities broker performing no more than the usual and customary broker's function.

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

(7) Voting security--Includes any security convertible into or evidencing a right to a acquire a voting security.

§11.1206. Exemptions.

(a) The commissioner by order may exempt from the provisions of this subchapter any offer, request, invitation, agreement, or acquisition which is found either:

(1) not to have been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic health maintenance organization; or

(2) otherwise not comprehended within the purposes of this subchapter.

(b) A change consisting only of the substitution of management contractors under a contract with the health maintenance organization as provided for in the Insurance Code §843.105 shall be subject to the approval of the commissioner according to the provisions of the Insurance Code §843.105 and shall be exempt from the provisions of this subchapter. No order of exemption is necessary for this purpose.

SUBCHAPTER N. HMO Solvency Surveillance Committee Plan of Operation

§11.1301. Plan of Operation. This plan of operation, hereinafter referred to as the plan, shall become effective upon written approval of the Texas Department of Insurance, hereinafter referred to as the department, as provided by the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs. As used in this subchapter, the committee shall be the solvency surveillance committee as provided for and defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, and the members shall be the members of the committee as provided for and defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs.

§11.1302. Solvency Survey Committee.

(a) Members. The composition of the committee shall be in accordance with the Insurance Code §843.436.

(1) The HMO members' terms shall last for three years unless otherwise appointed by the commissioner and shall be staggered with three appointments expiring each year. A member's term shall terminate if the member leaves the HMO whose characteristics were the basis for appointment. The HMO shall not automatically continue as a member.

(2) Members may serve multiple terms.

(3) A member shall serve until a successor is appointed unless such member's term is in conflict with the Insurance Chapter 843 and applicable insurance

laws and regulations of this state that apply to HMOs, or unless a member misses two or more consecutive meetings or engages in willful misconduct, in which case the commissioner may remove the member. The committee shall make recommendations to the commissioner and the department to fill vacancies. Members shall not receive any remuneration or emolument of office.

(4) The members shall elect a chairman, a vice chairman, a secretary-treasurer, and such other officers as they deem necessary. The term of office shall be one year or until a successor is elected and qualified. Vacancies occurring in elective office shall be filled by vote of the members.

(b) Voting. A majority of the members shall constitute a quorum for the transaction of business, and the acts of a majority of the members at a meeting at which a quorum is present shall be the acts of the committee. An affirmative vote of a majority of the total membership of the committee shall be required:

(1) to propose amendments to the plan;

(2) to approve any contract or service agreement;

(3) to levy an assessment or provide for a refund;

(4) to borrow money; or

(5) to extend funding of expenses of supervision, conservation, rehabilitation, or liquidation of an HMO as provided in Insurance Code §843.441 unless special notice of the desire to take action on this item is part of the notice of the meeting, in which case the acts of a majority of the members voting in person at a meeting at which a quorum is present shall be the acts of the committee.

(c) Meetings. On a day determined by the members, the committee shall hold a regular annual meeting. At its annual meeting, the committee may schedule additional regular meetings to be held during the period between annual meetings. Meetings shall be held at the department's offices unless the commissioner, chairman of the committee, or other officer acting on the chairman's behalf, designates some other place. At each such meeting the committee may:

(1) review the plan and submit to the department for approval any proposed amendment to the plan;

(2) review outstanding contracts or service agreements, if any, and, to the extent possible, make necessary or desirable corrections, improvements, or additions;

(3) consider and provide for collection of assessments for operating expenses of the committee;

(4) consider facts relevant to, and provide for, the collection of assessments as determined by the commissioner;

(5) consider any extension of funding for the expenses of supervision, conservation, rehabilitation, or liquidation of an HMO as provided in Insurance Code §843.441;

(6) review financial information relating to each HMO. Committee members shall be provided with reports regarding the financial condition of Texas licensed HMOs and regarding the financial condition, administration, and status of HMOs in supervision, conservation, rehabilitation, or liquidation at meetings. Committee members shall not reveal the condition of nor any information secured in the

course of any meeting of the committee with regard to any corporation, form, or person examined by the committee;

(7) advise the commissioner on actions necessary to prevent financial impairment;

(8) receive reports and advise the commissioner regarding management of HMO impairments and insolvencies;

(9) authorize appropriate legal action to recover unpaid assessments;

(10) review, consider, and act on the powers given the committee for a special or emergency meeting as outlined in subsection (d)(1) - (3) of this section; and

(11) review, consider, and act on other matters deemed by it to be necessary and proper for the administration of the committee.

(d) Special or emergency meetings. The committee shall hold a special or emergency meeting promptly after receiving notice from the commissioner of the need for such meeting. In addition, a special meeting of the committee may be held at the request of a majority of the membership, which shall be polled by the chairman at the request of any two members seeking a special meeting. At such meetings, the committee, if appropriate, shall perform the following functions.

(1) The committee shall receive and consider the report of the commissioner regarding HMO impairments or insolvencies within the meaning of Insurance Code Articles 21.28 and 21.28-A. Such reports may include progress and developments on management of such impairments or insolvencies.

(2) In consultation with the commissioner, the committee shall consider what assessment, if any, shall be levied, decide whether any refund should be made to an HMO, and consider and decide whether any assessment for expenses of supervision, conservation, rehabilitation, or liquidation shall be extended as provided in Insurance Code §843.441. Assessments shall conform to Insurance Code §843.441. Any HMO failing to pay an assessment after 30 days' written notice that payment is due, shall be reported to the commissioner, and the committee shall consider what other action, if any, shall be taken.

(3) The committee shall take all steps permitted by law, and deemed necessary, to protect the committee's rights as pertaining to the impaired or insolvent HMO or its enrollees.

(4) In addition to the powers described in paragraphs (1) - (3) of this subsection, the committee shall have and exercise such other powers as may be reasonably necessary to implement its powers and responsibilities under the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs.

(e) Notice. Notice of meetings of the committee shall be in accordance with Chapter 551 of the Government Code.

(f) Attendance at meeting. Committee meetings shall be open to the public, but the committee may hold a closed meeting under the provisions of Subchapter D of Chapter 551, Government Code, in which only committee members, the commissioner, and persons authorized by the commissioner shall be in attendance at such meeting.

SUBCHAPTER O. Administrative Procedures

§11.1401. Commissioner's Authority to Require Additional Information. The commissioner may require additional information as needed to make any determination required by the Insurance Code Chapters 1271 and 843, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs.

§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 COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-832-9623

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

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.

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 the Insurance Code Chapter 1451 Subchapter F 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.

§11.1605. 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, except small employer health benefit plans as defined by the Insurance Code §1501.002, shall comply with the requirements of the Insurance Code

Chapter 1369 Subchapter A and §21.3010 and §21.3011 of this title (relating to Definitions; Coverage of Off-Label Drugs and Minimum Standards of Coverage for Off-Label Drug Use).

(d) An HMO that provides coverage for prescription drugs or devices under an individual or group state-mandated health benefit plan shall comply with the requirements of the Insurance Code Chapter 1369 Subchapter C (Coverage of Prescription Contraceptive Drugs and Devices and Related Services).

(e) An HMO that provides coverage for prescription drugs under a group state-mandated health benefit plan and that utilizes one or more drug formularies to specify which prescription drugs the plan will cover shall comply with the requirements of the Insurance Code Chapter 1369 Subchapter B and §§21.3020 - 21.3023 of this title (relating to Definitions; Prescription Drug Formulary, Required Disclosure of Drug Formulary, Continuation of Benefits, and Nonformulary Prescription Drugs; Adverse Determination).

§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, specialty hospitals, and single healthcare service plan physicians or providers.

(i) Notwithstanding subsection (h) of this section, an HMO that has a contract with the Health and Human Services Commission is not required to meet the access requirements prescribed in this section for covered services provided to participants in the CHIP Perinatal Program.

(j) If any covered health care service or a participating physician and provider is not available to an enrollee within the mileage radii specified in subsection (h)(1) and (2) of this section because physicians and providers are not located within such mileage radii, or if the HMO is unable to obtain contracts after good faith attempts, or physicians and providers meeting the minimum quality of care and credentialing requirements of the HMO are not located within the mileage radii, the HMO shall submit an access plan to the department for approval, at least 30 days before implementation in accordance with the filing requirements in §11.301 of this title (relating to Filing Requirements). The access plan shall include the following:

(1) the geographic area identified by county, city, ZIP code, mileage, or other identifying data in which services and/or physicians and providers are not available;

(2) for each geographic area identified as not having covered health care services and/or physicians or providers available, the reason or reasons that covered health care services and/or physicians and providers cannot be made available;

(3) a map, with key and scale, which identifies the areas in which such covered health care services and/or physicians and providers are not available;

(4) the HMO's plan for making covered health care services and/or physicians and providers available to enrollees in each geographic area identified;

(5) the names and addresses of the participating physicians and providers and a listing of the covered health care services to be provided through the HMO delivery network to meet the medical needs of the enrollees covered under the HMO's plan required under paragraph (4) of this subsection;

(6) the names and address of other physicians and providers and a listing of the specialties for any other health care services or physicians and providers to be made available in the geographic area in addition to those physicians and providers participating in the HMO delivery network listed under paragraph (5) of this subsection;

(7) the procedures to be followed by the HMO to assure that primary care physicians, general hospitals, specialists, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, or single or limited health care service providers and all other mandated health care services are made available and accessible to

enrollees in the geographic areas identified as being areas in which such covered health care services and/or physicians and providers are not available and accessible, and any plans of the HMO for attempting to develop an HMO delivery network through which covered health care services are available and accessible to enrollees in these geographic areas in the future; and

(8) any other information which is necessary to assess the HMO's plan.

(k) The 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.

(l) 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.

(m) In accordance with the Insurance Code Chapter 1455 (Telemedicine and Telehealth), each evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or a telemedicine medical service.

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 the Insurance Code Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations), an applicant ANHC must:

(1) comply with each requirement for the issuance of a certificate of authority imposed on an HMO under the Insurance Code Chapters 1271 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 the 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 the Insurance Code Chapters 1271 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 the Insurance Code Chapters 1271 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 the Insurance Code Chapter 4054 and Chapter 19 of this title (relating to Agent's Licensing), as applicable.

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 the Insurance Code Chapters 1271 and 843 or as an approved nonprofit health corporation under the Insurance Code Chapter 844.

(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.

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. Unless the HMO has no enrollees, the QI program shall include the active involvement of one or more enrollee(s) who are not employees of the HMO.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a quality improvement committee (QIC) that shall include practicing physicians and individual providers; and may include one or more enrollee(s)

from throughout the HMO's service area. For purposes of this section, if an enrollee(s) is appointed to the committee, the enrollee(s) may not be an employee of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet no less than annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC shall evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual providers, and enrollees from the service area.

(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

(B) All committees shall meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.

§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. The credentialing process required by this section must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.

(5) Site visits for cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards

promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.

SUBCHAPTER V. Standards for Community Mental Health Centers

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

(a) Prior to obtaining a certificate of authority under Section 534.101 of the Health and Safety Code (concerning Health Maintenance Organizations Certificate of Authority), an applicant CHMO must comply with each requirement for the issuance of a certificate of authority imposed on a limited health care service plan under the Insurance Code Chapters 1271 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 the Insurance Code Chapters 1271 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

§11.2201. 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, as required under §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate), and may specify recognized procedures or other information which is used for the purpose of maintaining a statistical reporting system.

(c) Each single service HMO evidence of coverage shall 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.

§11.2207. Quality Improvement Structure and Program for Single Service HMOs.

(a) A single service HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Unless the HMO has no enrollees, the QI program shall include the active involvement of one or more enrollee(s) who are not employees of the HMO.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a QI committee (QIC) that shall include practicing physicians and individual providers, and may include one or more enrollee(s) from throughout the HMO's service area. For purposes of this section, if an enrollee(s) is appointed to the committee, the enrollee(s) may not be an employee of the HMO;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet no less than annually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC shall evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual providers, and enrollees from the service area.

(A) All committees shall collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services .

(B) All committees shall meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC shall use multidisciplinary teams, when indicated, to accomplish QI program goals.

(d) The QI program for single service HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) Written description. The QI program shall include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program shall include an annual QI work plan designed to reflect the type of services and the population served by the HMO in terms

of age groups, disease categories, and special risk status, as applicable. The work plan shall include:

(A) Objective and measurable goals; planned activities to accomplish the goals; time frames for implementation; responsible individuals; and evaluation methodology.

(B) The work plan shall address each program area, including:

(i) Network adequacy, which includes availability and accessibility of care, including assessment of open/closed physician and individual provider panels;

(ii) Continuity of health care and related services, as applicable;

(iii) Clinical studies;

(iv) The adoption and use of current professionally-recognized clinical practice guidelines, or, in the absence of current professionally-recognized clinical practice guidelines for particular practice areas or conditions, those developed by the health plan that:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services.

(v) Enrollee, physician, and individual provider satisfaction;

(vi) The complaint and appeal process, complaint data, and identification and removal of communication barriers that may impede enrollees, physicians and providers from effectively making complaints against the HMO;

(vii) Preventive health care through health promotion and outreach activities:

(viii) Claims payment processes, as applicable;

(ix) Contract monitoring, including delegation oversight and compliance with filing requirements;

(x) Utilization review processes, as applicable;

(xi) Credentialing;

(xii) Member services; and;

(xiii) Pharmacy services, including drug utilization.

(3) Evaluation. The QI program shall include an annual report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers. The credentialing process required by this section must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.

(5) Site Visits for Cause.

(A) The HMO shall have procedures for detecting deficiencies subsequent to the initial site visit. When the HMO identifies new deficiencies, the HMO shall reevaluate the site and institute actions for improvement.

(B) An HMO may conduct a site visit to the office of any physician or provider at any time for cause. The HMO shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(6) Peer Review. The QI program shall provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Chapters 151-164, Occupations Code. The HMO shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.

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 the Insurance Code Chapter 843, an applicant PSO must comply with each requirement for the issuance of a certificate of authority imposed on an HMO under the Insurance Code Chapters 1271 and 843, 28 Texas Administrative Code Chapter 11, and other applicable insurance laws and regulations of this state except where preempted by federal law.

(c) An applicant for a certificate of authority for a PSO shall complete and file with the department the application form for a health maintenance organization adopted by reference under §11.1001 of this title (relating to Required Forms) and the Financial Plan required by §11.2304 of this title (relating to Financial Plan Requirement).

§11.2315. Application of Other Insurance Laws. Subject to the provisions of this subchapter, the holder of a certificate of authority issued under this subchapter has all the powers granted to and duties imposed on a health maintenance organization under the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, and is subject to regulation and regulatory enforcement under these laws in the same manner as a health maintenance organization.

SUBCHAPTER 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, as required under §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate), and may specify recognized procedure codes or other information used for maintaining a statistical reporting system.

(c) 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 the Insurance Code Chapter 1355 Subchapter A), 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 the Insurance Code Chapter 1651 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 the Insurance Code §§1273.001 and 843.108, that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a POS plan.

(3) Cost containment requirements--Provisions in a POS rider requiring a specific action, such as the provision of specified information to the HMO, 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 the Insurance Code §1501.108;

(ii) a large employer plan, pursuant to the Insurance Code §1501.108;

(iii) an individual plan, pursuant to §11.506(3)(D) of this chapter (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate); or

(iv) an association plan, pursuant to §21.2704 of this title (relating to Mandatory Guaranteed Renewability Provisions for Health Benefit Plans Issued to Members of an Association or Bona Fide Association).

(B) An HMO that discontinues a POS rider plan must comply with all laws and rules applicable to that plan.

(C) An HMO that discontinues existing POS rider plans in order to bring the HMO into compliance with the 10% cap:

(i) shall offer, if the discontinued plan is issued to:

(I) a small employer group, to each employer, the option to purchase other small employer coverage offered by the small employer carrier at the time of the discontinuation, pursuant to the Insurance Code §1501.109(d);

(II) a large employer group, to each employer, the option to purchase any other large employer coverage offered by the large employer carrier at the time of the discontinuation, pursuant to the Insurance Code §1501.109(d);

(III) an individual, the option to purchase to each enrollee any other individual basic health care coverage offered by the HMO pursuant to §11.506(3)(D)(v) of this title;

(IV) an association, the option to purchase any other health benefit plan being offered by the HMO pursuant to §21.2704(d)(1)(B) of this title.

(ii) shall not issue any additional new POS rider plans:

(I) for at least one calendar year after the date on which it last discontinued any of its existing POS rider business and then only if it can establish to the satisfaction of the commissioner that:

(-a-) its total medical and hospital expenses incurred for the preceding four calendar quarters for all POS riders issued under this subchapter will not have exceeded 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the preceding four calendar quarters; and

(-b-) its total medical and hospital expenses incurred for all POS riders issued under this subchapter for the next four calendar quarters will not exceed 10% of the total medical and hospital expenses incurred by the HMO for all health plan products for the next four calendar quarters; or

(II) until it has become licensed as an indemnity carrier under the Code.

(4) An HMO that ceases to issue a POS rider plan in order to comply with the 10% cap required under paragraph (2) of this section shall continue to offer the plan to each new member of a group to which the POS rider plan has been issued unless and until the HMO divests itself of the group's business by discontinuing the plan as set forth in paragraph (3) of this section.

(5) An HMO that ceases to issue a POS rider plan in order to comply with the 10% cap required under paragraph (2) of this section must continue to offer the plan to each new individual entitled to coverage under an existing individual plan for which a POS rider has been issued unless and until the HMO divests itself of the individual plan by discontinuing the plan as set forth in paragraph (3) of this section.

§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 the Insurance Code Chapters 843, 541, 542, 543, 544, and 547.

(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 the Insurance Code Chapter 1251 Subchapter C; and

(N) if it is issued to an individual, shall contain provisions that comply with the Insurance Code §§1201.211 – 1201.217.

(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 the Insurance Code Chapters 843 and 1272, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs. These requirements are designed to ensure that a 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 Insurance Code Chapters 843 and 1272 and applicable insurance laws of this state related to health maintenance organization regulation, as identified by this subchapter, the Insurance Code Chapters 843 and 1272 and applicable insurance laws of this state that apply to HMOs will apply and the remaining terms and provisions of this subchapter shall continue in effect.

(c) Applicability to Group Model HMO. 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) Delegated entity--An entity, other than an HMO authorized to do business under the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the HMO any function regulated by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to providers not employed by the group is less than 20 percent of the total collected revenue of the group calculated on a calendar year basis.

(2) Delegated network--Any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with an HMO.

(3) Delegated third party--A third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility to perform any function regulated by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs.

(4) Health care--Any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, or dental care, or hospitalization, or incident to the furnishing of such services, care, or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury.

§11.2603. Requirements for Delegation by HMOs.

(a) Any delegation of any function pursuant to the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs by an HMO shall comply with this subchapter.

(b) Oversight by the department does not relieve the HMO of responsibility for monitoring and oversight of its delegated entities.

(c) Prior to entering into, renewing or amending a delegation agreement, an HMO shall make a reasonable effort to evaluate the delegated entity's current and prospective ability to perform the functions to be delegated, including, but not limited to, the solvency and financial operations of the delegated entity and the projected financial effects of the agreement upon the delegated entity.

(d) An HMO that delegates functions to a delegated entity must have a written contingency plan to resume any and all delegated functions, including, as applicable:

(1) quality of care;

(2) continuity of care, including a plan for transferring enrollees to new providers in the event of termination of the delegation agreement; and

(3) processing, adjudication and payment of claims.

(e) The department may require an HMO to immediately terminate any delegation agreement to ensure that the HMO is in compliance with the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs.

(f) The HMO retains ultimate responsibility for any and all functions delegated.

(g) A delegated entity's failure to comply with applicable statutes or rules constitutes a violation of the Insurance Code Chapter 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs by the delegating HMO.

(h) An HMO is responsible for monitoring each delegated entity with which it contracts to ensure compliance with all applicable statutes and rules, as well as for solvency.

(i) An HMO shall report to the department, within a reasonable time, all penalties assessed against a delegated entity under the provisions of the delegation agreement.

(j) If an HMO cannot ensure that a delegated entity is performing all delegated functions in accordance with all applicable statutes, rules, or an order issued by the department pursuant to this subchapter, the HMO shall resume all delegated functions from the delegated entity.

(k) If a license is required for any function delegated by an HMO, the HMO must ensure that the delegated entity or third party performing the function has a current appropriate license.

(l) Upon termination of a delegation agreement by either party, the HMO shall notify the department.

§11.2604. Delegation Agreements – General Requirements and Information to be Provided to HMO.

(a) An HMO that delegates to a delegated entity any function required by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs shall execute a written agreement with that delegated entity.

(b) Written agreements shall include the following:

(1) a provision that the delegated entity and any delegated third parties must agree to comply with all statutes and rules applicable to the functions being delegated by the HMO;

(2) a provision that the HMO shall monitor the acts of the delegated entity through a monitoring plan. The monitoring plan shall be set forth in the delegation agreement, and must contain, at a minimum:

(A) provisions for the review of the delegated entity's solvency status and financial operations. This shall include, at a minimum, review of the delegated entity's financial statements, consisting of at least a balance sheet, income statement, and statement of cash flows for the current and preceding year;

(B) provisions for the review of the delegated entity's compliance with the terms of the delegation agreement as well as with all applicable statutes and rules affecting the functions delegated by the HMO under the delegation agreement;

(C) a description of the delegated entity's financial practices in sufficient detail that will ensure that the delegated entity tracks and timely reports to the HMO liabilities including incurred but not reported obligations;

(D) a method by which the delegated entity shall report monthly a summary of the total amount paid by the delegated entity to physicians and providers under the delegation agreement; and

(E) a monthly log, maintained by the delegated entity, of oral and written complaints from physicians, providers, and enrollees regarding any delay in payment of claims or nonpayment of claims pertaining to the delegated function, including the status of each complaint;

(3) a statement that the HMO shall utilize the monitoring plan on an ongoing basis. Compliance with this requirement shall be documented by the HMO maintaining, at a minimum:

(A) periodic signed statements from the individual identified by the HMO in paragraph (23) of this subsection that the HMO has reviewed the information required in the monitoring plan; and

(B) periodic signed statements from the chief financial officer of the HMO acknowledging that the most recent financial statements of the delegated entity have been reviewed.

(4) a provision establishing the penalties to be paid by the delegated entity for failure to provide information required by this subchapter;

(5) a provision requiring quarterly assessment and payment of penalties under the agreement, if applicable;

(6) a provision that the agreement cannot be terminated without cause by the delegated entity or the HMO without written notice provided to the other party and the department before the 90th day preceding the termination date, provided that the commissioner may order the HMO to terminate the agreement under §11.2608 of this subchapter (relating to Department May Order Corrective Action);

(7) a provision that requires the delegated entity, and any entity or physician or provider with which it has contracted to perform a function of the HMO, to hold harmless an enrollee under any circumstance, including the insolvency of the HMO

or delegated entity, for payments for covered services other than copayments and deductibles authorized under the evidence of coverage;

(8) a provision that the delegation agreement may not be construed to limit in any way the HMO's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(9) a provision that any failure by the delegated entity to comply with applicable statutes and rules or monitoring standards shall allow the HMO to terminate delegation of any or all delegated functions;

(10) a provision that the delegated entity must permit the commissioner to examine at any time any information the department reasonably considers is relevant to:

(A) the financial solvency of the delegated entity; or

(B) the ability of the delegated entity to meet the entity's responsibilities in connection with any function delegated to the entity by the HMO;

(11) a provision that the delegated entity, in contracting with a delegated third party directly or through a third party, shall require the delegated third party to comply with the requirements of paragraph (10) of this subsection;

(12) a provision that the delegated entity shall provide the license number of any delegated third party performing any function that requires a license as a third party administrator under the Insurance Code Chapter 4151, or a license as a utilization review agent under the Insurance Code Article 21.58A, or that requires any other license under the Insurance Code or another insurance law of this state;

(13) if utilization review is delegated, a provision stating that:

(A) enrollees will receive notification at the time of enrollment identifying the entity that will be performing utilization review;

(B) the delegated entity or delegated third party performing utilization review shall do so in accordance with Texas Insurance Code Art. 21.58A and related rules; and

(C) utilization review decisions made by the delegated entity or a delegated third party shall be forwarded to the HMO on a monthly basis;

(14) a provision that any agreement in which the delegated entity directly or indirectly delegates to a delegated third party any function delegated to the delegated entity by the HMO pursuant to the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs, including any handling of funds, shall be in writing;

(15) a provision that upon any subsequent delegation of a function by a delegated entity to a delegated third party, the executed updated agreements shall be filed with the department and enrollees shall be notified of the change of any party performing a function for which notification of an enrollee is required by this chapter or the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs;

(16) an acknowledgment and agreement by the delegated entity that the HMO is not precluded from requiring that the delegated entity provide any and all evidence

requested by the HMO or the department relating to the delegated entity's or delegated third party's financial viability;

(17) a provision acknowledging that any delegated third party with which the delegated entity subcontracts will be limited to performing only those functions set forth and delegated in the agreement, using standards approved by the HMO and that are in compliance with applicable statutes and rules;

(18) a provision that any delegated third party is subject to the HMO's oversight and monitoring of the delegated entity's performance and financial condition under the delegation agreement;

(19) a provision that requires the delegated entity to make available to the HMO samples of each type of contract the delegated entity executes or has executed with physicians and providers to ensure compliance with the contractual requirements described by paragraphs (6) and (7) of this subsection, except that the agreement may not require that the delegated entity make available to the HMO contractual provisions relating to financial arrangements with the delegated entity's physicians and providers;

(20) a provision that requires the delegated entity to provide information to the HMO on a quarterly basis and in a format determined by the HMO to permit an audit of the delegated entity and to ensure compliance with the department's reporting requirements with respect to any functions delegated by the HMO to the delegated entity and to ensure that the delegated entity remains solvent to perform the delegated functions, including:

(A) a summary:

(i) describing any payment methods, including capitation or fee-for-services, that the delegated entity uses to pay its physicians and providers and any other third party performing a function delegated by the HMO; and

(ii) of the breakdown of the percentage of physicians and providers and any other third party paid by each payment method listed in clause (i) of this subparagraph;

(B) the period of time that claims and any other obligations for health care filed with the delegated entity, under this and any other delegation agreements to which the delegated entity is a party, have been pending but remain unpaid, divided into categories of 0 - 45 days, 46 - 90 days, and 91 or more days. The summary shall include aggregate information for all delegation agreements entered into by the delegated entity and information for the specific delegation agreement entered into between the parties;

(C) the aggregate dollar amount of claims and other obligations for health care owed by the delegated entity to any physician or provider, including estimates for incurred but not reported obligations;

(D) information that the HMO requires in order to file claims for reinsurance, coordination of benefits, and subrogation; and

(E) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Subchapter A, Chapter 160, Occupations Code, that relates to:

(i) any regulatory agency's inquiry or investigation of the delegated entity or of an individual physician or provider with whom the delegated entity contracts that relates to an enrollee of the HMO; and

(ii) the final resolution of any regulatory agency's inquiry or investigation;

(21) a provision relating to enrollee complaints that requires the delegated entity to ensure that upon receipt of a complaint, as defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, a copy of the complaint shall be sent to the HMO within two business days, except that in a case in which a complaint involves emergency care, as defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs, the delegated entity shall forward the complaint immediately to the HMO, and provided that nothing in this paragraph prohibits the delegated entity from attempting to resolve a complaint

(22) a provision that the HMO, the delegated entity and any delegated third party shall comply with the provisions of Chapter 22 of this title;

(23) a provision identifying an officer of the HMO as the representative of the HMO for all matters related to the delegation agreement; and

(24) a provision identifying which party to the agreement shall bear the expense of compliance with each requirement set forth in this subsection, including the cost of any examinations performed pursuant to this subchapter.

§11.2608. Department May Order Corrective Action.

(a) The department may require at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relates to any matters delegated by the HMO to the delegated entity;

(2) is necessary to ensure the HMO's compliance with statutory and regulatory requirements; or

(3) relates to the financial solvency and operations of the delegated entity.

(b) The commissioner shall order the HMO to take any action the commissioner determines is necessary to ensure that the HMO maintains compliance with the Insurance Code Chapter 1272, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs, including but not limited to:

(1) resumption of any or all functions delegated to the delegated entity, including claims processing, adjudication, and payments for health care previously rendered to enrollees of the HMO;

(2) temporarily or permanently ceasing assignment of new enrollees to the delegated entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive health care; or

(4) termination of the HMO's delegation agreement with the delegated entity.

§11.2609. Reserve Requirements for Delegated Networks. In addition to any other requirements set forth in this subchapter, HMOs that contract with delegated networks shall ensure that the delegated network complies with the Insurance Code Chapter 1272 Subchapter D. The HMO's agreement with the delegated network shall include a provision:

(1) that records related to the requirements of the Insurance Code Chapter 1272 Subchapter D shall be accessible at all times to the HMO;

(2) requiring all financial records and related information necessary to show the delegated network's compliance with the requirements of the Insurance Code Chapter 1272 Subchapter D;

(3) making the records described in paragraph (1) of this section available to the department upon request; and

(4) that records be kept providing evidence that the HMO has adequately monitored the delegated network for compliance with the requirements of the Insurance Code Chapter 1272 Subchapter D.

CERTIFICATION. This agency hereby certifies that the adopted amendments have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _________________, 2006.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§11.1, 11.2, 11.203, 11.204, 11.301, 11.302, 11.501, 11.503, 11.504 - 11.506, 11.508 -11.511, 11.602 ,11.706, 11.801, 11.804, 11.810, 11.901, 11.902, 11.904, 11.1201, 11.1206, 11.1301, 11.1302, 11.1401, 11.1403, 11.1600, 11.1605, 11.1607, 11.1702, 11.1703, 11.1801, 11.1901, 11.1902, 11.2103, 11.2201, 11.2207, 11.2303, 11.2315, 11.2402, 11.2405, 11.2406, 11.2501 – 11.2503, 11.2601 - 11.2604, 11.2608, and 11.2609 specified herein, concerning the regulation of health maintenance organizations (HMOs), are adopted.

AND IT IS SO ORDERED.

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MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

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Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO.__________