SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY
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28 TAC §11.303

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

INTRODUCTION. The Texas Department of Insurance proposes to amend 28 TAC §§11.204, 11.303, 11.1600, 11.1607, 11.1610, and 11.1612, concerning health maintenance organizations (HMOs). These amendments implement Senate Bill 1742, 86th Legislature, Regular Session (2019). The amendments also eliminate certain health care provider network adequacy review requirements that are duplicative of reviews conducted by the Health and Human Services Commission (HHSC) for provider networks associated with the Texas Children's Health Insurance Program (CHIP), Medicaid, or the State Rural Health Care System.

EXPLANATION. The proposed amendments to §§11.204, 11.303, 11.1600, 11.1607, 11.1610, and 11.1612 implement SB 1742. SB 1742 amends Insurance Code Chapter 1451, Subchapter K to add more detailed requirements for health care provider directories, including a requirement for more information regarding facilities and facility-based physicians. SB 1742 also amends Insurance Code §843.3481 to require HMOs to provide certain information regarding any preauthorization requirements for health care services.

The proposed amendments to §11.1607 and §11.1610 also eliminate certain network adequacy review requirements for a health benefit plan written by an HMO for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System. HHSC conducts its own network adequacy reviews of HMOs with

which it contracts that are duplicative of TDI's review. The changes will conserve agency resources and reduce the regulatory burden and costs imposed on these HHSC program participants.

The proposed amendments to the sections are described in the following paragraphs.

Section 11.204. Contents. An amendment to §11.204(15) capitalizes the word "paragraph" to conform the rule text to TDI's current style. Amendments to §11.204(19)(B)(iv) and §11.204(19)(C)(iii) replace "city" with "the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county" to align to the requirements of Insurance Code §1451.504 as amended by SB 1742. Amendments replace existing §11.204(19)(D) to require the additional information regarding health care facilities and facility-based physicians required under Insurance Code §1451.504 as amended by SB 1742. The existing language of §11.204(19)(D) is no longer needed because the information required by the provision is duplicative of the new requirements replacing it.

Section 11.303. Examination. An amendment to §11.303(a) adds a reference to 28 TAC §7.83 to clarify that the section applies to an appeal of an HMO examination report.

Section 11.1600. Information to Prospective and Current Contract Holders and Enrollees. Amendment to §11.1600(b)(9) implements SB 1742 by requiring HMOs to provide the information required by Insurance Code §843.3481 and also references additional requirements relating to preauthorization in 28 TAC Chapter 19, Subchapter R. The current information required in §11.1600(b)(9) is being deleted and replaced because Insurance Code §843.3481 requires that HMOs provide greater detail on their preauthorization requirements. Amendments to §11.1600(d) and §11.1600(j) capitalize the words "subsection" and "subsections" to conform the rule text to TDI's current style.

Section 11.1607. Accessibility and Availability Requirements. Amendment to §11.1607(l) expands the existing provisions to provide that §11.1607 does not apply to a health benefit plan written by an HMO for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System. TDI's review of the network adequacy requirements under this section is unnecessary, because it is duplicative of HHSC's review of its contractors' networks. Amendments to §11.1607(j) and §11.1600(k) capitalize the words "subsections" and "subsection" to conform the rule text to TDI's current style.

Section 11.1610. Annual Network Adequacy Report. The proposed amendment to §11.1610 adds new §11.1610(g). This subsection provides that §11.1610 does not apply to a health benefit plan written by an HMO for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System from the annual network adequacy report requirement of §11.1610. TDI's review of the annual network adequacy report under this section is unnecessary because it is duplicative of HHSC's review of its contractors' networks.

Section 11.1612. Mandatory Disclosure Requirements. An amendment to §11.1612(a)(1) revises the provision to include a requirement that the provider listing describe a provider's specialty, if any, to align with the requirements of Insurance Code §1451.504 and §1451.505, as amended by SB 1742. New §11.1612(h)(10) - (11) adds the new detailed facility and facility-based physician provider directory information requirements in Insurance Code §1451.504 as amended by SB 1742. Amendments to §11.1612(i) and §11.1612(j) capitalize the word "subsection" and "paragraph" to conform the rule text to TDI's current style.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Debra Diaz-Lara, director of the Managed Care Quality Assurance Office, has determined that during each

year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by the statute. This determination was made because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Diaz-Lara does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Diaz-Lara expects that administering the proposed amendments will have the public benefits of ensuring that TDI's rules conform to Insurance Code §§843.3481, 1451.504, and 1451.505; conserve agency resources; and reduce the regulatory burden and costs imposed on participants in HHSC's CHIP, Medicaid program, and the State Rural Health Care System.

Ms. Diaz-Lara expects that the proposed amendments will not increase the cost of compliance with Insurance Code §§843.3481, 1451.504, and 1451.505, because it does not impose requirements beyond those in the statute. Insurance Code §843.3481 requires HMOs to provide certain information regarding any preauthorization requirements for health care services. Insurance Code §1451.504 and §1451.505 require certain information be included in a provider directory. As a result, the cost associated with complying with these requirements does not result from the enforcement or administration of the proposed amendments.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect or

a disproportionate economic impact on small or micro businesses, or on rural communities. Because the proposed rule is designed to implement Insurance Code §§843.3481, 1451.504, and 1451.505, any economic impact results from the statute itself. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. Therefore, no additional rule amendments are required under Government Code §2001.0045. In addition, the proposed rule implements Insurance Code §§843.3481, 1451.504, and 1451.505, as enacted by SB 1742. The proposed rule also reduces the burden and responsibilities imposed on regulated persons and decreases the persons' cost for compliance with the rules by eliminating certain network adequacy review requirements for a health benefit plan written by an HMO for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System.

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

- will not create or eliminate a government program;

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

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

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

- will not create a new regulation;

- will expand and eliminate an existing regulation;

- will decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

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

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on October 26, 2020. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

To request a public hearing on the proposal, submit a request before the end of the comment period, and separate from any comments, to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The request for public hearing must be received by the department no later than 5:00 p.m., central time, on October 26, 2020. If TDI holds a public hearing, TDI will consider written and oral comments presented at the hearing.

SUBCHAPTER C. APPLICATION FOR CERTIFICATE OF AUTHORITY

28 TAC §11.204.

STATUTORY AUTHORITY. TDI proposes §11.204 under Insurance Code §§843.151, 843.2015, and 36.001.

Insurance Code §843.151 allows the Commissioner to adopt reasonable rules as necessary and proper to implement Chapter 843, including to ensure enrollees have adequate access to health care services.

Insurance Code §843.2015 allows the Commissioner to adopt rules as necessary to implement Insurance Code §843.2015, which requires an HMO to list network providers on its website. The rules may govern the form and content of the information required.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.204 implement Insurance Code §1451.504.

TEXT.

§11.204. Contents.

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

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

(2) a completed certificate of authority application form;

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

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

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

(A) a completed officers and directors page;

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

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

(6) organizational information, as follows:

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

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

(C) a chart showing contractual arrangements of the HMO's delivery network;

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

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

(B) a cash deposit held under Insurance Code §843.402 or as provided by Insurance Code §423.004 (concerning Statutory Deposits with Department) in the same amount and subject to the same conditions as the bond described in this paragraph;

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

(A) if the applicant is domiciled in another jurisdiction, an agent for service of legal process must be appointed in compliance with Insurance Code Chapter 804 (concerning Service of Process) using Form FIN 312 (rev. 04/00), and the applicant must furnish a copy of the certificate of authority from the domiciliary jurisdiction's licensing authority; and

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

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

(10) financial information, consisting of the following:

(A) a financial statement that includes a balance sheet reflecting the required net worth, assets, and any liabilities.

(B) if the applicant is newly formed, a balance sheet reflecting the HMO's proposed initial funding;

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

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

(11) the schedule of charges, excluding any charges for Medicaid products, with an actuarial certification and supporting documentation meeting the qualifications specified in §11.702 of this title (relating to Actuarial Certification);

(12) if the applicant proposes to write Medicaid products, an actuarial certification and supporting documentation meeting the qualifications specified in §11.702 of this title, and noting whether the proposed rates are the maximum rates allowed by the contracting state agency, if rates less than the maximum rates allowed are being proposed or if the contracting state agency rates are not available;

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

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

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

(B) any physician, medical group, association of physicians, or any other provider, and the form of any subcontract between those entities and any physician, medical group, association of physicians, or any other provider to provide health care services, provided that contracts, including subcontracts between physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees, must include a hold-harmless provision and comply with all other provisions of §11.901 of this title (relating to Required and Prohibited Provisions);

(C) any affiliated exclusive agent or agency;

(D) any affiliated person who will perform marketing, administrative, data processing services, or claims processing services;

(E) any affiliated person who will perform management services, together with a deposit or the original or a copy of a bond with no deductible meeting the requirements of Insurance Code §843.105 (concerning Management and Exclusive Agency Contracts);

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

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

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

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

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

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

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

(C) any other arrangements offering protection against insolvency, including guarantees, as specified in §11.808 of this title (relating to Liabilities) and §11.810 of this title (relating to Guarantee from a Sponsoring Organization);

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

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

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

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

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

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

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

(i) last name;

(ii) first name;

(iii) business address;

(iv) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county [~~city~~];

(v) state;

(vi) county;

(vii) Texas license number;

(viii) specialty;

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

(x) date of last credentialing or recredentialing; and

(xi) an indication of whether they are accepting new patients;

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

(i) name of facility;

(ii) business address;

(iii) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county [~~city~~];

(iv) state;

(v) county;

(vi) type of facility;

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

(viii) date of last credentialing or recredentialing;

(D) for each facility listed under Subparagraph (C) of this paragraph:

(i) create separate headings under the facility name for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, and assistant surgeons;

(ii) under each heading described by Clause (i) of this subparagraph, list each preferred facility-based physician practicing in the specialty corresponding with that heading;

(iii) for the facility and each facility-based physician described by Clause (ii) of this subparagraph, clearly indicate each health benefit plan issued by the HMO that may provide coverage for the services provided by that facility, physician, or facility-based physician group;

(iv) for each facility-based physician described by Clause (ii) of this subparagraph, include the name, street address, telephone number, and any physician group in which the facility-based physician practices;

(v) include the facility in a listing of all facilities and indicate each health benefit plan issued by the HMO that may provide coverage for the services provided by the facility; and

(vi) the list must list each facility-based physician individually and, if a physician belongs to a physician group, also as part of the physician group;

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

[~~(i) last name;~~]

[~~(ii) first name;~~]

[~~(iii) business address;~~]

[~~(iv) city;~~]

[~~(v) state;~~]

[~~(vi) county;~~]

[~~(vii) Texas license number;~~]

[~~(viii) hospital-based specialty; and~~]

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

(20) a written description of the types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made or to be made with physicians and providers in exchange for the provision of or the arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers; provided that such compensation arrangements are confidential under Insurance Code §843.078(l) and not subject to Government Code Chapter 552 (concerning Public Information);

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

(22) a description of the procedures by which:

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

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

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

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

(25) a written description of the utilization management and utilization review program;

(26) the URA name and certificate or registration number if the applicant performs utilization review under Insurance Code Chapter 4201 (concerning Utilization Review Agents) and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy), or the URA name and certificate number of the certified URA that will perform utilization review on behalf of the applicant if the applicant delegates utilization review;

(27) complaint and appeal procedures, templates of letters, and logs, including the complaint log, which must categorize each complaint using the following categories and noting all that are applicable to the complaint:

(A) quality of care or services;

(B) accessibility and availability of services;

(C) utilization review or management;

(D) complaint procedures;

(E) physician and provider contracts;

(F) group subscriber contracts;

(G) individual subscriber contracts;

(H) marketing;

(I) claims processing; and

(J) miscellaneous; and

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

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

28 TAC §11.303.

STATUTORY AUTHORITY. TDI proposes §11.303 under Insurance Code §843.151 and §36.001.

Insurance Code §843.151 allows the Commissioner to adopt reasonable rules as necessary and proper to implement Chapter 843, including to ensure enrollees have adequate access to health care services.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.303 affect Insurance Code Chapter 843.

TEXT.

§11.303. Examination.

(a) The department has authority to conduct examinations of HMOs under Insurance Code Chapters 401 (concerning Audits and Examinations) and 751 (concerning Market Conduct Surveillance), and Insurance Code §843.156 (concerning Examinations) and §843.251 (concerning Complaint System Required; Commissioner Rules and Examination), and such examinations are subject to §7.83 of this title (relating to Appeal of Examination Reports). The department will conduct examinations to determine the financial condition (financial exams), quality of health care services (quality of care exams), or compliance with laws affecting the conduct of business (market conduct exams).

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

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

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

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

(4) complaints and appeals: policies and procedures and templates of letters; complaint and appeal logs, including documentation and details of actions taken; and complaint and appeal files;

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

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

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

(8) executed agreements, including:

(A) management services agreements;

(B) administrative services agreements; and

(C) delegation agreements;

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

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

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

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

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

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

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

(c) The department will conduct quality of care exams as follows:

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

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

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

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

(5) Corrective action plan. If the examination team or examiner cites significant deficiencies, the HMO must provide a signed corrective action plan to the department no later than 30 days from receipt of the written examination report. The HMO's plan must provide for correction of these deficiencies no later than 90 days from the receipt of the written examination report.

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

SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §§11.1600, 11.1607, 11.1610, and 11.1612.

STATUTORY AUTHORITY. TDI proposes §§11.1600, 11.1607, 11.1610, and 11.1612 under Insurance Code §§843.151, 843.2015 and 36.001.

Insurance Code §843.151 allows the Commissioner to adopt reasonable rules as necessary and proper to implement Chapter 843, including to ensure enrollees have adequate access to health care services.

Insurance Code §843.2015 allows the Commissioner to adopt rules as necessary to implement Insurance Code §843.2015, which requires an HMO to list network providers on its website. The rules may govern the form and content of the information required.

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

CROSS-REFERENCE TO STATUTE. The amendments to §§11.1600, 11.1607, 11.1610, and 11.1612 implement Insurance Code §§843.3481, 1451.504, and 1451.505, as enacted by SB 1742. The amendments to §11.1607 and §11.1610 affect Insurance Code Chapter 843.

TEXT.

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

(a) An HMO must provide an accurate written description of health care plan terms and conditions to allow any prospective contract holder or enrollee or current contract holder or enrollee to make comparisons and informed decisions before selecting among health care plans. The HMO may deliver the written description of health care plan terms and conditions electronically but must provide a paper copy on request.

(b) The written or electronic plan description must be filed for approval in compliance with §11.301 of this title (relating to Filing Requirements); be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements), by category; and include these items in the following order:

(1) a statement that the entity providing the coverage is an HMO;

(2) a toll-free number, unless exempted by statute or rule, and address for obtaining additional information, including physician and provider information;

(3) a clear, complete, and accurate description of all covered services and benefits, including a description of the options, if any, for prescription drug coverage, both generic and brand name, and if applicable, an explanation of how to access formulary information consistent with §21.3031(b) of this title (relating to Formulary Information on Issuer's Website);

(4) a clear, complete, and accurate description of emergency care services and benefits, including coverage for out-of-area emergency care services and information on access to after-hours care;

(5) a clear, complete, and accurate description of out-of-area services and benefits (if any);

(6) as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), statements that:

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

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

(C) if the enrollee receives a balance bill, the enrollee should contact the HMO;

(7) a clear, complete, and accurate explanation of enrollee financial responsibility for payment of premiums, copayments, deductibles, and any other out-of-pocket expenses for noncovered or out-of-plan services, and an explanation that network physicians and providers have agreed to look only to the HMO and not to its enrollees for payment of covered services, except as set forth in this description of the plan;

(8) a clear, complete, and accurate description of any limitations or exclusions, including the existence of any drug formulary limitations;

(9) information regarding any preauthorization requirements, including information required by Insurance Code §843.3481 (concerning Posting of Preauthorization Requirements) and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy) [~~a clear, complete, and accurate description of any prior authorization requirements, including limitations or restrictions, and a summary of procedures to obtain approval for referrals to physicians and providers other than primary care physicians or dentists, and other review requirements, including preauthorization review, concurrent review, post service review, and post payment review, and the consequences resulting from the failure to obtain any required authorizations~~];

(10) a provision for continuity of treatment in the event of the termination of a primary care physician or dentist;

(11) a clear, complete, and accurate summary of the HMO's complaint and appeal procedures, a statement of the availability of the independent review process, and a statement that the HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO;

(12) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, with the information necessary to fully inform prospective or current enrollees about the network, including the information required by §11.1612 of this title (relating to Mandatory Disclosure Requirements), together with a link to the online directory required under §11.1612(a) of this title;

(13) a clear, complete, and accurate description of the service area;

(14) when the HMO product includes point-of-service coverage, including when such coverage is provided by an insurer, or when the product is explicitly marketed with the option of purchasing point-of-service coverage, a clear, complete, and accurate explanation of the point-of-service coverage, including:

(A) an explanation of how any deductible is calculated, clearly explaining if multiple deductibles may be applied under the plan as a whole;

(B) a method to obtain a real-time estimate of the amount of reimbursement that will be paid to a non-network provider for a particular service;

(C) a clear, complete, and accurate explanation of how reimbursements of non-network point-of-service services will be determined subject to §11.2503 of this title (relating to Coverage Relating to Point-of-Service Rider Plans) for point-of-service riders or §21.2902 of this title (relating to Arrangements between Indemnity Carriers and HMOs to Provide Coverage) for dual and blended point-of-service arrangements;

(D) if point-of-service coverage is provided under a dual or blended point-of-service arrangement, a clear, complete, and accurate explanation of how the coverage will be coordinated and who the enrollee should contact for common issues, including;

(i) the identity and contact information for each entity, the HMO, the indemnity carrier, or any third party administrator (TPA) that will administer the coverages offered under the point-of-service plan;

(ii) a clear, complete, and accurate description of all duties of the HMO and other carrier to each other relating to the point-of-service plan issued under this subchapter; and

(iii) as applicable, a clear, complete, and accurate explanation of out-of-plan coverage for point-of-service coverage offered in conjunction with plans subject to Insurance Code Chapter 1301 (concerning Preferred Provider Benefit Plans);

(E) a clear, complete, and accurate explanation that for an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the HMO delivery network.

(c) An HMO may use its member handbook to satisfy the requirements of this section if the information contained in the handbook is substantially similar to and provides the same level of disclosure as the written or electronic description prescribed by the commissioner and contains all the information required under this section.

(d) An HMO offering a Children's Health Insurance Program plan that files its plan description in the form of its member handbook in compliance with §11.301 of this title (relating to Filing Requirements), for information only, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook is exempt from the filing and approval requirements of Subsection [~~subsection~~] (b) of this section.

(e) If an HMO limits enrollees' access to health care to a limited provider network, then it must provide a notice in substantially the following form to prospective and current group contract holders: "Choosing Your Physician--Now that you have chosen (Name of HMO), your next choice will be deciding who will provide the majority of your health care

services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP is also part of a 'network' or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing a network and in most instances you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer."

(f) If an HMO does not limit an enrollee's selection of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or provider belongs, then it must provide a notice in compliance with Insurance Code Chapter 1451, Subchapter F, (concerning Access to Obstetrical or Gynecological Care) in substantially the following form to current or prospective enrollees: "ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

(g) An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in each limited provider network. An HMO must include an index of the alphabetical listing of all contracted physicians and providers, including behavioral health providers and substance abuse

treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network(s) to which the physician or provider belongs and the page number where the physician or provider's name can be found.

(h) An HMO must provide notice to enrollees informing them to contact the HMO on receipt of a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner. The notice must inform enrollees of the method(s) for contacting the HMO for this purpose.

(i) If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (for example, a hospital or skilled nursing facility), the plan description must disclose that on admission to the inpatient facility, a physician other than the primary care physician may direct and oversee the enrollee's care.

(j) An HMO that maintains a website must list the information on its website as required by Subsections [~~subsections~~] (b) - (g) of this section and Insurance Code §843.2015 (concerning Information Available Through Internet Site) and §1456.003 (concerning Required Disclosure: Health Benefit Plan). The information must be easily accessible from the home page of the HMO's website.

§11.1607. Accessibility and Availability Requirements.

(a) Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network that is adequate and complies with Insurance Code §843.082 (concerning Requirements for Approval of Application).

(b) There must be a sufficient number of primary care physicians and specialists with hospital admitting privileges to participating facilities who are available and accessible 24 hours per day, seven days per week, within the HMO's service area to meet the health care needs of the HMO's enrollees.

(c) An HMO must make general, special, and psychiatric hospital care available and accessible 24 hours per day, seven days per week, within the HMO's service area.

(d) If an HMO limits enrollees' access to a limited provider network, it must ensure that the limited provider network complies with all requirements of this section.

(e) An HMO must make emergency care available and accessible 24 hours per day, seven days per week, without restrictions on where the services are rendered.

(f) All covered services that are offered by an HMO must be sufficient in number and location to be readily available and accessible within the service area to all enrollees.

(g) An HMO must arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis on request and consistent with these guidelines:

(1) urgent care must be available within 24 hours for medical, dental, and behavioral health conditions;

(2) routine care must be available within:

(A) three weeks for medical conditions;

(B) eight weeks for dental conditions; and

(C) two weeks for behavioral health conditions.

(3) Preventive health services must be available within:

(A) two months for a child;

(B) three months for an adult; and

(C) four months for dental services.

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) 30 miles for primary care and general hospital care; and

(2) 75 miles for specialty care, special hospitals, and single health care service plan physicians or providers.

(i) Access to certain institutional providers. An HMO network providing access to more than one institutional provider in a region must make a good-faith effort to have a mix of for-profit, nonprofit, and tax-supported institutional participating providers, unless the mix is not feasible due to geographic, economic, or other operational factors. An HMO must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(j) An HMO that is unable to meet the requirements of Subsections [~~subsections~~] (b) - (h) of this section must file an access plan for approval with the department in compliance with §11.301 of this title (relating to Filing Requirements). The access plan must specify:

(1) the geographic area within the service area in which a sufficient number of contracted physicians and providers are not available, including a specification of the class of physician or provider;

(2) a map for each specialty, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, and providers are not available;

(3) the reason or reasons that the network does not meet the adequacy requirements specified in this section;

(4) procedures that the HMO will use to assist enrollees in obtaining medically necessary services when no network physician or provider is available, including procedures to coordinate care to hold enrollees harmless and eliminate or limit the likelihood of balance billing;

(5) a list of the physicians and providers within the relevant service area that the HMO attempted to contract with, identified by name and specialty or facility type, with:

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

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

(6) procedures detailing how out-of-network benefit claims will be handled when no physicians or providers are available, including procedures for compliance with §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers);

(7) steps the HMO will take to attempt to bring its network into compliance with this section; and

(8) a process for negotiating with a non-network physician or provider before services being rendered, when feasible.

(k) An HMO must submit an access plan that complies with Subsection [~~subsection~~] (j) of this section along with the annual report on network adequacy under §11.1610 of this title (relating to Annual Network Adequacy Report).

(l) This section does not apply to a health benefit plan written by an HMO for a contract with the Health and Human Services Commission (HHSC) to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System. [~~Notwithstanding subsection (h) of this section, an HMO that has a contract with the Health and Human Services Commission is not required to meet the access requirements prescribed in this section for covered services provided to participants in the Children's Health Insurance Program Perinatal Program.~~]

(m) An HMO may make arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level available within the HMO service area, such as, but not limited to, transplants and treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive the services.

(n) An HMO is not required to expand services outside its service area to accommodate enrollees who live outside the service area but work within the service area.

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

§11.1610. Annual Network Adequacy Report.

(a) An HMO must file a network adequacy report with the department on or before August 15 of each year and before marketing any plan in a new service area after August 15, 2017. The network adequacy report must specify:

(1) the trade name of each HMO plan in which enrollees currently participate;

(2) the applicable service area of each plan; and

(3) whether the HMO service delivery network supporting each plan meets the requirements in §11.1607 of this title (relating to Accessibility and Availability Requirements).

(b) If applicable, the network adequacy report must include an access plan that complies with §11.1607 of this title.

(c) As part of the annual network adequacy report, the HMO must provide additional data specified in this subsection for the previous calendar year. The data must

be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the HMO's plans include a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The HMO report must include the number of:

(1) claims paid for out-of-network benefits that were not based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 (concerning Emergency Care) or §1271.055 (concerning Out-of-Network Services);

(2) claims for out-of-network benefits that were based on an emergency or the unavailability of network physicians or providers under Insurance Code §1271.155 or §1271.055;

(3) complaints by non-network physicians and providers;

(4) complaints by network physicians and providers relating to inability to refer enrollees to network physicians or providers because network physicians or providers are not available;

(5) complaints by enrollees relating to the dollar amount of the HMO's payment for basic health care benefits;

(6) complaints by enrollees concerning balance billing;

(7) complaints by enrollees relating to the unavailability of network physicians or providers;

(8) complaints by enrollees relating to the accuracy of network physician and provider listings; and

(9) complaints by physicians and providers relating to the accuracy of network physician and provider listings.

(d) The annual network adequacy report required under this section must be submitted electronically in a format and by a method acceptable to the department. Unless and until a standardized form and method for submitting the above information is made available by the department, acceptable formats include Microsoft Word and Excel documents. Unless and until another electronic method of submission is required, the report must be submitted to the department's email address, mcqa@tdi.texas.gov, and must indicate in the subject field that the email relates to the filing of the annual network adequacy report.

(e) If the commissioner determines that the HMO's network and any access plan supporting the network are inadequate to ensure that benefits are available to all enrollees or are inadequate to ensure that all covered health care services are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions under the commissioner's authority in Insurance Code Chapter 82 (concerning Sanctions) and Insurance Code Chapter 83 (concerning Emergency Ceases and Desist Orders) to issue cease and desist orders:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and

(3) cessation of marketing entirely and withdrawal from the HMO market.

(f) This section does not affect the commissioner's authority to take or order any other appropriate action under the commissioner's authority in the Insurance Code.

(g) This section does not apply to a health benefit plan written by an HMO for a contract with the Health and Human Services Commission (HHSC) to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§11.1612. Mandatory Disclosure Requirements.

(a) Online directory. An HMO must develop and maintain a directory of contracting physicians and health care providers, display the directory on a public Internet website maintained by the HMO, and ensure that a direct electronic link to the directory is conspicuously displayed on the electronic summary of benefits and coverage of each plan issued by the HMO. The directory must:

(1) include the name, address, [~~and~~] telephone number, and specialty, if any, of each physician and provider;

(2) clearly indicate each health benefit plan issued by the HMO that may provide coverage for services provided by each physician or provider included in the directory;

(3) be electronically searchable by physician or health care provider name and location;

(4) be publicly accessible without the necessity of [~~or~~] providing a password, a username, or personally identifiable information; and

(5) be reviewed on an ongoing basis and corrected or updated, if necessary, not less than once each month.

(b) Identification of limited networks and index. An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. An HMO must include an index of the alphabetical listing of all physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network(s) to which the physician or provider belongs and the page number where the physician or provider's name can be found.

(c) Notice of rights under an HMO plan required. An HMO must include the notice specified in Figure: 28 TAC §11.1612(c), in all evidences of coverage certificates, disclosures of plan terms, and member handbooks in at least a 12-point font:

Figure: 28 TAC §11.1612(c)

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.
- You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: (website address to be filled out by the HMO) or by calling (to be filled out by the HMO) for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

(d) Disclosure concerning access to network physician and provider listing. An HMO must provide notice to all enrollees at least annually describing how the enrollee may access a current listing of all network physicians and providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which enrollees may obtain assistance during regular business hours to find available network physicians and providers.

(e) Disclosure concerning network information. An HMO must provide notice to all enrollees at least annually of:

(1) information that is updated at least annually regarding the following network information for each service area, or for the entire state if the plan is offered on a statewide service-area basis:

(A) the number of enrollees in the service area or region;

(B) for each physician and provider area of practice, including at a minimum internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of contracted physicians and providers, an indication of whether an active access plan under §11.1607 of this title (relating to Accessibility and Availability Requirements) applies to the services furnished by that class of physician or provider in the service area or region, and how the access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of contracted hospitals in the service area or region, an indication of whether an active access plan in compliance with §11.1607 of this title applies to hospital services in that service area or region, and how the access plan may be obtained or viewed, if applicable;

(2) information that is updated at least annually regarding whether any access plans approved under §11.1607 of this title apply to the plan and that complies with the following:

(A) if an access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the HMO's plan is not offered on a statewide service area basis, or for the entire state if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the access plan.

(f) Website disclosures. An HMO must provide information on its website regarding the HMO or health benefit plans offered by the HMO for use by current or prospective enrollees must provide a:

(1) web-based physician and provider listing for use by current and prospective enrollees; and

(2) web-based listing of the state regions, counties, or three-digit ZIP code areas within the HMO's service area(s), indicating, as appropriate, for each region, county, or ZIP code area, as applicable, that the HMO has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter.

(g) Reliance on physician and provider listing in certain cases. A claim for services rendered by a noncontracted physician or provider must be paid in the same manner as if no contracted physician or provider had been available under §11.1611 of this title

(relating to Out-of-Network Claims; Non- Network Physicians and Providers), as applicable, if an enrollee demonstrates that:

(1) in obtaining services, the enrollee reasonably relied on a statement that a physician or provider was a contracted physician or provider as specified in:

(A) a physician and provider listing; or

(B) provider information on the HMO's website;

(2) the physician and provider listing or website information was obtained from the HMO, the HMO's website, or the website of a third party designated by the HMO to provide that information for use by its enrollees;

(3) the physician and provider listing or website information was obtained not more than 30 days before the date of services; and

(4) the physician and provider listing or website information obtained indicates that the provider is a contracted provider within the HMO's network.

(h) Additional listing-specific disclosure requirements. In all contracted physician and provider listings, including any web-based postings of information made available by the HMO to provide information to enrollees about contracted physicians and providers, the HMO must comply with the following requirements:

(1) the physician and provider information must include a method for enrollees to identify the hospitals that have contractually agreed with the HMO to facilitate the usage of contracted providers by exercising good-faith efforts to accommodate requests from enrollees to use contracted physicians and providers;

(2) the physician and provider information must indicate whether each contracted physician and provider is accepting enrollees as new patients or participates in closed provider networks serving only certain enrollees;

(3) the physician and provider information must provide an email address and a toll-free telephone number through which enrollees may notify the HMO of inaccurate information in the listing, with specific reference to:

(A) information about the physician's or provider's contract status; and

(B) whether the physician or provider is accepting new patients;

(4) the physician and provider information must provide a method by which enrollees may identify contracted facility-based physicians able to provide services at contracted facilities;

(5) the physician and provider information must include a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network;

(6) as provided in Insurance Code §1456.003 (concerning Required Disclosure: Health Benefit Plan), the physician and provider information must give the identity of any health care facilities within the provider network in which facility-based physicians or other health care practitioners do not participate in the health benefit plan's provider network;

(7) the provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based physician or provider, specifying the applicable provider class;

(8) the physician and provider information must be dated; [~~and~~]

(9) the physician and provider information must be provided in at least 10-point font; [~~.~~]

(10) for each health care provider that is a facility included in a listing, the HMO must:

(A) create separate headings under the facility name for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, and assistant surgeons;

(B) under each heading described by Subparagraph (A) of this paragraph, list each preferred facility-based physician practicing in the specialty corresponding with that heading;

(C) for the facility and each facility-based physician described by Subparagraph (B), clearly indicate each health benefit plan issued by the HMO that may provide coverage for the services provided by that facility, physician, or facility-based physician group;

(D) for each facility-based physician described by Subparagraph (B) of this paragraph, include the name, street address, telephone number, and any physician group in which the facility-based physician practices; and

(E) include the facility in a listing of all facilities and indicate:

(i) the name of the facility;

(ii) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and

(iii) each health benefit plan issued by the HMO that may provide coverage for the services provided by the facility; and

(11) the listing must list each facility-based physician individually and, if a physician belongs to a physician group, also as part of the physician group.

(i) Annual enrollee notice concerning use of an access plan. An HMO operating a plan that relies on an access plan as specified in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees) and §11.1607 of this title must provide notice of this fact to each enrollee participating in the plan at issuance and at least 30 days before renewal. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available under Subsection [~~subsection~~] (e)(2) of this section; and

(2) information on how to obtain or view any access plan or plans the HMO uses.

(j) Disclosure of substantial decrease in the availability of certain contracted physicians. An HMO is required to provide notice as specified in this subsection of a substantial decrease in the availability of contracted facility-based physicians at a contracted facility.

(1) A decrease is substantial if:

(A) the contract between the HMO and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the contracted physicians for that specialty at the facility terminates, and the HMO receives notice as required under §11.901 of this title (relating to Required and Prohibited Provisions).

(2) Despite Paragraph [~~paragraph~~] (1) of this subsection, no notice of a substantial decrease is required if:

(A) alternative contracted physicians or providers of the same specialty as the physician group that terminates a contract as specified in Paragraph [~~paragraph~~] (1) of this subsection are made available to enrollees at the facility so the percentage level of contracted physicians of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available before the substantial decrease; or

(B) the HMO certifies to the department, by email to mcqa@tdi.texas.gov, that the HMO's determination that the termination of the physician

contract has not caused the contracted physician service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §11.1607 of this title, as those standards apply to the applicable physician specialty.

(3) An HMO must prominently post notice of any contract termination specified in Paragraph [~~paragraph~~] (1)(A) or (B) of this subsection and the resulting decrease in availability of contracted physicians on the portion of the HMO's website where its physician and provider listing is available to enrollees.

(4) Notice of any contract termination specified in Paragraph [~~paragraph~~] (1)(A) or (B) of this subsection and of the decrease in availability of physicians must be maintained on the HMO's website until the earlier of:

(A) the date on which adequate contracted physicians of the same specialty become available to enrollees at the facility at the percentage level specified in Paragraph [~~paragraph~~] (2)(A) of this subsection;

(B) six months from the date that the HMO initially posts the notice; or

(C) the date on which the HMO provides to the department, by email to mcqa@tdi.texas.gov, the certification specified in Paragraph [~~paragraph~~] (2)(B) of this subsection.

(5) An HMO must post notice as specified in Paragraph [~~paragraph~~] (3) of this subsection and update its web-based contracted physician and provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in Paragraph [~~paragraph~~] (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an HMO receives notice of a contract termination as specified in Paragraph [~~paragraph~~] (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in Paragraph [~~paragraph~~] (1)(B) of this subsection.

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

Issued in Austin, Texas, on September 4, 2020.

DocuSigned by:
James Person
75578E954EFC48A...

James Person, General Counsel
Texas Department of Insurance