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INTRODUCTION. The Commissioner of Insurance adopts amendments to 28 TAC §§21.2
- 21.4, 21.6, 21.102, 21.104, 21.120, 21.203 - 21.205, 21.301, 21.403, 21.408, 21.701, 21.703
- 21.705, 21.901, 21.1004 - 21.1007, 21.1101, 21.1110, 21.2001, 21.2006, 21.2010, 21.2011,

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21.2106, 21.2202, 21.2204, 21.2212, 21.2501, 21.2601, 21.2604, 21.2606, 21.2702, 21.2819, 21.2901, 21.2902, 21.3201, 21.3302, 21.3303, 21.3305, 21.3701, 21.3802, and 21.4105, relating to trade practices.

The amendments to §§21.2 - 21.4, 21.6, 21.204, 21.205, 21.301, 21.403, 21.408, 21.701, 21.703 - 21.705, 21.1004, 21.1006, 21.1101, 21.1110, 21.2010, 21.2011, 21.2106, 21.2202, 21.2204, 21.2212, 21.2601, 21.2604, 21.2606, 21.2702, 21.2819, 21.2901, 21.2902, 21.3201, 21.3302, 21.3303, 21.3305, 21.3701, 21.3802, and 21.4105 are adopted without changes to the proposed text published in the June 18, 2021, issue of the *Texas Register* (46 TexReg 3701).

The amendments to §§21.102, 21.104, 21.120, 21.203, 21.901, 21.1005, 21.1007, 21.2001, 21.2006, and 21.2501 are adopted with nonsubstantive changes to the proposed text.

REASONED JUSTIFICATION. Amendments to Chapter 21 are necessary to (1) change instances of the obsolete "State Board of Insurance" to "Department of Insurance;" (2) replace obsolete statutory citations to Insurance Code articles that have changed because of codification; (3) update agency names, websites, and addresses; (4) correct typographical, punctuational, and grammatical errors, and (5) make nonsubstantive language and usage changes to adhere to current agency style (e.g., capitalizing "Commissioner" and changing "shall" to other context-appropriate words).

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

Subchapter A. Unfair Competition and Unfair Practices of Insurers, and Misrepresentation of Policies. Amendments to §§21.2, 21.3, and 21.6 update obsolete

statutory citations. Additional amendments to §21.3 and §21.4 update obsolete references to the State Board of Insurance.

Additional amendments include amending §21.3 to replace "shall" with "may," amending §21.4 to remove superfluous "or" instances, and in §21.6 "shall" is replaced with "will."

Subchapter B. Advertising, Certain Trade Practices, and Solicitation.

Amendments to §§21.102, 21.104, and 21.120 remove obsolete references to "viatical." An amendment to §21.120 updates an obsolete mailing address. Amendments to §21.120 change "shall" to "must," change "division" to "title," and update a regulatory reference.

A change from the proposal text removes an unnecessary comma in §21.102(4) after "premium finance companies." A change from the proposed text in §21.104 replaces "shall" with "must." A change from the proposal text in §21.120(e)(1) adds a comma after "sales."

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

Additional amendments to §21.203 include replacing "shall" with "may" or "will," as appropriate; capitalization of "Commissioner of Insurance"; addition of missing periods; deletions of "the"; changes to syntax for proper grammar; and correcting a citation to the Insurance Code. In §21.204, additional amendments include replacing "shall" with "must," replacing "such" with "the" in two places and replacing "of" with "by." In §21.205, an additional amendment replaces "shall" with "must."

A change from the proposal text in §21.203 clarifies the corrected statutory reference, adding "Subchapter B" to Chapter 542.

Subchapter D. Statistical Agents. Amendments to §21.301 update obsolete statutory citations. Amendments also include deleting "shall" or replacing it with "will"

and "must," as appropriate; capitalizing "Commissioner"; inserting the word "following"; and inserting a comma and a colon where needed.

Subchapter E. Unfair Discrimination Based on Sex or Marital Status.

Amendments to §21.403 update obsolete references to "the board," remove obsolete references to "non-profit legal service corporations," delete unnecessary uses of the word "shall" and revise text as appropriate to reflect removal of "shall" and correct punctuation. Amendments to §21.403 and §21.408 update obsolete statutory citations.

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

Subchapter I. Prohibited Agent Practices. Amendments to §21.901 update obsolete statutory citations. Additional amendments add and delete commas; delete one instance of "shall" and replace another instance with "will"; and replace "shall be" with "are," "pursuant" with "according"; and "article" with "chapter."

A change from the proposal text in §21.901 revises "will" to "do" where "will" was used as a revision of the word "shall."

Subchapter J. Prohibited Trade Practices. Amendments to §§21.1004 - 21.1007 update obsolete statutory citations. Additional amendments add a hyphen in §21.1004; delete an unnecessary comma and replace "shall" with "may" and "shall be" with "is" in §21.1005, as appropriate; make the word "To" lowercase in the heading of §21.006 and replace "shall" with "does" in §21.1006.

An amendment to §21.1004 updates a section title. An amendment to §21.1004(d) updates a section title. In addition, amendments delete §21.1004(f) and (g) because subsection (f) is no longer effective, and subsection (g) is no longer relevant. Subsection (g) contains an expiration clause for subsection (f), providing for the section to expire on January 1, 2008.

An amendment to §21.1007 removes an unnecessary and obsolete mailing address.

A change from the proposal text in §21.1005 changes amended text at the end of section (a) from "will be" to "is."

A change from the proposal text in §21.1007 adds a hyphen in "PC327 WDR-1."

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

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

A change from the proposal text in §21.2001 removes an unnecessary ending parenthesis in (8)(B)(ii) after "Chapter 1578." A change from the proposal text in §21.2006 in subsection (a) changes "Insurance Codes" to "Insurance Code."

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

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

Subchapter Q. Complaint Records to be Maintained. Amendments to §21.2501 update obsolete statutory citations and eliminate unnecessary uses of "the."

A change from the proposal text in §21.2501 corrects a rule reference.

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

Subchapter S. Association Plans. Amendments to §21.2702 update obsolete statutory citations. Additional amendments include changing a colon to a period, capitalizing "Commissioner," eliminating unnecessary uses of "shall," and adding commas and hyphens where appropriate.

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

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

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

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

Subchapter CC. Electronic Health Care Transactions. Amendments to §21.3701 update obsolete statutory citations and a mailing address. Additional amendments include correcting a citation to a section in the Administrative Code, replacing "shall" with "must" or "will," as appropriate; replacing "ten" with "10"; and replacing "Department of Insurance" with "department." Amendments also update the titles of department staff, which have changed due to internal reorganizations.

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

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

SUMMARY OF COMMENTS AND AGENCY RESPONSE. The Texas Department of Insurance (TDI) received one comment from the Texas Medical Association on the proposed amendments. The commenter was neither for nor against the proposal, but requested changes.

Comment on Chapter 21 Generally

Comment. A commenter raises concerns that changing "shall" to "must" in some of the amended rules could change the meaning of the rules. As an example, the commenter points to the proposed amendment to §21.205. The commenter says that replacing the word "shall" with "must" or another comparable word may lead to someone misconstruing the rule proposal as removing the various duties imposed on health benefit

plan issuers under the rules. The commenter requests that TDI clarify its intent with the change of the word.

The commenter refers to §311.016 of the Government Code (the Code of Construction Act), which provides definitions for the words "may," "shall," and "must," and objects to TDI making any change of the use of the word "shall" in rule text that could be construed as removing a duty imposed on a health benefit plan issuer or that is inconsistent with use of the word "shall" in the underlying statute that forms the basis of the rule.

The commenter requests that TDI provide more information on its style guidelines so that stakeholders, the public, and the regulated community may better understand its intended use of "must" and "shall" and whether they are interchangeable under TDI style preferences.

Agency Response. TDI disagrees that changing "shall" to "must" in this rulemaking is a substantive change. As the Texas Supreme Court said in *Helena Chemical Co. v. Wilkins*, 47 S.W.3d 486, 493 (Tex. 2001), "shall" and "must" are both "generally recognized as mandatory, creating a duty or obligation." The proposed changes of the word "shall" contemplate the content of applicable statutes and the context of the rule text in implementing those statutes, and that context makes it clear that the meaning of the impacted rules is not being changed.

The purpose of changing the word "shall" is to provide plain language clarification of the rule text, consistent with current agency style and guidance on the TDI website, which provides links to resources on writing in plain language. Resources TDI uses for plain language guidance include plainlanguage.gov, which provides the federal government's plain language guidelines, and the National Archives guidelines for clear legal documents. Both sources advise using alternatives to the word "shall" to provide clarity for readers.

**SUBCHAPTER A. UNFAIR COMPETITION AND UNFAIR PRACTICES OF INSURERS,
AND MISREPRESENTATION OF POLICIES
28 TAC §§21.2 - 21.4 and 21.6**

STATUTORY AUTHORITY. The Commissioner adopts the amendments to §§21.2 - 21.4 and 21.6 under Insurance Code §§463.006, 541.401, 543.001, and 36.001.

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

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

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

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

TEXT.**§21.2. Interpretations.**

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

to be interpreted to accomplish the purpose of these sections in accordance with the provisions of Insurance Code Chapter 541 and Insurance Code §543.001.

§21.3. Unfair Trade Practices Prohibited.

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

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

§21.4. Misrepresentation Defined; Standards for Determining Misrepresentation.

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

- (1) any untrue statement of a material fact;
- (2) any omission to state a material fact necessary to make the statements made (considered in the light of the circumstances under which they are made) not misleading;

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

(4) any material misstatement of law; or

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

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

The use in any manner of the protection afforded by the Life and Health Insurance Guaranty Association Act (the Act) by any person in the sale of any product included within the scope of the Act (Insurance Code Chapter 463) will constitute unfair competition and unfair practices under Insurance Code Chapter 541 and will be subject to the provisions thereof.

**SUBCHAPTER B. ADVERTISING, CERTAIN TRADE PRACTICES, AND SOLICITATION
DIVISION 1. INSURANCE ADVERTISING
28 TAC §§21.102, 21.104, and 21.120**

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§21.102, 21.104, and 21.120 under Insurance Code §562.106 and §36.001.

Insurance Code §562.106 provides that if the Commissioner reasonably believes that a program operator or marketer may not be operating in compliance with Chapter 562, the Commissioner by order may require the program operator or marketer to submit to the Commissioner any advertisement, solicitation, or marketing materials or other document requested by the Commissioner.

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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.

TEXT.

§21.102. Scope.

For the purpose of this division:

(1) "Advertisement" includes, but is not limited to:

(A) printed and published material, audio visual material and electronic media, descriptive literature of an insurer or agent used in direct mail, newspapers, magazines, radio, telephone and television scripts, billboards, and similar displays;

(B) descriptive literature and sales aids of all kinds issued by an insurer or agent for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters;

(C) prepared sales talks, presentations and materials for use by agents, and those representations recurringly made by agents to members of the public;

(D) material used to:

(i) solicit additional coverage or policies from existing insureds; or

(ii) modify existing coverage or policies;

(E) material included with a policy when the policy is delivered and materials used in the solicitation of renewals and reinstatements, except those reinstatements provided for in the policy;

(F) lead solicitations which are defined as communications distributed to the public which, regardless of form, content, or stated purpose, are

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intended to result in the compilation or qualification of a list containing names or other personal information regarding persons who have expressed a specific interest in a product or coverage and which are intended to be used to solicit residents of this state for the purchase of a policy, as defined in paragraph (3) of this section; and

(G) any other communication directly or indirectly related to a policy, as defined in paragraph (3) of this section, and intended to result in the eventual sale or solicitation of a policy.

(2) "Advertisement" does not include:

(A) communications or materials used within an insurer's own organization, not used as sales aids and not disseminated to the public;

(B) communications with policyholders other than materials urging policyholders to purchase, increase, modify, or retain a policy;

(C) a general announcement by a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage;

(D) material used solely for the recruitment, training, and education of an insurer's personnel, agents, counselors, and solicitors, provided it is not also used to induce the public to purchase, increase, modify, or retain a policy of insurance; and

(E) correspondence between a prospective group or blanket policyholder and an insurer or agent in the course of negotiating a group or blanket contract.

(3) "Policy" includes any policy, plan, certificate, contract, evidence of coverage, agreement, statement of coverage, cover note, certificate of policy, rider or endorsement which provides, limits, or controls insurance for any kind of loss or expense or because of the continuation, impairment, or discontinuance of human life or annuity

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benefits issued by an insurer, life settlement contracts, premium finance agreements, or any other product offered by an insurer and regulated by the Department.

(4) "Insurer" includes any individual, partnership, corporation, organization, or person issuing evidence of coverage or insurance, or any other entity acting as an insurer to which this division can be made legally applicable including, as applicable, Health Maintenance Organizations, and all insurance companies doing the business of insurance in this state such as capital stock companies, mutual companies, title insurance companies, fraternal benefits societies, local mutual aid associations, local mutual burial associations, statewide mutual assessment companies, county mutual and farm mutual insurance companies, Lloyds' plan companies, reciprocal or interinsurance exchanges, stipulated premium insurance companies, and group hospital service companies and, as can be made appropriate, premium finance companies and life settlement providers.

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

(6) "Institutional advertisement" is an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or agent. Correspondence and materials used by an insurer only for the purpose of explaining Legislative or Texas Department of Insurance mandated changes, amendments, additions, or innovations relative to forms, rules, or rates which are subject to the Insurance Code shall be considered institutional advertising for the purpose of §21.104(b) of this division (relating to Requirement of Identification of Policy or Insurer). Web pages on an Internet website that do not refer to a specific insurance policy, certificate of coverage, or evidence of coverage or that do not provide an opportunity for an individual to apply for coverage or to request a quote are considered to be institutional advertisements. Advertisements in other media that do not refer to a

specific insurance policy, certificate of coverage, or evidence of coverage or that do not provide an opportunity for an individual to apply for coverage or to request a quote or other information, are considered to be institutional advertisements. In addition, web pages or navigation aids within an Internet website that provide a link to another web page, the content of which refers to a specific insurance policy, certificate of coverage, or evidence of coverage or provides an opportunity for an individual to apply for coverage or request a quote, but that do not, themselves, otherwise include such content are considered to be institutional advertisements.

(7) "Invitation to inquire" for the purpose of this section is an advertisement that refers to a specific insurance policy or provides an opportunity to request a quote or that, except for Internet advertising, provides an opportunity to request other information. An "invitation to inquire" advertisement for accident or health coverage may refer to rates only as permitted under §21.113(b) of this division (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising). An "invitation to inquire" is not an "invitation to contract."

(8) "Invitation to contract" is an advertisement that includes an application or enrollment form for insurance or which is presented with an opportunity to apply for the advertised coverage.

§21.104. Requirement of Identification of Policy or Insurer.

(a) An advertisement must identify the person or entity responsible for the advertisement.

(1) The full licensed name of the insurer is required to be stated in each of its invitation to inquire and invitation to contract advertisements, including the portion of the advertisement to be returned to the insurer or agent, unless the portion to be returned is delivered as a form detachable from another form containing the insurer's full licensed

name. The full licensed name must appear at or before the first appearance of any shortened or substitute name in the body of the text, which shortened or substitute name may be indicated as representing the insurer thereafter in the advertisement.

(2) It is sufficient to state the full licensed name, assumed name registered with the department pursuant to §19.902 of this title (relating to One Agent, One License) or Texas agent's license number of the agent when advertisements address coverages in general and do not describe a specific policy or coverages of a particular insurer.

(b) An advertisement other than institutional, may not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive a prospective purchaser as to the true identity of the insurer, or its relation with public or private institutions.

(c) No advertisement may use a combination of words, symbols, or physical materials which by their content, phraseology, shape, color, or other characteristics are so similar to combinations of words, symbols, or physical material normally or usually used by agencies of the federal government or of this state, or that otherwise appear to be of such a nature that the advertisement or solicitation has the capacity or tendency to confuse or mislead prospective insureds into believing that such advertisement or solicitation is connected with an agency of the municipal, state, or federal government.

(d) All advertisements, other than institutional, must explicitly and conspicuously disclose that the product concerned is property, life or other insurance, an annuity, HMO coverage, a life settlement contract, or a prepaid legal services contract, on the basis that each of these products are classified or addressed by statute or rule or as the products are filed with the department. It is sufficient for an insurer to use the term "PPO plan" in

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advertisements when referring to a preferred provider benefit plan offered under Insurance Code Chapter 1301.

(e) An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed may not imply licensing beyond those limits.

(f) An advertisement may not contain statements that avoid a clear and unequivocal statement that insurance or an annuity or HMO coverage is the subject matter of the solicitation.

(g) An advertisement that contains an application and is advertising more than one policy shall be presented in such manner as to clearly reflect that the cost and benefits are applicable to separate policies of insurance.

(h) No advertisement by an insurer or agent may be used that, directly or by implication, has the capacity and tendency to mislead or deceive prospective purchasers with respect to an insurer's assets, corporate structure, financial standing, age or relative position in the insurance business, or in any other material respect.

(i) Multiple insurers may be represented in one advertisement, provided that an invitation to inquire or invitation to contract advertisement must clearly identify the issuer of each product advertised and the advertisement discloses that each insurer has sole financial responsibility for its own products.

§21.120. Filing for Review.

(a) Any advertisement required to be submitted or submitted voluntarily by an insurer licensed to do business in Texas must be accompanied by a transmittal letter addressed to the Texas Department of Insurance, Life and Health Lines, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030. The transmittal letter must contain the following information:

(1) the identifying form number of each form submitted including a separate identifying form number for each Internet page and pop-up having a distinct URL;

(2) the type of advertisement submitted, i.e., institutional advertisement, invitation to inquire, or invitation to contract;

(3) the form number(s) of the approved policy and/or rider form(s) advertised;

(4) the method or media used for dissemination of the advertisement;

(5) the form number(s) for all other advertising material to be used with the advertisement(s) being submitted; and

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

(b) All advertisements must be submitted in duplicate.

(c) Advertisements may be submitted in printers' proof or as "pasteups."

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

the form number(s) and the department's filing number(s) under which those forms were previously reviewed and accepted.

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

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

(2) §3.3313 of this title (relating to Filing Requirements for Advertising), regarding Medicare supplement insurance;

(3) §3.3838 of this title (relating to Filing Requirements for Advertising), regarding long-term care insurance; and

(4) §11.603 of this title (relating to Filings), regarding certain Medicare HMO contracts.

SUBCHAPTER C. UNFAIR CLAIMS SETTLEMENT PRACTICES
28 TAC §§21.203 - 21.205

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§21.203 - 21.205 under Insurance Code §542.014 and §36.001.

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

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

TEXT.

§21.203. Unfair Claim Settlement Practices.

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

(1) misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

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

(3) failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies;

(4) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear;

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

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

(7) failing to provide promptly, when provided for in the policy, claim forms when the insurer requires such forms as a prerequisite for a claim settlement;

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

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

(10) failing to affirm or deny coverage of a claim to a policyholder within a reasonable time. The reasonable submission of a reservation of rights letter by an insurer to a policyholder within a reasonable time is deemed compliance with the provisions of this paragraph;

(11) except as may be specifically provided in the policy, to refuse, fail, or unreasonably delay offer of settlement under applicable first-party coverage on the basis that other coverage may be available or third parties are responsible in law for damages suffered;

(12) attempting to settle a claim for less than the amount to which a reasonable person would have believed she/he was entitled by reference to an advertisement, as described in §21.102 of this title (relating to Scope), made by an insurer or person acting on behalf of an insurer;

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

(14) failing to establish a policy and proper controls to make certain that agents calculate and deliver to policyholders or their assignees funds due under policy

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provisions relative to cancellation of coverage within a reasonable time after such coverages are terminated;

(15) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(16) failing to respond promptly to a request by a claimant for personal contact about or review of the claim;

(17) with respect to the Texas personal auto policy, delaying or refusing settlement of a claim solely because there is other insurance of a different type available to satisfy partially or entirely the loss forming the basis of that claim. The claimant who has a right to recover from either or both insurers is entitled to choose under which coverage and in what order payment is to be made;

(18) a violation of Insurance Code Chapter 542, Subchapter B, by an insurer subject to its provisions; or

(19) requiring a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless the claimant is ordered to produce those tax returns by a court of competent jurisdiction, the claim involves a fire loss, or the claim involves a loss of profits or income.

§21.204. Special Claim Reports and Statistical Plan.

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

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

(2) the total number of written claims denied for the past 12-month period or from the date of the insurer's last periodic report, whichever is shorter;

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

(4) the total number of written claims for which lawsuits were instituted against the insurer, including the original amount filed for by the insured, the amount of final adjudication, the reason for the lawsuit, and the classification by line of insurance of each individual written claim, for the past 12-month period or from the date of the insurer's last periodic report, whichever time is shorter; and

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

§21.205. Minimum Standard of Performance.

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

SUBCHAPTER D. STATISTICAL AGENTS

28 TAC §21.301

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.301 under Insurance Code §38.207 and §36.001.

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

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

TEXT.**§21.301. Performance Standards for Designated Statistical Agent.**

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

(1) Agreed upon standards of performance--A set of standards of performance for each statistical agent which is negotiated and agreed upon by the statistical agent affected and the department. For statistical agents already designated as of the effective date of this section, the standards of performance must be agreed upon within eight months of the effective date of this section. For statistical agents designated after the effective date of this section, the standards of performance must be agreed upon prior to the effective date of the statistical agent's designation.

(2) Commissioner--Commissioner of Insurance of the State of Texas.

(3) Department--Texas Department of Insurance.

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

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

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

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

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

(1) The seriousness of the noncompliance, including the nature, circumstances, extent, and gravity of the noncompliance.

(2) The hazard or potential hazard to the health safety, or economic welfare of the public created by the noncompliance.

(3) The economic harm to the public's interests or confidences caused by the noncompliance.

(4) The history of previous noncompliance with performance standards by the designated statistical agent.

(5) The amount necessary to deter future noncompliance.

(6) The designated statistical agent's efforts to correct the noncompliance.

(7) Whether the designated statistical agent intentionally or unintentionally failed to comply with the agreed upon standards of performance.

(8) Any other consideration that the Commissioner may deem appropriate.

(e) The amount of the administrative monetary penalty may not exceed \$25,000 for each act of noncompliance.

(f) The department reserves the right to assert any and all other rights it may have against the statistical agents or other related parties, including its right to terminate the designation of a statistical agent, if appropriate.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.403 and §21.408 under Insurance Code §541.401 and §36.001.

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

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

TEXT.

§21.403. Definitions.

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

(1) Insurer--Includes, but is not be limited to, all life, health, and accident companies; capital stock companies; mutual assessment life insurance companies; statewide mutual assessment corporations; county mutual insurance companies; local

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mutual aid associations; farm mutual insurance companies; mutual or natural premium life or casualty insurance companies; general casualty companies; Mexican casualty companies; Lloyds, reciprocal, or inter-insurance exchanges; nonprofit hospital, medical, or dental service corporations including, but not limited to, companies subject to the Insurance Code Chapter 842, as amended; stipulated premium insurance companies; fidelity, guaranty, and surety companies; title insurance companies; health maintenance organizations; and all other organizations, corporations, or persons engaged in the business of insurance, whether or not named previously; provided, however, these sections do not apply to any society, company, or other insurer whose activities are by statute exempt from the regulation of the department and which are entitled by statute to an exemption certificate from the department in evidence of their exempt status; nor to fraternal benefit societies.

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

§21.408. Amendments.

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

SUBCHAPTER H. UNFAIR DISCRIMINATION 28 TAC §§21.701 and 21.703 - 21.705

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STATUTORY AUTHORITY. The Commissioner adopts amendments to §§21.701 and 21.703 - 21.705 under Insurance Code §541.401 and §36.001. The Commissioner adopts amendments to §21.705 under Insurance Code §545.003.

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

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

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

TEXT.

§21.701. Purpose.

The purpose of these sections is to identify specific acts or practices which are prohibited by Insurance Code §541.057 and §544.002.

§21.703. Definitions Concerning Discrimination.

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

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

§21.704. Unfair Discrimination.

(a) General propositions.

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

(2) Sexual orientation may not be used in the underwriting process or in the determination of insurability.

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

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

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

(2) Questions relating to the proposed insured having, or having been diagnosed as having, acquired immune deficiency syndrome (AIDS) or AIDS-related complex are permissible if they are factual and designed to establish the existence of the condition.

(3) Questions relating to medical and other factual matters intending to reveal the possible existence of a medical condition are permissible if they are not used

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as a proxy to establish the sexual orientation of the proposed insured, and if the proposed insured has been given an opportunity to provide an explanation for any affirmative answers given in the application.

(4) Questions relating to applicant's having, or having been diagnosed as having, sexually transmitted disease are permissible.

(5) Neither the marital status, the living arrangements, the occupation, the gender, the medical history, the beneficiary designation, nor the zip code or other classification of a proposed insured may be used to establish, or aid in establishing, the proposed insured's sexual orientation.

(6) For purposes of rating a proposed insured for health and life insurance, an insurer may impose territorial rates, but only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.

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

(8) Whenever a proposed insured is requested to take an HIV-related test in connection with an application for insurance, the use of such a test must be revealed to the proposed insured or to any other person legally authorized to consent to such a test, and his or her written authorization obtained. The form of such authorization must be printed on a separate piece of paper and must contain the specific language in the form, entitled Notice and Consent for HIV-Related Testing, which the Texas Department of Insurance has adopted and incorporated herein by reference, effective January 7, 1997. This form is published by the Texas Department of Insurance and copies of this form are available from and on file at the offices of the Texas Department of Insurance, Life and

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Health Lines, MC-LH-LHL, P.O. Box 12030 Austin, Texas 78711-2030. Other information may be included so long as it is not misleading or violative of any applicable law or rule. Testing may be required only on a nondiscriminatory basis. No adverse underwriting decision shall be made on the basis of such a positive HIV-related test unless the established test protocol as provided by §21.705 of this title (relating to Nondiscriminatory Testing for Human Immunodeficiency Virus) has been followed.

(9) Insurers are permitted to ask a proposed insured whether the proposed insured has tested positive on an acquired immune deficiency syndrome-related test.

(10) The result of an HIV-related test is confidential.

(A) An insurer may not release or disclose the test results or allow them to become known, except in the following circumstances:

(i) as may be required by law; or

(ii) pursuant to the written request or authorization of the proposed insured or other person legally authorized to consent to the test on behalf of the proposed insured, with such release pursuant to written request limited to:

(I) the proposed insured;

(II) the person legally authorized to consent to the test;

(III) a licensed physician, medical practitioner, or other person designated by the proposed insured;

(IV) an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular proposed insured;

(V) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality;

(VI) persons within the insurer's organization who have the responsibility to make underwriting decisions on behalf of the insurer; or

(VII) outside legal counsel who needs such information to effectively represent the insurer in regard to matters concerning the proposed insured.

(B) Should a proposed insured or the person legally authorized to consent to the test request that the test result be sent to him or her directly, in addition to being provided notice as otherwise required by law, the insurer shall mail the test result to the proposed insured or the person legally authorized to consent to the test by registered mail with delivery restricted to the addressee.

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

(i) a physician designated by the proposed insured or other person legally authorized to consent to the test; or

(ii) in the absence of such designation, to the Texas Department of Health, in order that the proposed insured be provided notice of such result as required by law.

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

§21.705. Nondiscriminatory Testing for Human Immunodeficiency Virus.

A proposed insured for life or health and accident insurance, or for coverage by a company licensed under Insurance Code Chapter 842, or with a licensed health maintenance organization may be required to be tested for the presence of the human

immunodeficiency virus (HIV). Requiring such testing is not unfair discrimination provided:

(1) the testing is required on a nondiscriminatory basis for all individuals in the same class; and

(2) no proposed insured is denied coverage or rated a substandard risk on the basis of such testing unless:

(A) an initial enzyme linked immunosorbent assay (ELISA) test is administered to the proposed insured, and it indicates the presence of HIV antibodies;

(B) a second ELISA test is conducted and it indicates the presence of HIV antibodies; and

(C) a Western Blot test is conducted and it confirms the results of the two ELISA tests.

(3) the tests and testing procedures used have been approved by the United States Food and Drug Administration (FDA) and otherwise comply with applicable Texas and federal laws.

SUBCHAPTER I. PROHIBITED AGENT PRACTICES
28 TAC §21.901

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.901 under Insurance Code §541.401 and §36.001.

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

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

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

(a) Scope and application. This section applies to any person required to be licensed as an agent pursuant to the provisions of the Insurance Code or other insurance law of this state. For purposes of this section, "person" means both natural persons and business association entities.

(b) Prohibition. No person subject to the provisions of this section is permitted, directly or indirectly, to require, solicit or accept any power of attorney to act as attorney-in-fact for any applicant for any insurance coverage in this state for purposes of placing, procuring, instituting, maintaining, canceling or nonrenewing any insurance coverage, or for any other act in connection with the placement or institution of such insurance coverage.

(c) Exceptions. This section does not apply to the situations described in paragraphs (1) and (2) of this subsection, as follow:

(1) insurance activities for which the Insurance Code or other insurance law of this state expressly authorizes a person to conduct such insurance activities as an attorney-in-fact pursuant to a power of attorney; or

(2) instances in which a person required to be licensed as an agent under the Insurance Code is appointed attorney-in-fact by a relative or household member of such person for purposes which include placing personal lines insurance coverages for such relative or household member.

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

(e) Declaration of unfair practice. The failure to comply with the provisions of this section constitutes unfair competition and unfair practices according to Insurance Code Chapter 541 and is subject to the provisions of that chapter.

SUBCHAPTER J. PROHIBITED TRADE PRACTICES
28 TAC §§21.1004 - 21.1007

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§21.1004 - 21.1007 under Insurance Code §§541.401, 544.304, 544.354, and 36.001.

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

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

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

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

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

(a) Purpose and Applicability. The purpose of this section is to protect homeowners in Texas from increases in residential property insurance rates and premiums that vary greatly between renewal periods and to provide homeowners in Texas with just, fair, and reasonable residential property insurance rates and premiums. This section places restrictions on the use of residential property insurance claims in rates and premiums due to the introduction of, or changes to, a claims-free program or premium surcharge program in accordance with the Insurance Code and also establishes the requirements and procedures for insurers to file a transition plan. This section applies to the rates and premiums applicable to residential property insurance policies that are delivered, issued for delivery, or renewed on or after January 1, 2006.

(b) Definitions for the purposes of this section.

(1) Residential property insurance--Property or property and casualty insurance covering a dwelling, including homeowner's insurance, residential fire and allied lines insurance, farm and ranch insurance, or farm and ranch owners insurance.

(2) Premium surcharge--An additional amount due to a policyholder's claims experience that is added to the base rate. The term does not include a reduction or elimination of a discount previously received by an insured, reassignment of an insured from one rating tier to another, re-rating an insured, or re-underwriting an insured by using multiple affiliates.

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(3) Claims-free program--Any program that considers a policyholder's claim experience, in whole or in part, whether through the use of discounts, a tier classification, or other program that does not qualify as a premium surcharge if the policyholder has been a residential property insurance policyholder with that insurer or an affiliate of that insurer.

(4) Transition plan--A plan that promotes rates and premiums that are fair, just, and reasonable by moderating rate and premium increases caused by the introduction of, or change to, a claims-free or premium surcharge program, including a tier classification system.

(5) Natural cause--A weather related cause.

(6) Claim that is filed but is not paid or payable--A claim that is filed, including a customer inquiry, that does not result in an indemnity payment under the provisions of the policy.

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

(1) claims resulting from a loss caused by natural causes;

(2) a claim that is filed but not paid or payable under a residential property policy; or

(3) a claim that an insurer is prohibited from using under Insurance Code §544.353.

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

(e) Premium surcharge programs. Premium surcharge programs must be based on sound actuarial principles. Actuarial support as specified in §5.9332 of this title must be filed with the department in the event such program is introduced or changed.

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

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

(b) Definition of "Underwriting Guideline." For the purposes of this rule, an "underwriting guideline" is a rule, standard, marketing decision, guideline, or practice, whether written, oral or electronic, used by an insurer or its agent to examine, bind, accept, reject, renew, non-renew, cancel or limit coverages made available to classes of consumers.

(c) Definition of "Private Passenger Automobile Insurance." For the purposes of this rule, "private passenger automobile insurance" is the insurance for which a personal auto policy is issued.

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

(a) "Residential property insurance" means insurance against loss to real or tangible personal property at a fixed location provided in a homeowners policy or residential fire and allied lines policy.

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

(c) An insurer may not decline to write residential property insurance based on a minimum value of the property sought to be insured.

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

(a) Purpose. The purpose of this section is to protect persons and property from being unfairly stigmatized in obtaining residential property insurance due to previous mold damage, or by filing a mold damage claim, a water damage claim, or certain appliance-related claims under a residential property insurance policy.

(b) Definitions. The following words and terms, when used in this section, have the following meanings:

(1) Appliance--A household device operated by gas or electric current, including hoses directly attached to the device. The term includes air conditioning units, heating units, refrigerators, dishwashers, icemakers, clothes washers, water heaters, and disposals.

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(2) Appliance-related claim--A claim for a loss arising from the discharge or leakage of water or steam from an appliance that is the direct result of the failure of the appliance.

(3) Consumer--The person making the application to insure a property and includes both existing insureds and applicants for insurance.

(4) Insurer--An insurance company, reciprocal or interinsurance exchange, mutual, capital stock company, county mutual insurance company, farm mutual insurance company, association, Lloyd's plan company, or other entity writing residential property insurance in this state. The term includes an affiliate as described by Insurance Code §823.003 if that affiliate is authorized to write and is writing residential property insurance in Texas. The term does not include the Texas Windstorm Insurance Association, the FAIR Plan, or an eligible surplus lines insurer regulated under Insurance Code Chapter 981.

(5) Residential property insurance--Insurance against loss to residential real property at a fixed location or tangible personal property provided in a homeowners policy, including a tenant policy, a condominium owners policy, or a residential fire and allied lines policy.

(6) Underwriting guideline--A rule, standard, guideline, or practice, whether written, oral, or electronic, that is used by an insurer or an agent of an insurer to decide to accept or reject an application for a residential property insurance policy or to determine how to classify risks that are accepted for the purpose of determining a rate.

(7) Water damage claim--A claim for a loss arising from the discharge or leakage of water or steam that is the direct result of the failure of a plumbing system or other system that contains water or steam.

(c) Water damage claims - underwriting. An insurer may not use an underwriting guideline based solely on a single previous water damage claim either filed by the applicant or on the covered property. This subsection does not affect the surcharge and

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renewal provisions in Insurance Code §551.107 (concerning Renewal of Certain Policies; Premium Surcharge Authorized; Notice).

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

(1) Except as provided in Insurance Code §544.353(e) (concerning Restrictions on Use of Claims History for Water Damage) an insurer must not use a previous appliance-related claim as a basis for determining a rate to be paid or for determining whether to issue, renew, or cancel a residential property insurance policy if the consumer complies with the requirements in Insurance Code §544.353(c) and §544.353(d). It is the consumer's option whether to have the appliance-related claim inspected and certified. The consumer is responsible for the cost of the inspection and certification. An appliance-related claim that is not inspected and certified is subject to subsection (c) of this section.

(2) Nothing in this subsection exempts an insurer from the notice provisions in Insurance Code §551.107(e). However, appliance-related losses are a special class of non-weather-related losses. The notice must be specific to the insured's appliance-related loss history.

(3) The following individuals are inspectors that may have the knowledge and experience in water damage remediation to inspect and certify the proper remediation of an appliance-related claim:

(A) inspectors licensed or certified through the Voluntary Inspection Program under Insurance Code Chapter 2003, Subchapter C;

(B) persons licensed to perform real estate property inspections under the Real Estate Licensing Act;

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(C) persons licensed as mold assessment consultants or mold remediation contractors by the Department of Licensing and Regulation under Occupations Code Chapter 1958;

(D) engineers licensed by the Texas Board of Professional Engineers;
and

(E) persons authorized by an insurer to perform appliance-related water damage remediation inspections.

(4) An insurer that maintains a list of authorized inspectors must give verbal and written notice that a claimant has the right to choose an inspector. The inspector does not have to be on the insurer's list. The insurer must give verbal notice when the claimant calls to report the claim. The insurer must send written notice within 15 days after the insurer receives notice of the claim.

(5) If a consumer uses an inspector from an insurer's list, the insurer may not reject or challenge the certification. If the consumer uses an inspector who is not on the insurer's list, the insurer may reject or challenge the certification by reinspecting the property. The insurer must give the consumer a list of all reasons it will not accept the certification. The insurer must keep all documentation of the reinspection.

(6) If an inspector physically inspects the property and determines that the appliance-related water damage was properly remediated, the inspector must issue a water damage repair certificate (PC327 WDR-1) within 10 days of completing the inspection.

(7) Water damage repair certificate form (PC327 WDR-1). An inspector must use the water damage repair certificate form (PC327 WDR-1) found on TDI's website at www.tdi.texas.gov. TDI adopts by reference the water damage repair certificate form (PC327 WDR-1) that an inspector must use, subject to the provisions of this subchapter

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

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

(e) This subsection contains provisions related to underwriting based on previous mold damage or a previous mold damage claim.

(1) An insurer may not use an underwriting guideline based on previous mold damage or a previous mold damage claim filed by the applicant or on the covered property if:

(A) the property is eligible for residential property insurance coverage;

(B) the property had mold damage;

(C) mold remediation was performed on the property; and

(D) the property was:

(i) remediated in accordance with the requirements in Occupations Code Chapter 1958, Subchapter D and any applicable rules adopted by the Department of Licensing and Regulation, and inspected by a licensed mold assessment consultant; and a mold damage remediation certificate (PC326 MDR-1) was issued to the property owner under Occupations Code §1958.154, certifying with reasonable certainty that the underlying cause or causes of the mold at the property were remediated; or

(ii) inspected by a licensed, independent mold assessment consultant or a licensed adjuster; and a mold damage remediation certificate (PC326 MDR-1) was issued to the property owner under Occupations Code §1958.154, certifying

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that, based on the mold assessment inspection, the property does not contain evidence of mold damage.

(2) Mold damage remediation certificate form (PC326 MDR-1). Mold remediation contractors, mold assessment consultants, and adjusters must use the mold damage remediation certificate form (PC326 MDR-1) found on TDI's website at www.tdi.texas.gov or by requesting the form from the TDI Property and Casualty Lines Office, or from the Department of Licensing and Regulation. TDI adopts by reference the mold damage remediation certificate form (PC326 MDR1) that must be used, subject to the provisions of this subchapter, Occupations Code Chapter 1958, and Insurance Code Chapter 544. Persons using the form should confirm that they are using the most recent online version before giving a copy to the property owner.

(3) This subsection does not affect the surcharge and renewal provisions in Insurance Code §551.107 (concerning Renewal of Certain Policies; Premium Surcharge Authorized; Notice).

(f) This subsection contains provisions for filing underwriting guidelines related to water damage claims, previous mold damage, or mold damage claims.

(1) All underwriting guidelines relating to water damage claims, previous mold damage, or mold damage claims must be filed with TDI. They must comply with the requirements in this section and with any rules adopted by the Commissioner.

(2) Underwriting guidelines relating to water damage claims, previous mold damage, or mold damage claims must be submitted to TDI as described in §5.9310(f) of this title relating to Property and Casualty Transmittal Information and General Filing Requirements.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.1101 and §21.1110 under Insurance Code §§845.004, 846.005, and 36.001.

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

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

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

TEXT.**§21.1101. Definitions.**

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

(1) Affiliation period--A period of time that under the terms of the coverage offered by an HMO, must expire before the coverage becomes effective. During an affiliation period an HMO is not required to provide health care services or benefits to the participant or beneficiary and a premium may not be charged to the participant or beneficiary.

(2) COBRA--Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (29 USC Section 1161, et seq.).

(3) COBRA continuation coverage--Coverage that satisfies an applicable COBRA continuation provision.

(4) Commissioner--The Commissioner of Insurance.

(5) Creditable coverage--

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

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

(ii) a group health benefit plan provided by a health insurance carrier or an HMO;

(iii) an individual health insurance policy or evidence of coverage;

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

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

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

(vii) a medical care program of the Indian Health Service or of a tribal organization;

(viii) a state or political subdivision health benefits risk pool;

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

(x) a public health plan as defined in this section;

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

(xii) short-term limited duration insurance as defined in this section.

(B) Creditable coverage does not include:

(i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(vi) credit-only insurance;

(vii) coverage for onsite medical clinics;

(viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;

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

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

(xi) if offered separately, coverage for other limited benefits specified by federal regulations;

(xii) if offered as independent, noncoordinated benefits, coverage for specified disease or illness;

(xiii) if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or

(xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage

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supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

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

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

(i) an insurance company;

(ii) a group hospital service corporation operating under Insurance Code Chapter 842;

(iii) a fraternal benefit society operating under Insurance Code Chapter 885;

(iv) a stipulated premium insurance company operating under Insurance Code Chapter 884; or

(v) an HMO; or

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

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), and operating under Insurance Code Chapter 846; or

(ii) another analogous benefit arrangement; or

(C) a plan issued by any other entity not licensed under the Insurance Code or another insurance law of this state that contracts directly for health care services

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on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis.

(7) Health insurance coverage--Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract.

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

(A) a person defined as a health maintenance organization under Insurance Code §843.002;

(B) an approved nonprofit health corporation that is certified under Occupations Code Chapter 162, and that holds a certificate of authority issued by the Commissioner under Insurance Code Chapter 844;

(C) a statewide rural health care system under Insurance Code §845.052 and §845.054; or

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

(9) Issuer of a health benefit plan--An insurance company, a group hospital service corporation operating under Insurance Code Chapter 842, a fraternal benefit society operating under Insurance Code Chapter 885, a stipulated premium insurance company operating under Insurance Code Chapter 884, a Lloyd's plan operating under Insurance Code Chapter 941, a reciprocal or interinsurance exchange operating under Insurance Code Chapter 942, or an HMO that issues a health benefit plan.

(10) Medical care--Amounts paid for:

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) transportation primarily for and essential to the medical care described in subparagraph (A) of this paragraph; or

(C) insurance covering medical care described in either subparagraphs (A) or (B) of this paragraph.

(11) Preexisting condition provision--A provision that denies, excludes, or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(12) Public health plan--Any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan.

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

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

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

substantially complete application for coverage and before the first day of coverage is a waiting period.

§21.1110. Form CCC.

(a) Form CCC relating to Insurance Code §1205.002 and §1357.056 for certification and disclosure of coverage under a health benefit plan is included in subsection (b) of this section in its entirety and has been filed with the Office of the Secretary of State.

(b) Form CCC referenced in this subchapter is as follows.

Figure: §28 TAC 21.110(b)

FIGURE NO. 1
CERTIFICATE OF HEALTH BENEFIT PLAN COVERAGE

* IMPORTANT – This certificate provides evidence of your health coverage. You may need to furnish this certificate if you become eligible under a health benefit plan that excludes coverage for medical conditions you have before you enroll. The definition of preexisting condition is defined by State law. If you become covered under another health benefit plan, check with the plan administrator or health carrier to see if you need to provide this certificate.

1. Date of this certificate: _____

2. Name of issuer of health benefit plan: _____

Name of individual: _____

3. Identification number of individual: _____

4. Name of any dependents to whom this certificate applies: _____

5. Name, address and telephone number of entity responsible for providing this certificate: _____

6. For further information, call: _____

7. (a) For individual coverage:
If all individual(s) identified in items 2 and 4 have at least 18 months of creditable coverage check here ___ and skip items 8 and 9.

(b) For group health benefit plans:
If all individual(s) identified in items 2 and 4 have at least 12 months of creditable coverage check here ___ and skip item 8.

8. Date creditable coverage began: _____

Date waiting period or affiliation period began: _____

9. For individual insurance: date that a substantially completed application was filed: _____

10. Date coverage ended: _____ (or check here if coverage is continuing as of the date of this certificate: _____).

Note: Separate certificates will be furnished if information is not identical for each covered individual.
FORM CCC

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

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

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

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

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

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

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

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

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

TEXT.**§21.2001. Definitions.**

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

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

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

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

(4) Child--

(A) a person under 18 years of age who is not and has not been married or who has not had the disabilities of minority removed for general purposes; or

(B) in the context of child support, "child" includes a person over 18 years of age for whom a person may be obligated to pay child support.

(5) Child support agency--As defined in Family Code §101.004.

(6) Custodial parent--

(A) a managing conservator of a child or a possessory conservator of a child who is a parent of the child; or

(B) a guardian of the person of a child, or another custodian of a child if the guardian or custodian is designated by a court or administrative agency of this or another state.

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

(8) Insurer--

(A) a health insurer;

(B) a governmental entity subject to:

(i) Insurance Code, Articles 3.51-1, 3.51-4, or 3.51-5; or

(ii) Insurance Code Chapter 1578; Local Government Code, Chapter 177; or Insurance Code §1355.151 or §1364.101;

(C) a multiple employer welfare arrangement, as that term is defined by Insurance Code §§846.001, 846.002, 846.202, and 846.251; or

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

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

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

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

(12) Qualified actuary--An actuary who is either:

(A) a Fellow of the Society of Actuaries, or

(B) a Member of the American Academy of Actuaries.

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

(a) For the purpose of providing notification to the custodial parent under Insurance Code §1504.054 and §21.2008 of this title (relating to Information Provided by an Insurer), the custodial parent must notify the insurer of any change of address. If no such change of address is submitted by the custodial parent to the insurer, then the insurer must comply with the provisions of Insurance Code §1504.054 and §21.2008 of

this title (relating to Information Provided by an Insurer) regarding notification to the custodial parent if such notice is sent to the last known address of the custodial parent.

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

§21.2010. Prohibition on Service Area Restrictions.

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

(1) cover the child under coverage for which the parent who has been ordered to provide the coverage is eligible and not enforce otherwise applicable policy provisions that would deny, limit, or reduce payment for claims for such child; or

(2) provide coverage through the use of alternative delivery systems, such as reciprocal agreements with indemnity insurers or HMOs.

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

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

(d) If the coverage is provided under subsection (a)(2) of this section, the insurer must submit a certification to the Texas Department of Insurance. The certification must

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be filed with the Texas Department of Insurance, Life and Health Division by email to MCQA@tdi.texas.gov, signed by an officer of the insurer and include:

- (1) the insurer's full name;
- (2) a statement that the insurer has elected to utilize an alternative delivery system to provide coverage for children who are the subject of a medical support order;
- (3) the name of the HMO or indemnity carrier with which the insurer has contracted to provide coverage to children who are the subject of a medical support order and a statement, if applicable, that the HMO or indemnity carrier has filed the applicable forms providing the coverage as required by Insurance Code Chapter 1701, and Insurance Code §1504.002 and §1504.052 or §11.301 of this title (relating to Filing Requirements);
- (4) a statement that the coverage provided by the alternative delivery system is either identical, greater or comparable to the coverage provided other dependent children under the policy under which coverage is required by a medical support order; and
- (5) if the coverage is not identical, the certification must also be signed by a qualified actuary or an officer of the insurer who attests that the coverage provided is at least actuarially equivalent to or greater than the coverage provided to other dependent children under the policy under which coverage is required by a medical support order. The determination of actuarial equivalence of the coverages must take into account plan design (e.g., copayments, coinsurance, deductibles, etc.) and scope of benefits. The certification must identify any other variables considered in the analysis relating to the actuarial equivalence of the coverages.

§21.2011. Unfair or Deceptive Practices.

(a) A violation of §21.2002 of this title (relating to Prohibition Against Denial of Enrollment), §21.2003 of this title (relating to Requirements Concerning Adopted Children

or Children Placed for Adoption), §21.2004 of this title (relating to Enrollment of Child Who Is the Subject of a Medical Support Order), §21.2005 of this title (relating to Prohibition on Cancellation or Nonrenewal), §21.2009 of this title (relating to Submission and Payment of Claims), and §21.2010 of this title (relating to Prohibition on Service Area Restrictions) is considered an unfair or deceptive practice and will subject the insurer to the penalties provided in Insurance Code Chapter 541 and other applicable provisions of the Insurance Code.

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

SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS **28 TAC §21.2106**

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.2106 under Insurance Code §§843.151, 1251.008, 1370.004, and 36.001.

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

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

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

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

TEXT.

§21.2106. Forms.

(a) The forms identified in §21.2103 of this title (relating to Mandatory Benefit Notices) are included in subsection (b) of this section in their entirety. The forms can be obtained from the TDI website, www.tdi.texas.gov.

(b) The forms referenced in this chapter are:

- (1) Figure Number 1: Form Number 349 Mastectomy:

Figure: 28 TAC §21.2106(b)(1)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Mastectomy or Lymph Node Dissection
Minimum Inpatient Stay. If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of

- (a) 48 hours following a mastectomy, and
- (b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 349 Mastectomy

- (2) Figure Number 2: Form Number 1764 Reconstructive Surgery After Mastectomy-Enrollment:

Figure: 28 TAC §21.2106(b)(2)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- (a) all stages of the reconstruction of the breast on which mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- (c) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

[Include any specific deductibles, copayments, and/or coinsurance applicable to the coverage and/or benefits, which may not be greater than the deductibles, copayments and/or coinsurance applicable to other coverage and/or benefits under the health benefit plan.]

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 1764 Reconstructive Surgery After Mastectomy-Enrollment

(3) Figure Number 3: Form Number 1764 Reconstructive Surgery After Mastectomy-Annual:

Figure: 28 TAC §21.2106(b)(3)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 1764 Reconstructive Surgery After Mastectomy-Annual

(4) Figure Number 4: Form Number 258 Prostate:

Figure: 28 TAC §21.2106(b)(4)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- (a) a physical examination for the detection of prostate cancer; and
- (b) a prostate-specific antigen test for each covered male who is
 - (1) at least 50 years of age; or
 - (2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 258 Prostate

(5) Figure Number 5: Form Number 102 Maternity:

Figure: 28 TAC §21.2106(b)(5)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- (a) 48 hours following an uncomplicated vaginal delivery, and
- (b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

[In-home postdelivery care language, if applicable, is to be inserted here.]

Prohibitions. We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 102 Maternity

(6) Figure Number 6: Form Number 1467 Colorectal Cancer Screening:

Figure: 28 TAC §21.2106(b)(6)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

- (a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
- (b) a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 1467 Colorectal Cancer Screening

(7) Figure Number 7: Form Number LHL391 Human Papillomavirus,

Ovarian Cancer, and Cervical Cancer Screening:

Figure: 28 TAC §21.2106(b)(7)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage or benefits provided by your contract with (name of carrier).

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§21.2202, 21.2204, and 21.2212 under Insurance Code §§541.401, 543.001, and 36.001.

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

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

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

TEXT.**§21.2202. Authority.**

This subchapter is issued based upon the authority granted the Commissioner under Insurance Code §543.001; Chapter 541, Subchapter J; and §36.001.

§21.2204. Definitions.

For the purposes of this subchapter, the following terms have the following meanings unless the explicit wording of a section or portion of a section directs otherwise.

(1) Actuarial Standards Board--the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(2) Concept Illustration--the use of non-guaranteed policy values to pay premiums or policy expenses (suspension or reduction of premiums) or to generate distributions to the policyholder or owner (cash flows).

(3) Contract premium--the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

(4) Currently payable scale--a scale of non-guaranteed elements in effect for a policy form as of the illustration date or declared to become effective within 95 days of the illustration date.

(5) Disciplined current scale--a scale of non-guaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

(A) are consistent with all provisions of this regulation;

(B) limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(C) do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(D) do not permit assumed expenses to be less than minimum assumed expenses.

(6) Generic name--a short title descriptive of the policy being illustrated such as "whole life," "term life" or "flexible premium adjustable life."

(7) Guaranteed elements--the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.

(8) Illustrated scale--a scale of non-guaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(A) the disciplined current scale; or

(B) the currently payable scale.

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

(A) Basic illustration--an illustration that shows both guaranteed and non-guaranteed elements.

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

(C) In-force illustration--an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

(10) Illustration actuary--an actuary meeting the requirements of §21.2211(c) of this title (relating to Annual Certification) who certifies to illustrations based on the standard of practice promulgated by the Actuarial Standards Board.

(11) Illustration date--the date on which the illustration was prepared.

(12) Insurer--a life insurance company as defined by Insurance Code §841.001 and §982.001; a fraternal benefit society as defined by Insurance Code §885.051 and §885.052; a Mutual Life Insurance Company as defined by Insurance Code Chapter 882; or a Stipulated Premium Insurance Company as defined by Insurance Code Chapter 884.

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

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

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

(A) fully allocated expenses;

(B) marginal expenses; and

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

(15) Non-guaranteed elements--the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

(16) Non-term group life--a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(A) every plan of coverage was selected by the employer or other group representative;

(B) some portion of the premium is paid by the group or through payroll deduction; and

(C) group underwriting or simplified underwriting is used.

(17) Participating life insurance policy--a life insurance policy which provides for possible policyholder dividends.

(18) Policy owner--the owner named in the policy or the certificate holder in the case of a group policy.

(19) Premium outlay--the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket.

(20) Self-supporting illustration--an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

(21) Universal life insurance policy--a life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other separate accounts) and mortality and expense charges are made to the policy. A universal life policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

§21.2212. Penalties.

Any violation of this subchapter constitutes a misrepresentation of the terms of an issued and unissued policy in violation of Insurance Code Chapter 541, Subchapter B, and to be a misrepresentation of the terms, benefits, and advantages of a policy within the meaning of Insurance Code §543.001. Violations of this subchapter subject the insurer and agent to the penalties provided in Insurance Code Chapter 541 and other applicable provisions of the Insurance Code.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.2501 under Insurance Code §541.401 and §36.001.

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

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

TEXT.**§21.2501. Applicability and Purpose.**

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

(1) This subchapter does not apply to complaints received and maintained by Health Maintenance Organizations. Insurance Code Chapter 843, Subchapter G, as

amended, as well as §11.205 of this title (relating to Additional Documents to be Available for Review), expressly and specifically provide for complaint record maintenance by HMOs.

(2) This subchapter does not apply to the complaints received by an insurer in its capacity as a utilization review agent. Complaint record maintenance and reporting for such complaints are addressed in §19.1705 of this title (relating to General Standards of Utilization Review).

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§21.2601, 21.2604, and 21.2606 under Insurance Code §1358.057 and §36.001.

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

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

TEXT.

§21.2601. Definitions.

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

(1) Basic benefit--Health care service or coverage, which is included in the evidence of coverage, policy, or certificate, without additional premium.

(2) Caretaker--A family member or significant other responsible for ensuring that an insured not able to manage his or her illness (due to age or infirmity) is properly managed, including overseeing diet, administration of medications, and use of equipment and supplies.

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

(4) Diabetes equipment--The term "diabetes equipment" includes items defined in Insurance Code §1358.051 and §1358.056, and §21.2605 of this title (relating to Diabetes Equipment and Supplies).

(5) Diabetes supplies--The term "diabetes supplies" includes items defined in Insurance Code §1358.051 and §1358.056, and §21.2605 of this title.

(6) Diabetes self-management training--Instruction enabling an insured and/or his or her caretaker to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

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

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

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

(I) an insurance company;

(II) a group hospital service corporation operating under Insurance Code Chapter 842;

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(III) a fraternal benefit society operating under Insurance Code Chapter 885;

(IV) a stipulated premium insurance company operating under Insurance Code Chapter 884;

(V) a reciprocal exchange operating under Texas Insurance Code Chapter 942; or

(VI) a health maintenance organization (HMO) operating under Insurance Code Chapter 843;

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

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

(B) A plan offered by an approved nonprofit health corporation that is certified under Texas Occupation Code §162.001(b), and that holds a certificate of authority issued by the Commissioner under Insurance Code Chapter 844.

(C) A health benefit plan is not:

(i) a plan that provides coverage:

(I) only for a specified disease or other limited benefit;

(II) only for accidental death or dismemberment;

(III) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(IV) as a supplement to liability insurance;

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(V) for credit insurance;

(VI) dental or vision care only; or

(VII) hospital confinement indemnity coverage only.

(ii) a small employer plan written under Insurance Code Chapter 1501;

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

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

(v) workers' compensation insurance coverage;

(vi) medical payment insurance issued as part of a motor vehicle insurance policy; or

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

(8) Insured--A person enrolled in a health benefit plan who has been diagnosed with:

(A) insulin dependent or noninsulin dependent diabetes; or

(B) elevated blood glucose levels induced by pregnancy or another medical condition associated with elevated glucose levels.

(9) Nutrition counseling--As defined in Occupations Code §701.002.

(10) Physician--A Doctor of Medicine or a Doctor of Osteopathy licensed by the Texas State Board of Medical Examiners.

(11) Practitioner--An Advanced Practice Nurse, Doctor of Dentistry, Physician Assistant, Doctor of Podiatry, or other licensed person with prescriptive authority.

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

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

(1) office visits and consultations with physicians and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;

(2) immunizations required by Insurance Code Chapter 1367, Subchapter B, Coverage for Childhood Immunizations;

(3) immunizations for influenza and pneumococcus;

(4) inpatient services, and physician and practitioner services when the insured is confined to:

(A) a hospital;

(B) a rehabilitation facility; or

(C) a skilled nursing facility;

(5) inpatient and outpatient laboratory and diagnostic imaging services;

(6) diabetes equipment and supplies in accordance with §21.2605 of this title (relating to Diabetes Equipment and Supplies); and

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(7) diabetes self-management training, in accordance with subsection (b)(1)(A)(iii) of this section and §21.2606 of this title (relating to Diabetes Self-Management Training);

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

(1) for all insureds:

(A) at initial visit by the insured:

(i) a complete history and physical including an assessment of immunization status;

(ii) development of a management plan addressing all of the following that are applicable to the insured:

(I) nutrition and weight evaluation;

(II) medications;

(III) an exercise regimen;

(IV) glucose and lipid control;

(V) high risk behaviors;

(VI) frequency of hypoglycemia and hyperglycemia;

(VII) compliance with applicable aspects of self care;

(VIII) assessment of complications;

(IX) follow up on any referrals;

(X) psychological and psychosocial adjustment;

(XI) general knowledge of diabetes; and

(XII) self-management skills;

(iii) diabetes self-management training given or referred by the physician or practitioner as required by §21.2606 of this title and §21.2607 of this title;

(iv) referral for a dilated funduscopy eye exam to be performed by an ophthalmologist or therapeutic optometrist for an insured with Type 2 Diabetes.

(B) at every visit the following:

- (i) weight and blood pressure taken,
- (ii) foot exam performed without shoes or socks, and
- (iii) dental inspection.

(C) every six months the following:

- (i) review of the management plan, and
- (ii) glycosylated hemoglobin test.

(D) annually the following:

- (i) lipid profile,
- (ii) microalbuminuria;
- (iii) influenza immunization;
- (iv) referral for a dilated funduscopy eye exam performed by an ophthalmologist or therapeutic optometrist; and
- (v) for insureds under 18 years of age, a referral for a retinal camera examination to be performed by an ophthalmologist or therapeutic optometrist.

(2) For treatment of an insured 65 years of age and over or an insured with complications affecting two or more body systems:

(A) minimum practice standards as set forth in paragraph (1) of this subsection; and

(B) specific inquiries into and consideration of treatment goals for comorbidity and polypharmacy.

(3) For pregnant insureds with pre-existing or gestational diabetes:

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(A) minimum practice standards as set forth in paragraph (1) of this subsection; and

(B) enhanced fetal monitoring based on the standards promulgated by the American College of Gynecologists and Obstetricians.

(4) For insureds with Type 1 Diabetes:

(A) minimum practice standards as set forth in paragraph (1) of this subsection;

(B) an initial diagnosis, consideration of hospitalization due to the insured's:

(i) age;

(ii) physical condition;

(iii) psychosocial circumstances; or

(iv) lack of access to outpatient diabetes self-management training as required in §21.2606 of this title or §21.2607 of this title; and

(C) ongoing management, which includes quarterly office visits, at which evaluation includes:

(i) weight;

(ii) blood pressure;

(iii) ophthalmologic exam;

(iv) thyroid palpation;

(v) cardiac exam;

(vi) examination of pulses;

(vii) foot exam;

(viii) skin exam;

(ix) neurological exam;

(x) dental inspection;

- (xi) results of home glucose self-monitoring;
- (xii) frequency and severity of hypoglycemia or hyperglycemia;
- (xiii) medical nutrition plan;
- (xiv) exercise regimen;
- (xv) adherence problems;
- (xvi) psychosocial adjustment;
- (xvii) reevaluation of short- and long-term self-management goals;
- (xviii) anticipatory guidance related to issues of Type 1 Diabetes;
- (xix) glycosylated hemoglobin;
- (xx) counseling for high-risk behaviors; and
- (xxi) for insureds under 18 years of age, growth assessment.

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

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

(1) office visits and consultations with physicians and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;

(2) immunizations required by Insurance Code Chapter 1367, Subchapter B, Coverage for Childhood Immunizations;

(3) immunizations for influenza and pneumococcus;

(4) inpatient services, physician, and practitioner services when an insured is confined to:

(A) a hospital;

(B) a rehabilitation facility; or

(C) a skilled nursing facility;

(5) inpatient and outpatient laboratory and diagnostic imaging services;

(6) diabetes equipment and supplies in accordance with §21.2605 of this title; and

(7) diabetes self-management training in accordance with §21.2606 of this title.

§21.2606. Diabetes Self-Management Training.

(a) A health benefit plan must provide diabetes self-management training or coverage for diabetes self-management training for which a physician or practitioner has written an order, including a written order of a practitioner practicing under protocols jointly developed with a physician, to each insured or the caretaker of the insured in accordance with the standards contained in Insurance Code §1358.054.

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

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

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

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

(1) the initial diagnosis of diabetes;

(2) the written order of a physician or practitioner indicating that a significant change in the symptoms or condition of the insured requires changes in the insured's self-management regime;

(3) the written order of a physician or practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

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

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

SUBCHAPTER S. ASSOCIATION PLANS

28 TAC §21.2702

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.2702 under Insurance Code §§843.151, 1115.005, 1251.0008, and 36.001.

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

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

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

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

TEXT.**§21.2702. Definitions.**

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

(1) Association--An association (other than an employer association), including but not limited to a labor union or organizations of such unions, membership corporations organized or holding a certificate of authority under the Texas Non-profit Corporation Act, and cooperatives and corporations subject to the supervision and control of the Farm Credit Administration of the United States of America, that:

(A) has a constitution and bylaws;

(B) has been actively in existence for at least 2 years; and

(C) has been formed and maintained in good faith for purposes other than obtaining coverage under a health benefit plan to cover members for the benefit of persons other than the association or its officers or trustees.

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

(A) has been actively in existence for at least 5 years;

(B) does not condition membership in the association on any health-status-related factor relating to an individual (including the individual eligible for

membership or a dependent of the individual eligible for membership, if dependent coverage is offered);

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

(D) does not make a health benefit plan offered through the association available other than in connection with a member of the association.

(3) Creditable Coverage--As defined in §21.1101 of this title (relating to Definitions).

(4) Genetic information--Information derived from the results of a genetic test.

(5) Genetic test--A laboratory test of an individual's deoxyribonucleic acid (DNA), ribonucleic acid (RNA), proteins, or chromosomes to identify by analysis of the DNA, RNA, proteins, or chromosomes the genetic mutations or alterations in the DNA, RNA, proteins, or chromosomes that are associated with a predisposition for a clinically recognized disease or disorder. The term does not include:

(A) a routine physical examination or a routine test performed as a part of a physical examination;

(B) a chemical, blood or urine analysis;

(C) a test to determine drug use; or

(D) a test for the presence of the human immunodeficiency virus.

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

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

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

(A) Under all circumstances:

- (i) coverage only for accident;
- (ii) credit-only insurance;
- (iii) disability insurance coverage;
- (iv) Medicare services under a federal contract;
- (v) coverage issued as a supplement to liability insurance;
- (vi) insurance coverage arising out of workers' compensation

or similar insurance;

(vii) automobile medical payment insurance coverage;

(viii) jointly managed trusts authorized under 29 United States Code §§141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 United States Code §157;

(ix) short-term limited duration insurance as defined in this section;

(x) liability insurance, including general liability insurance and automobile liability insurance; or

(xi) coverage for onsite medical clinics.

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

(i) coverage for a specified disease or illness;

(ii) Medicare supplement and Medicare select policies regulated in accordance with federal law;

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

(iv) coverage that provides limited-scope dental or vision benefits;

(v) coverage provided by a single-service HMO;

(vi) hospital indemnity or other fixed indemnity insurance;

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

(viii) coverage that provides other limited benefits specified by federal regulations; or

(ix) other coverage that is:

(I) similar to the coverage described in subparagraphs (A) and (B) of this paragraph under which benefits for medical care are secondary or incidental to other insurance benefits; and

(II) specified in federal regulations.

(8) Health carrier--Any entity authorized under the Texas Insurance Code or another insurance law of this state that provides health benefit plans in this state, including an insurance company; a group hospital service corporation operating under Insurance Code Chapter 842; a stipulated premium insurance company operating under Insurance Code Chapter 884; an approved nonprofit health corporation that is certified under Occupations Code Chapter 162 and that holds a certificate of authority issued by the Commissioner under Insurance Code Chapter 844, or an HMO.

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

- (A) health status;
- (B) medical condition, including both physical and mental illness;
- (C) claims experience;
- (D) receipt of health care;
- (E) medical history;
- (F) genetic information;
- (G) evidence of insurability, including conditions arising out of acts of domestic violence, including family violence as defined by Insurance Code Chapter 544, Subchapter D; or
- (H) disability.

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

SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS **28 TAC §21.2819**

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.2819 under Insurance Code §§843.336, 1301.007 and 36.001.

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

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

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

TEXT.**§21.2819. Catastrophic Event.**

(a) An MCC, a physician, or a provider must notify the department if, due to a catastrophic event, it is unable to meet the deadlines in §21.2804 of this title (relating to Requests for Additional Information from Treating Preferred Provider), §21.2806 of this title (relating to Claim Filing Deadline), §21.2807 of this title (relating to Effect of Filing a Clean Claim), §21.2808 of this title (relating to Effect of Filing a Deficient Claim), §21.2809 of this title (relating to Audit Procedures), and §21.2815 of this title (relating to Failure to Meet the Statutory Claims Payment Period), as applicable. The entity must send the notification required under this subsection to the department within five days of the catastrophic event.

(b) Within 10 days after the entity returns to normal business operations, the entity must send a certification of the catastrophic event to the Texas Department of Insurance by email to promptpay@tdi.texas.gov. The certification must:

(1) be in the form of a sworn affidavit from:

(A) for a physician or a provider, the physician, the provider, the office manager, the administrator, or their designees; or

(B) for an MCC, a corporate officer or a corporate officer's designee;

(2) identify the specific nature and date of the catastrophic event; and

(3) identify the length of time the catastrophic event caused an interruption in the claims submission or processing activities of the physician, the provider, or the MCC.

(c) A valid certification to the occurrence of a catastrophic event under this section tolls the applicable deadlines in §§21.2804, 21.2806, 21.2807, 21.2808, 21.2809, and 21.2815 of this title for the number of days identified in subsection (b)(3) of this section as of the date of the catastrophic event.

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

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

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

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

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

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

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

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

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

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

TEXT.**§21.2901. Definitions.**

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

(1) Corresponding benefits--Benefits provided under the indemnity portion of a point-of-service (POS) plan, as defined in Insurance Code §1273.001 and §843.108, that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a point-of-service plan.

(2) Cost containment requirements--Provisions in POS indemnity coverage requiring a specific action, such as the provision of specified information to the plan, that must be taken by an enrollee or by a physician or a provider on behalf of the enrollee in order to avoid the imposition of a specified penalty on the coverage provided under the plan for a proposed service or treatment.

(3) 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.

(4) Non-participating physicians and providers--Physicians and providers that are not part of an HMO delivery network.

(5) 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.

(6) Participating physicians and providers--Physicians and providers that are part of an HMO delivery network.

(7) 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 are provided by an HMO under a POS plan.

(8) Point-of-service coverage (POS coverage)--Coverage provided under a POS plan.

(9) 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.

(10) Point-of-service HMO coverage (POS HMO coverage)--Services provided by an HMO in an evidence of coverage under a POS plan.

(11) Point-of-service indemnity coverage (POS indemnity coverage)--Coverage for which an indemnity carrier is at risk under a POS plan for self-referred health care services, benefits and supplies, other than emergency services, selected at the option of the enrollee, from non-participating physicians or providers, as well as services, benefits and supplies from participating physicians or providers under circumstances in which the enrollee fails to comply with the requirements of the HMO providing the POS HMO coverage under a POS plan for obtaining in-plan covered services.

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

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

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

(2) all duties of the HMO and indemnity carrier to each other relating to the POS plan issued under this subchapter;

(3) all costs allocable to the HMO or the indemnity carrier relating to the POS plan;

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

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

(A) the HMO, the indemnity carrier or a TPA may collect the premiums for both coverages;

(B) the purchaser may issue one payment for both coverages; and

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

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(6) premium rates charged by the HMO must be based on the actuarial value of the POS HMO coverage and may be different from the premium rates charged by the indemnity carrier, which must be based on the actuarial value of the POS indemnity coverage offered by the indemnity carrier;

(7) the HMO and indemnity carrier must maintain separate books and records for the POS plan, including but not limited to information regarding premiums, lists of covered persons, claim payment data, complaint records, maintenance tax records, and all other books and records required to be maintained by law or rule;

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

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

(10) the agreement between the indemnity carrier and the HMO may not be canceled or terminated until the coverage for each enrollee in a POS plan issued by both the indemnity carrier and HMO is terminated or canceled according to the provisions of this subchapter; and

(11) the arrangements to be made in the event of insolvency, loss of certification or any other circumstances affecting the ability of the indemnity carrier, the HMO, or both to comply with this subchapter.

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

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

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

(3) the POS HMO evidence of coverage must include all mandatory HMO coverages and the POS indemnity coverage must contain all mandatory indemnity coverages;

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

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

(B) benefits under the POS HMO coverage may not be reduced by the benefits received under the POS indemnity coverage; and

(C) benefits for POS indemnity coverage under the plan may be reduced by benefits received under the POS HMO coverage.

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

(6) each POS contract must identify the respective premium rates for the POS HMO coverage and for the POS indemnity coverage, as well as the name and address of the entity to whom the premiums must be paid.

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

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- (1) list all POS HMO coverage;
 - (2) specify how services, benefits and supplies under the POS HMO coverage are accessed;
 - (3) list all POS indemnity coverage;
 - (4) specify how claims are made for POS indemnity coverage;
 - (5) disclose all copayments required;
 - (6) disclose all coinsurance required for POS indemnity coverage, which must never exceed 50% of the total amount to be covered;
 - (7) disclose all deductibles required;
 - (8) disclose all precertification requirements for POS indemnity coverage under the plan including any penalties for failing to comply with any precertification or cost containment provisions, provided that any such penalties do not reduce benefits by more than 50% in the aggregate;
 - (9) disclose how the enrollee may complain about a denial of coverage and appeal an adverse determination rendered concerning the coverage under the POS plan and disclose any rights the enrollee may have to an independent review of an adverse determination under Insurance Code Chapter 4201;
 - (10) POS indemnity coverage issued to a group must contain provisions that comply with Insurance Code §§1251.111 - 1251.116; and
 - (11) POS indemnity coverage issued to an individual must contain provisions that comply with Insurance Code §§1201.111 - 1201.217.
- (d) POS dual contracts. Contracts comprising a POS dual contract plan must comply with the following:
- (1) The contract issued by the indemnity carrier must comply with all applicable requirements for indemnity carriers and must:
 - (A) list all indemnity coverage;

(B) specify how claims are made;

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

(D) disclose all applicable deductibles;

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

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

(G) POS indemnity coverage issued to a group must contain provisions that comply with Insurance Code §§1251.111 - 1251.116;

(H) POS indemnity coverage issued to an individual must contain provisions that comply with Insurance Code §§1201.111 - 1201.217.

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

(A) list all covered services, benefits and supplies;

(B) specify how covered services, benefits and supplies are accessed by the enrollee; and

(C) disclose all applicable copayments.

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

(1) Insurance Code Chapter 1271 and Chapter 11 of this title (relating to Health Maintenance Organizations), including the filing fee requirements; and

(2) Insurance Code Chapter 1701 and Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings), including the filing fee requirements.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.3201 under Insurance Code §1452.052 and §36.001.

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

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

TEXT.

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

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

(b) Definitions. The following words and terms when used in this section have the following meanings.

(1) Advanced practice nurse--An advanced practice nurse as that term is defined by Occupations Code §301.152.

(2) 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.

(3) Department--Texas Department of Insurance.

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

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

(6) Physician--An individual licensed to practice medicine in this state.

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

(8) Preferred provider benefit plan--A plan issued by an insurer under Insurance Code Chapter 1301.

(9) Preferred provider organization--An organization contracting with an insurer issuing a preferred provider benefit plan under Insurance Code Chapter 1301 for the purpose of providing a network of preferred providers.

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

(A) qualifications of physicians, advanced practice nurses and physician assistants are reassessed;

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

(C) continued eligibility to provide services is determined.

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

(d) Effective date. The application form is required for initial credentialing or recredentialing that occurs on or after August 1, 2002 for physicians. The application form is required for advanced practice nurses and physician assistants for initial credentialing and recredentialing that occurs on or after May 20, 2003.

(e) Availability. This form may be obtained on the department's website at www.tdi.texas.gov. Reproduction of this form without any changes is allowed.

(f) Electronic submission. The form may be submitted electronically to the credentialing entity in the same format as the hard copy form if the credentialing entity accepts such electronic submissions.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§21.3302, 21.3303, and 21.3305 under Senate Bill 8, 77th Legislature, 2001, and Insurance Code §36.001.

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

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

TEXT.**§21.3302. Definitions.**

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

(1) Issuer--Those entities that offer a health benefit plan as identified in Insurance Code §1454.002.

(2) Physician--A person licensed by the Texas State Board of Medical Examiners to practice medicine and surgery in this state.

(3) Provider--A hospital, nurse practitioner, registered nurse, physician assistant, home health aide, nurse midwife, surgery center, or other outpatient care center.

§21.3303. Applicability.

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

§21.3305. Complaints.

(a) A complaint against an issuer filed with the Texas Department of Insurance for alleged violations of Insurance Code §1454.051 must include:

- (1) a description of the alleged violation under Insurance Code §1454.051;
- (2) the complainant's name, address, telephone number and fax number;

- (3) the physician's or provider's name, if different from the complainant;
 - (4) the name of the issuer;
 - (5) a statement indicating the complaint applies to a health benefit plan as set forth in §21.3303 of this subchapter (relating to Applicability); and
 - (6) documentation from the physician or provider that:
 - (A) identifies the amount reimbursed by the issuer for a covered reproductive health or reproductive oncology service provided to a woman;
 - (B) identifies the amount of time and resources spent in providing the covered reproductive health or reproductive oncology service;
 - (C) using objective criteria, identifies the same or comparable covered service provided exclusively to men or to the general population offered by the issuer;
 - (D) identifies the difference, if any, in the amount of time and resources spent in providing the covered reproductive health or reproductive oncology service and the same or comparable covered service using objective criteria;
 - (E) identifies the level of expertise needed to provide the covered reproductive health or reproductive oncology service and the same or comparable covered service; and
 - (F) compares the difference in reimbursements for the covered reproductive health or reproductive oncology service and the same or comparable service from the issuer within the same geographic service area as the physician or the provider performing the service.
- (b) Within 10 days of receipt of a complaint, the department will determine whether all the information in subsection (a) of this section has been received.
- (c) If all the information identified in subsection (a) of this section is included in the complaint:

- (1) the complaint will be considered filed on the date of receipt;
 - (2) the complainant will be notified in writing and the issuer will be contacted for a response; and
 - (3) the 120-day time period in Insurance Code §1454.107 will commence.
- (d) If all the information identified in subsection (a) of this section is not included with the complaint, the complaint will be returned to the complainant with a letter explaining the deficiencies.
- (e) If the department believes that the information received by the department under subsection (a) of this section substantiates the alleged unfair discrimination in compensation as contemplated in Insurance Code Chapter 1454 and this subchapter, action will be taken in accordance with Insurance Code Chapter 1454, Subchapter C.

**SUBCHAPTER CC. ELECTRONIC HEALTH CARE TRANSACTIONS
28 TAC §21.3701**

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.3701 under Insurance Code §1213.006 and §36.001.

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

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

TEXT.

§21.3701. Electronic Claims Filing Requirements.

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

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

- (1) health care claims or equivalent encounter information;
- (2) referral certifications; and/or
- (3) any authorization or eligibility transactions.

(c) An issuer of a health benefit plan must give 90 calendar days written notice prior to requiring electronic filing of any information described in subsection (b) of this section.

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

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

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(1) No method available for the submission of claims in electronic form. This exception applies to situations in which the federal standards for electronic submissions (45 C.F.R., Parts 160 and 162) do not support all of the information necessary to process the claim.

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

(3) Demonstrable undue hardship, including fiscal or operational hardship.

(4) Any other special circumstances that would justify a waiver.

(f) The physician's or provider's request for a waiver must be in writing and must include documentation supporting the issuance of a waiver.

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

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

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

(1) the physician's or provider's initial request for a waiver sent to the issuer of the health benefit plan, including the documentation required by subsection (f) of this section;

(2) the waiver determination received from the issuer of the health benefit plan;

(3) any additional documentation supporting issuance of a waiver or removal of restrictions, conditions or limitations of a granted waiver; and

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

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

(1) documentation supporting the waiver determination issued to the physician or provider; and

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

(k) The department may request additional information from either party and may request the parties to appear at a hearing. Either party may choose to attend a hearing conducted at the department or participate in a hearing via telephone.

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

(m) Either party may request a hearing before the Deputy Commissioner of Life and Health for reconsideration of the Director of the Managed Care Quality Assurance Office's determination. Either party may choose to attend a hearing conducted at the department or participate in a hearing via telephone. A request for reconsideration must

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be received by the Chief Clerk at MC-GC-CCO, P.O. Box 12030, Austin, Texas 78711-2030 within 14 calendar days of receiving notice of the appeal determination.

(n) The physician or provider requesting or receiving a waiver, appealing a waiver determination, or requesting reconsideration of an appeal determination under this section may elect to file the required electronic transactions in a non-electronic format until a final determination on the request is made.

(o) The issuer of a health benefit plan may not refuse to contract or to renew a contract with a physician or provider based in whole or in part on the physician or provider requesting or receiving a waiver, appealing a waiver determination, or requesting reconsideration of an appeal determination under this section.

(p) This section applies to:

(1) a contract between a physician or provider and an issuer of a health benefit plan that requires electronic submission of the information described in subsection (b) of this section and entered into or renewed on or after September 1, 2004; and

(2) existing contracts to the extent that any contract provisions related to electronic submission of the information described in subsection (b) of this section are made applicable to a physician or provider on or after September 1, 2004.

SUBCHAPTER DD. ELIGIBILITY STATEMENTS **28 TAC §21.3802**

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.3802 under Insurance Code §1274.004 and §36.001.

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

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

TEXT.**§21.3802. Definitions.**

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

(1) Enrollee--An individual who is eligible for coverage under a health benefit plan, including a covered dependent.

(2) Health benefit plan--A group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage only for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement, Medicare Select, Medicare Advantage, or any successor policies regulated in accordance with federal law;

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

(H) coverage that provides only dental or vision benefits;

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(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation insurance coverage or similar insurance coverage;

(L) automobile medical payment insurance coverage;

(M) a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed indemnity insurance coverage;

(O) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(P) liability insurance coverage, including general liability insurance and automobile liability insurance coverage; or

(Q) coverage that provides other limited benefits specified by federal regulations.

(3) Health benefit plan issuer--Any entity that issues a health benefit plan, including:

(A) a health maintenance organization operating under Insurance Code Chapter 843;

(B) an approved nonprofit health corporation that holds a certificate of authority under Insurance Code Chapter 844;

(C) an insurance company, including an insurance company offering a preferred provider benefit plan under Insurance Code Chapter 1301;

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(D) a group hospital service corporation operating under Insurance Code Chapter 842;

(E) a fraternal benefit society operating under Insurance Code Chapter 885; or

(F) a stipulated premium company operating under Insurance Code Chapter 884.

(4) Health care provider--

(A) a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a pharmacist or dentist; or

(ii) a pharmacy, hospital, or other institution or organization;

(B) a person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or

(C) a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

(5) Participating provider--

(A) a physician or health care provider who contracts with a health benefit plan issuer to provide medical care or health care to enrollees in a health benefit plan; or

(B) a physician or health care provider who accepts and treats a patient on a referral from a physician or provider described by subparagraph (A) of this paragraph.

(6) Physician--

(A) an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code;

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(B) a professional association organized under the Texas Professional Association Law (Business Organizations Code Chapters 301 and 302);

(C) a nonprofit health corporation certified under Chapter 162, Occupations Code;

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

(E) another entity wholly owned by physicians.

(7) Primary enrollee--The individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility under the health benefit plan.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §21.4105 under Insurance Code §847.007 and §36.001.

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

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

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

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

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

(c) Posting of standards. The department will post a table on its website that contains a summary of its comparison of national accreditation organization standards with the statutory and regulatory requirements of the department and indicates which portions of the examination process the department will presume compliance for accredited entities. The presumed compliance table listing the summary of the comparison of national accreditation standards and department statutory and regulatory requirements may be obtained from:

(1) the department's website at www.tdi.texas.gov; or

(2) the Financial Regulation Division, MC-FRD, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

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

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

Issued at Austin, Texas, on October 15, 2021.

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James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts the amendments to 28 TAC §§21.2 - 21.4, 21.6, 21.102, 21.104, 21.120, 21.203 - 21.205, 21.301, 21.403, 21.408, 21.701, 21.703 - 21.705, 21.901, 21.1004 - 21.1007, 21.1101, 21.1110, 21.2001, 21.2006, 21.2010, 21.2011, 21.2106, 21.2202, 21.2204, 21.2212, 21.2501, 21.2601, 21.2604, 21.2606, 21.2702, 21.2819, 21.2901, 21.2902, 21.3201, 21.3302, 21.3303, 21.3305, 21.3701, 21.3802, and 21.4105.

DocuSigned by:

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Cassie Brown
Commissioner of Insurance