Subchapter F. Evidence of Coverage
28 TAC §11.506

Subchapter J. Physician and Provider Contracts and Arrangements
28 TAC §11.901 and §11.902

Subchapter Q. Other Requirements
28 TAC §11.1611 and §11.1612

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §§11.506, 11.901, 11.902, 11.1611, and 11.1612, concerning health maintenance organizations. The commissioner adopts §11.901 without changes to the proposed text published in the September 20, 2024, issue of the *Texas Register* (49 TexReg 7407). Sections 11.506, 11.902, 11.1611, and 11.1612 are adopted with changes to the proposed text to correct errors and in response to public comments.

REASONED JUSTIFICATION. The amendments are necessary to implement the following legislation:

- House Bill 711, 88th Legislature, 2023, which prohibits anticompetitive contract provisions;

- House Bill 1647, 88th Legislature, 2023, which provides protections for certain clinician-administered drugs;

- House Bill 3078, 85th Legislature, 2017, which transfers regulation of podiatrists to the Texas Department of Licensing and Regulation;

- Senate Bill 1003, 88th Legislature, 2023, which expands facility-based provider types that must be listed in provider directories;

- Senate Bill 1264, 86th Legislature, 2019, which creates new payment standards and balance billing protections for care provided by non-network facility-based providers in a network facility, diagnostic imaging and laboratory services in connection with care from a network provider, and emergency care; and

- Senate Bill 2476, 88th Legislature, 2023, which creates new payment standards and balance billing protections for emergency medical services.

The amendments remove payment rules that were invalidated by court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020), and update provisions for out-of-network care consistent with SB 1264 and SB 2476.

The amendments also make nonsubstantive changes to (1) add or amend Insurance Code citations for accessibility and consistency with agency rule drafting style preferences; and (2) correct and revise punctuation, capitalization, and grammar to reflect current agency drafting style and plain language preferences.

Descriptions of the amended sections follow.

Subchapter F. Evidence of Coverage

Section 11.506. Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate. The amendments add the title of §11.1611 to subsection (b)(2)(B) to conform to agency style and add the phrase "must be included" to subsection (b)(3) to clarify the meaning and complete the sentence. The Texas Department of Insurance (TDI) has declined to adopt proposed changes to subsection (b)(3)(A) and (D) that would have replaced "health status-related" with "health-status-related," because those changes would have conflicted with the term "health status-related factor" as defined in 28 TAC §11.2.

Amendments to subsection (b)(2)(C) implement SB 1264 by updating the disclosure related to facility-based physicians and other health care practitioners. In response to comments, TDI changed the proposed text to clarify that the required statement must be consistent with the rules in 28 TAC §21.4903, which implement the process by which a consumer may waive their balance billing protections. TDI also changed the disclosure as proposed to use language suggested by commenters that more closely matches statutory text.

Amendments to subsection (b)(3)(B)(iii) update rule citations to reflect amendments made to rules in Administrative Code Chapter 26.

An amendment to subsection (b)(13) adds the word "terminate" to the incontestability provision to align with terminology used in Insurance Code Chapters 843 and 1271.

In response to comments, TDI has declined to adopt the changes proposed to subsection (b)(14).

An amendment to subsection (b)(17) replaces the term "mental retardation" with "intellectual disability" to align with changes made throughout the Insurance Code by House Bill 446, 88th Legislature, 2023.

An amendment to subsection (b)(19) corrects an error in a citation to the Insurance Code.

Amendments to subsection (b)(24) expand and update the prescription drug coverage requirements by removing the references to formularies and requiring compliance with all of Insurance Code Chapter 1369 rather than solely Subchapter B of that chapter. These changes are needed because substantive coverage requirements exist throughout Chapter 1369, most of which are not contingent on formulary use.

Amendments remove parentheses from references to the titles of statutory citations and revise other punctuation to reflect this change; add apostrophes to denote possession, where appropriate; replace "percent" with "%"; correct verb tenses; update a title to Insurance Code Chapter 1369, Subchapter B; remove the title to a redundant Insurance Code citation; and otherwise align rule text with current agency drafting style and plain language preferences.

Subchapter J. Physician and Provider Contracts and Arrangements

Section 11.901. Required and Prohibited Provisions. The amendments to §11.901(a) remove the incorrect use of "of this title" in reference to an Insurance Code citation.

The amendments also delete a duplicative citation to an Insurance Code title in subsection (b)(3) and update the mailing address for the Managed Care Quality Assurance Office in subsection (b)(4). An amendment to subsection (b)(11) corrects the title of

Insurance Code §1661.005 to read "Refund of Overpayment" instead of "Refunds of Overpayments."

An amendment to subsection (c)(1)(A) adds a reference to ICD-11-CM.

TDI changed subsection (d)(3) as proposed to replace "physician or provider's" with "physician's or provider's."

Amendments to subsection (e) replace "the effective date of this subsection" with "August 1, 2017," to provide the effective date of the last amendments to the subsection.

New subsection (g) is added to implement HB 711, including the prohibitions in Insurance Code §1458.101 on contractual anti-steering, anti-tiering, most favored nation, and gag clauses.

Amendments also remove parentheses from statutory citations for uniformity in formatting, add an apostrophe to denote possession, and revise unnecessary use of the words "hereby" and "hereafter."

Section 11.902. Prohibited Actions. An amendment designates subsection (a) to contain existing paragraphs (1) - (7), to allow for the addition of a subsection (b) to the section. An amendment to paragraph (4) replaces the outdated reference to the "Texas State Board of Podiatric Medical Examiners" with the "Texas Department of Licensing and Regulation," reflecting the enactment of HB 3078 in 2017.

Amendments implement HB 711 by adding new subsection (b). The new subsection prohibits an HMO from using steering or a tiered network to encourage an enrollee to obtain a health care service from a particular provider, unless it is done for the primary benefit of the enrollee or contract holder in compliance with the requirements of the Insurance Code, including Insurance Code §1458.101(i). New subsection (b) also

defines "steering" and "tiered network" according to HB 711, clarifies that fiduciary duty violations will be determined by TDI on the basis of an assessment of the HMO's conduct, and provides non-exhaustive examples of conduct that would violate the fiduciary duty under Insurance Code §1458.101(i). In response to a comment, the reference in subsection (b)(1) to "providers" is changed from the text as proposed to reference "physicians or providers."

Amendments remove parentheses from the titles of statutory citations to reflect current agency drafting style.

Subchapter Q. Other Requirements

Section 11.1611. Out-of-Network Claims; Non-Network Physicians and Providers. To implement SB 1264 and SB 2476, amendments update requirements for out-of-network claims. An amendment replaces former subsection (a) with a new subsection (a) containing text with references to out-of-network payment standards in Insurance Code Chapter 1271. In response to a comment, TDI changed new subsection (a) as proposed to add a reference to Insurance Code Chapter 1467.

An amendment also replaces former subsection (b) with a new subsection (b) that provides requirements for an HMO in circumstances when medically necessary covered services are not available through a network physician or provider. In response to a comment questioning the meaning of "reasonably available," TDI changed the text of subsection (b) as proposed to delete the word "reasonably." TDI also changed the text of subsections (b) and (c) as proposed to add the phrase "within the applicable network adequacy standards" to each subsection. This language clarifies that the consumer protections apply even if care is available from a contracted physician or provider if that

contracted physician or provider is located outside the applicable network mileage requirements. In response to a comment, TDI changed the proposed text to replace "were medically necessary" with "are medically necessary" to conform to the use of present tense elsewhere in rule and statute. New subsection (b)(1) requires an HMO to facilitate the enrollee's access to care and follow access plan procedures. New subsection (b)(2) requires an HMO to inform the enrollee of their rights to receive out-of-network care under the in-network benefit level and to advise the consumer to contact the HMO if they receive a balance bill. TDI changed subsection (b)(2) as proposed by replacing "inform the enrollee as follows" with "inform the enrollee of their rights under this section, including" to clarify that the HMO can adjust the contents of the notice to use plain language and reflect the enrollee's rights in a specific situation, consistent with the requirements in subsection (c)(4).

TDI changed subsection (b)(2)(B) as proposed to clarify that the enrollee can ask the HMO to recommend a physician or provider that the enrollee can use without being balance billed. In response to a comment, TDI changed paragraph (2) as proposed by merging proposed subparagraphs (B) and (C), and redesignating paragraphs proposed as (3)(A) and (B) as paragraphs (2)(C) and (D). As part of this clarification, changes to the proposed text also remove paragraph (3) and its language that limited the provision to enrollees in a point-of-service plan.

The proposed amendments to subsection (c) are changed in response to comments. First, to align with wording in subsection (b), TDI changed the proposed text to clarify that subsection (c) applies when in-network care is not available within the applicable network adequacy standards. TDI has declined to adopt proposed amendments to subsection (c)(1) that would have modified the existing requirements

related to referrals under Insurance Code §1271.055, but instead adopts a cross-reference to clarify that referrals must be processed consistent with the statute. The proposed specification in subsection (c)(1) that a referral is to a "non-network" physician or provider is deleted to reduce confusion in cases where a referral is to a contracted provider outside the network adequacy milage requirements. For purposes of this section, a referral to a contracted provider outside the network mileage requirements is "non-network" and subject to the requirements addressed in §11.1611. In response to a commenter's concerns about the wording of paragraph (2), TDI changed the proposed text to delete that paragraph because it is unnecessary to restate the statute. Changes to the adopted text also move proposed requirements under subsection (c)(1) for an HMO to approve a network gap exception and facilitate access to care to subsection (c)(2) to clarify that the HMO must take those actions concurrent with the referral and ensure the enrollee can access a physician or provider that meets the specified criteria. These changes clarify the distinction between the statutory referral requirements and the additional requirements for the HMO to facilitate access to care when a network gap occurs. The adopted amendments specify that an HMO must allow an enrollee to use a physician or provider that has the necessary expertise, is reasonably available, and that the enrollee can use without being liable for additional cost-sharing.

In response to a comment expressing concern that an HMO's network gaps could leave enrollees with insufficient options, TDI changed the text as proposed to add subsections (c)(3) and (c)(4) to explain that the requirement for an HMO to recommend an additional physician or provider varies depending on whether the approved referral meets the rule's criteria. If the referral meets the rule's criteria, the HMO must provide the enrollee with another recommendation upon request. If the referral does not meet the

rule's criteria--such as because the HMO is unable to achieve an agreement with that physician or provider that will protect the enrollee from being balance billed, or because the referral was to a physician that is not reasonably available considering the enrollee's location--the HMO must inform the enrollee as to why the criteria is not met and the enrollee's right to request that the HMO recommend additional physicians or providers. These changes align with corresponding requirements for PPOs and EPOs in 28 TAC §3.3707(j) and ensure that an enrollee who confronts a network gap still has a choice of at least two physicians or providers.

Amendments strike former subsection (d), which was invalidated by court order and redesignate subsequent subsections. The subsections that follow it are redesignated to reflect the removal of former subsection (d).

Redesignated subsection (d) is amended to remove reference to subsections (a) - (c) and to revise a reference to the Consumer Protection Section to instead reference the TDI toll-free consumer information help line.

Redesignated subsection (e) is amended to remove former paragraph (1), relating to the methodology for usual and customary charges, because HMOs are required to make payments based on the usual and customary rate, rather than the usual and customary charge. Subsequent paragraphs under subsection (e) are renumbered as appropriate to reflect the change.

An amendment adds new subsection (f) to implement HB 1647 by referencing coverage requirements for clinician-administered drugs in Insurance Code Chapter 1369, Subchapter W, as added by HB 1647. If a clinician-administered drug is provided by a non-network provider and eligible to be covered under the plan's in-network benefit, the HMO must issue payment consistent with subsection (d).

Amendments update grammar and punctuation throughout to reflect current agency drafting style and plain language preferences.

Section 11.1612. Mandatory Disclosure Requirements. Amendments implement SB 1003 and SB 1264, remove duplicative or unnecessary requirements, and make nonsubstantive formatting and grammatical changes to improve readability.

Amendments to subsection (a) broaden the provisions to apply to all physician and provider directories, rather than only online directories. Some requirements that were previously required under subsection (h) are moved into subsection (a). Paragraph (1) is expanded to require a directory to indicate whether physicians and providers are accepting new patients, which was previously required under subsection (h)(2). Paragraph (2) is added to require a directory to explain limitations of accessibility and referrals to specialists, including those imposed by a limited provider network, which was previously required under subsection (h)(5). Paragraph (3) is added to require the directory to be dated and provided in at least 10-point type, which was previously required in subsection (h)(9) and (10). Subsequent paragraphs are renumbered as appropriate to reflect the addition of new paragraphs. Paragraph (8) is added to require the directory to include an email address and toll-free telephone number through which enrollees may notify an HMO of inaccurate information, which was previously required in subsection (h)(3). TDI changed paragraph (8) as proposed to replace the word "listing" with "directory" to be consistent with the terminology used in subsection (a).

An amendment to subsection (b) revises the wording in the last sentence for clarity. TDI changed the text of subsection (b) as proposed by replacing "physician or provider's" with "physician's or provider's."

Amendments to subsection (c) replace the word "font" with "type" and replace Figure: 28 TAC §11.1612(c). New Figure: 28 TAC §11.1612(c) reflects updated consumer protections enacted under SB 1264 and SB 2476 and uses plain language to improve consumer understanding of the notice. TDI changed new Figure: §11.1612(c) as proposed to clarify that the statement that protections do not apply for ground ambulance services should be included only if balance billing is permitted under applicable state and federal law.

Amendments in subsection (d) revise text to provide plainer language.

Amendments to subsection (e) modify formatting and punctuation; clarify that information may be provided for each service area or county; and remove former paragraph (2), which was duplicative of requirements in former paragraph (1). Because of the removal of paragraph (2), the text of former paragraph (1) is combined with the text following subsection (e), and the subparagraphs under former paragraph (1) are redesignated as paragraphs.

Amendments to subsection (f) provide plainer language by removing or revising wording that is repetitive or does not align with agency style.

Subsection (g) is amended to add a requirement that an HMO make restitution to an enrollee for any additional amount paid by the enrollee as a result of inaccurate provider information provided by the HMO. Also, former paragraph (4) is removed because it is repetitive of paragraph (1).

Subsection (h) is amended to reference, rather than restate, statutory requirements; exclude dental and vision networks, consistent with statute; and remove provisions that apply to all networks and are added to subsection (a). Paragraph (1) is deleted because consumers are now protected from balance billing at all network facilities. Paragraph (2)

is deleted because the provision in it is added to subsection (a)(1). Paragraph (3) is also deleted because the provision in it is added to subsection (a)(8). To reflect the deletion of paragraphs (1) - (3), paragraph (4) is redesignated as paragraph (1). In addition, it is amended to add a reference to non-physician providers and a citation to Insurance Code §1451.504. Paragraph (5) is deleted because the provision in it is added to subsection (a)(2). Paragraph (6) is also deleted because it is unnecessary to restate the requirements of Insurance Code §1456.003(c). To reflect the renumbering of paragraph (4) and the deletion of paragraphs (5) and (6), paragraph (7) is renumbered as paragraph (2). In addition, it is amended to cite and align with Insurance Code Chapter 1456, use language more consistent with the statute, and replace the term "insurer" with "HMO." Paragraphs (8) and (9) are deleted and moved to subsection (a)(3). Paragraphs (10) and (11) are deleted because they unnecessarily restate the requirements of Insurance Code §1451.504(c) and (d).

Amendments to subsection (i) clarify and streamline the required disclosure. This includes removing paragraph (2) and the paragraph (1) designation, and incorporating the remaining text of paragraph (1) into the text that follows subsection (i). A reference to subsection (e)(2) is also revised to reflect the removal of former paragraph (2) from subsection (e).

Amendments to subsection (j) clarify that the disclosure of a substantial decrease in availability applies to both physicians and other providers, but that the decreases in numbers of physicians and other providers must be assessed separately. The requirement for HMOs to notify TDI by email of contract terminations that do not impact network compliance is removed, with amendments to subsection (j)(2)(B) and the removal of subjection (j)(4)(C).

SUMMARY OF COMMENTS. TDI provided an opportunity for public comment on the rule proposal for a period that ended on October 21, 2024, and the proposal was published in the *Texas Register* (49 TexReg 7407) on September 20, 2024.

Commenters: TDI received comments from two commenters. Commenters in support of the proposal with changes were the Texas Association of Health Plans and the Texas Medical Association.

Comments on §11.506

Comment. Two commenters suggest clarifying the disclosure in §11.506(b)(2)(C) concerning facility-based physicians or other health care practitioners. One commenter suggests adding a cross-reference to the balance billing waiver rules in 28 TAC §21.4903 to make it clear that the new rule does not supersede it. Another commenter suggests that TDI simply repeat the text in Insurance Code §1456.006, rather than addressing the additional requirements in Insurance Code Chapter 1271 added by Senate Bill 1264. If TDI retains the broader disclosure, the commenter recommends using language closer to the statute and clarifying that the balance billing prohibition applies only to a covered service or supply.

Agency Response. TDI agrees with the commenters, in part, and has changed the text proposed for §11.506(b)(2)(C)(ii) to replace "affirmatively chooses a non-network facility-based physician or other health care practitioner" with "elects to receive out-of-network care and signs a waiver of balance billing protections." The adopted text also clarifies that the balance billing prohibition applies "for a covered service or supply provided in a network facility" and removes another reference to "in a network facility" to avoid

duplication. These changes align more closely with statutory language. TDI has also changed the statement to ensure it is "consistent with 28 TAC §21.4903," enhancing clarity and ensuring compliance with relevant regulations.

Comment. One commenter opposes the proposed changes to §11.506(b)(14) and §11.1611(c) that remove the text "after receipt of reasonably requested documentation" in connection with the requirement to allow a referral to a non-network provider. The commenter states that, while the commenter agrees referral requests could be handled promptly, forcing HMOs to allow a referral without documentation that demonstrates that the out-of-network care is necessary could create an opportunity for providers to abuse the system and lead to increased costs for consumers. Another commenter supports the proposed change but asks TDI to clarify that the deadline is "from the date the request was sent."

Agency Response. TDI agrees with the first commenter that removing the requirement for reasonably requested documentation could have unintended consequences. Keeping this requirement ensures clarity in the referral process and protects enrollees' access to necessary services. TDI adopts §11.506(b)(14) without the proposed change and retains the phrase "after receipt of reasonably requested documentation" in §11.1611(c).

Comments on §11.902

Comment. One commenter notes that the reference to steering in §11.902(b)(1) only includes "providers," and recommends specifying "physicians or providers" to be consistent with terminology used throughout the rule.

Agency Response. TDI agrees and has made the suggested change.

Comments on §11.1611

Comment. One commenter states that the proposed amendments to §11.1611 are unclear in multiple respects; the commenter seeks additional information from TDI on its intent and requests another opportunity before adoption for notice and comment on the proposed section.

Agency Response. TDI does not agree with the commenter; the proposal's intent is clear. TDI declines to repropose the changes to §11.1611; however, TDI will monitor implementation of the section to determine whether additional rulemaking is necessary.

Comment. One commenter suggests modifying §11.1611(a) to specifically reference Insurance Code §§1271.155, 1271.157, 1271.158, or 1271.159, as applicable, rather than simply referencing the balance billing protections under Insurance Code Chapter 1271. The commenter also suggests adding a reference to the payment standards under Insurance Code Chapter 1467.

Agency Response. TDI disagrees that specific section references under Insurance Code Chapter 1271 are needed but agrees to add a reference to the payment standards under Insurance Code Chapter 1467, as applicable. Insurance Code §1271.159 is set to expire September 1, 2025, so if a specific reference was added, §11.1611 would quickly become outdated and require amendment.

Comment. One commenter asks whether the rule text in §11.1611(b) uses the past-tense "were" instead of "are" intentionally and whether TDI intends for the rule to apply to services that were already rendered if a referral is not subsequently denied.

Agency Response. The use of the past tense was inadvertent. To better align with Insurance Code §1271.055, TDI has changed the proposed text of §11.1611(b) to replace "were" with "are." TDI agrees that in some instances, where necessary care is time sensitive, retrospective approvals of referral requests may be appropriate.

Comment. One commenter notes that Insurance Code §1271.055 does not prohibit a physician or provider from balance billing, and requests that TDI modify §11.1611(b) to clarify the enrollee's responsibility for a balance bill when the enrollee does not choose a physician or provider recommended by an HMO. The commenter also expresses concerns that the language in §11.1611(c) may limit patient choice and reduce the likelihood of clinically driven referrals, especially when the HMO has an inadequate network. The commenter states that the HMO-recommended physician or provider should not be the only option available to the enrollee and that it is unfair for the HMO to offer the enrollee just one recommendation. The commenter notes that it may be entirely rational for the enrollee or the enrollee's requesting physician to choose someone other than the HMO-recommended physician or provider, and that an enrollee should not be penalized for choosing an alternative physician or provider that might better meet their needs.

Agency Response. The section does not change the statutory prohibitions on balance billing or imply that balance billing is prohibited under Insurance Code §1271.055. TDI agrees that enrollees should have the right to select a different physician or provider than the one recommended by an HMO. Therefore, TDI has changed §11.1611(b) as adopted to ensure that all enrollees have the option to select an alternative physician or provider with the understanding that the enrollee may be responsible for a balance bill and not just those in a point-of-service plan. TDI expects HMOs to make good faith efforts to

facilitate care without placing undue burdens on enrollees when the HMO has failed to meet network adequacy standards.

Comment. One commenter states that the "reasonably available" standard in §11.1611 is unclear and asks whether it requires an enrollee to travel beyond the mileage limits set for an adequate network.

Agency Response. The protections in §11.1611(b) and (c) apply when a network provider is not available within the established network adequacy standards. In response to this comment, TDI has changed these subsections as adopted to clarify this standard, which is consistent with a similar provision in §3.3708(b) for PPO and EPO plans. With respect to the availability of physicians and providers recommended by an HMO, TDI reviews access plans under §11.1611(j) to ensure that HMOs have appropriate procedures in place for delivering care when gaps exist.

Comment. One commenter asks whether the language in §11.1611(c) is intended to limit the statutory payment provisions in Insurance Code §1271.055 to situations where the referral is to a non-network physician or provider that the enrollee may use without being responsible for an amount in excess of their in-network cost-sharing. The commenter notes that §11.1611(b) and (c) require an HMO to provide an option where the enrollee will not be responsible for an amount in excess of the cost-sharing under the plan. The commenter presumes that these provisions intend for the HMO to reach an agreed upon amount with the recommended physician or provider in advance. The commenter asks TDI to confirm that the rule is not interpreting Insurance Code §1271.055 to impose a balance billing prohibition. The commenter strongly opposes such an interpretation.

Agency Response. The rule does not narrow application of Insurance Code §1271.055 and does not imply that balance billing is prohibited by that section. Balance billing prohibitions are outlined in the statute and remain unchanged by this rule. The rule maintains TDI's long-standing position that HMO plans provide comprehensive health care on a prepaid basis and must allow enrollees to access all medically necessary covered services without being responsible for amounts in excess of their plan's cost-sharing responsibilities. In cases of network gaps, HMOs typically facilitate an enrollee's access to care and negotiate single case agreements to prevent balance billing.

Comment. One commenter recommends revising §11.1611(c)(2) to replace "health care physician or provider" with "physician or health care provider." The commenter points out that the proposed phrasing is inconsistent with terms defined under Insurance Code §843.002 and appears to be an unintended error. The commenter also asks whether the language in subsection (c)(2) is adequately aligned with Insurance Code §1271.055(c) and recommends replacing the existing language with a reference to a "specialist of the same license and same or similar type of specialty."

Agency Response. Because it is unnecessary to restate the statute, in response to comments on this point TDI does not adopt §11.1611(c)(2) as proposed, and instead adds a cross-reference to Insurance Code §1271.055 in subsection (c)(1) to clarify that referrals must be processed consistent with the statutory requirements.

Comment. With respect to the requirement in §11.1611(c) for HMOs to recommend a physician or provider, one commenter acknowledges the usefulness of offering enrollees options where they are responsible for only plan cost-sharing, but notes that it should

not be the enrollee's only option. The commenter expresses concern that the requirement could reduce the likelihood of the referral being clinically driven, as contemplated by Insurance Code §1271.055. The commenter has concerns with the language in (c)(1) as proposed because the focus on a network gap exception departs from the referral language in Insurance Code §1271.055 and raises questions about whether TDI is intending to narrow the statutory requirement. The commenter also states that it is unfair to an enrollee to provide only one physician or provider that the enrollee can use in the case of a network gap and recommends that the enrollee have at least three physicians or providers to choose from. The commenter suggests that setting a lower bar for network gaps than TDI sets when reviewing network adequacy standards causes plans to have deficient networks.

Agency Response. TDI appreciates the commenter's support for giving enrollees an option where they are responsible only for plan cost-sharing amounts. HMOs typically pursue single-case agreements based on the clinically driven referral. If an HMO is unsuccessful in reaching such an agreement, or the referral does not meet the rule's other requirements, the HMO must notify the enrollee and recommend other appropriate physicians or providers who are qualified and available to deliver the necessary care. TDI agrees with the commenter that combining the existing referral requirements with the new proposed requirements could create confusion, so in response TDI adopts §11.1611 with a cross-reference to Insurance Code §1271.055 in subsection (c)(1), moves new language requiring the HMO to approve a network gap exception and facilitate access to care to paragraph (2) of the subsection, and adds new paragraphs (3) and (4) to provide additional explanation of when the HMO is required to recommend an additional physician or provider. TDI agrees with the commenter that enrollees should have a choice

of more than one physician or provider when faced with a network gap. New paragraphs (3) and (4) specify that an enrollee can ask the HMO for a recommendation in addition to a referral and clarify that enrollees should have a choice of at least two physicians or providers that meet the rule's criteria. This is consistent with requirements for PPO and EPO plans under §3.3707(j)(2). This change also gives the HMO flexibility to negotiate with alternative physicians or providers if they cannot reach a single case agreement with the referred-to physician or provider.

Comment. One commenter asks TDI to revise §11.1611 to clarify that when an HMO recommends a physician or provider, it is subject to the steering limitations and fiduciary duty set forth in §11.902(b).

Agency Response. TDI declines to make a change because the requirements in connection with steering are clearly addressed in §11.902(b) and Insurance Code §1458.101(i).

Comment. One commenter asks how the requirements in §11.1611(d) interact with the explanation-of-benefits requirements under SB 1264. The commenter also expresses concern that the rule makes it sound as though the physician does something wrong if they balance bill, even though there are instances when balance billing is permitted.

Agency Response. The requirements in §11.1611(d) are in addition to the balance billing prohibition notice in Insurance Code §1271.008 and the explanation-of-benefits requirements in 28 TAC §21.5040. TDI does not believe there is any conflict between the requirements and has not heard of these disclosures creating confusion for consumers.

Subchapter F. Evidence of Coverage
28 TAC §11.506

STATUTORY AUTHORITY. The commissioner adopts amendments to §11.506 under Insurance Code §§843.151, 1271.152, 1456.006, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various sections of the Insurance Code related to HMOs and ensure adequate access to health care services, including establishing physician-to-patient ratios and requirements relating to mileage, travel time, and appointment waiting times.

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

Insurance Code §1456.006 authorizes the commissioner to prescribe disclosure requirements related to out-of-network care from facility-based physicians and providers.

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.

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

(a) Each enrollee residing in Texas is entitled to an evidence of coverage under a health care plan. An HMO may deliver the evidence of coverage electronically but must provide a paper copy on request.

(b) Each group, individual, and conversion contract and group certificate must contain the following provisions:

(1) Face page. Where applicable, the name, address, website address, and phone number of the HMO must appear. The toll-free number referred to in Insurance Code §521.102, concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints, must appear on the face page.

(A) The face page of an agreement is the first page that contains any written material.

(B) If the agreements or certificates are in booklet form, the first page inside the cover is considered the face page.

(C) The HMO must provide the information regarding the toll-free number referred to in Insurance Code Chapter 521, Subchapter C, concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints, in compliance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

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

(A) Copayments. An HMO may require copayments to supplement payment for health care services.

(i) Each basic health care service HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50% of the total cost of services provided.

(ii) A basic health care service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total 200% of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

(iii) The HMO must state the copayment, the limit on enrollee copayments, and the enrollee reporting responsibility in the group, individual, or conversion agreement and group certificate.

(B) Deductibles. A deductible must be for a specific dollar amount of the cost of the basic, limited, or single health care service. Except for a consumer choice benefit plan authorized by Insurance Code Chapter 1507, concerning Consumer Choice of Benefits Plans, an HMO may not charge a deductible for services received in the HMO's delivery network. Except in cases involving emergency care and services that are not available in the HMO's delivery network, as described in §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers), an HMO may charge an out-of-network deductible for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

(C) Facility-based physicians or other health care practitioners. In compliance with Insurance Code §1456.003, concerning Required Disclosure: Health Benefit Plan, a statement must be included that is consistent with §21.4903 of this title (relating to Out-of-Network Notice and Disclosure Requirements) and that provides notice that:

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

(ii) unless the enrollee elects to receive out-of-network care and signs a waiver of balance billing protections, a non-network facility-based physician or other health care practitioner may not balance bill the enrollee for amounts not paid by the health benefit plan for covered services or supplies provided in a network facility; and

(iii) if the enrollee receives a balance bill, the enrollee should contact the HMO.

(D) Immunizations. An HMO may not charge a copayment or deductible for immunizations as described in Insurance Code Chapter 1367, Subchapter B, concerning Childhood Immunizations, for a child from birth through the date the child is 6 years of age, except that a small employer health benefit plan as defined by Insurance Code §1501.002, concerning Definitions, that covers the immunizations may charge a copayment, and a consumer choice benefit plan under Insurance Code Chapter 1507 may charge a copayment and a deductible.

(3) Cancellation and nonrenewal. A statement must be included that specifies the following grounds for cancellation and nonrenewal of coverage and the minimum notice period that will apply.

(A) Unless otherwise prohibited by law, an HMO may cancel coverage of a subscriber in a group and the subscriber's enrolled dependents under circumstances described in this subparagraph, so long as the circumstances do not include health status-related factors:

(i) for nonpayment of amounts due under the contract, after not less than 30-days' written notice, except no additional written notice will be required for failure to pay premium;

(ii) after not less than 15-days' written notice, in the case of fraud or intentional misrepresentation of a material fact, except as described in paragraph (13) of this subsection;

(iii) after not less than 15-days' written notice, in the case of fraud in the use of services or facilities;

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

(v) after not less than 30-days' written notice, where the subscriber does not reside, live, or work in the service area of the HMO or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area.

(B) An HMO may cancel a group under circumstances described below, unless otherwise prohibited by law:

(i) for nonpayment of premium, at the end of the grace period as described in paragraph (12) of this subsection;

(ii) in the case of fraud on the part of the group, after 15-days' written notice;

(iii) for employer groups, for violation of participation or contribution rules, under §26.8 of this title (relating to Guaranteed Issue; Contribution and Participation Requirements) and §26.303 of this title (relating to Coverage Requirements);

(iv) for employer groups, under §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market) and §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) on discontinuance of:

(I) each of its small or large employer coverages; or

(II) a particular type of small or large employer coverage;

(v) where no enrollee resides, lives, or works in the service area of the HMO or area for which the HMO is authorized to do business, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees after 30-days' written notice; and

(vi) if membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, after 30-days' written notice.

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

(D) An HMO may cancel an individual contract under circumstances described below, unless otherwise prohibited by law:

(i) for nonpayment of premiums under the terms of the contract, including any timeliness provisions, without written notice, subject to paragraph (12) of this subsection;

(ii) in the case of fraud or intentional material misrepresentation, except as described in paragraph (13) of this subsection, after not less than 15-days' written notice;

(iii) in the case of fraud in the use of services or facilities, after not less than 15-days' written notice;

(iv) after not less than 30-days' written notice where the subscriber does not reside, live, or work in the service area of the HMO or area in which the HMO is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area;

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

(vi) in case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, after 180-days' written notice to the commissioner and the enrollees, in which case the HMO may not re-enter

the individual market in that service area for five years beginning on the date of discontinuance of the last coverage not renewed.

(4) Claim payment procedure. A provision that sets forth the procedure for paying claims, including any time frame for payment of claims that must comply with Insurance Code Chapter 542, Subchapter B, concerning Prompt Payment of Claims; Insurance Code §1271.005, concerning Applicability of Other Law; and rules adopted under these Insurance Code provisions.

(5) Complaint and appeal procedures. A description of the HMO's complaint and appeal process available to complainants, including internal adverse determination appeal and independent review procedures under Insurance Code Chapter 4201, concerning Utilization Review Agents, and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy).

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

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

(8) Eligibility. A statement of the eligibility requirements for membership.

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

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of the dependents, including adoptees or

children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the health care of the dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of the dependents;

(iii) in the service area with the subscriber's spouse; or

(iv) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

(B) The statement must provide the conditions under which dependent enrollees may be added to those originally covered.

(C) The statement must describe any limiting age for subscriber and dependents.

(D) The statement must provide a clear statement regarding the coverage of newborn children.

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

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

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

(iv) The HMO may not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency or born in a

non-network facility to a mother who does not have HMO coverage, but may require that the newborn be transferred to a network facility at the HMO's expense and, if applicable, to a network provider when the transfer is medically appropriate as determined by the newborn's treating physician.

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 31 days following birth. The HMO must allow an enrollee 31 days after the birth of the child to notify the HMO, either verbally or in writing, of the addition of the newborn as a covered dependent.

(E) The statement must include a clear statement regarding the coverage of the enrollee's grandchildren that complies with Insurance Code §1201.062, concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program, and §1271.006, concerning Benefits to Dependent Child and Grandchild.

(9) Emergency services. A description of how to obtain services in emergency situations, including:

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

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

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

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

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or in a comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to stabilization must be provided to enrollees as approved by the HMO, provided that:

(i) the HMO must approve or deny coverage of poststabilization care as requested by a treating physician or provider; and

(ii) the HMO must approve or deny the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case may approval or denial exceed one hour from the time of the request; and

(F) for purposes of this paragraph, "comparable facility" includes the following:

(i) any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics that have licensed or certified or both licensed and certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002, concerning Definitions;

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

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

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

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

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

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

(VI) a hospital operated by a federal agency.

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

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

(12) Grace period. A provision for a grace period of at least 30 days for the payment of any premium due after the first premium payment during which the coverage remains in effect. An HMO may add a charge to the premium for late payments received within the grace period.

(A) If payment is not received within the 30 days, coverage may be canceled after the 30th day and the terminated members may be held liable for the cost

of services received during the grace period, if this requirement is disclosed in the agreement.

(B) Despite subparagraph (A) of this paragraph, provisions regarding the liability of group contract holder for an enrollee's premiums must comply with Insurance Code §843.210, concerning Terms of Enrollee Eligibility, and §21.4003 of this title (relating to Group Policyholder, Group Contract Holder, and Carrier Premium Payment and Coverage Obligations).

(13) Incontestability:

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

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

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

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

(C) For a group contract or certificate, the HMO may increase its premium to the appropriate level if the HMO determines that the subscriber made a

material misrepresentation of health status on the application. The HMO must provide the contract holder 31-days' prior written notice of any premium rate change.

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

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

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

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

(15) Schedule of charges. A statement that discloses the HMO's right to change the rate charged with 60-days' written notice under Insurance Code §843.2071, concerning Notice of Increase in Charge for Coverage, and Insurance Code Chapter 1254, concerning Notice of Rate Increase for Group Health and Accident Coverage.

(16) Service area. A description and a map of the service area, with key and scale, that identifies the county, or counties, or portions of counties to be served, and indicates primary care physicians, hospitals, and emergency care sites. A ZIP code map and a physician and provider list may be used to meet the requirement.

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

(18) Termination due to student dependent's change in status. A provision regarding coverage of student dependents that complies with Insurance Code Chapter 1503, concerning Coverage of Certain Students, if applicable.

(19) Conformity with state law. A provision that if the agreement or certificate contains any provision or part of a provision not in conformity with Insurance Code Chapter 1271, concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges, or other applicable laws, the remaining provisions and parts of provisions that can be given effect without the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

(20) Conformity with Medicare supplement minimum standards and long-term care minimum standards. Each group, individual, and conversion agreement, and group certificate must comply with Chapter 3, Subchapter T, of this title (relating to

Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y, of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement or long-term care rules, or both, and the HMO rules, the Medicare supplement or long-term care rules will govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO must follow the Medicare supplement, the long-term care rules, and the HMO rules where applicable.

(21) Nonprimary care physician specialist as primary care physician. A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician as set out in Insurance Code §1271.201, concerning Designation of Specialist as Primary Care Physician.

(22) Selected obstetrician or gynecologist. Group, individual, and conversion agreements, and group certificates, except small employer health benefit plans as defined by Insurance Code §1501.002, must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of Insurance Code Chapter 1451, Subchapter F, concerning Access to Obstetrical or Gynecological Care. An HMO may not prevent an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

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

(B) Access to the health care services of an obstetrician or gynecologist includes:

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

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

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

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

(E) An HMO may limit an enrollee in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical

care. The limitation must not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO must include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in Insurance Code Chapter 1451, Subchapter F. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from the enrollee's primary care physician or primary care provider. The enrollee must have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

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

(23) Diagnosis of Alzheimer's disease. An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease under Insurance Code Chapter 1354, concerning Eligibility for Benefits for Alzheimer's Disease, by a physician licensed in this state satisfies any requirement for demonstrable proof of organic disease.

(24) Drug coverage. An agreement that covers prescription drugs must comply with Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, and Chapter 21, Subchapter V, of this title (relating to Pharmacy Benefits), as applicable.

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

Subchapter J. Physician and Provider Contracts and Arrangements
28 TAC §11.901 and §11.902

STATUTORY AUTHORITY. The commissioner adopts amendments to §11.901 and §11.902 under Insurance Code §§843.151, 1458.004, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various sections of the Insurance Code related to HMOs and ensure adequate access to health care services, including establishing physician-to-patient ratios and requirements relating to mileage, travel time, and appointment waiting times.

Insurance Code §1458.004 authorizes the commissioner to adopt rules to implement Chapter 1458.

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.

§11.901. Required and Prohibited Provisions.

(a) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding a hold-harmless clause as described in Insurance Code §843.361, concerning Enrollees Held Harmless.

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

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

(3) The following is an example of an approvable hold-harmless clause: "(Physician or Provider) agrees that in no event, including, but not limited to, nonpayment by the HMO, HMO insolvency, or breach of this agreement, may (Physician or Provider) bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than the HMO acting on their behalf for services provided under this agreement. This provision does not prohibit collection of supplemental charges or copayments made in compliance with the terms of (applicable agreement) between the HMO and subscriber or enrollee. (Physician or Provider) further agrees that:

(A) this provision will survive the termination of this agreement regardless of the cause giving rise to termination and must be construed to be for the benefit of the HMO subscriber or enrollee; and

(B) this provision supersedes any oral or written contrary agreement now existing or later entered into between (Physician or Provider) and subscriber, enrollee, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than 15 days after the commissioner has received written notice of the proposed changes."

(b) Physician and provider contracts, subcontracts, and arrangements must include provisions:

(1) regarding retaliation as described in Insurance Code §843.281, concerning Retaliatory Action Prohibited;

(2) regarding continuity of treatment, if applicable, as described in Insurance Code §843.309, concerning Contracts with Physicians or Providers: Notice to Certain Enrollees of Termination of Physician or Provider Participation in Plan, and §843.362, concerning Continuity of Care; Obligation of Health Maintenance Organization;

(3) regarding written notification to enrollees receiving care from a physician or provider of the termination of that physician or provider in compliance with Insurance Code §843.308, concerning Notification of Patients of Deselected Physician or Provider, and §843.309;

(4) regarding posting of complaint notices in physician or provider offices as described in Insurance Code §843.283, concerning Posting of Information on Complaint Process Required, provided that a representative notice that complies with this requirement may be obtained from the Managed Care Quality Assurance Office, MC: LH-

MCQA, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030, or the department's website at www.tdi.texas.gov;

(5) regarding indemnification of the HMO as described in Insurance Code §843.310, concerning Contracts with Physicians or Providers: Certain Indemnity Clauses Prohibited;

(6) regarding prompt payment of claims as described in Insurance Code Chapter 542, Subchapter B, concerning Prompt Payment of Claims; §1271.005, concerning Applicability of Other Law; and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J, concerning Payment of Claims to Physicians and Providers; and Chapter 21, Subchapter T, of this title (relating to Submission of Clean Claims) with respect to payment to the physician or provider for covered services rendered to enrollees;

(7) regarding capitation, if applicable, as described in Insurance Code §843.315, concerning Payment of Capitation; Assignment of Primary Care Physician or Provider, and §843.316, concerning Alternative Capitation System;

(8) regarding selection of a primary care physician or provider, if applicable, as described in Insurance Code §843.203, concerning Selection of Primary Care Physician or Provider;

(9) providing that a podiatrist, practicing within the scope of the law regulating podiatry, is permitted to furnish X-rays and non-prefabricated orthotics covered by the evidence of coverage as described in Insurance Code §843.311, concerning Contracts with Podiatrists;

(10) regarding the requirements of §21.3701 of this title (relating to Electronic Claims Filing Requirements) if the contract requires electronic submission of any information described by that section;

(11) requiring the preferred provider to comply with all applicable requirements of Insurance Code §1661.005, concerning Refund of Overpayment; and

(12) requiring a contracting physician or provider to retain in the contracting physician's or provider's records updated information concerning a patient's other health benefit plan coverage.

(c) Physician and provider contracts and arrangements must include provisions entitling the physician or provider, on request, to all information necessary to determine that the physician or provider is being compensated in compliance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. The information provided must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including email, computer disks, or other electronic storage and transfer technology, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided under this paragraph must comply with paragraph (4) of this subsection. The HMO must provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(1) The information provided must include a physician-specific or provider-specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by a physician or provider, including at a minimum, the:

(A) fee schedule, including, if applicable, CPT, HCPCS, CDT, ICD-9-CM, ICD-10-CM, ICD-11-CM, and successor codes, and modifiers:

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

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

(B) all applicable coding methodologies;

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

(D) all applicable downcoding policies;

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

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

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

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

(3) Nothing in this subsection may be construed to require an HMO to provide specific information that would violate any applicable copyright law or licensing agreement. However, the HMO must supply, instead of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the contract for covered services that are rendered to enrollees as required by paragraph (1) of this subsection.

(4) No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this subsection will be effective as to the contracting physician or provider, unless the HMO provides at least 90-calendar-days' written notice to the contracting physician or provider identifying with specificity the amendment, revision, or substitution. An HMO may not make retroactive

changes to claims payment procedures or any of the information required to be provided by this subsection. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this subsection, the written notice specified in this section does not supersede the requirement for mutual agreement.

(5) The HMO must provide the information required by paragraphs (1) - (4) of this subsection to the contracting physician or provider by the 30th day after the date the HMO receives the contracting physician's or provider's request.

(6) A physician or provider receiving information under this subsection may not:

(A) use or disclose the information for any purpose other than:

(i) the physician's or provider's practice management;

(ii) billing activities;

(iii) other business operations; or

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

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

(C) rely on information provided under this paragraph about a service as a representation that an enrollee is covered for that service under the terms of the enrollee's evidence of coverage.

(7) A physician or provider that receives information under this subsection may terminate the contract on or before the 30th day after the date the physician or

provider receives the information without penalty or discrimination in participation in other health care products or plans. The contract between the HMO and physician or provider must provide for reasonable advance notice to enrollees being treated by the physician or provider before the termination consistent with Insurance Code §843.309.

(8) The provisions of this subsection may not be waived, voided, or nullified by contract.

(d) Physician and provider contracts, subcontracts, and arrangements must include provisions regarding written notification of termination to a physician or provider in compliance with Insurance Code §843.306, concerning Termination of Participation; Advisory Review Panel, and §843.307, concerning Expedited Review Process on Termination or Deselection, including provisions providing that:

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

(2) not later than 30 days following receipt of the written notification of termination, a physician or provider may request a review by the HMO's advisory review panel except in a case involving:

(A) imminent harm to patient health;

(B) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(C) fraud or malfeasance; and

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

(e) On request by a participating physician or provider, an HMO must include a provision in the physician's or provider's contract providing that the HMO and the HMO's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" means "a group of electronic claims submitted for processing at the same time within a Health Insurance Portability and Accountability Act (HIPAA) standard ASC X12N 837 Transaction Set and identified by a batch control number." This subsection applies to a contract entered into or renewed on or after August 1, 2017. For a contract entered into or renewed before August 1, 2017, the law and regulations in effect at the time the contract was entered or renewed, whichever is later, governs.

(f) A contract between an HMO and a dentist may not limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115, concerning Contracts with Dentists.

(g) A contract between an HMO and a provider, as that term is defined in Insurance Code §1458.001, concerning General Definitions, must comply with Insurance Code §1458.101, concerning Contract Requirements, to the extent applicable.

§11.902. Prohibited Actions.

(a) An HMO may not:

(1) require a physician to use a hospitalist for a hospitalized patient by contract under Insurance Code §843.320, concerning Use of Hospitalist;

(2) refuse to contract with a nurse first assistant to be part of a provider network or refuse to reimburse a nurse first assistant under Insurance Code §843.3045, concerning Nurse First Assistant;

(3) require a physician to use the services of a nurse first assistant as defined by Occupations Code §301.354, concerning Nurse First Assistants; Assisting at Surgery by Other Nurses;

(4) refuse to contract with a podiatrist licensed by the Texas Department of Licensing and Regulation who joins the professional practice of a contracted physician or provider under Insurance Code §843.319, concerning Certain Required Contracts;

(5) refuse a request to identify a physician assistant or advanced practice registered nurse as a provider in the HMO's network under Insurance Code §843.312, concerning Physician Assistants and Advanced Practice Nurses;

(6) employ an optometrist or therapeutic optometrist to provide a vision care product or service, pay an optometrist or therapeutic optometrist for a service not provided, or restrict or limit an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials under Insurance Code §1451.156 (concerning Prohibited Conduct); or

(7) contract with a dentist to limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115, concerning Contracts with Dentists.

(b) An HMO that uses steering or a tiered network to encourage an enrollee to obtain a health care service from a particular provider, as defined under Insurance Code

Chapter 1458, concerning Provider Network Contract Arrangements, must do so in a manner that complies with the requirements of the Insurance Code, including the fiduciary duty imposed by Insurance Code §1458.101(i), concerning Contract Requirements, to act only for the primary benefit of the enrollee or contract holder. For the purposes of this section:

(1) "steering" refers to offering incentives to encourage enrollees to use specific physicians or providers;

(2) "tiered network" refers to a network of contracted physicians and providers in which an HMO assigns contracted physicians and providers to tiers within the network that are associated with different levels of cost sharing; and

(3) violations of the fiduciary duty under Insurance Code §1458.101(i) will be determined by TDI based on an assessment of the HMO's conduct. Examples of conduct that would violate the HMO's fiduciary duty include, but are not limited to:

(A) using a steering approach or a tiered network to provide a financial incentive as an inducement to limit medically necessary services, to encourage receipt of lower quality medically necessary services or receipt of services, or in violation of state or federal law;

(B) failing to implement reasonable processes to ensure that the contracted physicians and providers that enrollees are encouraged to use within any steering approach or tiered network are not of a materially lower quality as compared with contracted physicians and providers that enrollees are not encouraged to use;

(C) failing to implement reasonable processes to ensure that the HMO does not make materially false statements or representations about a physician's or provider's quality of care or costs; or

(D) failing to use objectively and verifiably accurate and valid information as the basis of any encouragement or incentive under this subsection.

Subchapter Q. Other Requirements
28 TAC §11.1611 and §11.1612

STATUTORY AUTHORITY. The commissioner adopts amendments to §11.611 and §11.1612 under Insurance Code §§843.151, 843.2015(c), 1271.152, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various sections of the Insurance Code related to HMOs and ensure adequate access to health care services, including establishing physician-to-patient ratios and requirements relating to mileage, travel time, and appointment waiting times.

Insurance Code §843.2015(c) authorizes the commissioner to adopt rules necessary to implement the requirements for an HMO's online listing of physicians and providers, including rules that govern the form and content of information that must be provided under statute.

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

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

TEXT.

§11.1611. Out-of-Network Claims; Non-Network Physicians and Providers.

(a) For an out-of-network claim for which the enrollee is protected from balance billing under Insurance Code Chapter 1271, concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges, the HMO must pay the claim according to that chapter and Insurance Code Chapter 1467, concerning Out-of-Network Dispute Resolution, as applicable.

(b) For an out-of-network claim that does not fall under subsection (a) of this section, if the services are medically necessary, covered under the plan, and not available through a network physician or provider within the applicable network adequacy standards, the HMO must pay the claim as required under Insurance Code §1271.055, concerning Out-of-Network Services, and:

(1) facilitate the enrollee's access to care consistent with subsection (c) of this section and the access plan and documented plan procedures specified in §11.1607(j) of this title (relating to Accessibility and Availability Requirements); and

(2) inform the enrollee of their rights under this section, including:

(A) the out-of-network care that the enrollee receives for the identified services will be covered under the same benefit level as though the services were received from a network physician or provider and will not be subject to any service area limitation;

(B) the enrollee can ask the HMO to recommend a physician or provider that the enrollee can use without being responsible for an amount in excess of the cost-sharing under the plan and the enrollee should contact the HMO if they receive a balance bill;

(C) if the enrollee chooses not to use the physician or provider the HMO recommends, they may choose to use an alternative non-network physician or provider with the understanding that the enrollee will be responsible for any balance bill amount the alternative non-network physician or provider may charge in excess of the HMO's usual and customary rate; and

(D) the amount of the HMO's usual and customary rate for the anticipated services.

(c) If medically necessary covered services, other than emergency care, are not available through a network physician or provider within the applicable network adequacy standards, on the request of a network physician or provider the HMO must:

(1) consistent with Insurance Code §1271.055, process a referral to a physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation;

(2) concurrent with the referral, approve a network gap exception and facilitate access to care to ensure the enrollee can access a physician or provider that:

(A) has expertise in the necessary specialty;

(B) is reasonably available considering the medical condition and location of the enrollee; and

(C) the enrollee may use without being responsible for an amount in excess of the enrollee's cost-sharing responsibilities for care from a network physician or provider;

(3) if the HMO approves a referral to a physician or provider that meets the criteria in subsection (c)(2) of this section, the HMO must also, upon request from an

enrollee or an individual acting on behalf of an enrollee and within the time appropriate to the circumstances, recommend at least one additional physician or provider that meets the criteria in subsection (c)(2) of this section; and

(4) if the HMO approves a referral to a physician or provider that does not meet the criteria in subsection (c)(2) of this section,

(A) the HMO must inform the enrollee of:

(i) why the physician or provider does not meet the criteria in subsection (c)(2) of this section; and

(ii) the enrollee's right to request that the HMO recommend physicians or providers that meet the criteria; and

(B) upon request by the enrollee or an individual acting on behalf of the enrollee and within the time appropriate to the circumstances, the HMO must recommend a choice of at least two physicians or providers that meet the criteria in subsection (c)(2) of this section.

(d) After determining that a claim from a non-network physician or provider for services provided under this section is payable, an HMO must issue payment to the non-network physician or provider at the usual and customary rate or at a rate agreed to by the HMO and the non-network physician or provider. If the rate was not agreed to by the physician or provider, the HMO must provide an explanation of benefits to the enrollee that includes a statement that the HMO's payment is at least equal to the usual and customary rate for the service, that the enrollee should notify the HMO if the non-network physician or provider bills the enrollee for amounts beyond the amount paid by the HMO, of the procedures for contacting the HMO on receipt of a bill from the non-network physician or provider for amount beyond the amount paid by the HMO, and the number

for the department's toll-free consumer information help line for complaints regarding payment.

(e) Any methodology used by an HMO to calculate reimbursements of non-network physicians or providers for covered services not available from network physicians or providers must comply with the following:

(1) if based on claims data, then the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

(2) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than 3 years old; and

(3) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

(f) An HMO must cover a clinician-administered drug under the plan's in-network benefit if it meets the criteria under Insurance Code Chapter 1369, Subchapter Q, concerning Clinician-Administered Drugs.

§11.1612. Mandatory Disclosure Requirements

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

(1) include the name, address, telephone number, and specialty, if any, of each physician and provider and indicate whether each contracted physician and provider

is accepting enrollees as new patients or participates in closed provider networks serving only certain enrollees;

(2) include a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network;

(3) be dated and provided in at least 10-point type;

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

(5) when provided electronically, be searchable by physician or health care provider name and location;

(6) be publicly accessible without the necessity of providing a password, a username, or personally identifiable information;

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

(8) include an email address and a toll-free telephone number through which enrollees may notify the HMO of inaccurate information in the directory.

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

provider belongs to and the page number where the physician's or provider's name can be found.

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

Figure: 28 TAC §11.1612(c)

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at [enter website] or by calling [enter phone number].

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care. [*Include if balance billing is permitted for ground ambulance services under applicable state and federal law:* However, protections do not apply for ground ambulance services.]

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at tdi.texas.gov.

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

(e) Disclosure concerning network information. An HMO must provide notice to all enrollees at least annually of information that is updated at least annually regarding the following network information for each service area or county, or for the entire state if the plan is offered on a statewide service-area basis:

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

(2) for each physician and provider area of practice, including at a minimum internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of contracted

physicians and providers, an indication of whether an active access plan under §11.1607 of this title (relating to Accessibility and Availability Requirements) applies to the services furnished by that class of physician or provider in the service area or region, and how the access plan may be obtained or viewed, if applicable; and

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

(f) Website disclosures. An HMO must provide information on its website for use by current or prospective enrollees that includes a:

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

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

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

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

(g) Reliance on physician and provider listing in certain cases. A claim for services rendered by a noncontracted physician or provider must be paid in the same manner as if no contracted physician or provider had been available under §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers), as applicable, and the HMO must make restitution to the enrollee for any amounts the

enrollee demonstrates that they paid the physician or provider above what they would have paid a network physician or provider, if an enrollee demonstrates that:

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

(A) a physician and provider listing; or

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

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

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

(h) Additional listing-specific disclosure requirements. In all contracted physician and provider listings, including any web-based postings of information made available by the HMO to provide information to enrollees about contracted physicians and providers, the HMO must comply with the requirements in Insurance Code Chapter 1451, Subchapter K, and paragraphs (1) and (2) of this subsection. The requirements of this subsection do not apply to provider listings for a single health care service that provides coverage only for dental or vision care.

(1) The physician and provider information must provide a method by which enrollees may identify contracted facility-based physicians and providers able to provide services at contracted facilities, consistent with Insurance Code §1451.504, concerning Physician and Health Care Provider Directories.

(2) The physician and provider information must specifically identify any network facility at which the HMO has no contracts with a class of facility-based physician,

specifying the applicable type of facility-based physician, consistent with Insurance Code Chapter 1456, concerning Disclosure of Provider Status.

(i) Annual enrollee notice concerning use of an access plan. An HMO operating a plan that relies on an access plan as specified in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees) and §11.1607 of this title must provide notice of this fact to each enrollee participating in the plan at issuance and at least 30 days before renewal. The notice must include a link to any webpage listing of information on network waivers and access plans made available under subsection (e) of this section.

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

(1) A decrease is substantial if:

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

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

(2) For purposes of this subsection, decreases in numbers of physicians and other providers must be assessed separately, but no notice of a substantial decrease is required if:

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

(B) the HMO determines that the termination of the contract has not caused the network to be noncompliant with the adequacy standards specified in §11.1607 of this title, as those standards apply to the applicable physician or provider specialty.

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

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

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

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

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

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

(B) the later of:

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

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

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on March 10, 2025.

Signed by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §§11.506, 11.901, 11.902, 11.1611, and 11.1612 are adopted.

Signed by:
C Brown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2025-9191