

Subchapter C. Application for Certificate of Authority
28 TAC §11.202

**Subchapter D. Regulatory Requirements for an HMO After Issuance of Certificate
of Authority**
28 TAC §11.301 and §11.302

Subchapter F. Evidence of Coverage
28 TAC §§11.501 - 11.504 and 11.506
[~~28 TAC §11.505~~]

Subchapter H. Schedule of Charges
28 TAC §11.701

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

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28 TAC §11.1402

Subchapter Q. Other Requirements
28 TAC §11.1604

Subchapter Z. Point-of-Service Riders
28 TAC §11.2503

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to repeal 28 TAC §11.505 and amend §§11.202, 11.301, 11.302, 11.501 - 11.504, 11.506, 11.701, 11.901, 11.902, 11.1402, 11.1604, and 11.2503, concerning health maintenance organizations (HMOs). The repeal and amendments update HMO filing rules to align with filing requirements in 28 TAC Chapter 3, Subchapter A, and implement House Bills 388, 2221, and 3211, 89th Legislature, 2025; and Senate Bills 493, 896, 926, and 1236, 89th Legislature, 2025.

EXPLANATION. Amendments to §§11.504, 11.506, 11.901, 11.902, 11.1402, and 11.2503 are necessary to implement the following legislation:

- HB 388 requires health plans to use a uniform coordination of benefits questionnaire that is adopted by TDI.

- HB 2221 repeals certain provisions in Insurance Code Chapter 541, concerning unlawful rebates and inducements, and replaces them with similar provisions in new Chapter 1702.

- HB 3211 establishes new contracting requirements for vision care plans.

- SB 493 prohibits certain pharmacy benefit manager contract provisions.

- SB 896 extends the period during which a newborn child is automatically covered and the deadline to enroll a newborn child into coverage.

- SB 926 expands provisions related to health plans that use steering or tiering to encourage enrollees to use certain network physicians and providers.

- SB 1236 expands requirements for pharmacy benefit network contracts.

In separate proposals also published in this issue of the *Texas Register*, TDI proposes to amend 28 TAC Chapters 3 and 26 to make changes to implement the previously referenced legislation. In a separate proposal published October 24, 2025 (50 TexReg 6976), TDI proposed a uniform coordination of benefits questionnaire in 28 TAC Chapter 3, Subchapter V, to implement HB 388. At a later date, TDI also plans to propose amendments to 28 TAC Chapter 21 to implement provisions in HB 2221 and SB 1236.

Additional amendments to §§11.202, 11.301, 11.302, 11.501 - 11.504, 11.701, and 11.1604, and the repeal of §11.505 are necessary to update HMO filing rules to align with filing requirements for life, health, and HMO products in 28 TAC Chapter 3, Subchapter A. Historically, HMO filing requirements were addressed exclusively in Chapter 11. However, in 2025, TDI modernized the rules in 28 TAC Chapter 3, Subchapter A, and expanded the scope to include all HMO filings that are filed with TDI's Life and Health Division through

the NAIC's System for Electronic Rates and Forms Filing (SERFF) after an HMO receives a certificate of authority. The proposed amendments and repeal remove provisions that duplicate or conflict with the provisions in 28 TAC Chapter 3, Subchapter A. Because of the proposed reorganization of §11.301, cross-references in other sections of Chapter 11 are amended to conform to the reorganized subsections and paragraphs.

Descriptions of the sections as proposed follow, organized by subchapter.

Subchapter C.

Section 11.202. An amendment is proposed to §11.202 to delete subsection (i), which requires each item in the application to be identified by a unique form number. This requirement is no longer necessary. Form numbers are needed only for filings made in SERFF, and applicable requirements are contained in 28 TAC Chapter 3, Subchapter A. The deletion of subsection (i) conforms to the proposed amendments to §11.301.

Subchapter D.

Section 11.301. The proposed amendments to §11.301 modify the filing requirements to conform to changes adopted in 28 TAC Chapter 3, Subchapter A, which broadly address filing requirements for life, health, and HMO products and remove the need for most HMO-specific filing requirements. As part of these amendments, provisions throughout the section are reorganized into subsections, renumbered paragraphs, and redesignated subparagraphs.

To improve readability, amendments to newly designated subsection (a) add statutory citations that are currently included in paragraph (1) and remove language addressing filings for preapproval or for information only because those filing types are addressed in subsequent subsections. Cross-references to paragraphs (4) and (5) are revised to instead reference newly designated subsections (c) and (d) to reflect the

section's proposed reorganization. A sentence related to paper and electronic filings is deleted since other references in the section delineating such filing methods are also removed.

Paragraph (1) and subparagraph (A) are redesignated as subsection (b) and the catchline is modified to remove the words "and format," consistent with other changes to the subsection. To improve readability, the references to statutory citations that require filings for approval are moved to subsection (a). References to statutes and rules specifying the information that must be contained for a filing to be considered complete are reorganized into new paragraphs (1) - (3). New paragraph (4) adds a reference to filing rules in 28 TAC Chapter 3, Subchapter A, regarding submission requirements for life, health, and HMO products. Subparagraphs (B) - (E), related to filing format and methods, are deleted. Because almost all filings are made electronically, the provisions for paper filings are not necessary. The references to filing methods are unnecessary because they are addressed in newly designated subsections (c) and (d).

Paragraphs (2) and (3), related to form numbers, certification and transmittal forms, supporting documentation, and filing fees, are deleted because similar provisions are contained in 28 TAC Chapter 3, Subchapter A. Since form numbers are not required for filings outside the scope of 28 TAC Chapter 3, Subchapter A, and as previously discussed, the proposal makes a conforming amendment to §11.202 to remove a reference to paragraph (2).

Paragraph (4) is redesignated as subsection (c). References to submissions through SERFF are replaced with a reference to 28 TAC Chapter 3, Subchapter A, which requires electronic submission through SERFF.

Paragraph (5) is redesignated as subsection (d). The catchline is expanded to include filings for review because some filings, such as the schedule of charges, are classified as rate filings subject to review under 28 TAC Chapter 3, Subchapter A. To avoid

duplication with filing requirements in 28 TAC Chapter 3, Subchapter A, the requirement for accompanying documents is removed. References to SERFF submissions are replaced with a reference to 28 TAC Chapter 3, Subchapter A, which requires electronic submission through SERFF.

Paragraph (6) is redesignated as subsection (e).

Paragraph (7) is redesignated as subsection (f) and updated to align with 28 TAC Chapter 3, Subchapter A. The catchline is revised to reference "requests for corrections" instead of "pending." Internal cross-references are updated to conform with organizational changes throughout the section. Subparagraph (C), which addresses holding a filing in a pending status, is deleted, since a corresponding requirement is not found in Insurance Code Chapter 1271 or in the filing rules in 28 TAC Chapter 3, Subchapter A. Redesignated paragraph (3) is revised to add a reference to 28 TAC §3.23 and to indicate that if an HMO has not addressed TDI's request for corrections or additional information within 10 business days, TDI may consider the filing withdrawn from review. This aligns with 28 TAC §3.23(c)(3) and replaces the current provision, stating that after 15 calendar days, the HMO may withdraw the filing before the end of the review period.

Section 11.302. An amendment is proposed to §11.302(b)(4) to revise a reference to §11.301 to conform to proposed amendments to that section.

Subchapter F.

Section 11.501. The proposed amendments to §11.501 remove outdated filing fee provisions in subsection (b) and replace them with references to the filing requirements in 28 TAC Chapter 3, Subchapter A. Subsection (c), regarding matrix filing fees, is deleted.

Section 11.502. The proposed amendments to §11.502 modify subsection (a) to revise the reference to §11.301 to conform to the proposed amendments reorganizing that section and add a reference to filing requirements in 28 TAC Chapter 3, Subchapter A.

Section 11.503. The proposed amendments to §11.503 revise subsection (a) to add a reference to filing requirements contained in 28 TAC Chapter 3, Subchapter A. Subsection (c) is amended to remove a reference to §11.505, which is proposed for repeal. To avoid duplication with provisions in §3.23 and 28 TAC §11.301, subsections (d) - (f) are deleted.

Section 11.504. The proposed amendments to §11.504 revise subsection (a)(1) to add a reference to filing requirements in 28 TAC Chapter 3, Subchapter A, and revise subsection (a)(3) to implement HB 2221 by adding a reference to new Insurance Code Chapter 1702.

Repeal of Section 11.505. The proposed repeal of §11.505 avoids duplication with filing requirements in 28 TAC Chapter 3, Subchapter A.

Section 11.506. The proposed amendments to §11.506(b)(8)(D)(iii) and (v) implement SB 896 by expanding required coverage for newborn children from 31 days to 60 days following birth and by extending the deadline to notify the HMO.

Subchapter H.

Section 11.701. The proposed amendments to §11.701 add a reference in subsection (a) to the filing requirements in 28 TAC Chapter 3, Subchapter A. New subsection (c) is added to reference requirements for major medical rate filings in 28 TAC Chapter 3, Subchapter F, which implements Insurance Code Chapter 1698.

Subchapter J.

Section 11.901. The proposed amendments to §11.901 implement legislation related to health plan contracting. An amendment to subsection (b)(12) implements HB 388 by adding a citation to new Insurance Code §1203.153, in connection to a requirement for a contracted physician or provider to retain records on a patient's other health plan coverage, including the coordination of benefits questionnaire. New subsection (h) is added to implement SB 1236 by requiring that a contract between an HMO and a pharmacy or pharmacist comply with pharmacy benefits contracting standards in Insurance Code Chapter 1369.

Section 11.902. Subsection (a)(7) is redesignated as (a)(8), and new subsection (a)(7) is added to implement HB 3211 by prohibiting HMO conduct that violates §1451.1545 or §1451.157. New subsection (a)(9) is added to implement SB 493 by prohibiting conduct that violates Insurance Code §4151.155.

Subsection (b) is amended to implement SB 926 by adding a reference to Insurance Code §843.322. To avoid duplicating the statute, subparagraphs (A) - (D) of paragraph (3) are deleted.

Subchapter O.

Section 11.1402. An amendment is proposed to §11.1402 to implement HB 3211 by adding new subsection (e) to require vision care plans specifically to comply with Insurance Code §1451.1545.

Subchapter Q.

Section 11.1604. A proposed amendment to §11.1604 revises a reference in paragraph (2) to §11.301 to conform to proposed amendments to that section.

Subchapter Z.

Section 11.2503. An amendment is proposed to §11.2503(d) to implement HB 2221 by adding a citation to Insurance Code Chapter 1702.

The sections as proposed also include nonsubstantive editorial and formatting changes to conform them to the agency's current style and to improve the rule's clarity. These changes appear throughout the amended sections and include correcting the style of statutory citations; adding headings to cited statutes and rules; updating cross-references to other rules; updating terminology; and making other grammatical, punctuational, and formatting changes to reflect TDI's current drafting style and plain language preferences.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of the Regulatory Initiatives Office in the Life and Health Division, has determined that during each year of the first five years the sections as proposed are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering them other than that imposed by statute. Ms. Bowden made this determination because the sections as proposed do not add to or decrease state revenues

or expenditures, and because local governments are not involved in enforcing or complying with them.

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

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the sections as proposed are in effect, Ms. Bowden expects that administering them will have the public benefit of ensuring that TDI's rules conform to House Bills 388, 2221, and 3211, and Senate Bills 493, 896, 926, and 1236. The sections as proposed will also have the public benefit of simplifying HMO filing rules in Chapter 11 by conforming them to unified life, health, and HMO filing rules in 28 TAC Chapter 3, Subchapter A.

Ms. Bowden expects that the sections as proposed will not increase the cost of compliance. The 28 TAC Chapter 3 filing requirements were adopted in April 2025 and are already being applied to HMOs. The sections as proposed conform the HMO rules in Chapter 11 with the 28 TAC Chapter 3 rules and will not increase compliance costs. Any cost for those required to comply with the sections as proposed are attributable to House Bills 388, 2221, and 3211, and Senate Bills 493, 896, 926, and 1236.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the sections as proposed will not have an adverse economic effect on small or micro businesses, or on rural communities. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. As explained in the Public Benefits and Cost Note, TDI has determined that this proposal does not impose

a cost on regulated persons. Therefore, no additional rule amendments are required under Government Code §2001.0045.

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

- will not create or eliminate a government program;
- will not require the creation of new employee positions or the elimination of existing employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;
- will not require an increase or decrease in fees paid to the agency;
- will not create a new regulation;
- will expand, limit, or repeal an existing regulation;
- will not increase or decrease the number of individuals subject to the rule's applicability; and
- will not positively or adversely affect the Texas economy.

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

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on June 8, 2026. Consistent with Government Code §2001.024(a)(8), TDI requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2864. This proposal will be part of a rule hearing docket that will begin at 10:00 a.m., central time, on June 1, 2026. TDI will hold the public hearing both remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.034. Visit www.tdi.texas.gov/alert/event/index.html for more info on the proposed rule, hearing, and comment submission.

Subchapter C. Application for Certificate of Authority 28 TAC §11.202

STATUTORY AUTHORITY. TDI proposes amendments to §11.202 under Insurance Code §§843.080, 843.151 and 36.001.

Insurance Code §843.080 authorizes the commissioner to adopt reasonable rules that the commissioner considers necessary for the proper administration of Insurance Code Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments for the commissioner's approval or information.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code and to ensure adequate access to health care services.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.202 implement Insurance Code Chapter 843, Subchapter C.

TEXT.

§11.202. Binding, Indexing, and Numbering Requirements.

(a) A proposed HMO may submit an application for a certificate of authority in electronic format, by electronic file transmission or in a data storage format acceptable to the department, or by paper.

(b) If an HMO submits an application in paper format, the applicant must submit three separate copies of the application in separate three-ring binders^[7] so that pages may be easily replaced when necessary. Paper applications must include dividers with identifying subject tabs preceding each separate exhibit.

(c) Applications submitted in an electronic format must include separate file folders with names identifying each exhibit.

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

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

(f) An HMO should not use identical items in more than one section of the application. Instead of using the same information in more than one place, an application must refer to the file or page on which the required form or list may be found.

(g) An original application becomes the charter file once the applicant submits all required revisions and the commissioner approves the application.

(h) The application is subject to Government Code Chapter 552, ~~[(f)concerning Public Information[]].~~

~~[(i) Each item in the application must be identified by a unique number as more fully described in §11.301(2) of this title (relating to Filing Requirements).]~~

Subchapter D. Regulatory Requirements for an HMO After Issuance of Certificate of Authority
28 TAC §11.301

STATUTORY AUTHORITY. TDI proposes amendments to §11.301 and §11.302 under Insurance Code §§843.080, 843.151 and 36.001.

Insurance Code §843.080 provides that the commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of Insurance Code Chapter 843 to require an HMO, after receiving its certificate of authority, to submit modifications or amendments for the commissioner's approval or information.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code and to ensure adequate access to health care services.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.301 and §11.302 implement Insurance Code Chapters 843 and 1271.

TEXT.

§11.301. Filing Requirements.

(a) Filings required. Consistent with Insurance Code §843.080, concerning Modification or Amendment of Application Information, and Insurance Code Chapter 1271, Subchapter C, concerning Commissioner Approval, after [After] the commissioner issues an HMO's certificate of authority, the HMO is required to file with the commissioner[~~, either for approval before effect or for information only,~~] any items specified in §11.204 of this title (relating to Contents) that the HMO has deleted, amended, or revised as outlined in subsections (c) and (d) [paragraphs (4) and (5)] of this section and any items specified in §11.302 of this title (relating to Service Area Expansion or Reduction Applications). These requirements include filing changes made necessary by federal or state law or regulations. ~~[All requirements in this section apply to both electronic and paper filings unless stated otherwise.]~~

(b) [(1)] Completeness [and format] of filings. [(A)] The department will not accept a filing for review until the filing is complete. An application to modify an approved application for a certificate of authority ~~[that requires the commissioner's approval under Insurance Code §843.080 (concerning Modification or Amendment of Application Information) or Insurance Code Chapter 1271, Subchapter C, (concerning Commissioner Approval)]~~ is considered complete when all information ~~[required by this section; §11.302; and Chapter 11, Subchapter T, of this title (relating to Quality of Care)]~~ that is applicable and reasonably necessary for the department to make a final determination has been filed, including information required by: [-]

(1) this section;

(2) §11.302 of this title;

(3) Subchapter T of this chapter (relating to Quality of Care); and

(4) Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

~~[(B) Unless otherwise required by this chapter or the Insurance Code, an HMO may submit a filing electronically through the NAIC's System for Electronic Rate and Form Filing or through any other method acceptable to the department.]~~

~~[(C) Unless otherwise required by this chapter or the Insurance Code, paper filings must:]~~

~~[(i) be submitted on 8-1/2- by 11-inch paper;]~~

~~[(ii) not be submitted in bound booklets;]~~

~~[(iii) be legible;]~~

~~[(iv) be in typewritten, computer generated, or printer's proof format; and]~~

~~[(v) except for maps, not contain any color highlighting unless accompanied by a clean copy without highlighting.]~~

~~[(D) As provided in this section, an HMO may submit some filings as provided in §7.201 of this title (relating to Forms Filings).]~~

~~[(E) As provided in this section, an HMO may submit some filings as provided in §11.203(a) of this title (relating to Revisions During Review Process).]~~

~~[(2) Identifying form numbers required. Each item required to be filed by paragraphs (4) and (5) of this section must be identified by a printed unique form number, adequate to distinguish it from other items. The identifying form numbers must be composed of a total of no more than 40 letters, numbers, symbols, or spaces.]~~

~~[(A) The identifying form number must appear in the lower left-hand corner of the page. In the case of a multiple-page document, the identifying form number must only appear on the lower left-hand corner of the first page, and page numbers should appear on subsequent pages.]~~

~~[(B) If an item is to be replaced or revised after issuance of a certificate of authority, a new identifying form number must be assigned.]~~

~~[(i) A change in address or phone number on a form will not require a new identifying form number.]~~

~~[(ii) A new edition date added to the original identifying form number is an acceptable way of revising the number so that it is identifiable from any previously approved item; for example, if "G-100" was the originally approved number, then the revision may be numbered "G-100 12/79."]~~

~~[(iii) Changing the case of the suffix is not considered to be a change in the number; for example, "ED" and "ed," or "REV" and "rev" are the same for form numbering purposes.]~~

~~[(3) Attachments for filings. Filings required by paragraphs (4)(A) and (B) and (5)(A) and (B) of this section must be accompanied by the following:]~~

~~[(A) an HMO certification and transmittal form for each new, revised, or replaced item;]~~

~~[(B) the supporting documentation considered necessary by the commissioner to review the filing and, for filings submitted on paper, a cover letter which includes the following:]~~

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

~~[(ii) form numbers that are being submitted; and]~~

~~[(iii) a paragraph that describes the type of filing being submitted, along with any additional information that would aid in processing the filing, including the reasons for submitting the filing; and]~~

~~[(C) the applicable filing fee as determined by §7.1301 of this title (relating to Regulatory Fees), unless the filing is made electronically through the NAIC's System for Electronic Rate and Form Filing, in which case the fees should not be attached to the filing.]~~

~~For filings made electronically, the department will send an invoice for the fees, and the HMO must pay, as provided in §7.1302 of this title (relating to Billing System).]~~

(C) ~~[(4)]~~ Filings requiring approval. After issuance of a certificate of authority, each HMO must file with the commissioner, using the method specified below, a written request to implement or modify the following operations or documents and receive the commissioner's approval before putting the modifications into effect:

(1) as provided in Chapter 3, Subchapter A, of this title:

~~[(A) electronically through the NAIC's System for Electronic Rate and Form Filing;]~~

(A) ~~[(i)]~~ evidence of coverage filings, as described in §11.501 of this title (relating to Contents of the Evidence of Coverage);

(B) ~~[(ii)]~~ a description and a map of the service area, with key and scale, which must identify the county or counties or portions of counties to be served;

(C) ~~[(iii)]~~ the written description of health care plan terms and conditions made available to any current or prospective group contract holder and current or prospective enrollee of the HMO, including the member handbook for all plans other than Children's Health Insurance Program (CHIP) plans in compliance with the requirements of Insurance Code §843.201, ~~[(f)]~~ concerning Disclosure of Information About Health Care Plan Terms, ~~[(g)]~~ and §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees); and

(D) ~~[(iv)]~~ any material change in the HMO's emergency care procedures;

~~[(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department;]~~

(E) ~~[(i)]~~ any material change in network configuration; and

(F) [~~(ii)~~] if a material change in the network configuration results in the HMO's inability to comply with the network adequacy standards described in §11.1607 of this title (relating to Accessibility and Availability Requirements), an access plan that complies with that section;

(2) [~~(C)~~] as provided in §7.201 of this title (relating to Forms Filings):

(A) [~~(i)~~] the form of all contracts described in §11.204(14)(A), (C), (D), and (E) of this title, including any amendments to those contracts and prior notification of the cancellation of any management contracts in §11.204(14)(E) of this title;

(B) [~~(ii)~~] the form of all contracts or subcontracts between affiliated physician and provider groups with the individual members of the groups providing health care services to the HMO's enrollees described in §11.204(14)(B) of this title, including any amendments to those contracts;

(C) [~~(iii)~~] any new or revised loan agreements or amendments documenting loans made by the HMO to any affiliated person or to any medical or other health care physician or provider, whether providing services currently, previously, or potentially in the future,^[:] and any guarantees of any affiliated person's, physician's, or provider's obligations to any third party;

(D) [~~(iv)~~] any agreement by which an affiliate agrees to handle an HMO's investments under §11.806 of this title (relating to Investment Management by Affiliate Corporation);

(E) [~~(v)~~] any change in the physical address of the books and records described in §11.205 of this title (relating to Additional Documents to be Available for Review);

(F) [~~(vi)~~] any change to any of the requirements for guarantees under §11.810 of this title (relating to Guarantee from a Sponsoring Organization);

(G) ~~[(vii)]~~ any insurance contracts or amendments, guarantees, or other protection against insolvency, including the stop-loss or reinsurance agreements, if changing the carrier or description of coverage, between the HMO and affiliates, as described in §11.204(16) of this title; and

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

(3) ~~[(D)]~~ as provided in §11.203(a) of this title, a copy of any proposed amendment to basic organizational documents, bylaws, rules, or any similar document regulating the conduct of the internal affairs of the applicant and, if the approved amendment must be filed with the secretary of state, a certified copy of the amendment with the file mark of the secretary of state; and

(4) ~~[(E)]~~ as provided in Chapter 11, Subchapter B, of this title (relating to Name Application Procedure), any name or assumed name on a form, as specified in §11.105 of this title (relating to Use of the Term "HMO," Service Marks, Trademarks, Assumed Name).

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

(1) as provided in Chapter 3, Subchapter A, of this title:

~~[(A) electronically through the NAIC's System for Electronic Rate and Form Filing;]~~

(A) [(i)] the formula or method for calculating the schedule of charges as specified in Chapter 11, Subchapter H, of this title (relating to Schedule of Charges);

(B) [(ii)] any modification of drug coverage under Insurance Code §1369.0541, ~~[(concerning Modification of Drug Coverage Under Plan)];~~ and

(C) [(iii)] the member handbook for CHIP plans, together with a certification from the HMO that the handbook has been approved by the Texas Health and Human Services Commission and a copy of the document approving the handbook;

~~[(B) on paper or electronically through the NAIC's System for Electronic Rate and Form Filing or any other method acceptable to the department;]~~

(D) [(i)] a copy of the form of any new contract or subcontract or any substantive change to previously filed copies of forms of all contracts between the HMO and any physician or provider described in §11.204(14)(B) of this title, and copies of forms of all contracts between the HMO and an insurer or group hospital service corporation to offer indemnity benefits, whether used with all contracts or on an individual basis. All copies of amended contracts must be marked to indicate revisions. In addition, the HMO must answer all questions listed on the HMO certification and transmittal form;

(E) [(ii)] a copy of the executed agreement between the HMO and any delegated entities and delegated networks as defined in §11.2602 of this title (relating to Definitions); and

(F) [(iii)] any change in the quality assurance program, including the peer review program, as required by Insurance Code §843.082(1), ~~[(concerning Requirements for Approval of Application)];~~ or §843.102, ~~[(concerning Health Maintenance Organization Quality Assurance)];~~ with descriptions of arrangements for

sharing pertinent medical records between physicians and providers contracting or subcontracting under §11.204(14)(B) of this title with the HMO and ensuring the records' confidentiality;

(2) [(C)] as provided in §7.201 of this title, a copy of any notice of cancellation of fidelity bonds, new fidelity bonds, or amendments to fidelity bonds, for officers and employees, including notarized certification by the corporate secretary or corporate president that the material is true, accurate, and complete, as described in §11.204(7) and (14)(D) of this title;

(3) [(D)] as provided in §11.203(a) of this title:

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

(B) [(ii)] any change of the certificate of authority for a domestic or foreign HMO[,] and, if a foreign HMO, a certified copy of the certificate of authority and power of attorney.

(e) [(6)] Approval period. Any modification for which the commissioner's approval is required may be considered approved, unless it is disapproved within 30 days from the date the filing is determined by the department to be complete. The commissioner may postpone the action for a period not to exceed 30 days, as necessary for proper consideration. The department will notify the HMO in writing if it postpones a decision on a modification.

(f) [(7)] Approval, disapproval, and requests for corrections [pending].

(1) [(A)] Filings requiring approval under subsection (c)(1)(A) - (C) [paragraph (4)(A)(i)–(iii)] of this section will be approved or disapproved in writing within the period set forth in subsection (e) [paragraph (6)] of this section unless, before the department's

issuance of notice of proposed negative action under §1.704(a) of this title (relating to Summary Procedure; Notice), the HMO has been contacted by the department regarding corrections or additional information necessary for commissioner's approval, and files a written consent to waive the approval period with the department.

(2) ~~[(B)]~~ The department may waive the approval period on its receipt of the HMO's written consent.

~~[(C) The department may hold the filing in a pending status for a reasonable period, but not more than 15 calendar days after the date of the department's request.]~~

(3) Consistent with §3.23 of this title (relating to Acceptance, Rejection, and Disposition of Filings), if ~~[(D) If]~~ the HMO has not addressed the department's request for corrections or additional information within 10 business days, then the department may consider the filing withdrawn from review ~~[15 calendar days, then the HMO may withdraw the filing before the end of the applicable review period, which is either the 30th day after filing or the 60th day after filing for an extended review period].~~

§11.302. Service Area Expansion or Reduction Applications.

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

(b) For the purposes of an application to expand or reduce an existing service area~~[- reduce an existing service area,]~~ or add a new service area, an HMO must file the following items:

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area, as required by §11.204(13) of this title (relating to Contents);

(2) network configuration information, as required by §11.204(19) of this title;

(3) combined financial projections, as described in §11.204(10)(B) of this title, including a breakdown of the income statement for existing business, and the effect of the proposed service area expansion or reduction; and

(4) if any of the items specified in §11.301 of this title (relating to Filing Requirements) are changed by a service area expansion or reduction application, the new item or any amendments to an existing item must be filed as specified in §11.301 ~~for approval or filed for information, as outlined in §11.301(4) and (5)]~~ of this title.

(c) The department will not accept an application for review until the application is complete. An application to modify the certificate of authority that requires the commissioner's approval under Insurance Code §843.080, ~~[concerning Modification or Amendment of Application Information,]~~ or Chapter 1271, Subchapter C, ~~[concerning Commissioner Approval,]~~ is considered complete when all information required by §11.301 of this title; this section; and Chapter 11, Subchapter T, of this title (relating to Quality of Care) that is reasonably necessary for a final determination by the department has been filed with the department.

(d) Before consideration of a service area expansion or reduction application, an HMO must comply with the requirements of Chapter 11, Subchapter T, of this title, in the existing service areas and in the proposed service areas.

Subchapter F. Evidence of Coverage **28 TAC §§11.501 - 11.506**

STATUTORY AUTHORITY. TDI proposes amendments to §§11.501 - 11.504 and §11.506 under Insurance Code §§843.151, 1271.004, 1501.010, 1702.006, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules

to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

Insurance Code §1271.004 authorizes the commissioner to adopt rules necessary to implement the section and meet the minimum requirements of federal law, including regulations.

Insurance Code §1501.010 directs the commissioner to adopt rules necessary to implement Insurance Code Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 1702.

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

CROSS-REFERENCE TO STATUTE. The amendments to §§11.501 - 11.504 and §11.506 implement Insurance Code Chapters 843 and 1271. The amendments to §11.504 implement Insurance Code Chapter 1702. The amendments to §11.506 implement Insurance Code §§1271.103, 1501.157 and 1501.607.

TEXT.

§11.501. Contents of the Evidence of Coverage.

(a) An evidence of coverage or an amendment to an evidence of coverage may not be issued, delivered, or used in Texas unless it has been filed for review and has received the approval of the commissioner. The following forms are always considered to be part of the evidence of coverage:

- (1) group agreement;

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

(3) conversion and individual agreements;

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

(5) group subscriber enrollment form;

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

(7) matrix filings;

(8) schedule of benefits; and

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

(b) Each of the forms described in subsection (a) of this section must be identified with a unique form number and individually approved by the commissioner before being issued, delivered, or used in Texas, consistent with the filing requirements under Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). [~~Each form described in subsection (a) of this section will be considered a separate evidence of coverage filing and, except as provided in subsection (c) of this section, is subject to the filing fee prescribed in §7.1301(g)(4) of this title (relating to Regulatory Fees) for initial submissions.~~]

~~[(c) The filing fee for matrix filings is \$100 per individual evidence of coverage provision, with a maximum fee of \$500, whether the filing is an initial submission or a resubmission.]~~

§11.502. Filing Requirements for Evidence of Coverage Filed as Part of an Application for a Certificate of Authority.

(a) The filing and formatting requirements of §11.301 [~~(1)(B) and (2)(A)~~] of this title (relating to Filing Requirements) and Chapter 3, Subchapter A, (relating to Submission

Requirements for Filings and Departmental Actions Related to Such Filings) apply to an evidence of coverage[7] when filed as part of the application for a certificate of authority.

(b) During the review period, an applicant must submit each new page or form reflecting any revisions.

(c) No later than the 10th calendar day after approval or issuance of a certificate of authority, an HMO must file a clean, final version of the evidence of coverage with revisions and a copy of the original version of the evidence of coverage showing the new or revised text as redlined. The submission must include:

(1) an explanation that the evidence of coverage was submitted as part of the application for a certificate of authority and is being submitted in compliance with subsection (c) of this section;

(2) a certification that the forms are without deviation and are the exact final evidence of coverage versions that resulted in approval of the certificate of authority application; and

(3) the final version of an approved service area description and map as attached to the evidence of coverage, with key and scale, which must identify the county or counties or portions of counties to be served.

(d) Any discrepancy in content between the final document to be issued and the approved version is grounds for revocation of a certificate of authority.

§11.503. Filing Requirements for Evidence of Coverage after Receipt of Certificate of Authority.

(a) After receipt of a certificate of authority, no evidence of coverage filing may be amended or altered in any manner, and no new evidence of coverage filing may be used, unless the proposed new or revised evidence of coverage filing has been filed for review and has received the commissioner's approval [~~of the commissioner~~]. The evidence of

coverage must be filed as provided in Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and §11.301 of this title (relating to Filing Requirements).

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

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

~~[(d) The review period for an evidence of coverage filing begins on the date an acceptable, typed draft of the form is received.]~~

~~[(e) The review period may be extended on 30 days written notice of extension to the HMO before the expiration of the initial review period.]~~

~~[(f) At the end of the review period, the evidence of coverage filing is considered approved unless it has already been withdrawn, affirmatively approved, or disapproved by the commissioner.]~~

§11.504. Disapproval of Evidence of Coverage.

(a) If the department disapproves any portion of an evidence of coverage, the department will specify the reason for the disapproval. The department may disapprove any form or withdraw any previous approval if a form:

(1) fails to meet the requirements of Insurance Code Chapter 1271, [~~concerning Benefits Provided by Health Maintenance Evidence of Coverage; Charges;~~] this chapter;~~;~~ Chapter 3, Subchapter A, of this title (relating to Submission Requirements

for Filings and Departmental Actions Related to Such Filings];^[7] or other applicable statutes and regulations;

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

(3) contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate Insurance Code Chapters 541_z [~~concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices~~];^[7] 542_z [~~concerning Processing and Settlement of Claims~~];^[7] 543_z [~~concerning Prohibited Practices Related to Policy or Certificate of Membership~~];^[7] 544_z [~~concerning Prohibited Discrimination~~];^[7] ~~or~~ 547_z [~~concerning False Advertising by Unauthorized Insurers~~];^[7] or Insurance Code Chapter 1702, concerning Regulation Of Certain Trade Practices, or any other applicable laws [~~law~~] or regulations;

(4) provides services or benefits that are too restrictive to achieve the form's purpose [~~for which the form was designed~~];

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

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

(7) is contrary to the laws or policies [~~law or policy~~] of this state.

(b) If the department disapproves a form, the HMO may file a written request for a hearing on the matter under Insurance Code §1271.102_z [~~concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval~~].

§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 HMO's 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 it applies 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^[7] when the copayments made by the enrollee in that calendar year total 200% of the total annual premium cost that ~~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_i^[7] the limit on enrollee copayments_i^[7] 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, as [sø] 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 HMO's service area [~~of the HMO~~] or area [~~for which~~] the HMO is authorized to do business in, 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 HMO's service area [~~of the HMO~~] or area [~~for which~~] the HMO is authorized to do business in, 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 an employer's 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) Unless otherwise prohibited by law, an [~~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 HMO's service area [~~of the HMO~~] or area [~~in which~~] the HMO is authorized to do business in, 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 for.

(iii) The HMO may require that the subscriber notify the HMO not later than the 60th day ~~[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 it 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 60 ~~[31]~~ days following birth. The HMO must allow

an enrollee 60 ~~[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 only 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 ~~[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 H. Schedule of Charges **28 TAC §11.701**

STATUTORY AUTHORITY. TDI proposes amendments to §11.701 under Insurance Code §§843.151, 1271.253, 1698.051, and 36.001. Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code as applicable to HMOs, including Insurance Code Chapter 1271.

Insurance Code §1271.253 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under Insurance Code Chapter 1271, Subchapter F.

Insurance Code §1698.051 requires that the commissioner by rule establish a process under which the commissioner will review individual and small group health benefit plan rates and rate changes for compliance with Insurance Code Chapter 1698 and other applicable state and federal laws, including 42 USC §§300gg, 300gg-94, and 18032(c) and those sections' implementing regulations, including rules establishing geographic rating areas.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.701 implement Insurance Code Chapter 1271 and Chapter 1698.

TEXT.

§11.701. Schedule of Charges Must be Filed Before Use.

(a) No schedule of charges, formula, or method for calculating the schedule of charges may be used until a copy of the formula or method for calculating the schedule of charges with supporting documentation has been filed with the commissioner, as required by §11.703 of this title (relating to Filings and Supporting Documentation) and consistent with Chapter 3, Subchapter A of this title (relating to Submission Requirements For Filings and Departmental Actions Related to Such Filing).

(b) The schedule of charges must include all charges made for group, conversion, or individual coverage.

(c) Any applicable schedule of charges must comply with the requirements under Chapter 3, Subchapter F, of this title (relating to Rate Review for Health Benefit Plans).

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

STATUTORY AUTHORITY. TDI proposes amendments to §11.901 and §11.902 under Insurance Code §§843.151, 4151.006, and 36.001. Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

Insurance Code §4151.006 authorizes the commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 4151, including rules establishing required contract provisions.

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

CROSS-REFERENCE TO STATUTE. The amendment to §11.901(b)(12) implements Insurance Code §1203.153 The amendment to §11.901(h) implements Insurance Code Chapter 1369 and SB 1236. Section 11.901(i) implements Chapter 1451, Subchapter D. Section 11.902(a)(7) implements §1451.1545 and §1451.157. The amendment to §11.902(a)(8) implements Insurance Code §4151.155. The amendment to §11.902(b) implements Insurance Code §832.322.

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, consistent with Insurance Code §1203.153, concerning Uniform Coordination of Benefits Questionnaire Required.

(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.

(h) A contract between an HMO and a pharmacy or pharmacist must comply with Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services.

§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) engage in conduct that violates Insurance Code §1451.1545, concerning Participation in Vision Care Plan; Effect on Other Plans, or §1451.157, concerning Vision Plan Conduct;

(8) ~~[(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; or ~~[-]~~

(9) engage in conduct that violates Insurance Code §4151.155, concerning Certain Disclosures and Communications by Pharmacist or Pharmacy Protected.

(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 §843.322, concerning Incentives to Use Certain Physicians and Providers, and 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 O. Administrative Procedures **28 TAC §11.1402**

STATUTORY AUTHORITY. TDI proposes amendments to §11.1402 under Insurance Code §843.151 and §36.001. Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.1402 implement Insurance Code §843.305 and §1451.1545 as added by HB 3211.

TEXT.

§11.1402. Notification to Physicians and Providers.

(a) An HMO that provides coverage for health care services or medical care through one or more physicians or providers is required by Insurance Code §843.305_z [(f)] concerning Annual Application Period for Physician and Providers to Contract_z[(f)] to provide a 20-calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in each of the HMO's networks providing health care services or medical care under the terms and conditions established by the HMO for the provision of the services and the designation of the physicians and providers. Section 843.305 may not be construed to:

(1) require that an HMO use a particular type of provider or physician in its operation;

(2) require that an HMO accept a physician or provider of a category or type that does not meet the practice standards and qualifications established by the HMO; or

(3) require that an HMO contract directly with the physicians or providers.

(b) An HMO subject to Insurance Code §843.305 must publish a notice of an application period to physicians and providers both in the public notice section of at least one major newspaper with general circulation in each of its service areas and on the HMO's website. The notice must be published for at least five consecutive days during the period of January 2 through January 23 of each calendar year and must include the caption "Notice to Physicians and Providers" in bold type, the name and address of the HMO, what networks the HMO provides, and the specific dates of the 20-day period during which physicians and providers may make application to be a participating physician or provider in each network.

(c) An HMO must notify a physician or provider of acceptance or nonacceptance, in writing, no later than 90 days from receipt of an application for participation by that physician or provider in a network.

(d) An HMO must file a copy of the published notice with the department in compliance with §11.301 of this title (relating to Filing Requirements), for information, within 30 days of publication. The filing must include the following:

(1) the name of the newspaper and the beginning and ending date of the publication; and

(2) a copy of the website screen shots and the beginning and ending date of the publication.

(e) Notwithstanding other provisions in this section, with respect to vision care plans, an HMO must comply with Insurance Code §1451.1545, concerning Participation in Vision Care Plan; Effect on Other Plans.

Subchapter Q. Other Requirements **28 TAC §11.1604**

STATUTORY AUTHORITY. TDI proposes amendments to §11.1604 under Insurance Code §§843.151, 844.004, and 36.001. Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure that enrollees have adequate access to health care services.

Insurance Code §844.004 authorizes the commissioner to adopt rules to implement Insurance Chapter 844.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.1604 implement Insurance Code Chapter 843.

TEXT.

§11.1604. Requirements for Certain Contracts Between Primary HMOs and ANHCs and Between Primary HMOs and Provider HMOs.

A primary HMO that enters into a contract with an ANHC in which the ANHC agrees to arrange for or provide health care services other than medical care or services ancillary to the practice of medicine, or with a provider HMO in which the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the primary HMO as part of the primary HMO delivery network must:

(1) submit a monitoring plan to the department setting out:

(A) how the primary HMO will ensure that the ANHC or provider HMO has an effective administrative system for providing timely and accurate reimbursement to all physicians and providers under contract with the ANHC or provider HMO; and

(B) how the primary HMO will ensure that all HMO functions delegated or assigned under contract with the ANHC or provider HMO are consistent with full compliance by the primary HMO with all department regulatory requirements;

(2) file with the department a copy of the form of the written contract with an ANHC or provider HMO, in accordance with §11.301 [~~§11.301(5)~~] of this title (relating to Filing Requirements), that:

(A) requires that the ANHC or provider HMO cannot terminate the contract without 90-days written notice;

(B) contains a hold-harmless provision that prohibits the ANHC or provider HMO and its contracted physicians and providers from billing for or attempting to collect from HMO members, except for authorized copayments and deductibles, charges for covered services under any circumstance, including the insolvency of the primary HMO, ANHC, or provider HMO;

(C) contains a provision stating that nothing in the contract will be construed to in any way limit the HMO's authority or responsibility to comply with all of the department's regulatory requirements;

(D) includes the ANHC's or provider HMO's acknowledgment and agreement that:

(i) the primary HMO is required to establish, operate, and maintain a health care delivery system, quality assurance system, physician and provider credentialing system, and other systems and programs meeting department standards and is directly accountable for compliance with the standards;

(ii) the role of the ANHC or provider HMO in contracting with the primary HMO is limited to implementing certain systems of the primary HMO, using [~~utilizing~~] standards approved by the primary HMO, and subject to the primary HMO's oversight and monitoring of the ANHC's or provider HMO's performance; and

(iii) the primary HMO may take necessary action to ensure that all HMO systems and functions that are delegated or assigned under the contract with the ANHC or provider HMO are in full compliance with all department regulatory requirements;

(E) requires the ANHC to make available to the primary HMO the ANHC's contracts with physicians and providers to ensure compliance with contractual requirements set out in subparagraphs (B) and (C) of this paragraph;

(F) requires the ANHC to provide the primary HMO with evidence of both financial solvency and financial ability to perform, such as a certified financial audit of the ANHC conducted by an independent certified public accountant, using generally accepted accounting and auditing principles; and

(G) requires the ANHC or provider HMO to provide the primary HMO, on at least a monthly basis and in a usable form necessary for audit purposes, the data

necessary for the HMO to comply with department reporting requirements with respect to any services provided under the HMO-ANHC or HMO-provider HMO agreement, including the following data:

(i) number of primary HMO enrollees served or assigned to the ANHC or primary HMO to receive services, including the number added and terminated since the last reporting period;

(ii) form of the contracts and subcontracts between the ANHC and physicians and providers who will be providing services to enrollees of the primary HMO and any material changes to the contracts and subcontracts;

(iii) copayments received by the ANHC or provider HMO;

(iv) summary of the amounts paid by the ANHC or provider HMO to physicians and providers;

(v) methods by which physicians and providers were paid by the ANHC or provider HMO, for example, capitation, fee-for-services, or other risk-sharing arrangements;

(vi) utilization data;

(vii) summary of the amounts paid by the ANHC or provider HMO for administrative services relating to the primary HMOs;

(viii) the time that claims and debts related to claims owed by the ANHC or provider HMO have been pending;

(ix) information required for the primary HMO to be able to file claims for reinsurance, coordination of benefits, and subrogation;

(x) physician and provider and enrollee satisfaction data;

(xi) complaint data;

(xii) documentation of any inquiry or investigation of the ANHC or provider HMO, or any individual subcontracting physician or provider, made by

regulatory agencies, and documentation of the final resolution of the inquiry or investigation; and

(xiii) any other data necessary to ensure proper monitoring and control of the primary HMO delivery network by the primary HMO;

(3) conduct an on-site audit of the ANHC or provider HMO at least annually, or more frequently on indication of material noncompliance, to obtain information necessary to verify compliance with all of the department's regulatory requirements, and provide written documentation of each audit to the department on request; and

(4) take prompt action to correct any failure by the ANHC or provider HMO to comply with the department's regulatory requirements relating to any matters delegated by the primary HMO to the ANHC or provider HMO and necessary to ensure the primary HMO's compliance with the regulatory requirements.

Subchapter Z. Point-Of-Service Riders **28 TAC §11.2503**

STATUTORY AUTHORITY. TDI proposes to amend §11.2503 under Insurance Code §1702.006 and §36.001. Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 1702.

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

CROSS-REFERENCE TO STATUTE. The amendments to §11.2503 implement Insurance Code Chapter 1702, as added by HB 2221.

TEXT.

§11.2503. Coverage Relating to Point-of-Service Rider Plans.

(a) An HMO may not consider an in-plan covered service to be a benefit provided under the point-of-service rider.

(b) An HMO may not require an enrollee to use either the point-of-service rider benefits or in-plan covered services first.

(c) An HMO that includes limited provider networks:

(1) may not limit the access, under the point-of-service rider, of an enrollee whose in-plan covered services are restricted to the limited provider network, to either participating physicians and providers or nonparticipating physicians and providers;

(2) may not impose cost-sharing arrangements for an enrollee whose in-plan covered services are restricted to a limited provider network, and who, through the point-of-service rider, accesses a participating physician or provider outside the limited provider network, that differ from the cost-sharing arrangements for in-plan covered services obtained by the enrollee from a physician or provider in the limited provider network; and

(3) may provide for cost-sharing arrangements for benefits obtained from nonparticipating physicians and providers that are different from the cost sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50% [~~50 percent~~] of the total amount to be covered.

(d) An HMO that issues or offers to issue a point-of-service rider plan is subject, to the same extent as the HMO is subject in issuing any other health plan product, to all

applicable provisions of Insurance Code Chapters 541, ~~concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices;~~ 542, ~~concerning Processing and Settlement of Claims;~~ 543, ~~concerning Prohibited Practices Related to Policy or Certificate of Membership;~~ 544, ~~concerning Prohibited Discrimination;~~ 547, ~~concerning False Advertising by Unauthorized Insurers;~~ 843, ~~concerning Health Maintenance Organizations;~~ ~~and~~ 1273, ~~concerning Point-Of-Service Plans;~~ and 1702, concerning Regulation of Certain Trade Practices.

(e) A point-of-service rider plan offered under this subchapter must contain:

(1) a point-of-service rider that:

(A) includes coverage that corresponds to all in-plan covered services provided in the evidence of coverage as well as coverage that is provided to an enrollee as part of the enrollee's in-plan coverage through separate riders attached to the evidence of coverage;

(B) may include benefits in addition to in-plan covered services;

(C) may limit or exclude coverage for benefits that do not correspond to in-plan covered services;

(D) may not limit coverage for benefits that correspond to in-plan covered services except as provided in subparagraphs (E), (F), and (G) of this paragraph;

(E) may include reasonable out-of-pocket limits and annual and lifetime benefit allowances that differ from limits or allowances on in-plan covered services provided under other riders attached to the evidence of coverage as ~~so~~ long as the allowances and limits comply with applicable federal and state laws;

(F) may provide for cost-sharing arrangements that are different from the cost-sharing arrangements for in-plan covered services, provided that coinsurance required under a point-of-service rider must never exceed 50% ~~50 percent~~ of the total amount to be covered;

(G) may be reduced by benefits obtained as in-plan covered services;

(H) may not reduce or limit in-plan covered services in any way by coverage for benefits obtained by an enrollee under the point-of-service rider;

(I) if applicable, must disclose:

(i) how the point-of-service rider cost-sharing arrangements differ from those in the evidence of coverage;

(ii) any reduction of benefits as set forth in subparagraph (G) of this paragraph;

(iii) any deductible that must be met by the enrollee under the point-of-service rider; and

(iv) whether copayments made for in-plan covered services apply toward the point-of-service rider deductible;

(J) must provide coverage for services obtained without the HMO's authorization from a participating physician or provider, but the enrollee must comply with any precertification requirements as set forth in subparagraph (L) of this paragraph that are applicable to the point-of-service rider;

(K) must include a description of how an enrollee may access out-of-plan covered benefits under the point-of-service rider, including coverage contained in other riders attached to the evidence of coverage;

(L) must disclose all precertification requirements for coverage under the point-of-service rider including any penalties for failure to comply with any precertification or cost containment provisions, provided that the penalties will not reduce benefits more than 50% [~~50 percent~~] in the aggregate;

(M) if it is issued to a group, must contain provisions that comply with Insurance Code Chapter 1251, Subchapter C, [~~concerning Partnership for Long-Term Care Program~~]; and

(N) if it is issued to an individual, must contain provisions that comply with Insurance Code §§1201.211 - 1201.217, [{}concerning Policy Provision: Notice of Claim, Policy Provision: Claim Forms, Policy Provision: Proof of Loss, Policy Provision: Time of Payment of Claims, Policy Provision: Payment of Claims, Policy Provision: Physical Examinations and Autopsy, Policy Provision: Legal Actions{}];

(2) an evidence of coverage that includes a description and reference to the point-of-service rider sufficient to notify a prospective or current enrollee that the plan provides the option of accessing participating physicians and providers as well as nonparticipating physicians and providers for out-of-plan covered benefits, and that accessing these benefits through the point-of-service rider may involve greater costs than accessing corresponding in-plan covered services; and

(3) a side-by-side summary of the schedule of the corresponding coverage for services, benefits, and supplies available under the point-of-service rider and services, benefits, and supplies available in the evidence of coverage that together constitute the point-of-service rider plan.

Subchapter F. Evidence of Coverage Repeal of 28 TAC §11.505

STATUTORY AUTHORITY. TDI proposes the repeal of §11.505 under Insurance Code §§843.151 and 36.001. Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various parts of the Insurance Code related to HMOs and ensure adequate access to health care services.

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

CROSS-REFERENCE TO STATUTE. The repeal of §11.505 implements Insurance Code Chapter 1271.

TEXT.

§11.505. Specifications for Evidence of Coverage Including Insert Pages and Matrix Filings.

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

Issued in Austin, Texas, on April 27, 2026.

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