INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE C. MANAGED CARE

CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS; EVIDENCE OF COVERAGE; CHARGES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1271.001. APPLICABILITY OF DEFINITIONS. In this chapter, terms defined by Section 843.002 have the meanings assigned by that section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE. (a) Each enrollee residing in this state is entitled to evidence of coverage under a health care plan.

(b) The health maintenance organization shall issue the evidence of coverage, except as provided by Subsection (c).

(c) If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage.

(d) By agreement between the health maintenance organization, insurer, or group hospital service corporation and the subscriber or person entitled to receive the evidence of coverage, policy, or contract, the evidence of coverage required by this section may be delivered electronically.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.032(a), eff. September 1, 2005.

Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE POLICY. An evidence of coverage is not a health insurance policy as that term is defined by this code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN. (a) In this section, "individual health care plan" means a health care plan:

(1) that provides health care services for individuals and their dependents;

(2) under which an enrollee:

(A) pays the premium; and

(B) is not covered under the contract in accordance with a continuation of services or continuation of benefits requirement applicable under federal or state law; and

(3) in which the evidence of coverage meets the requirements of the definition of "basic health care services" provided by Section 843.002.

(b) A health maintenance organization may provide an individual health care plan in accordance with this section and Section 1271.307.

(c) A health maintenance organization may limit enrollment in an individual health care plan to individuals who reside or work within the service area for the plan's network.

(d) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.005. APPLICABILITY OF OTHER LAW. (a) Chapters 1368 and 1652 apply to a health maintenance organization other than a health maintenance organization that offers only a single health care service plan.

(b) Subchapter B, Chapter 1355, applies to a health maintenance organization providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that:

(1) Subchapter B, Chapter 1355, does not conflict with this chapter, Chapter 843, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507; and

(2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the

service area of the health maintenance organization and is subject to inspection and review as required by this chapter, Chapter 843, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, or rules adopted under this chapter, Chapter 843, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(c) A health maintenance organization shall comply with Subchapter B, Chapter 542, with respect to prompt payment to an enrollee.

(d) Notwithstanding any other law, Subchapter C, Chapter 1355, applies to a group contract issued by a health maintenance organization.

(e) Notwithstanding any other law, Section 1201.062 applies to an evidence of coverage issued by a health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(b), eff. September 1, 2005.

Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND GRANDCHILD. (a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, is 25 years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

(b) A health maintenance organization may provide benefits under a health care plan to an enrollee's dependent grandchild who is living with and in the household of the enrollee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.007. RELIGIOUS CONVICTIONS. (a) This chapter, Chapters 843, 1272, and 1367, Subchapter A, Chapter 1452, and Subchapter B, Chapter 1507, do not require a health maintenance organization, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates the religious convictions of the health maintenance

organization, physician, or provider.

(b) A health maintenance organization that limits or denies health care services under this section shall state the limitations in the evidence of coverage as required by Section 1271.052.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(c), eff. September 1, 2005.

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A health maintenance organization shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply provided by a non-network physician or provider. The notice must include:

(1) a statement of the billing prohibition under Section 1271.155, 1271.157, or 1271.158, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) A health maintenance organization shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the health maintenance organization makes a payment under Section 1271.155, 1271.157, or 1271.158, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.02, eff. September 1, 2019.

SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND CERTIFICATE REQUIREMENTS. (a) An evidence of coverage that is a

contract must contain a clear and complete statement of the information required by Sections 1271.052, 1271.053, and 1271.054.

(b) An evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by Sections 1271.052, 1271.053, and 1271.054.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.052. INFORMATION ABOUT BENEFITS AND LIMITATIONS. An evidence of coverage must state:

(1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan; and

(3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES. An evidence of coverage must indicate where and in what manner information is available about how to obtain services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) An evidence of coverage must contain a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including:

(1) the enrollee's right to appeal denial of an adverse determination to an independent review organization; and

(2) the procedures for appealing to an independent review organization.

(b) A health maintenance organization may indicate a subsequent change to the methods for resolving enrollee complaints in a separate document issued to the enrollee.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence of coverage must contain a provision regarding non-network physicians and providers in accordance with the requirements of this section.

(b) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider and within a reasonable period, shall:

(1) allow referral to a non-network physician or provider; and

(2) fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

(c) Before denying a request for a referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS AND STATEMENTS PROHIBITED. An evidence of coverage may not contain a provision or statement that:

(1) is unjust, unfair, inequitable, misleading, or deceptive;

(2) encourages misrepresentation; or

(3) is untrue, misleading, or deceptive within the meaning of Section 843.204.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.057. DISCRETIONARY CLAUSES PROHIBITED. (a) An evidence of coverage may not contain a discretionary clause provision.

(b) A discretionary clause provision includes a provision that:

(1) purports or acts to bind the enrollee to, or grant

deference in subsequent proceedings to, adverse eligibility or benefit decisions or interpretations of the evidence of coverage by the health maintenance organization; or

(2) specifies:

(A) that an enrollee or other claimant may not contest or appeal a denial of a benefit;

(B) that the health maintenance organization's interpretation of the terms of an evidence of coverage or other form or its decision to deny coverage or the amount of benefits is binding on an enrollee or other claimant;

(C) that in an appeal, the health maintenance organization's decision-making power as to the interpretation of the terms of an evidence of coverage or other form, or as to coverage, is binding; or

(D) a standard of review in any appeal process that gives deference to the original benefit decision or provides standards of interpretation or review that are inconsistent with the laws of this state, including the common law.

Added by Acts 2011, 82nd Leg., R.S., Ch. 560 (H.B. 3017), Sec. 1, eff. June 17, 2011.

SUBCHAPTER C. COMMISSIONER APPROVAL

Sec. 1271.101. APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT. (a) An evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner.

(b) Except as provided by Subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of Section 1271.102.

(c) If the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. However,

Subchapters B and E apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL OF APPROVAL. (a) The commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of this chapter.

(b) If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The commissioner may, by written notice, extend the period for approval or disapproval as necessary for proper consideration of the filing for not more than an additional 30 days.

(c) If the commissioner disapproves a form, the commissioner shall notify the person who filed the form of the reason for the disapproval.

(d) A hearing on the disapproval of a form shall be granted not later than the 30th day after the date the person filing the form makes a written request for a hearing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM. (a) After notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates this chapter, Chapter 843, 1272, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, or a rule adopted by the commissioner.

(b) If the commissioner withdraws approval of a form under this section, the form may not be issued until it is approved.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.074(d), eff. September 1, 2005.

Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES. A health maintenance organization that offers a basic health care plan shall provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE SERVICES. The commissioner may adopt minimum standards relating to basic health care services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.153. PERIODIC HEALTH EVALUATIONS. (a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.

(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Subchapter F, Chapter 1451.

(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.154. WELL-CHILD CARE FROM BIRTH. (a) In this section, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments. The term includes administration

of newborn screening required by the Department of State Health Services and the cost of the newborn screening test kit described by Section 33.019, Health and Safety Code.

(b) A health maintenance organization shall ensure that each health care plan provided by the health maintenance organization includes well-child care from birth that complies with:

(1) federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments; and

(2) the rules adopted by the executive commissioner of the Health and Human Services Commission to implement those requirements, including rules on the cost of the newborn screening test kit described by Section 33.019, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 599 (S.B. 747), Sec. 4, eff. September 1, 2019.

Sec. 1271.155. EMERGENCY CARE. (a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate.

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition;

(3) services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition shall be provided to covered

enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d); and

(4) supplies related to a service described by this subsection shall be provided to covered enrollees.

(c) A health maintenance organization shall approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

(d) A health maintenance organization shall respond to inquiries from a treating physician or provider in compliance with this provision in the health care plan of the health maintenance organization.

(e) A health care plan of a health maintenance organization shall comply with this section regardless of whether the physician or provider furnishing the emergency care has a contractual or other arrangement with the health maintenance organization to provide items or services to covered enrollees.

(f) For emergency care subject to this section or a supply related to that care, a health maintenance organization shall make a payment required by Subsection (a) directly to the non-network physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(g) For emergency care subject to this section or a supply related to that care, a non-network physician or provider or a person asserting a claim as an agent or assignee of the physician or provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable

copayment, coinsurance, and deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the physician or provider under Chapter 1467.

(h) This section may not be construed to require the imposition of a penalty under Section 843.342.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. 1357), Sec. 3, eff. March 1, 2010.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.03, eff. September 1, 2019.

Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND THERAPIES. (a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

(b) For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.157. NON-NETWORK FACILITY-BASED PROVIDERS. (a) In this section, "facility-based provider" means a physician or provider who provides health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a covered health care

service performed for or a covered supply related to that service provided to an enrollee by a non-network physician or provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a network provider. The health maintenance organization shall make a payment required by this subsection directly to the physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(c) Except as provided by Subsection (d), a non-network facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; and

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the physician or provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

(e) This section may not be construed to require the imposition of a penalty under Section 843.342.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.04, eff. September 1, 2019.

Sec. 1271.158. NON-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a covered health care service performed by or a covered supply related to that service provided to an enrollee by a non-network diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care service performed by a network physician or provider. The health maintenance organization shall make a payment required by this subsection directly to the physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(c) Except as provided by Subsection (d), a non-network diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; and

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the physician or provider does not have a contract with the enrollee's health benefit plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

(e) This section may not be construed to require the imposition of a penalty under Section 843.342.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.04, eff. September 1, 2019.

SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN FOR CERTAIN ENROLLEES

Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY CARE PHYSICIAN. (a) An evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

(b) The application must:

(1) include information specified by the health maintenance organization, including certification of the medical need; and

(2) be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's primary care physician.

(c) To be eligible to serve as the enrollee's primary care physician, a physician specialist must:

(1) meet the health maintenance organization's requirements for primary care physician participation; and

(2) agree to accept the responsibility to coordinate all of the enrollee's health care needs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.202. APPEAL. If a health maintenance organization denies a request under Section 1271.201, the enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION. (a) The effective date of the designation of a nonprimary care physician specialist as an enrollee's primary care physician under Section 1271.201 may not be applied retroactively.

(b) A health maintenance organization may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. SCHEDULE OF CHARGES

Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR COMPUTING SCHEDULE OF CHARGES. (a) The formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan.

(b) The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. The filing of the method or formula must contain:

(1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and

(2) supporting information that the commissioner considers adequate.

(c) The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory. Benefits must be reasonable with respect to the rates produced by the formula or method.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH STATUS PROHIBITED. The charges resulting from the application of a formula or method described by Section 1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION CONTRACTS, AND RENEWAL

Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP

COVERAGE. (a) In this section, "involuntary termination for cause" does not include termination for any health-related reason.

(b) A health maintenance organization shall provide a group coverage continuation privilege as required by and subject to the eligibility provisions of this subchapter.

(c) An enrollee is entitled to continue group coverage as provided by this subchapter if:

(1) the enrollee's coverage under a group contract is terminated for any reason except involuntary termination for cause; and

(2) the enrollee for at least three consecutive months immediately before the termination of coverage has been continuously covered under the group contract and under any previous group contract providing similar services and benefits that the current group contract replaced.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE; DEADLINE. An enrollee must provide to the employer or group contract holder a written notice of election to continue group coverage under this subchapter not later than the 60th day after the later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the enrollee is given notice of the right of continuation by the employer or group contract holder.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 5, eff. June 19, 2009.

Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE. (a) An enrollee electing continuation of group coverage must pay to the employer or group contract holder the amount of contribution required by the employer or group contract holder, plus an amount equal to two percent of the group rate for the coverage being continued under the group contract.

(b) The enrollee must make the payment not later than the

45th day after the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made by the 30th day after the date on which payment is due.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 6, eff. June 19, 2009.

Sec. 1271.304. TERMINATION OF CONTINUED COVERAGE. Group continued coverage under this subchapter may not terminate until the earliest of:

(1) the date the maximum continuation period provided by law would end, which is:

(A) for any enrollee not eligible for continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), the end of the nine-month period after the date the election to continue coverage is made; or

(B) for any enrollee eligible for continuation coverage under COBRA, six additional months following any period of continuation provided under that statute;

(2) the date on which failure to make timely payments terminates coverage;

(3) the date on which the enrollee is covered for similar services and benefits by any other plan or program, including a hospital, surgical, medical, or major medical expense insurance policy, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(4) the date on which the group coverage terminates in its entirety.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 550 (S.B. 1771), Sec. 7, eff. June 19, 2009.

Sec. 1271.306. CONVERSION CONTRACTS. (a) A health maintenance organization may offer to each enrollee a conversion contract.

(b) A health maintenance organization shall issue the conversion contract without evidence of insurability if written application for the contract and payment of the first premium are made not later than the 31st day after the date of termination of coverage.

(c) A conversion contract must meet the minimum standards for services and benefits for conversion contracts. The commissioner shall adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

(d) The premium for a conversion contract shall be determined in accordance with the health maintenance organization's premium rates for coverage provided under the group contract or plan. The premium may be based on the geographic location of each person to be covered and must be based on the type of conversion contract and the coverage provided by the contract. The premium may not exceed 200 percent of the premium rates for the same coverage provided under a group contract or plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL HEALTH CARE PLANS AND CONVERSION CONTRACTS. (a) In this section, "individual health care plan" has the meaning assigned by Section 1271.004.

(b) An individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee. A health maintenance organization may decline to renew an individual health care plan or conversion contract only:

(1) for failure to pay premiums or contributions in accordance with the terms of the plan or because the issuer of the plan has not received timely premium payments;

(2) for fraud or intentional misrepresentation;

(3) because the health maintenance organization ceases to offer coverage in the individual market in accordance

with rules established by the commissioner;

(4) because the enrollee no longer resides or works in the area in which the health maintenance organization is authorized to provide coverage, if coverage under the plan is terminated uniformly for this reason without regard to any factor related to the health status of a covered enrollee; or

(5) in accordance with applicable federal law, including regulations.

(c) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.