

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE C. MANAGED CARE

CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH MAINTENANCE ORGANIZATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1272.001. DEFINITIONS. (a) In this chapter:

(1) "Delegated entity" means an entity, other than a health maintenance organization authorized to engage in business under Chapter 843, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507. The term does not include:

(A) an individual physician; or

(B) a group of employed physicians, practicing medicine under one federal tax identification number, whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis.

(2) "Delegated network" means a delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with a health maintenance organization.

(3) "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility for performing a

function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration is directly or indirectly related to a function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(4) "Delegation agreement" means an agreement by which a health maintenance organization assigns the responsibility for a function regulated by this chapter, Chapter 222, 251, or 258, as applicable to a health maintenance organization, Chapter 843 or 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(5) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits an enrollee's access to physicians and providers to those physicians and providers in the subnetwork.

(b) 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.

Amended by:

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

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.02701, eff. September 1, 2007.

Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK OR DELEGATED ENTITY WITH CERTAIN LEGAL REQUIREMENTS. A limited provider network or delegated entity shall comply with each statutory or regulatory requirement that relates to a function assumed by or carried out by the network or entity under this chapter.

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

SUBCHAPTER B. DELEGATION AGREEMENTS

Sec. 1272.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111.

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

Sec. 1272.052. DELEGATION AGREEMENT REQUIRED. (a) A health maintenance organization that delegates a function required by this chapter, Chapter 843, 1271, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, shall execute a written delegation agreement with the entity to which the function is delegated.

(b) The health maintenance organization shall file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

(c) The parties to the delegation agreement shall determine which party bears the expense of complying with a requirement of this subchapter, including the cost of an examination required by the department under Subchapter B, Chapter 401, if applicable.

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(f), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.002, eff. April 1, 2009.

Sec. 1272.053. MONITORING PLAN. A delegation agreement required by Section 1272.052 must establish a monitoring plan that:

(1) allows the health maintenance organization to monitor compliance with the minimum solvency requirements established under Subchapter D, if applicable; and

(2) includes:

(A) a description of financial practices that will ensure that the delegated entity tracks and reports

liabilities that have been incurred but not reported;

(B) a summary of the total amount paid by the entity to physicians and providers on a monthly basis; and

(C) a summary of complaints from physicians, providers, and enrollees regarding delays in payment or nonpayment of claims, including the status of each complaint, on a monthly basis.

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

Sec. 1272.054. REQUIREMENTS FOR TERMINATION WITHOUT CAUSE. A delegation agreement required by Section [1272.052](#) must provide that the agreement cannot be terminated without cause by the delegated entity or the health maintenance organization unless the party terminating the agreement provides written notice before the 90th day before the termination date.

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

Sec. 1272.055. COLLECTION OF PAYMENTS. A delegation agreement required by Section [1272.052](#) must prohibit the delegated entity and the physicians and providers with whom the entity has contracted from billing or attempting to collect from an enrollee under any circumstance, including the insolvency of the health maintenance organization or entity, payments for covered services other than authorized copayments and deductibles.

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

Sec. 1272.056. COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS. A delegation agreement required by Section [1272.052](#) must provide that:

(1) the agreement does not limit in any way the health maintenance organization's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and

(2) the delegated entity shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity.

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

Sec. 1272.057. EXAMINATION BY COMMISSIONER. A delegation agreement required by Section 1272.052 must require the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to:

(1) the financial solvency of the entity; or

(2) the ability of the entity to meet the entity's responsibilities in connection with any function delegated to the entity by the health maintenance organization.

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

Sec. 1272.058. INFORMATION RELATING TO DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires:

(1) a license as a third-party administrator under Chapter 4151 or utilization review agent under Chapter 4201; or

(2) another license under this code or another insurance law of this state.

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

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.003, eff. April 1, 2009.

Sec. 1272.059. CONTRACTS WITH DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must provide that:

(1) any agreement under which the delegated entity directly or indirectly delegates a function required by this chapter, Chapter 843, 1271, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, including the handling of funds, if applicable, to a delegated third party must be in writing; and

(2) the delegated entity, in contracting with a delegated third party directly or through a third party, shall require the delegated third party to comply with the requirements of Section 1272.057 and any rules adopted by the commissioner implementing that section.

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(g),
eff. September 1, 2005.

Sec. 1272.060. UTILIZATION REVIEW. A delegation agreement required by Section 1272.052 must provide that:

(1) enrollees shall receive notification at the time of enrollment of which entity is responsible for performing utilization review;

(2) the delegated entity or third party performing utilization review shall perform that review in accordance with Chapter 4201; and

(3) the delegated entity or third party shall forward utilization review decisions made by the entity or third party to the health maintenance organization on a monthly basis.

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

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.004,
eff. April 1, 2009.

Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY AND HEALTH MAINTENANCE ORGANIZATION. A delegation agreement required by Section 1272.052 must provide that the delegated entity acknowledges and agrees that:

(1) the health maintenance organization:

(A) is required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards;

(B) is directly accountable for compliance with those standards; and

(C) is not precluded from contractually requesting that the delegated entity provide proof of financial viability;

(2) the role of another delegated entity with which the delegated entity subcontracts through a delegated third party

is limited to performing certain delegated functions of the health maintenance organization, using standards that are approved by the health maintenance organization and that are in compliance with applicable statutes and rules and subject to the health maintenance organization's oversight and monitoring of the entity's performance; and

(3) if the delegated entity fails to meet monitoring standards established to ensure that functions delegated or assigned to the entity under the delegation agreement are in full compliance with all statutory and regulatory requirements, the health maintenance organization may cancel delegation of any or all delegated functions.

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

Sec. 1272.062. INFORMATION TO BE PROVIDED BY DELEGATED ENTITY TO HEALTH MAINTENANCE ORGANIZATION. (a) A delegation agreement required by Section [1272.052](#) must provide that:

(1) except as provided by Subsection (b), the delegated entity shall make available to the health maintenance organization samples of contracts with physicians and providers to ensure compliance with the contractual requirements described by Sections [1272.054](#) and [1272.055](#); and

(2) the delegated entity shall provide to the health maintenance organization, in a format usable for audit purposes and not more frequently than quarterly unless otherwise specified in the delegation agreement, the data necessary for the health maintenance organization to comply with the department's reporting requirements with respect to any delegated functions performed under the delegation agreement, including:

(A) a summary describing the methods, including capitation, fee-for-service, or other risk arrangements, that the delegated entity used to pay the entity's physicians and providers, and including the percentage of physicians and providers paid for each payment category;

(B) the period that claims and debts for medical services owed by the delegated entity have been pending and the aggregate dollar amount of those claims and debts;

(C) information to enable the health maintenance organization to file claims for reinsurance, coordination of benefits, and subrogation, if required by the delegation agreement; and

(D) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Subchapter A, Chapter 160, Occupations Code, that relates to:

(i) a regulatory agency's inquiry or investigation of the delegated entity or an individual physician or provider with whom the entity contracts that relates to an enrollee of the health maintenance organization; and

(ii) the final resolution of a regulatory agency's inquiry or investigation.

(b) A delegation agreement may not require a delegated entity to make available to the health maintenance organization contractual provisions relating to financial arrangements with the entity's physicians and providers.

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

Sec. 1272.063. ENROLLEE COMPLAINTS. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) if the delegated entity receives a complaint that does not involve emergency care, the entity shall report the complaint to the health maintenance organization not later than the second business day after the date the entity receives the complaint; and

(2) if the delegated entity receives a complaint involving emergency care, the entity shall immediately forward the complaint to the health maintenance organization.

(b) Subsection (a) does not prohibit a delegated entity from attempting to resolve a complaint.

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

Sec. 1272.064. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

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

SUBCHAPTER C. INFORMATION REPORTING TO DELEGATED ENTITY

Sec. 1272.101. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111.

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

Sec. 1272.102. REPORTING REQUIRED. (a) The commissioner shall determine the information a health maintenance organization shall provide to a delegated entity with which the health maintenance organization has entered into a delegation agreement.

(b) The information must include:

(1) for each enrollee who is eligible or assigned to receive services from the delegated entity:

(A) the enrollee's name, birth date or social security number, age, and sex;

(B) the benefit plan and any riders to that plan that are applicable to the enrollee; and

(C) the enrollee's employer;

(2) the name and birth date or social security number of each enrollee added or terminated since the health maintenance organization last provided the information;

(3) if the health maintenance organization pays any claims on behalf of the delegated entity, a summary of the number and amount of:

(A) claims paid during the previous reporting period; and

(B) pharmacy prescriptions paid for each enrollee during the previous reporting period for which the delegated entity has taken partial risk;

(4) information that enables the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation;

(5) patient complaint data that relates to the delegated entity;

(6) detailed risk-pool data, reported quarterly and on

settlement;

(7) if hospital or facility costs impact the delegated entity's costs, the percent of premium attributable to hospital or facility costs, reported quarterly; and

(8) if there are changes in hospital or facility contracts with the health maintenance organization, the projected impact of those changes on the percent of premium attributable to hospital and facility costs during the 30-day period following those changes.

(c) Notwithstanding Subsection (b)(3), a delegated entity may, on request, receive additional nonproprietary information regarding claims paid by a health maintenance organization on behalf of the entity.

(d) A health maintenance organization shall provide information required under Subsections (b)(1)-(5) in standard electronic format at least monthly unless the delegation agreement provides otherwise.

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

Sec. 1272.103. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

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

SUBCHAPTER D. RESERVE REQUIREMENTS

Sec. 1272.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section [843.111](#).

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

Sec. 1272.152. GENERAL RESERVE REQUIREMENTS. (a) A delegated network shall maintain reserves adequate for the liabilities and risks assumed by the network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks for which the reserves are maintained, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Except as provided by Sections 1272.153 and 1272.154, a delegated network shall maintain reserves as described by Subsection (c) only with respect to the portion of services assumed under the delegation agreement that is outside the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(c) A delegated network shall maintain financial reserves equal to the greater of:

(1) 80 percent of the amount of liabilities and risks for which reserves must be maintained under this subchapter and that have been incurred but not paid by the network; or

(2) an amount equal to two months of the premium amount assumed by the network for services with respect to which reserves must be maintained under this subchapter.

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

Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE AND HOSPITAL OR INSTITUTIONAL SERVICES. A delegated network that assumes under a delegation agreement both medical care and hospital or institutional services shall maintain reserves adequate to cover the liabilities and risks associated with medical care or hospital or institutional services, whichever category of services is allocated the largest portion of the premium by the health maintenance organization.

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

Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION DRUGS. A delegated network that assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, shall maintain, in addition to any other reserves required under this subchapter, reserves adequate to cover the liabilities and risks associated with the prescription drug benefits.

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

Sec. 1272.155. FORM OF RESERVES. The reserves required under this subchapter must be:

(1) secured by and consist only of United States legal tender or bonds of the United States or this state;

(2) held at a financial institution in this state that is chartered by the United States or this state; and

(3) held in trust for, for the benefit of, or to provide health care services to enrollees under the delegation agreement.

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

Sec. 1272.156. ESCROW ACCOUNT. (a) A delegated network required to maintain reserves under this subchapter shall establish an escrow account to pay claims and deposit the reserves into the escrow account on:

(1) notification of the network's intent to terminate or refuse to renew a contract under which the network assumed liabilities and risks from a health maintenance organization; or

(2) modification of a contract under which the network assumed liabilities and risks from a health maintenance organization if the modified contract eliminates those liabilities and risks.

(b) The delegated network shall notify the commissioner on establishing an escrow account under this section.

(c) On the 271st day after the date the reserves are deposited into the escrow account, the delegated network is entitled to the release of funds remaining in escrow. Funds released from the escrow account shall be distributed to each individual who contributed to the reserves deposited into the account in proportion to the individual's total contribution.

(d) The commissioner shall take any action necessary to ensure the release of funds remaining in escrow after the date specified by Subsection (c).

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

SUBCHAPTER E. COMPLIANCE

Sec. 1272.201. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance

organization, as defined by Section [843.111](#).

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

Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS OPERATING CONDITION. (a) If a health maintenance organization becomes aware of information that indicates a delegated entity with which the health maintenance organization has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the health maintenance organization shall in writing:

- (1) notify the entity of those findings; and
- (2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition.

(b) A health maintenance organization shall provide to the commissioner a copy of each notice and request submitted to a delegated entity under this section and each response or other documentation the health maintenance organization receives or generates in response to the notice and request.

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

Sec. 1272.203. RESPONSE TO NOTICE. A delegated entity shall respond in writing to a request from a health maintenance organization under Section [1272.202](#) not later than the 30th day after the date the entity receives the request.

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

Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE ORGANIZATION. A health maintenance organization shall cooperate with a delegated entity to correct a failure by the entity to comply with the department's regulatory requirements relating to:

- (1) a function delegated to the entity by the health maintenance organization; or
- (2) a matter necessary for the health maintenance organization to ensure compliance with each statutory or regulatory requirement.

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

Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT. (a) On receipt of a notice under Section 1272.202 or if complaints are filed with the department, the department may conduct an examination regarding:

(1) any matter contained in the notice; and

(2) any other matter relating to the financial solvency of the delegated entity or the entity's ability to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(b) Except as provided by Subsection (c), the department, on completion of an examination under this section, shall report to the delegated entity and the health maintenance organization:

(1) the results of the examination; and

(2) any action the department determines is necessary to ensure that:

(A) the health maintenance organization meets the health maintenance organization's responsibilities under this code, any other insurance laws of this state, and rules adopted by the commissioner; and

(B) the entity is able to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(c) The department may not report to the health maintenance organization information relating to fee schedules, prices, or cost of care or other information not relevant to the monitoring plan.

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

Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE PLAN. The delegated entity and health maintenance organization shall respond to the department's report under Section 1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

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

Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION. The

department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relate to a function delegated by the health maintenance organization to the entity; or

(2) are necessary to ensure the health maintenance organization's compliance with each statutory or regulatory requirement.

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

Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE ORDER.

(a) Regardless of whether a delegated entity complies with a request for corrective action under Section 1272.207, the commissioner may order a health maintenance organization with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the health maintenance organization is complying with this chapter, Chapter 843, 1271, or 1367, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507.

(b) Actions the commissioner may order a health maintenance organization to take under this section include:

(1) reassuming the functions delegated to the delegated entity, including claims payments for services previously provided to enrollees;

(2) temporarily or permanently ceasing assignment of new enrollees to the entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive services; or

(4) terminating the delegation agreement with the entity.

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(h), eff. September 1, 2005.

Sec. 1272.209. PUBLIC DOCUMENTS. (a) Except as provided by Subsection (b), a report required under Section 1272.205(b) or

corrective plan required under Section [1272.206](#) is a public document.

(b) Health care provider fee schedules, prices, costs of care, or other information that is not relevant to the monitoring plan or is confidential by law is not a public document under this section.

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

Sec. 1272.210. RECORD OF COMPLAINTS; REPORT. (a) The department shall:

(1) maintain enrollee and provider complaints in a manner that identifies complaints made about limited provider networks and delegated entities; and

(2) periodically issue a report on the complaints that includes a list of complaints organized by:

(A) category;

(B) action taken on the complaint; and

(C) entity or network name and type.

(b) The department shall make available to the public the report and information to assist the public in evaluating the information contained in the report.

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

Sec. 1272.211. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

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

SUBCHAPTER F. PENALTIES

Sec. 1272.251. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section [843.111](#).

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

Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF THIRD-PARTY ADMINISTRATOR OR UTILIZATION REVIEW AGENT. Notwithstanding any other provision of this code or another

insurance law of this state, the commissioner may suspend or revoke the license of a third-party administrator or utilization review agent that fails to comply with Subchapter B, C, or E.

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

Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH MAINTENANCE ORGANIZATION. The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84 on a health maintenance organization that does not provide in a timely manner information required by Subchapter C.

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

Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED. A health maintenance organization by contract shall establish penalties for a delegated entity that does not provide in a timely manner information required under a monitoring plan established under Section 1272.053.

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

Sec. 1272.255. RULES. The commissioner may adopt rules as necessary to implement this subchapter.

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

SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER NETWORK OR DELEGATED ENTITY

Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES. (a) A contract between a health maintenance organization and a limited provider network or delegated entity must provide that:

(1) if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity, on the request of a network physician or provider, shall:

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

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

(2) before the limited provider network or delegated entity may deny a referral to a non-network physician or provider, a specialist of the same or similar specialty as the type of physician or provider to whom the referral is requested must conduct a review of the request.

(b) The limited provider network or delegated entity shall allow the referral within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee who is a patient, but not later than the fifth business day after the date the network or entity receives any reasonably requested documentation.

(c) An enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or through the delegated entity.

(d) A denial of out-of-network services under this section is subject to appeal under Chapter 4201.

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

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.005, eff. April 1, 2009.

Sec. 1272.302. CONTINUITY OF CARE. (a) In this section, "special circumstance" means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, or life-threatening illness and an enrollee who is past the 24th week of pregnancy.

(b) A contract between a health maintenance organization and a limited provider network or delegated entity must require that each contract between the network or entity and a physician or provider must:

(1) require that reasonable advance notice be given to an enrollee of an impending termination from the network or entity of a physician or provider who is currently treating the enrollee;

and

(2) provide that the termination of the physician's or provider's contract, except for reason of medical competence or professional behavior, does not release the network or entity from the obligation to reimburse the physician or provider for treatment of an enrollee who has a special circumstance at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of the enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

(c) The treating physician or provider shall identify a special circumstance. That physician or provider must:

(1) request that the enrollee be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the enrollee who is a patient of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the limited provider network or delegated entity.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery.

(f) A contract between a limited provider network or delegated entity and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

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