INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE C. MANAGED CARE

CHAPTER 1273. POINT-OF-SERVICE PLANS

SUBCHAPTER A. BLENDED CONTRACTS

Sec. 1273.001. DEFINITIONS. In this subchapter:

(1) "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

(2) "Health maintenance organization" has the meaning assigned by Section 843.002.

(3) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee chooses to obtain benefits or services through:

(i) a health maintenance organization delivery network, including a limited provider network; or

(ii) a non-network delivery system outside the health maintenance organization delivery network, including an exclusive provider benefit plan under Chapter 1301 or a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of health care services are provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization.

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

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 1, eff. September 1, 2011.

Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may contract with a health maintenance organization to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care.

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

Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance organization and an insurer may offer a blended contract. The use of a blended contract is limited to point-of-service arrangements between a health maintenance organization and an insurer.

(b) A blended contract delivered, issued, or used in this state is subject to, and must be filed with the department for approval as provided by, Chapter 1701 and Section 1271.101.

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

Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING PROVISIONS. Indemnity benefits and services provided under a point-of-service plan may be limited to those services described by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

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

Sec. 1273.005. RULES. The commissioner may adopt rules to implement this subchapter.

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

## SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

Sec. 1273.051. DEFINITIONS. In this subchapter:

(1) "Employee" means an individual employed by an employer.

(2) "Health benefit plan" has the meaning assigned by Section 1501.002.

(3) "Non-network plan" means health benefit coverage that provides an enrollee an opportunity to obtain health care services through a health delivery system other than a health maintenance organization delivery network, as defined by Section 843.002.

(4) "Point-of-service plan" means an arrangement under which an enrollee chooses to obtain benefits or services through:

(A) a health maintenance organization delivery network, including a limited provider network; or

(B) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services.

(5) "Preferred provider benefit plan" means an insurance policy issued under Chapter 1301.

(6) "Small employer health benefit plan" has the meaning assigned by Section 1501.002.

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

Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN REQUIRED. (a) Except as provided by Subsection (b), if the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more health maintenance organizations, each health maintenance organization offering coverage must offer to all eligible employees, at the time of enrollment and at least annually, the opportunity to obtain coverage through a non-network plan.

(b) Each health maintenance organization to which Subsection (a) applies may enter into an agreement designating one or more of those health maintenance organizations to offer the coverage required by Subsection (a) for eligible employees of the employer.

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

Sec. 1273.053. COVERAGE OPTIONS. The coverage required to be offered under this subchapter may be provided through:

(1) a point-of-service plan;

(2) a preferred provider benefit plan; or

(3) any coverage arrangement that provides an enrollee with access to services outside the health maintenance organization's or limited provider network's delivery network.

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

Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium for coverage required to be offered under this subchapter must be based on the actuarial value of that coverage and may be different from the premium for coverage otherwise offered by the health maintenance organization.

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

Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different cost-sharing provisions may be imposed for a point-of-service plan offered under this subchapter, and those provisions may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

(b) An employee who chooses the non-network plan is responsible for any additional costs for the non-network plan, and the employer may impose a reasonable administrative fee for providing the non-network plan.

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

Sec. 1273.056. EXCEPTIONS. This subchapter does not apply to:

(1) a small employer health benefit plan; or

(2) a group model health maintenance organization that is a nonprofit, state-certified health maintenance organization that:

(A) provides the majority of its professional

services through a single group medical practice that is governed by a board composed entirely of physicians; and

(B) educates medical students or resident physicians through a contract with the medical school component of a Texas state-supported college or university accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association.

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

Sec. 1273.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

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