

INSURANCE CODE

TITLE 6. ORGANIZATION OF INSURERS AND RELATED ENTITIES

SUBTITLE C. LIFE, HEALTH, AND ACCIDENT INSURERS AND RELATED  
ENTITIES

CHAPTER 843. HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 843.001. SHORT TITLE. This chapter may be cited as the Texas Health Maintenance Organization Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.002. DEFINITIONS. In this chapter:

(1) "Adverse determination" means a determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate.

(2) "Basic health care services" means health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.

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

(4) "Capitation" means a method of compensating a physician or provider for arranging for or providing a defined set of covered health care services to certain enrollees for a specified period that is based on a predetermined payment per enrollee for the specified period, without regard to the quantity of services actually provided.

(5) "Complainant" means an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint.

(6) "Complaint" means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction

relating to plan administration, procedures related to review or appeal of an adverse determination under Section 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or

(B) a provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination.

(7) "Emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

(A) place the individual's health in serious jeopardy;

(B) result in serious impairment to bodily functions;

(C) result in serious dysfunction of a bodily organ or part;

(D) result in serious disfigurement; or

(E) for a pregnant woman, result in serious jeopardy to the health of the fetus.

(8) "Enrollee" means an individual who is enrolled in a health care plan and includes covered dependents.

(9) "Evidence of coverage" means any certificate, agreement, or contract, including a blended contract, that:

(A) is issued to an enrollee; and

(B) states the coverage to which the enrollee is entitled.

(9-a) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 915,

Sec. 3(1), eff. September 1, 2013.

(9-b) "Freestanding emergency medical care facility" means a facility licensed under Chapter 254, Health and Safety Code.

(10) "Group hospital service corporation" means a corporation operating under Chapter 842.

(11) "Health care" means prevention, maintenance, rehabilitation, pharmaceutical, and chiropractic services, other than medical care, provided by qualified persons.

(12) "Health care plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of health care services; and

(B) that consists in part of providing or arranging for health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of health care services.

(13) "Health care services" means services provided to an individual to prevent, alleviate, cure, or heal human illness or injury. The term includes:

(A) pharmaceutical services;

(B) medical, chiropractic, or dental care;

(C) hospitalization;

(D) care or services incidental to the health care services described by Paragraphs (A)-(C); and

(E) services provided under a limited health care service plan or a single health care service plan.

(14) "Health maintenance organization" means a person who arranges for or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan.

(15) "Health maintenance organization delivery network" means a health care delivery system in which a health maintenance organization arranges for health care services directly or indirectly through contracts and subcontracts with physicians and providers.

(16) "Life-threatening" means a disease or condition

from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(17) "Limited health care service plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of limited health care services; and

(B) that consists in part of providing or arranging for limited health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of limited health care services.

(18) "Limited health care services" means:

(A) services for mental health, chemical dependency, or intellectual disability, or any combination of those services; or

(B) an organized long-term care service delivery system that provides for diagnostic, preventive, therapeutic, rehabilitative, and personal care services required by an individual with a loss in functional capacity on a long-term basis.

(19) "Medical care" means the provision of those services defined as practicing medicine under Section 151.002, Occupations Code.

(20) "Net worth" means the amount by which total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 427, is exceeded by total admitted assets.

(21) "Person" means any natural or artificial person, including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, intellectual disability center, mental health center, limited liability company, or limited liability partnership or the statewide rural health care system under Chapter 845.

(22) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes);

(C) an approved nonprofit health corporation

certified under Chapter 162, Occupations Code;

(D) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, that employs or contracts with physicians to teach or provide medical services or employs physicians and contracts with physicians in a practice plan; or

(E) another person wholly owned by physicians.

(23) "Prospective enrollee" means:

(A) an individual eligible to enroll in a health maintenance organization purchased through a group of which the individual is a member; or

(B) for an individual who is not a member of a group or whose group has not purchased or does not intend to purchase a health maintenance organization's health care plan, an individual who has expressed an interest in purchasing individual health maintenance organization coverage and is eligible for coverage by a health maintenance organization.

(24) "Provider" means:

(A) a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a chiropractor, registered nurse, pharmacist, optometrist, or acupuncturist; or

(ii) a pharmacy, hospital, or other institution or organization;

(B) a person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or

(C) a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

(25) "Single health care service" means a health care service:

(A) that an enrolled population may reasonably need to be maintained in good health with respect to a particular health care need to prevent, alleviate, cure, or heal human illness or injury of a single specified nature; and

(B) that is provided by one or more persons licensed or otherwise authorized by the state to provide that service.

(26) "Single health care service plan" means a plan:

(A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of a single health care service;

(B) that consists in part of providing or arranging for the single health care service on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of that service; and

(C) that does not include arranging for the provision of more than one health care need of a single specified nature.

(27) "Sponsoring organization" means a person who guarantees the uncovered expenses of a health maintenance organization and who is financially capable, as determined by the commissioner, of meeting the obligations resulting from that guarantee.

(28) "Uncovered expenses" means the estimated amount of administrative expenses and the estimated cost of health care services that are not guaranteed, insured, or assumed by a person other than the health maintenance organization. The term does not include the cost of health care services if the physician or provider agrees in writing that an enrollee is not liable, assessable, or in any way subject to making payment for the services except as described in the evidence of coverage issued to the enrollee under Chapter [1271](#). The term includes any amount due on loans in the next calendar year unless the amount is specifically subordinated to uncovered medical and health care expenses or the amount is guaranteed by a sponsoring organization.

(29) "Uncovered liabilities" means obligations resulting from unpaid uncovered expenses, the outstanding indebtedness of loans that are not specifically subordinated to uncovered medical and health care expenses or guaranteed by the sponsoring organization, and all other monetary obligations that are not similarly subordinated or guaranteed.

(30) "Delegated entity" means an entity, other than a health maintenance organization authorized to engage in business under this chapter, 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, Section [1367.053](#), Subchapter A, Chapter [1452](#), Subchapter B, Chapter [1507](#), Chapter [222](#), [251](#), or [258](#), as applicable to a health maintenance organization, or Chapter [1271](#) or [1272](#). 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.

(31) "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.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1179, Sec. 8, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.205(a), 10A.206, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.029, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. [1357](#)), Sec. 2, eff. March 1, 2010.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. [2292](#)), Sec. 1, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. [1358](#)), Sec. 3(1), eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 838 (S.B. [202](#)), Sec. 3.022,

eff. September 1, 2015.

Acts 2023, 88th Leg., R.S., Ch. 30 (H.B. 446), Sec. 8.01, eff. September 1, 2023.

Sec. 843.003. POWERS OF INSURERS AND GROUP HOSPITAL SERVICE CORPORATIONS. (a) An insurer authorized to engage in the business of insurance in this state under Chapter 822, 841, or 883, an accident insurance company, health insurance company, or life insurance company authorized to engage in the business of insurance in this state under Chapter 982, or a group hospital service corporation may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under this chapter.

(b) Any two or more insurers or group hospital service corporations described by Subsection (a), or their subsidiaries or affiliates, may jointly organize and operate a health maintenance organization under this chapter.

(c) An insurer or group hospital service corporation may contract with a health maintenance organization to provide:

(1) insurance or similar protection against the cost of care provided by the health maintenance organization; and

(2) coverage if the health maintenance organization does not meet its obligations.

(d) The authority of an insurer or group hospital service corporation under a contract described by Subsection (c) may include the authority to make benefit payments to a health maintenance organization for health care services provided by physicians or providers under a health care plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.004. GOVERNING BODY OF HEALTH MAINTENANCE ORGANIZATION. The governing body of a health maintenance organization may include physicians, providers, or other individuals, or any combination of physicians, providers, and other individuals.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.



Sec. 843.005. USE OF INSURANCE-RELATED TERMS BY HEALTH MAINTENANCE ORGANIZATION. A health maintenance organization that is not authorized as an insurer may not use in its name, contracts, or literature the word "insurance," "casualty," "surety," or "mutual," or any other words that are:

(1) descriptive of the insurance, casualty, or surety business; or

(2) deceptively similar to the name or description of an insurer or surety corporation engaging in business in this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.006. PUBLIC DOCUMENTS. (a) Except as provided by Subsection (b), each application, filing, and report required under this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272 is a public document.

(b) An examination report is confidential but may be released if, in the opinion of the commissioner, the release is in the public interest.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.030, eff. April 1, 2009.

Sec. 843.007. CONFIDENTIALITY OF MEDICAL AND HEALTH INFORMATION. (a) Any information relating to the diagnosis, treatment, or health of an enrollee or applicant obtained by a health maintenance organization from the enrollee or applicant or from a physician or provider shall be held in confidence and may not be disclosed to any person except:

(1) to the extent necessary to accomplish the purposes of this chapter or:

(A) Section 1367.053;

(B) Subchapter A, Chapter 1452;

(C) Subchapter B, Chapter 1507;

(D) Chapter 222, 251, or 258, as applicable to a health maintenance organization; or

(E) Chapter 1271 or 1272;

(2) with the express consent of the enrollee or applicant;

(3) in compliance with a statute or court order for the production or discovery of evidence; or

(4) in the event of a claim or litigation between the enrollee or applicant and the health maintenance organization in which the information is pertinent.

(b) A health maintenance organization is entitled to claim the statutory privilege against disclosure that the physician or provider who provides the information to the health maintenance organization is entitled to claim.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.031, eff. April 1, 2009.

Sec. 843.008. COSTS OF ADMINISTERING HEALTH MAINTENANCE ORGANIZATION LAWS. Money collected under this chapter and Chapters 222, 251, and 258, as applicable to a health maintenance organization, must be sufficient to administer this chapter and:

(1) Section 1367.053;

(2) Subchapter A, Chapter 1452;

(3) Subchapter B, Chapter 1507;

(4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.032, eff. April 1, 2009.

Sec. 843.009. APPEALS; JUDICIAL REVIEW. (a) A person who is affected by a rule, ruling, or decision of the department or the commissioner is entitled to have the rule, ruling, or decision

reviewed by the commissioner by applying to the commissioner.

(b) An application must identify:

- (1) the applicant;
- (2) the rule, ruling, or decision affecting the applicant;
- (3) the interest of the applicant in the rule, ruling, or decision;
- (4) the grounds of the applicant's objection;
- (5) the action sought of the commissioner; and
- (6) the reasons and grounds for the commissioner to take the action.

(c) An applicant shall file the original application with the chief clerk of the department with a certification that a true and correct copy of the application has been filed with the commissioner.

(d) Not later than the 30th day after the date the application is filed, and after 10 days' written notice to each party of record, the commissioner shall review the action in a hearing. In the hearing, any evidence and any matter pertinent to the application may be submitted to the commissioner regardless of whether it was included in the application.

(e) After the hearing, the commissioner shall render a decision at the earliest possible date. The application has precedence over all other business of a different nature pending before the commissioner.

(f) The commissioner shall adopt rules, consistent with this section, relating to applications under this section and consideration of those applications that the commissioner considers advisable.

(g) A person who is affected by a rule, ruling, or decision of the commissioner and is dissatisfied with the rule, ruling, or decision may, after failing to get relief from the commissioner, file a petition seeking judicial review of the rule, ruling, or decision under Subchapter D, Chapter 36. The action has precedence over all other causes on the docket of a different nature.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Text of section effective until April 01, 2025

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:

(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 533, Government Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.119, eff. April 1, 2025.

Text of section effective on April 01, 2025

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:

(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.119, eff. April 1, 2025.

#### SUBCHAPTER B. APPLICABILITY OF AND CONSTRUCTION WITH OTHER LAWS

Sec. 843.051. APPLICABILITY OF INSURANCE AND GROUP HOSPITAL SERVICE CORPORATION LAWS. (a) Except to the extent that the commissioner determines that the nature of health maintenance organizations, health care plans, or evidences of coverage renders

a provision of the following laws clearly inappropriate, Subchapter A, Chapter 542, Subchapters D and E, Chapter 544, and Chapters 541, 543, and 547 apply to:

(1) health maintenance organizations that offer basic, limited, and single health care coverages;

(2) basic, limited, and single health care plans; and

(3) evidences of coverage under basic, limited, and single health care plans.

(b) A health maintenance organization is subject to:

(1) Chapter 402;

(2) Chapter 827 and is an authorized insurer for purposes of that chapter; and

(3) Subchapter G, Chapter 1251, and Section 1551.064.

(c) Except as otherwise provided by this chapter or other law, insurance laws and group hospital service corporation laws do not apply to a health maintenance organization that holds a certificate of authority under this chapter. This subsection applies to an insurer or a group hospital service corporation only with respect to the health maintenance organization activities of the insurer or corporation.

(d) Activities permitted under other chapters of this code are not subject to this chapter.

(e) Except for Chapter 251, as applicable to a third-party administrator, and Chapters 259, 4151, and 4201, insurance laws and group hospital service corporation laws do not apply to a physician or provider. Notwithstanding this subsection, a physician or provider who conducts a utilization review during the ordinary course of treatment of patients under a joint or delegated review agreement with a health maintenance organization on services provided by the physician or provider is not required to obtain certification under Subchapter C, Chapter 4201.

(f) A health maintenance organization is subject to Chapter 823 as if the health maintenance organization were an insurer under that chapter.

(g) The merger of a health maintenance organization with another health maintenance organization is subject to Chapter 824 as if the health maintenance organizations were insurance

corporations under that chapter. The commissioner may adopt rules as necessary to implement this subsection in a way that reflects the nature of health maintenance organizations, health care plans, or evidences of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 364 (S.B. 1284), Sec. 1, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.033, eff. April 1, 2009.

Sec. 843.052. LAWS RELATING TO SOLICITATION OR ADVERTISING.

(a) Solicitation of enrollees by a health maintenance organization or its representative or agent does not violate a law relating to solicitation or advertising by a physician or provider.

(b) The provision of factually accurate information by a health maintenance organization or its personnel to prospective enrollees regarding coverage, rates, location and hours of service, and names of affiliated institutions, physicians, and providers does not violate any law relating to solicitation or advertising by a physician or provider. The provision of that information with respect to a physician or provider may not be contrary to or in conflict with any law or ethical provision regulating the practice of a practitioner of any professional service provided through or in connection with the physician or provider.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.053. LAWS RELATING TO RESTRAINT OF TRADE. (a) A health maintenance organization that contracts with a health facility or enters into an independent contractual arrangement with physicians or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Sections 15.01-15.26, Business & Commerce Code.

(b) Notwithstanding any other law, a physician who contracts with one or more physicians in the process of conducting activities that are permitted by law but that do not require a

certificate of authority under this chapter is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Sections 15.01-15.26, Business & Commerce Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.054. LAWS REQUIRING CERTIFICATE OF NEED FOR HEALTH CARE FACILITY OR SERVICE. (a) A health maintenance organization is not exempt from any statute that provides for the regulation and certification of need of health care facility construction, expansion, or other modification, or the institution of a health care service through the issuance of a certificate of need, if at the time of establishment of operation or during the course of operation of the health maintenance organization it becomes subject to the provisions of that statute.

(b) If the proposed plan of operation of a health maintenance organization includes providing a health care facility or service that makes the health maintenance organization subject to a statute described by Subsection (a), the commissioner may not issue a certificate of authority until the commissioner has received a certified copy of the certificate of need granted to the health maintenance organization by the appropriate agency.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.055. LAWS RELATING TO PRACTICE OF MEDICINE. (a) This chapter does not authorize the practice of medicine as defined by state law.

(b) This chapter does not repeal, modify, or amend Section [164.051](#), [164.052](#), [164.053](#), [164.054](#), or [164.056](#), Occupations Code, and a health maintenance organization is not exempt from those sections.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.056. INAPPLICABILITY OF BANKRUPTCY LAW. By applying for and receiving a certificate of authority to engage in business in this state, a health maintenance organization agrees and admits that it is not subject to and is not eligible to proceed

under the United States Bankruptcy Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

#### SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 843.071. CERTIFICATE OF AUTHORITY REQUIRED; USE OF "HEALTH MAINTENANCE ORGANIZATION" OR "HMO". (a) A person may not organize or operate a health maintenance organization in this state, or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization, without obtaining a certificate of authority under this chapter.

(b) A person may not use "health maintenance organization" or "HMO" in the course of operation unless the person:

(1) complies with this chapter and:

(A) Section 1367.053;

(B) Subchapter A, Chapter 1452;

(C) Subchapter B, Chapter 1507;

(D) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(E) Chapters 1271 and 1272; and

(2) holds a certificate of authority under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.034, eff. April 1, 2009.

Sec. 843.072. AUTHORIZATION REQUIRED TO ACT AS HEALTH MAINTENANCE ORGANIZATION. (a) A person, including a physician or provider, may not perform any act of a health maintenance organization except in accordance with the specific authorization of this chapter or other law.

(b) A person, including a physician or provider, who performs an act of a health maintenance organization that requires a certificate of authority under this chapter without first obtaining the certificate is subject to all enforcement processes



and procedures available against an unauthorized insurer under Chapter 101 and Subchapter C, Chapter 36.

(c) This section does not apply to an activity exempt from regulation under Section 843.051(e), 843.053, 843.073, or 843.318. Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.073. CERTIFICATE OF AUTHORITY REQUIREMENT: APPLICABILITY TO PHYSICIANS AND PROVIDERS. (a) A person is not required to obtain a certificate of authority under this chapter to the extent that the person is:

(1) a physician engaged in the delivery of medical care; or

(2) a provider engaged in the delivery of health care services other than medical care as part of a health maintenance organization delivery network.

(b) Except as provided by Section 843.101 or 843.318(a), a physician or provider that employs or enters into a contractual arrangement with a provider or group of providers to provide basic or limited health care services or a single health care service is subject to this chapter and the following provisions and is required to obtain a certificate of authority under this chapter:

(1) Section 1367.053;

(2) Subchapter A, Chapter 1452;

(3) Subchapter B, Chapter 1507;

(4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.035, eff. April 1, 2009.

Sec. 843.074. CERTIFICATE OF AUTHORITY REQUIREMENT: APPLICABILITY TO MEDICAL SCHOOL AND MEDICAL AND DENTAL UNIT. A medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, is not required to obtain a certificate of authority under this chapter to

the extent that the medical school or medical and dental unit contracts to deliver medical care within a health maintenance organization delivery network. This chapter is otherwise applicable to the medical school or medical and dental unit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.075. CERTIFICATE OF AUTHORITY FOR SINGLE HEALTH CARE SERVICE PLAN. The commissioner may issue a certificate of authority to a health maintenance organization organized and operated solely to provide a single health care service plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.076. APPLICATION. (a) Any person may apply to the commissioner for and obtain a certificate of authority to organize and operate a health maintenance organization.

(b) An application for a certificate of authority must:

(1) be on a form prescribed by rules adopted by the commissioner; and

(2) be verified by the applicant or an officer or other authorized representative of the applicant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.077. ELIGIBILITY OF FOREIGN CORPORATION. A foreign corporation may qualify for a certificate of authority under this chapter, including a certificate of authority for a single health care service plan, subject to the corporation's:

(1) registration to engage in business in this state as a foreign corporation under the Texas Business Corporation Act; and

(2) compliance with this chapter and other applicable state laws.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.078. CONTENTS OF APPLICATION. (a) An application for a certificate of authority must include:

(1) a copy of the applicant's basic organizational document, if any, such as the articles of incorporation, articles

of association, partnership agreement, trust agreement, or other applicable documents;

(2) all amendments to the applicant's basic organizational document; and

(3) a copy of the bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.

(b) An application for a certificate of authority must include a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including:

(1) each member of the board of directors, board of trustees, executive committee, or other governing body or committee;

(2) the principal officer, if the applicant is a corporation; and

(3) each partner or member, if the applicant is a partnership or association.

(c) An application for a certificate of authority must include a copy of any independent contract or other contract made or to be made between the applicant and any physician, provider, or person listed under Subsection (b).

(d) An application for a certificate of authority must include:

(1) a copy of the form of evidence of coverage to be issued to an enrollee;

(2) a copy of the form of the group contract, if any, to be issued to an employer, union, trustee, or other organization; and

(3) a written description of health care plan terms made available to any current or prospective group contract holder or current or prospective enrollee of the health maintenance organization in accordance with Section [843.201](#).

(e) An application for a certificate of authority must include a financial statement that is current on the date of the application and that includes:

(1) the sources and application of funds;

(2) projected financial statements during the initial period of operations;

(3) a balance sheet reflecting the condition of the applicant on the date operations are expected to start;

(4) a statement of revenue and expenses with expected member months; and

(5) a cash flow statement that states any capital expenditures, purchase and sale of investments, and deposits with the state.

(f) An application for a certificate of authority must include the schedule of charges to be used during the first 12 months of operation.

(g) An application for a certificate of authority must include a statement acknowledging that lawful process in a legal action or proceeding against the health maintenance organization on a cause of action arising in this state is valid if served in accordance with Chapter 804.

(h) An application for a certificate of authority must include a statement reasonably describing the service area or areas to be served by the applicant.

(i) An application for a certificate of authority must include a description of the complaint procedures the applicant will use.

(j) An application for a certificate of authority must include a description of the procedures and programs to be implemented by the applicant to meet the quality of health care requirements of this chapter and:

- (1) Section 1367.053;
- (2) Subchapter A, Chapter 1452;
- (3) Subchapter B, Chapter 1507; and
- (4) Chapters 1271 and 1272.

(k) An application for a certificate of authority must include network configuration information, including an explanation of the adequacy of the physician and other provider network configuration. The information provided must:

(1) include the names of physicians, specialty physicians, and other providers by zip code or zip code map; and

(2) indicate whether each physician or other provider is accepting new patients from the health maintenance organization.

(1) An application for a certificate of authority must include a written description of the types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, or capitated risk arrangements, made or to be made with physicians and providers in exchange for the provision of or an arrangement to provide health care services to enrollees, including any financial incentives for physicians and providers. The compensation arrangements are confidential and are not subject to the public information law, Chapter 552, Government Code.

(m) An application for a certificate of authority must include documentation demonstrating that the applicant will comply with Section 1271.005(c).

(n) An application for a certificate of authority must include any other information that the commissioner requires to make the determinations required by this chapter and:

(1) Section 1367.053;

(2) Subchapter A, Chapter 1452;

(3) Subchapter B, Chapter 1507;

(4) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(5) Chapters 1271 and 1272.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.036, eff. April 1, 2009.

Sec. 843.079. CONTENTS OF APPLICATION: LIMITED HEALTH CARE SERVICE PLAN. In addition to the items required under Section 843.078, an application for a certificate of authority for a limited health care service plan must include a specific description of the health care services to be provided by the applicant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.080. MODIFICATION OR AMENDMENT OF APPLICATION INFORMATION. (a) The commissioner may adopt reasonable rules that the commissioner considers necessary for the proper administration of this chapter to require a health maintenance organization, after receiving its certificate of authority, to submit modifications or amendments to the operations or documents described in Sections 843.078 and 843.079 to the commissioner, for the commissioner's approval or only to provide information, before implementing the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner at the time of the next site visit or examination.

(b) As soon as reasonably possible after any filing for approval required under this section is made, the commissioner shall approve or disapprove the filing in writing. If, before the 31st day after the date a modification or amendment for which the commissioner's approval is required is filed, the commissioner does not disapprove the modification or amendment, it is considered approved. The commissioner may delay action as necessary for proper consideration for not more than an additional 30 days.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.082. REQUIREMENTS FOR APPROVAL OF APPLICATION. The commissioner shall issue a certificate of authority on payment of the application fee prescribed by Section 843.154(c) if the commissioner is satisfied that:

(1) with respect to health care services to be provided, the applicant:

(A) has demonstrated the willingness and potential ability to ensure that the health care services will be provided in a manner to:

(i) ensure both availability and accessibility of adequate personnel and facilities; and

(ii) enhance availability, accessibility, quality of care, and continuity of services;

(B) has arrangements, established in accordance with rules adopted by the commissioner, for a continuing quality of health care assurance program concerning health care processes and

outcomes; and

(C) has a procedure, that is in accordance with rules adopted by the commissioner, to develop, compile, evaluate, and report statistics relating to the cost of operation, the pattern of utilization of services, and availability and accessibility of services;

(2) the person responsible for the conduct of the affairs of the applicant is competent, is trustworthy, and has a good reputation;

(3) the health care plan, limited health care service plan, or single health care service plan is an appropriate mechanism through which the health maintenance organization will effectively provide or arrange for the provision of basic health care services, limited health care services, or a single health care service on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;

(4) the health maintenance organization is fully responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees, after considering:

(A) the financial soundness of the health care plan's arrangement for health care services and the schedule of charges used in connection with the arrangement;

(B) the adequacy of working capital;

(C) any agreement with an insurer, a group hospital service corporation, a political subdivision of government, or any other organization for insuring the payment of the cost of health care services or providing for automatic applicability of an alternative coverage in the event the plan is discontinued;

(D) any agreement that provides for the provision of health care services; and

(E) any deposit of cash or securities submitted in accordance with Section 843.405 as a guarantee that the obligations will be performed; and

(5) the proposed plan of operation, as shown by the information submitted under Section 843.078 and, if applicable, Section 843.079, or by independent investigation, does not violate

state law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.083. DENIAL OF CERTIFICATE OF AUTHORITY. (a) If the commissioner certifies that the health maintenance organization's proposed plan of operation does not meet the requirements of Section 843.082, the commissioner may not issue a certificate of authority.

(b) The commissioner shall notify the applicant that the plan is deficient and specify the deficiencies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.084. DURATION OF CERTIFICATE OF AUTHORITY. A certificate of authority continues in effect:

(1) while the certificate holder meets the requirements of this chapter and:

(A) Section 1367.053;

(B) Subchapter A, Chapter 1452;

(C) Subchapter B, Chapter 1507;

(D) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(E) Chapters 1271 and 1272; or

(2) until the commissioner suspends or revokes the certificate or the commissioner terminates the certificate at the request of the certificate holder.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.037, eff. April 1, 2009.

Sec. 843.085. CHANGE IN CONTROL: COMMISSIONER APPROVAL. Any change in control, as defined by Chapter 823, of a health maintenance organization is subject to the approval of the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

#### SUBCHAPTER D. GENERAL POWERS AND DUTIES OF HEALTH MAINTENANCE



ORGANIZATIONS

Sec. 843.101. PROVIDING OR ARRANGING FOR CARE. (a) A health maintenance organization may provide or arrange for medical care services only through:

- (1) other health maintenance organizations; or
- (2) physicians or groups of physicians who have independent contracts with the health maintenance organizations.

(b) A health maintenance organization may provide or arrange for health care services only through:

- (1) other health maintenance organizations;
- (2) providers or groups of providers who are:
  - (A) under contract with or are employed by the health maintenance organization; or
  - (B) under contract with an entity that is under contract with the health maintenance organization to provide a network of providers to provide health care services only if the contract between the entity and the health maintenance organization:
    - (i) does not limit the health maintenance organization's authority or responsibility, including financial responsibility, to comply with any regulatory requirement that applies to a function performed by the entity;
    - (ii) requires the entity to comply with all regulatory requirements that apply to a function performed by the entity; and
    - (iii) expressly sets forth the requirements of Subparagraphs (i) and (ii); or
- (3) additional health maintenance organizations or physicians or providers who have contracted for health care services with:

- (A) the other health maintenance organizations;
- (B) physicians with whom the health maintenance organization has contracted; or
- (C) providers who are under contract with or are employed by the health maintenance organization.

(b-1) Except as provided by Subsection (b-2) and

notwithstanding any other law, an entity described by Subsection (b)(2)(B) and the health maintenance organization with which the entity contracts are subject to Chapter 1272 as if the entity were a delegated entity unless the entity:

(1) is a delegated network or delegated third party as defined by Section 1272.001; or

(2) is not a delegated entity as provided by Section 1272.001(a)(1)(A) or (B).

(b-2) An entity subject to Chapter 1272 under Subsection (b-1) that does not assume risk and the health maintenance organization with which the entity contracts are not subject to the following provisions:

(1) Section 1272.053(1);

(2) Section 1272.057(1);

(3) Section 1272.061(1)(C); and

(4) Subchapter D, Chapter 1272.

(c) Notwithstanding Subsections (a) and (b), a health maintenance organization may provide or authorize the following in a manner approved by the commissioner:

(1) emergency care;

(2) services by referral; and

(3) services provided outside the service area.

(d) A health maintenance organization may not employ or contract with other health maintenance organizations or physicians or providers in a manner that is prohibited by a law of this state under which those health maintenance organizations or physicians or providers are licensed or otherwise authorized.

(e) A health maintenance organization may serve as a workers' compensation health care network, as defined by Section 1305.004, in accordance with Chapter 1305.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.060, eff. September 1, 2005.

Acts 2017, 85th Leg., R.S., Ch. 366 (H.B. 3218), Sec. 1, eff. September 1, 2017.

Sec. 843.102. HEALTH MAINTENANCE ORGANIZATION QUALITY ASSURANCE. (a) A health maintenance organization shall establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice. The procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

(b) A health maintenance organization shall operate a continuing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services and ancillary and preventive health care services, in all institutional and noninstitutional settings.

(c) The commissioner by rule may establish minimum standards and requirements for the quality assurance programs, including standards for ensuring availability, accessibility, quality, and continuity of care.

(d) A health maintenance organization shall record formal proceedings of quality assurance program activities and maintain documentation in a confidential manner. The health maintenance organization shall make the quality assurance program minutes available to the commissioner.

(e) A health maintenance organization shall establish and maintain a physician review panel to assist in:

- (1) reviewing medical guidelines or criteria; and
- (2) determining prescription drugs to be covered by the health maintenance organization, if the health maintenance organization offers a prescription drug benefit.

(f) A health maintenance organization shall ensure the use and maintenance of an adequate patient record system to facilitate documentation and retrieval of clinical information for the health maintenance organization's evaluation of continuity and coordination of patient care and assessment of the quality of health and medical care provided to enrollees.

(g) The clinical records of enrollees shall be available to the commissioner for examination and review to determine compliance. The records are confidential and privileged and are not subject to the public information law, Chapter 552, Government

Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this section.

(h) A health maintenance organization shall establish a mechanism for the periodic reporting of quality assurance program activities to its governing body, providers, and appropriate health maintenance organization staff.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.103. ACQUISITION AND OPERATION OF FACILITIES; CERTAIN LOANS; COMMISSIONER APPROVAL OF AFFILIATE TRANSACTIONS.

(a) A health maintenance organization may:

(1) purchase, lease, construct, renovate, operate, or maintain hospitals or medical facilities and ancillary equipment and other property reasonably required for the principal office of the health maintenance organization or for another purpose necessary in engaging in the business of the health maintenance organization; and

(2) make loans to a medical group, under an independent contract with the group to further its program, or corporations under its control, to acquire or construct medical facilities and hospitals, or to further a program providing health care services to enrollees.

(b) If the exercise of a power granted under Subsection (a) involves an affiliate, as described by Section [823.003](#), the health maintenance organization before exercising that power shall file notice and adequate supporting information with the commissioner for approval.

(c) The commissioner shall disapprove the exercise of a power described by Subsection (a) that would in the commissioner's opinion:

(1) substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations; or

(2) impair the interests of the public or the health maintenance organization's enrollees or creditors in this state.

(d) If the commissioner does not disapprove the exercise of a power described by Subsection (a) before the 31st day after the

date notice is filed under this section, the exercise of the power is considered approved. The commissioner may, by official order, delay action as necessary for proper consideration for not more than an additional 30 days.

(e) The commissioner may adopt rules exempting from the filing requirements of Subsection (b) an activity that has a de minimis effect.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.104. CONTRACTS FOR CERTAIN ADMINISTRATIVE FUNCTIONS. A health maintenance organization may contract with any person to perform functions such as marketing, enrollment, and administration on behalf of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.105. MANAGEMENT AND EXCLUSIVE AGENCY CONTRACTS.

(a) A health maintenance organization may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner.

(b) The commissioner must approve or disapprove the contract not later than the 30th day after the date the contract is filed or within a reasonable extended period that the commissioner specifies by notice given within the 30-day period.

(c) The commissioner shall disapprove the proposed contract if the commissioner determines that the contract:

(1) subjects the health maintenance organization to excessive charges;

(2) extends for an unreasonable time;

(3) does not contain fair and adequate standards of performance;

(4) authorizes persons to manage the health maintenance organization who are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the health maintenance organization with due regard for the interests of the health maintenance organization's enrollees or creditors or the public; or

(5) contains provisions that impair the interests of the public in this state or the health maintenance organization's enrollees or creditors.

(d) The commissioner shall disapprove a proposed management contract unless the commissioner determines that the management contractor has in force in its own name a fidelity bond on its officers and employees in the amount of at least \$100,000 or another amount prescribed by the commissioner.

(e) The fidelity bond must be issued by an insurer that holds a certificate of authority in this state. If, after notice and hearing, the commissioner determines that a fidelity bond is not available from an insurer that holds a certificate of authority in this state, the management contractor may obtain a fidelity bond procured by a surplus lines agent resident in this state in compliance with Chapter 981.

(f) The fidelity bond must obligate the surety to pay any loss of money or other property that the health maintenance organization sustains because of an act of fraud or dishonesty by an employee or officer of the management contractor during the period that the management contract is in effect.

(g) Instead of a fidelity bond, the management contractor may deposit with the comptroller cash or securities acceptable to the commissioner. The deposit must be maintained in the amount and is subject to the same conditions required for a fidelity bond under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.106. INSURANCE, REINSURANCE, INDEMNITY, AND REIMBURSEMENT. A health maintenance organization may contract with an insurer or group hospital service corporation authorized to engage in business in this state to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care and medical care services provided by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.107. INDEMNITY BENEFITS; POINT-OF-SERVICE

PROVISIONS. A health maintenance organization may offer:

- (1) indemnity benefits covering out-of-area emergency care;
- (2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation;
- (3) a point-of-service plan under Subchapter A, Chapter 1273; or
- (4) a point-of-service rider under Section 843.108.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.038, eff. April 1, 2009.

Sec. 843.108. POINT-OF-SERVICE RIDER. (a) In this section, "point-of-service rider" means a rider under which indemnity benefits for the cost of health care services are provided by a health maintenance organization in conjunction with corresponding benefits arranged for or provided by a health maintenance organization.

(b) A health maintenance organization may offer a point-of-service rider for out-of-network coverage without obtaining a separate certificate of authority as an insurer if the expenses incurred under the point-of-service rider do not exceed 10 percent of the total medical and hospital expenses incurred for all health plan products sold by the health maintenance organization. If the expenses exceed that level, the health maintenance organization may not issue new point-of-service riders until the expenses fall below that level or until the health maintenance organization obtains a certificate of authority as an insurer.

(c) Indemnity benefits for services provided under a point-of-service rider may be limited to those services defined in the evidence of coverage 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 enrollees in a limited provider network, higher cost-sharing may be

imposed only when benefits or services are obtained outside the health maintenance organization delivery network.

(d) A health maintenance organization that issues a point-of-service rider under this section must meet additional net worth requirements prescribed by the commissioner. The commissioner shall base the net worth requirements on the actuarial relation of the amount of insurance risk assumed through the point-of-service rider to the amount of solvency and reserve requirements otherwise required of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.109. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY. A health maintenance organization may accept from a governmental or private entity payments for all or part of the cost of services provided or arranged for by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.110. CORPORATION, PARTNERSHIP, OR ASSOCIATION POWERS. A health maintenance organization has all powers of a partnership, association, or corporation, including a professional association or corporation, as appropriate under the organizational documents of the health maintenance organization, that are not in conflict with this chapter or other applicable law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.111. GROUP MODEL HEALTH MAINTENANCE ORGANIZATIONS. (a) In this section, "group model health maintenance organization" means a health maintenance organization that provides the majority of its professional services through a single group medical practice that is formally affiliated with the medical school component of a state-supported public college or university in this state.

(b) Unless this section and a power specified in Section [843.101](#), [843.103](#), [843.104](#), [843.106](#), [843.107](#), [843.109](#), or [843.110](#) are specifically amended by law, a law, without regard to the time of enactment, may not be construed to prohibit or restrict a group



model health maintenance organization from:

(1) selectively contracting with or declining to contract with a provider as the group model health maintenance organization considers necessary;

(2) contracting for or declining to contract for an individual health care service or full range of health care services as the group model health maintenance organization considers necessary, if the service or services may be legally provided by the contracting provider; or

(3) requiring enrolled members of the group model health maintenance organization who wish to obtain the services covered by the group model health maintenance organization to use the providers specified by the group model health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.112. DENTAL POINT-OF-SERVICE OPTION. (a) In this section:

(1) "Point-of-service option" means a plan provided through a contractual arrangement under which:

(A) indemnity benefits for the cost of dental care services, other than emergency care or emergency dental care, are provided by an insurer or group hospital service corporation in conjunction with corresponding benefits arranged or provided by a health maintenance organization; and

(B) an enrollee may choose to obtain benefits or services under the indemnity plan or the health maintenance organization plan in accordance with specific provisions of a point-of-service contract.

(2) "Provider panel" means the providers with whom a health maintenance organization contracts to provide dental services to enrollees covered under a dental benefit plan.

(b) This section applies to a dental health maintenance organization or another single service health maintenance organization that provides dental benefits. This section does not apply to a health maintenance organization that has 10,000 or fewer enrollees in this state who are enrolled in dental benefit plans

based on a provider panel.

(c) If an employer, association, or other private group arrangement that employs 25 or more employees or has 25 or more members offers and contributes to the cost of dental benefit plan coverage to employees or individuals only through a provider panel, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another entity to offer, a dental point-of-service option to the employer, association, or other private group arrangement. The employer may offer the dental point-of-service option to the employee or individual to accept or reject.

(d) If a health maintenance organization's dental provider panel is the sole delivery system offered to employees by an employer, the health maintenance organization:

(1) shall offer the employer a dental point-of-service option;

(2) may not impose a minimum participation level on the dental point-of-service option; and

(3) as part of the group enrollment application, shall provide to each employer disclosure statements as required by rules adopted under this code for each dental plan offered.

(e) An employer may require an employee or individual who accepts the point-of-service option to be responsible for the payment of a premium, over the amount of the premium for the coverage provided to employees or members under the dental benefit plan offered through a provider panel, directly or by payroll deduction in the same manner in which the other premium is paid. The premium for the point-of-service option must be based on the actuarial value of that coverage.

(f) Different cost-sharing provisions may be imposed for the point-of-service option.

(g) An employer may charge an employee or individual who accepts the point-of-service option a reasonable administrative fee for costs associated with the employer's reasonable administration of the point-of-service option.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.113. SPECIFIED POWERS NOT EXCLUSIVE. The powers of a health maintenance organization are not limited to the powers specified by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

#### SUBCHAPTER E. REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Sec. 843.151. RULES. The commissioner may adopt reasonable rules as necessary and proper to:

(1) implement this chapter and Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, including rules to:

(A) prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in this chapter;

(B) ensure that enrollees have adequate access to health care services; and

(C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and

(2) meet the requirements of federal law and regulations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.039, eff. April 1, 2009.

Sec. 843.152. SUBPOENA AUTHORITY. In implementing this chapter and the following provisions, the commissioner may exercise subpoena authority in accordance with Subchapter C, Chapter 36:

(1) Section 1367.053;

(2) Subchapter A, Chapter 1452;

(3) Subchapter B, Chapter 1507;

(4) Chapters 222, 251, and 258, as applicable to a

health maintenance organization; and

- (5) Chapters [1271](#) and [1272](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.040, eff. April 1, 2009.

Sec. 843.153. AUTHORITY TO CONTRACT. In performing duties under this chapter and the following provisions, the commissioner may contract with a state agency or, after notice and opportunity for hearing, with a qualified person to make recommendations concerning determinations to be made by the commissioner:

- (1) Section [1367.053](#);
- (2) Subchapter [A](#), Chapter [1452](#);
- (3) Subchapter [B](#), Chapter [1507](#);
- (4) Chapters [222](#), [251](#), and [258](#), as applicable to a

health maintenance organization; and

- (5) Chapters [1271](#) and [1272](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.041, eff. April 1, 2009.

Sec. 843.154. FEES. (a) The commissioner shall, within the limits prescribed by this section, prescribe the fees to be charged under this section.

(b) Except for fees collected under Subsections (e) and (f), fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

(b-1) A fee collected under Subsection (e) or (f) shall be deposited to the credit of the account described by Section [401.156\(a\)](#).

(c) A health maintenance organization shall pay to the commissioner a fee in an amount not to exceed:

- (1) \$18,000 for filing and review of its original application for a certificate of authority;
- (2) \$200 for filing of an evidence of coverage that

requires approval; and

(3) \$100 for a filing that is required by rule but does not require approval.

(d) A health maintenance organization shall pay to the comptroller a fee in an amount not to exceed \$500 for filing of an annual report under Section [843.155](#).

(e) A health maintenance organization shall pay to the commissioner a fee, in an amount certified by the commissioner to be just and reasonable, for the expenses of all examinations of health maintenance organizations made on behalf of the state by the commissioner or under the commissioner's authority.

(f) A health maintenance organization shall pay to the commissioner a fee in an amount assessed by the commissioner and paid in accordance with rules adopted by the commissioner for the expenses of an examination under Section [843.156](#)(a) that:

(1) are incurred by the commissioner or under the commissioner's authority; and

(2) are directly attributable to that examination, including the actual salaries and expenses of the examiners directly attributable to that examination, as determined under rules adopted by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 659 (S.B. [1291](#)), Sec. 5, eff. September 1, 2011.

Sec. 843.155. ANNUAL REPORT. (a) Not later than March 1 of each year, a health maintenance organization shall file with the commissioner a report covering the preceding calendar year.

Text of subsection as amended by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 9

(b) The report shall:

(1) be verified by at least two principal officers;

(2) be in a form prescribed by the commissioner; and

(3) include:

(A) a financial statement of the health maintenance organization, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year;

(C) a statement of:

- (i) an evaluation of enrollee satisfaction;
- (ii) an evaluation of quality of care;
- (iii) coverage areas;
- (iv) accreditation status;
- (v) premium costs;
- (vi) plan costs;
- (vii) premium increases;
- (viii) the range of benefits provided;
- (ix) copayments and deductibles;
- (x) the accuracy and speed of claims payment by the organization;
- (xi) the credentials of physicians of the organization; and
- (xii) the number of providers;

(D) updated financial projections for the next calendar year of the type described in Section 843.078(e), until the health maintenance organization has had a net income for 12 consecutive months; and

(E) other information relating to the performance of the health maintenance organization as necessary to enable the commissioner to perform the commissioner's duties under this chapter and Chapter 20A.

Text of subsection as amended by Acts 2007, 80th Leg., R.S., Ch. 730  
(H.B. 2636), Sec. 2E.042

(b) The report shall:

- (1) be verified by at least two principal officers;

(2) be in a form prescribed by the commissioner; and

(3) include:

(A) a financial statement of the health maintenance organization, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year;

(C) updated financial projections for the next calendar year of the type described in Section 843.078(e), until the health maintenance organization has had a net income for 12 consecutive months; and

(D) other information relating to the performance of the health maintenance organization as necessary to enable the commissioner to perform the commissioner's duties under:

(i) this chapter;

(ii) Section 1367.053;

(iii) Subchapter A, Chapter 1452;

(iv) Subchapter B, Chapter 1507;

(v) Chapters 222, 251, and 258, as applicable to a health maintenance organization; and

(vi) Chapters 1271 and 1272.

(c) Sections 36.108 and 201.055 and Chapter 802 apply to the annual report of a health maintenance organization.

(d) The annual report filed by the health maintenance organization shall be made publicly available on the department's Internet website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by health maintenance organizations under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.042, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 9, eff. September 1, 2007.

Sec. 843.156. EXAMINATIONS. (a) The commissioner may examine the quality of health care services and the affairs of any health maintenance organization or applicant for a certificate of authority under this chapter. The commissioner may conduct an examination as often as the commissioner considers necessary, but shall conduct an examination at least once every three years.

(b) A health maintenance organization shall make its books and records relating to its operations available for an examination and shall facilitate an examination in every way.

(c) Each physician and provider with whom the health maintenance organization has a contract, agreement, or other arrangement is required to make available for an examination only that portion of the physician's or provider's books and records that is relevant to the physician's or provider's relationship with the health maintenance organization.

(d) On request of the commissioner, a health maintenance organization shall provide to the commissioner a copy of any contract, agreement, or other arrangement between the health maintenance organization and a physician or provider. Documentation provided to the commissioner under this subsection is confidential and is not subject to the public information law, Chapter 552, Government Code.

(e) Medical, hospital, and health records of enrollees and records of physicians and providers providing service under an independent contract with a health maintenance organization are subject to an examination only as necessary for a continuing quality of health assurance program concerning health care procedures and outcomes that is established in accordance with an approved plan under this chapter. The plan shall provide for adequate protection of the confidentiality of medical information. Medical information may be disclosed only in accordance with this chapter and other applicable law and is subject to subpoena only on a showing of good cause.

(f) The commissioner may examine and use the records of a health maintenance organization, including records of a quality of care assurance program and records of a medical peer review



committee, as necessary to implement the purposes of this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, including commencement of an enforcement action under Section 843.461 or 843.462. Information obtained under this subsection is confidential and privileged and is not subject to the public information law, Chapter 552, Government Code, or to subpoena except as necessary for the commissioner to enforce this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272. In this subsection, "medical peer review committee" has the meaning assigned by Section 151.002, Occupations Code.

(g) For the purpose of an examination, the commissioner may administer oaths to and examine the officers and agents of a health maintenance organization and the principals of physicians and providers described by this section concerning their business.

(h) Chapter 86, Section 401.101, and Subchapters B and D, Chapter 401, apply to a health maintenance organization, except to the extent that the commissioner determines that the nature of the examination of a health maintenance organization renders the applicability of those provisions clearly inappropriate.

(i) Section 38.001, Section 81.003, and Chapter 82 apply to a health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.043, eff. April 1, 2009.

Sec. 843.157. REHABILITATION, LIQUIDATION, SUPERVISION, OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATION. (a) The rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be treated as the rehabilitation, liquidation, supervision, or conservation of an insurer and be conducted under the supervision of the commissioner under Chapter 441 or 443, as appropriate.

(b) The commissioner may also order the rehabilitation, liquidation, supervision, or conservation of a health maintenance organization if in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous to the enrollees or to the people of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.044, eff. April 1, 2009.

#### SUBCHAPTER F. RELATIONS WITH ENROLLEES AND GROUP CONTRACT HOLDERS

Sec. 843.201. DISCLOSURE OF INFORMATION ABOUT HEALTH CARE PLAN TERMS. (a) A health maintenance organization shall provide an accurate written or electronic description of health care plan terms, including restrictions or limitations related to a limited provider network or delegated network within a health care plan, to allow a current or prospective group contract holder or current or prospective enrollee to make comparisons and informed decisions before selecting among health care plans. The written or electronic description must:

(1) be in readable and understandable format prescribed by the commissioner; and

(2) include a current list of physicians and providers, including a delineation of any limited provider network or delegated network.

(b) A health maintenance organization may satisfy the requirement imposed under Subsection (a) through the member handbook provided under Section 843.205 if:

(1) the handbook's contents are substantially similar to and provide the same level of disclosure as the written or electronic description prescribed by the commissioner; and

(2) the current list of physicians and providers is also provided.

(c) If an enrollee designates a primary care physician who practices in a limited provider network or delegated entity, not later than the 30th day after the date of the enrollee's enrollment,

the health maintenance organization shall provide the information required under this section to the enrollee with the enrollee's identification card or in a mailing separate from other information.

(d) A health maintenance organization shall provide to an enrollee on request information on:

(1) whether a physician or other health care provider is a participating provider in the health maintenance organization's network;

(2) whether proposed health care services are covered by the health plan; and

(3) what the enrollee's personal responsibility will be for payment of applicable copayment or deductible amounts.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 261, Sec. 2, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.208(a), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. [1731](#)), Sec. 12, eff. September 1, 2007.

Sec. 843.2015. INFORMATION AVAILABLE THROUGH INTERNET SITE. (a) A health maintenance organization that maintains an Internet site shall list on the Internet site the physicians and providers, including, if appropriate, mental health providers and substance abuse treatment providers, that may be used by enrollees in accordance with the terms of the enrollee's health care plan. The listing must identify those physicians and providers who continue to be available to provide services to new patients or clients.

(b) The health maintenance organization shall update at least quarterly an Internet site subject to this section.

(c) The commissioner may adopt rules as necessary to implement this section. The rules may govern the form and content of the information required to be provided under Subsection (a).

Acts 2003, 78th Leg., ch. 1177, Sec. 3, eff. Sept. 1, 2003.

Sec. 843.202. DISCLOSURE OF INFORMATION TO MEDICARE RECIPIENTS. (a) Before a prospective enrollee is enrolled in a health care plan offered to Medicare recipients by a Medicare-contracting health maintenance organization, the health maintenance organization must provide the prospective enrollee with a disclosure form adopted by the commissioner under Subsection (b).

(b) The commissioner shall adopt a disclosure form informing a prospective enrollee in a Medicare-contracting health maintenance organization of:

(1) the effect of enrollment in the health maintenance organization on the prospective enrollee's opportunity to purchase Medicare supplement insurance; and

(2) any differences in the benefits and costs between the health care plan offered to Medicare recipients and Medicare supplement insurance.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.203. SELECTION OF PRIMARY CARE PHYSICIAN OR PROVIDER. (a) Each plan application form shall prominently include a space in which the enrollee at the time of application or enrollment shall select a primary care physician or primary care provider.

(b) An enrollee shall at all times have the right to select or change a primary care physician or primary care provider within the health maintenance organization network of available primary care physicians and primary care providers, except that a health maintenance organization may limit an enrollee's request to change physicians or providers to not more than four changes in a 12-month period.

(c) For purposes of this subchapter, an applicant physician, as defined by Chapter 1452, may not be considered to be an available primary care physician or primary care provider within the health maintenance organization delivery network for selection by an enrollee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 2, eff. September 1, 2007.

Sec. 843.204. UNTRUE OR MISLEADING INFORMATION. (a) A health maintenance organization or a representative of a health maintenance organization may not:

(1) use or distribute or knowingly permit the use or distribution of prospective enrollee information that is untrue or misleading; or

(2) use or knowingly permit the use of:

(A) advertising that is untrue or misleading;

(B) solicitation that is untrue or misleading;

or

(C) any form of evidence of coverage that is deceptive.

(b) In this chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, a statement or item of information is:

(1) considered to be untrue if the statement or item does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a health care plan; and

(2) considered to be misleading, whether or not the statement or item is literally untrue, if, in the total context in which the statement is made or the item is communicated, the statement or item may be reasonably understood by a reasonable person who does not possess special knowledge regarding health care coverage as indicating:

(A) the inclusion of a benefit or advantage that does not exist and that is of possible significance to an enrollee of, or person considering enrollment in, a health care plan; or

(B) the absence of an exclusion, limitation, or disadvantage that does exist and that is of possible significance to an enrollee of, or person considering enrollment in, a health care plan.

(c) In this chapter, Section 1367.053, Subchapter A,

Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, an evidence of coverage is considered to be deceptive if the evidence of coverage, taken as a whole and with consideration given to typography and format as well as language, would cause a reasonable person who does not possess special knowledge regarding health care plans and evidences of coverage for health care plans to expect charges or benefits, services, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.045, eff. April 1, 2009.

Sec. 843.205. MEMBER'S HANDBOOK; INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) In this section, "major population" means a group constituting 10 percent or more of the enrolled population of the health maintenance organization.

(b) A health maintenance organization shall establish procedures to:

(1) provide to an enrollee a member handbook and materials relating to the complaint and appeals process in the languages of the major populations of the enrolled population; and

(2) provide access to a member handbook and the complaint and appeals process to an enrollee who has a disability that affects the enrollee's ability to communicate or read.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.206. NOTICE OF CHANGE IN PAYMENT ARRANGEMENTS. A health maintenance organization shall notify a group contract holder within 30 days of any substantive change to the payment arrangements between the health maintenance organization and physicians or providers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.207. NOTICE OF CHANGE IN OPERATIONS. A health maintenance organization shall provide to its enrollees reasonable notice of any material adverse change in the operation of the health maintenance organization that will directly affect the enrollees. Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.2071. NOTICE OF INCREASE IN CHARGE FOR COVERAGE.

(a) Not less than 60 days before the date on which an increase in a charge for coverage under this chapter takes effect, a health maintenance organization shall:

(1) give to each enrollee under an individual evidence of coverage written notice of the effective date of the increase; and

(2) provide the enrollee a table that clearly lists:

(A) the actual dollar amount of the charge for coverage on the date of the notice;

(B) the actual dollar amount of the charge for coverage after the charge increase; and

(C) the percentage change between the amounts described by Paragraphs (A) and (B).

(b) The notice required by this section must be based on coverage in effect on the date of the notice.

(c) This section may not be construed to prevent a health maintenance organization, at the request of an enrollee, from negotiating a change in benefits or rates after delivery of the notice required by this section.

(d) A health maintenance organization may not require an enrollee entitled to notice under this section to respond to the health maintenance organization to renew the coverage or take other action relating to the renewal or extension of the coverage before the 45th day after the date the notice described by Subsection (a) is given.

(e) The notice required by this section must include:

(1) contact information for the department, including information concerning how to file a complaint with the department;

(2) contact information for the Texas Consumer Health

Assistance Program, including information concerning how to request from the program consumer protection information or assistance with filing a complaint; and

(3) the addresses of Internet websites that provide consumer information related to rate increase justifications, including the websites of the department and the United States Department of Health and Human Services.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 3.001, eff. September 1, 2011.

Sec. 843.208. CANCELLATION OR NONRENEWAL OF COVERAGE. A health maintenance organization may cancel or refuse to renew the coverage of an enrollee only for:

(1) failure to pay the charges for the coverage; or

(2) another reason prescribed by rules adopted by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.209. IDENTIFICATION CARD. An identification card or other similar document issued by a health maintenance organization to an enrollee must:

(1) indicate that the health maintenance organization is regulated under this code and subject to the provisions of Subchapter J; and

(2) display:

(A) the first date on which the enrollee became enrolled; or

(B) a toll-free number a physician or provider may use to obtain that date.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 4, eff. June 17, 2003.

Sec. 843.210. TERMS OF ENROLLEE ELIGIBILITY. (a) A contract between a health maintenance organization and a group contract holder must provide that:

(1) in addition to any other premiums for which the group contract holder is liable, the group contract holder is liable for an enrollee's premiums from the time the enrollee is no



longer part of the group eligible for coverage under the contract until the end of the month in which the contract holder notifies the health maintenance organization that the enrollee is no longer part of the group eligible for coverage by the contract; and

(2) the enrollee remains covered by the contract until the end of that period.

(b) Each health maintenance organization that enters into a contract described by Subsection (a) shall notify the group contract holder periodically as provided by this section that the contract holder is liable for premiums on an enrollee who is no longer part of the group eligible for coverage under the contract until the health maintenance organization receives notification of termination of the enrollee's eligibility for that coverage.

(c) If the health maintenance organization charges the group contract holder on a monthly basis for the coverage premiums, the health maintenance organization shall include the notice required by Subsection (b) in each monthly statement sent to the group contract holder. If the health maintenance organization charges the group contract holder on other than a monthly basis for the premiums, the health maintenance organization shall notify the group contract holder periodically in the manner prescribed by the commissioner by rule.

(d) The notice required by Subsection (b) must include a description of methods preferred by the health maintenance organization for notification by a group contract holder of an enrollee's termination from coverage eligibility.

Added by Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 2, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1217 (S.B. 1143), Sec. 1, eff. September 1, 2009.

Sec. 843.211. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter applies to a person to whom a health maintenance organization contracts to:

(1) process or pay claims;

(2) obtain the services of physicians or other providers to provide health care services to enrollees; or

(3) issue verifications or preauthorizations.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 13, eff. September 1, 2007.

#### SUBCHAPTER G. DISPUTE RESOLUTION

Sec. 843.251. COMPLAINT SYSTEM REQUIRED; COMMISSIONER RULES AND EXAMINATION. (a) A health maintenance organization shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

(b) The commissioner may adopt reasonable rules as necessary or proper to implement the provisions of this subchapter relating to the complaint system and administer matters relating to the complaint system.

(c) The commissioner may examine a complaint system for compliance with this subchapter and may require the health maintenance organization to make corrections as the commissioner considers necessary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.252. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a health maintenance organization of a complaint, the health maintenance organization, not later than the fifth business day after the date of receiving the complaint, shall send to the complainant a letter acknowledging the date of receipt of the complaint.

(b) The letter required under Subsection (a) must:

(1) include a description of the health maintenance organization's complaint procedures and time frames; and

(2) if the complaint is made orally, be accompanied by a one-page complaint form that prominently and clearly states that

the form must be returned to the health maintenance organization for prompt resolution of the complaint.

(c) A health maintenance organization shall acknowledge, investigate, and resolve a complaint not later than the 30th calendar day after the date the health maintenance organization receives the written complaint or one-page complaint form from the complainant.

(d) Subsections (a)-(c) do not apply to a complaint concerning an emergency or a denial of continued hospitalization. A health maintenance organization shall investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization:

(1) in accordance with the medical or dental immediacy of the case; and

(2) not later than one business day after the health maintenance organization receives the complaint.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.253. COMPLAINT INVESTIGATION AND RESOLUTION. (a) A health maintenance organization shall investigate each complaint received in accordance with the health maintenance organization's policies and in compliance with this chapter.

(b) After a health maintenance organization has investigated a complaint, the health maintenance organization shall issue a response letter to the complainant within the time prescribed by Section 843.252(c) that:

(1) explains the health maintenance organization's resolution of the complaint;

(2) states the specific medical and contractual reasons for the resolution;

(3) states the specialization of any physician or other provider consulted; and

(4) contains a complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.254. APPEAL TO COMPLAINT APPEAL PANEL; DEADLINES.

(a) A health maintenance organization shall provide an appeals process for a complainant who is not satisfied with the resolution of the complaint. The appeals process must include the right of the complainant to:

(1) appear in person before a complaint appeal panel at the site at which the enrollee normally receives health care services or at another site agreed to by the complainant; or

(2) address a written appeal to the complaint appeal panel.

(b) The health maintenance organization shall send an acknowledgment letter to the complainant not later than the fifth business day after the date the written request for appeal is received.

(c) The health maintenance organization shall complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.255. COMPOSITION OF COMPLAINT APPEAL PANEL. (a) A health maintenance organization shall appoint members to a complaint appeal panel to advise the health maintenance organization on the resolution of a disputed decision appealed by a complainant.

(b) A complaint appeal panel shall be composed of an equal number of health maintenance organization staff members, physicians or other providers, and enrollees. A member of a complaint appeal panel may not have been previously involved in the disputed decision.

(c) The physicians or other providers on a complaint appeal panel must have experience in the area of care that is in dispute and must be independent of any physician or provider who made any previous determination. If specialty care is in dispute, the complaint appeal panel must include a person who is a specialist in the field of care to which the appeal relates.

(d) The enrollee members of a complaint appeal panel may not be employees of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.256. INFORMATION PROVIDED TO COMPLAINANT RELATING TO COMPLAINT APPEAL PANEL. Not later than the fifth business day before the date a complaint appeal panel is scheduled to meet, unless the complainant agrees otherwise, the health maintenance organization shall provide to the complainant or the complainant's designated representative:

(1) any documentation to be presented to the complaint appeal panel by the health maintenance organization staff;

(2) the specialization of any physicians or providers consulted during the investigation; and

(3) the name and affiliation of each health maintenance organization representative on the complaint appeal panel.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.257. RIGHTS OF COMPLAINANT AT COMPLAINT APPEAL PANEL MEETING. A complainant, or a designated representative if the enrollee is a minor or is disabled, is entitled to:

(1) appear in person before the complaint appeal panel;

(2) present alternative expert testimony; and

(3) request the presence of and question any person responsible for making the disputed decision that resulted in the appeal.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.258. APPEAL INVOLVING ONGOING EMERGENCY OR CONTINUED HOSPITALIZATION. (a) The investigation and resolution of an appeal of a complaint relating to an ongoing emergency or denial of continued hospitalization shall be concluded:

(1) in accordance with the medical or dental immediacy of the case; and

(2) not later than one business day after the complainant's request for appeal is received.

(b) Because of the ongoing emergency or continued

hospitalization and at the request of the complainant, the health maintenance organization shall provide, instead of a complaint appeal panel, a review by a physician or provider who:

(1) has not previously reviewed the case; and

(2) is of the same or a similar specialty as the physician or provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the appeal.

(c) The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide the appeal.

(d) The physician or provider may deliver initial notice of the decision on the appeal orally if the physician or provider subsequently provides written notice of the decision not later than the third day after the date of the decision.

(e) The investigation and resolution of an appeal after emergency care has been provided shall be conducted in accordance with the procedures otherwise established under this subchapter, including the right to review by a complaint appeal panel.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.259. NOTICE OF DECISION ON APPEAL. (a) A health maintenance organization shall include in a notice of the final decision on an appeal a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

(b) The notice must include the toll-free telephone number and address of the department.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.260. RECORD OF COMPLAINTS. (a) A health maintenance organization shall maintain a complaint and appeal log regarding each complaint. The log must identify those complaints relating to limited provider networks and delegated entities.

(b) A health maintenance organization shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on each complaint, including a

complaint relating to a limited provider network or delegated entity, until the third anniversary of the date the complaint was received.

(c) A complainant is entitled to a copy of the record of the complainant's complaint and any proceeding relating to that complaint.

(d) The department, during any investigation of a health maintenance organization, may review documentation maintained under Subsection (b), including original documentation, regarding a complaint and action taken on the complaint.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.209(a), eff. Sept. 1, 2003.

Sec. 843.261. SPECIAL PROVISIONS FOR APPEALS OF ADVERSE DETERMINATIONS. (a) A health maintenance organization shall implement and maintain an internal appeal system that:

(1) provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination; and

(2) includes procedures for notification, review, and appeal of an adverse determination in accordance with Chapter [4201](#).

(b) An appeal must be initiated by an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record.

(c) When an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record expresses orally or in writing any dissatisfaction or disagreement with an adverse determination, the health maintenance organization or utilization review agent shall:

(1) consider the expression of dissatisfaction or disagreement as an appeal of the adverse determination; and

(2) review and resolve the appeal in accordance with Chapter [4201](#).

(d) A health maintenance organization may integrate its appeal procedures related to adverse determinations with the complaint and appeal procedures established by the health

maintenance organization under Section 843.251 and otherwise governed by this subchapter only if the procedures related to adverse determinations comply with this section and Chapter 4201. Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.046, eff. April 1, 2009.

Sec. 843.262. CERTAIN DECISIONS BINDING. (a) If an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record appeals an adverse determination as provided under Section 843.261 and the health maintenance organization or utilization review agent, as applicable, resolves the claim in favor of the enrollee, the decision is binding on the health maintenance organization.

(b) After a binding decision in favor of an enrollee relating to a proposed health care service, the health maintenance organization shall provide or arrange for the health care service within a time frame that is appropriate for the treatment of the medical condition that was the subject of the appeal.

(c) After a binding decision in favor of an enrollee relating to a health care service already provided, the health maintenance organization shall pay the cost of the service, if not already paid by the health maintenance organization, not later than the 45th day after the date the health maintenance organization receives notice of the binding decision. A health maintenance organization that fails to pay the cost of service as required by this subsection is subject to penalties provided under Section 843.342.

(d) This section applies only to a health care plan of a political subdivision that is exempt from application of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Added by Acts 2003, 78th Leg., ch. 348, Sec. 1, eff. Sept. 1, 2003.

#### SUBCHAPTER H. GENERAL PROVISIONS REGARDING COMPLAINTS



Sec. 843.281. RETALIATORY ACTION PROHIBITED. (a) A health maintenance organization may not engage in retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or enrollee because the group or enrollee or a person acting on behalf of the group or enrollee has filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization.

(b) A health maintenance organization may not engage in retaliatory action, including refusal to renew or termination of a contract, against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.282. SUBMITTING COMPLAINTS TO DEPARTMENT. (a) Any person, including a person who has attempted to resolve a complaint through a health maintenance organization's complaint system process and is dissatisfied with the resolution, may submit a complaint to the department alleging a violation of:

- (1) this chapter;
- (2) Section [1367.053](#);
- (3) Subchapter [A](#), Chapter [1452](#);
- (4) Subchapter [B](#), Chapter [1507](#);
- (5) Chapters [222](#), [251](#), and [258](#), as applicable to a health maintenance organization; or
- (6) Chapter [1271](#) or [1272](#).

(b) The commissioner shall complete an investigation of a complaint against a health maintenance organization to determine whether a violation has occurred not later than the 60th day after the date the department receives the complaint and all information necessary for the commissioner to make a determination.

(c) The commissioner may extend the time necessary to complete an investigation if:

- (1) additional information is needed;
- (2) an on-site review is necessary;
- (3) the health maintenance organization, the

physician or provider, or the complainant does not provide all documentation necessary to complete the investigation; or

(4) other circumstances beyond the control of the department occur.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.047, eff. April 1, 2009.

Sec. 843.283. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. A contract between a health maintenance organization and a physician or provider must require the physician or provider to post, in the office of the physician or provider, a notice to enrollees on the process for resolving complaints with the health maintenance organization. The notice must include the department's toll-free telephone number for filing a complaint.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

#### SUBCHAPTER I. RELATIONS WITH PHYSICIANS AND PROVIDERS

Sec. 843.301. PRACTICE OF MEDICINE NOT AFFECTED. This chapter, Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272 do not:

(1) authorize any person, other than a licensed physician or practitioner of the healing arts, acting within the scope of the person's license, to engage directly or indirectly in the practice of medicine or a healing art; or

(2) authorize any person to regulate, interfere with, or intervene in any manner in the practice of medicine or a healing art.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.048, eff. April 1, 2009.

Sec. 843.302. DISCLOSURE OF APPLICATION PROCEDURES AND

QUALIFICATION REQUIREMENTS TO PHYSICIAN OR PROVIDER. A health maintenance organization shall, on request, make available and disclose to a physician or provider written application procedures and qualification requirements for contracting with the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.303. DENIAL OF INITIAL CONTRACT TO PHYSICIAN OR PROVIDER. (a) A health maintenance organization that denies a contract to a physician or provider who initially applies to contract with the health maintenance organization to provide health care services on behalf of the health maintenance organization shall provide to the applicant written notice of the reasons the initial application was denied.

(b) Unless otherwise limited by Article 21.52B, this section does not prohibit a health maintenance organization from rejecting an initial application from a physician or provider based on the determination that the plan has sufficient qualified physicians or providers.

(c) A health maintenance organization may not deny a contract to a podiatrist described by Section [843.319](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 237, Sec. 3, eff. Sept. 1, 2003.

Sec. 843.304. EXCLUSION OF PROVIDER BASED ON TYPE OF LICENSE PROHIBITED. (a) A provider licensed or otherwise authorized to practice in this state may not be denied the opportunity to participate in providing health care services that are delivered by a health maintenance organization and that are within the scope of the provider's license or authorization solely because of the type of license or authorization held by the provider.

(b) If a hospital, facility, agency, or supplier is certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or

another national accrediting body, a health maintenance organization shall accept that certification or accreditation.

(c) This section does not require that a health maintenance organization:

(1) use a particular type of provider in its operation;

(2) accept each provider of a category or type, except as provided by Article 21.52B; or

(3) contract directly with providers of a particular category or type.

(d) This section does not limit a health maintenance organization's authority to establish the terms under which health care services are provided by providers.

(e) A provider must comply with the terms established by the health maintenance organization for the provision of health services and for designation as a provider by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.3041. ACUPUNCTURIST SERVICES. (a) A health maintenance organization that includes acupuncture in the services covered by the organization's health care plan may not refuse to provide reimbursement for the performance of a covered acupuncture service solely because the service is performed by an acupuncturist.

(b) This section does not require a health maintenance organization to offer acupuncture as a covered service.

Added by Acts 2005, 79th Leg., Ch. 622 (H.B. 2371), Sec. 1, eff. September 1, 2005.

Sec. 843.3042. CHIROPRACTIC SERVICES. (a) A health maintenance organization offering a health care plan that covers a service that is within the scope of a chiropractor's license may not refuse to provide reimbursement to an in-network chiropractor for the performance of the covered service solely because the service is provided by a chiropractor.

(b) This section does not require a health maintenance

organization to cover a particular health care service.

(c) This section does not affect the right of a health maintenance organization to determine whether a health care service is medically necessary.

(d) A health maintenance organization that violates this section is subject to an administrative penalty as provided by Chapter 84 of not more than \$1,000 for each claim that remains unpaid in violation of this section. Each day the violation continues constitutes a separate violation.

Added by Acts 2019, 86th Leg., R.S., Ch. 116 (S.B. 1739), Sec. 1, eff. September 1, 2019.

Sec. 843.3045. NURSE FIRST ASSISTANT. A health maintenance organization may not refuse to contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network or refuse to reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.210(a), eff. Sept. 1, 2003.

Sec. 843.305. ANNUAL APPLICATION PERIOD FOR PHYSICIANS AND PROVIDERS TO CONTRACT. (a) This section applies only to a health maintenance organization that provides coverage for health care services through:

(1) one or more physicians or providers who are not partners or employees of the health maintenance organization; or

(2) one or more physicians or providers who are not owned or operated by the health maintenance organization.

(b) A health maintenance organization shall provide a period of 20 calendar days each calendar year during which any physician or provider in a service area may, under the terms established by the health maintenance organization for the provision of services and the designation of physicians and providers, apply to participate in providing health care services.

(c) A health maintenance organization that denies the application of a physician or provider shall notify the physician

or provider in writing of the reason for the denial.

(d) This section does not require that a health maintenance organization:

(1) use a particular type of physician or provider in its operation;

(2) accept a physician or provider of a category or type that does not meet the practice standards and qualifications established by the health maintenance organization; or

(3) contract directly with physicians or providers of a particular category or type.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.306. TERMINATION OF PARTICIPATION; ADVISORY REVIEW PANEL. (a) Before terminating a contract with a physician or provider, a health maintenance organization shall provide to the physician or provider a written explanation of the reasons for termination.

(b) On request, before the effective date of the termination and within a period not to exceed 60 days, a physician or provider is entitled to a review by an advisory review panel of the health maintenance organization's proposed termination, except in a case involving:

(1) imminent harm to patient health;

(2) 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

(3) fraud or malfeasance.

(c) An advisory review panel must:

(1) be composed of physicians and providers who are appointed to serve on the standing quality assurance committee or utilization review committee of the health maintenance organization; and

(2) include, if available, at least one representative of the physician's or provider's specialty or a similar specialty.

(d) The health maintenance organization must consider, but

is not bound by, the recommendation of the advisory review panel.

(e) The health maintenance organization on request shall provide to the affected physician or provider a copy of the recommendation of the advisory review panel and the health maintenance organization's determination.

(f) A health maintenance organization may not terminate participation of a physician or provider solely because the physician or provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 2, eff. September 1, 2015.

Sec. 843.307. EXPEDITED REVIEW PROCESS ON TERMINATION OR DESELECTION. On request by the physician or provider, a physician or provider whose participation in a health care plan is being terminated or who is deselected is entitled to an expedited review process by the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.308. NOTIFICATION OF PATIENTS OF DESELECTED PHYSICIAN OR PROVIDER. (a) Except as provided by Subsection (b), if a physician or provider is deselected for a reason other than the request of the physician or provider, a health maintenance organization may not notify patients of the deselection until the effective date of the deselection or the advisory review panel makes a formal recommendation.

(b) If the contract of a physician or provider is deselected for a reason related to imminent harm, a health maintenance organization may notify patients immediately.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.309. CONTRACTS WITH PHYSICIANS OR PROVIDERS: NOTICE TO CERTAIN ENROLLEES OF TERMINATION OF PHYSICIAN OR PROVIDER PARTICIPATION IN PLAN. A contract between a health maintenance

organization and a physician or provider must provide that reasonable advance notice shall be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.310. CONTRACTS WITH PHYSICIANS OR PROVIDERS: CERTAIN INDEMNITY CLAUSES PROHIBITED. A contract between a health maintenance organization and a physician or provider may not contain a clause purporting to indemnify the health maintenance organization for any liability in tort resulting from an act or omission of the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.311. CONTRACTS WITH PODIATRISTS. A contract between a health maintenance organization and a podiatrist licensed by the Texas Department of Licensing and Regulation must provide that:

(1) the podiatrist may request, and the health maintenance organization shall provide not later than the 30th day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the health maintenance organization may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(3) the podiatrist may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the evidence of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. [4170](#)), Sec. 19.011, eff. September 1, 2019.

Sec. 843.3115. CONTRACTS WITH DENTISTS. (a) In this section, "covered service" means a dental care service for which reimbursement is available under an enrollee's health care plan



contract, or for which reimbursement is available subject to a contractual limitation, including:

- (1) a deductible;
- (2) a copayment;
- (3) coinsurance;
- (4) a waiting period;
- (5) an annual or lifetime maximum limit;
- (6) a frequency limitation; or
- (7) an alternative benefit payment.

(b) A contract between a health maintenance organization and a dentist may not limit the fee the dentist may charge for a service that is not a covered service.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1061 (S.B. 554), Sec. 1, eff. September 1, 2011.

Sec. 843.312. PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. (a) A health maintenance organization may not refuse a request by a physician participating in the health maintenance organization delivery network and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code, to identify a physician assistant or advanced practice nurse as a provider in the network.

(b) A health maintenance organization may refuse a request under Subsection (a) if the physician assistant or advanced practice nurse does not meet the quality of care standards previously established by the health maintenance organization for participation in the network by physician assistants and advanced practice nurses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.313. ECONOMIC PROFILING. (a) A health maintenance organization that conducts or uses economic profiling of physicians or providers participating in the health maintenance organization delivery network shall make available to a network physician or provider on request that physician's or provider's economic profile, including the standards by which the physician or

provider is measured.

(b) The use of an economic profile must recognize the characteristics of a physician's or provider's practice that may account for variations from expected costs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.314. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) A health maintenance organization may not use a financial incentive or make a payment to a physician or provider if the incentive or payment acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.315. PAYMENT OF CAPITATION; ASSIGNMENT OF PRIMARY CARE PHYSICIAN OR PROVIDER. (a) This section applies to a health maintenance organization that to any extent uses capitation as a method of compensation.

(b) A health maintenance organization shall begin payment of capitated amounts to an enrollee's primary care physician or primary care provider, computed from the date of enrollment, not later than the 60th day after the date the enrollee selects or is assigned a primary care physician or primary care provider.

(c) If selection or assignment of a primary care physician or primary care provider does not occur at enrollment, capitated amounts that would have been paid to a selected or assigned primary care physician or primary care provider if a selection or assignment had been made shall be reserved as a capitated amount payable until the enrollee makes a selection or the health maintenance organization assigns a primary care physician or primary care provider.

(d) If an enrollee does not select a primary care physician or primary care provider at the time of application or enrollment, a health maintenance organization may assign the enrollee to a primary care physician or primary care provider.

(e) A primary care physician or primary care provider

assigned under Subsection (d) must be located within the zip code nearest the enrollee's residence or place of employment.

(f) Subject to Subsection (e), the health maintenance organization shall make the assignment in a manner that results in a fair and equal distribution of enrollees among the health maintenance organization delivery network's primary care physicians or primary care providers.

(g) A health maintenance organization shall inform an enrollee of:

(1) the name, address, and telephone number of a primary care physician or primary care provider to whom the enrollee has been assigned under Subsection (d); and

(2) the enrollee's right to select a different primary care physician or primary care provider.

(h) At any time, an enrollee is entitled to reject the primary care physician or primary care provider assigned and select another physician or provider from the list of primary care physicians or primary care providers for the health maintenance organization delivery network. A rejection by an enrollee of an assigned physician or provider is not a change in provider for purposes of the limitation described by Section [843.203](#).

(i) A health maintenance organization shall notify a physician or provider of an enrollee's selection of that person as the primary care physician or primary care provider, or of the assignment of the enrollee to that physician or provider by the health maintenance organization, not later than the 30th working day after the date of the selection or assignment.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.316. ALTERNATIVE CAPITATION SYSTEM. As an alternative to the procedures prescribed by Section [843.315](#), a health maintenance organization may request approval from the department of a capitation payment system that ensures:

(1) immediate availability and accessibility of a primary care physician or primary care provider; and

(2) payment to a primary care physician or primary care provider of a capitated amount certified by a qualified

actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk assumed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.317. EXCLUSION OF PHYSICIAN OR PROVIDER BASED ON AFFILIATION WITH HEALTH MAINTENANCE ORGANIZATION PROHIBITED. A physician, health care provider, group of physicians or health care providers, or health care facility or institution may not exclude a physician or provider from staff privileges or a facility or institution solely because the physician or provider is associated with a health maintenance organization that holds a certificate of authority under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.318. CERTAIN CONTRACTS OF PARTICIPATING PHYSICIAN OR PROVIDER NOT PROHIBITED. (a) This chapter and this code do not prohibit a physician or provider who is participating in a health maintenance organization delivery network, whether by contracting with a health maintenance organization under Section [843.101](#) or by subcontracting with a physician or provider in the health maintenance organization delivery network, from entering into a contractual arrangement within a health maintenance organization delivery network described by Subsections (b)-(e).

(b) A physician may contract to provide medical care or arrange to provide medical care through subcontracts with other physicians. A physician may contract to provide through another provider any service that is ancillary to the practice of medicine, other than hospital or other institutional or inpatient provider services.

(c) A provider may contract to provide, or arrange to provide through a subcontract with a similarly licensed provider, any health care service that the providers are licensed to provide, other than medical care.

(d) A provider may contract to provide, or arrange to provide through a subcontract with another provider, a health care service that the provider is not licensed to provide, other than medical care, if the contracted or subcontracted services

constitute less than 15 percent of the total amount of services the provider is to provide or arrange to provide.

(e) A contract or subcontract authorized under this section may provide for compensation under:

- (1) a fee-for-service arrangement;
- (2) a risk-sharing arrangement; or
- (3) a capitation arrangement under which a fixed predetermined payment is made in exchange for the provision of, or for the arrangement to provide and the guaranty of the provision of, a defined set of covered services to covered persons for a specified period without regard to the quantity of services actually provided.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.025, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.025, eff. September 1, 2007.

Sec. 843.319. CERTAIN REQUIRED CONTRACTS. Notwithstanding Section [843.304](#), a health maintenance organization may not deny a contract to a podiatrist licensed by the Texas Department of Licensing and Regulation who joins the professional practice of a contracted physician or provider, satisfies the application procedures of the health maintenance organization, and meets the qualification and credentialing requirements for contracting with the health maintenance organization.

Added by Acts 2003, 78th Leg., ch. 237, Sec. 4, eff. Sept. 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. [4170](#)), Sec. 19.012, eff. September 1, 2019.

Sec. 843.320. USE OF HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

- (1) serves as physician of record at a hospital for a hospitalized patient of another physician; and
- (2) returns the care of the patient to that other

physician at the end of the patient's hospitalization.

(b) A contract between a health maintenance organization and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.211(a), eff. Sept. 1, 2003.

Sec. 843.321. AVAILABILITY OF CODING GUIDELINES. (a) A contract between a health maintenance organization and a physician or provider must provide that:

(1) the physician or provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the physician or provider will receive under the contract;

(2) the health maintenance organization or the health maintenance organization's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the health maintenance organization receives the request;

(3) the health maintenance organization or the health maintenance organization's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the physician or provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) the contract may be terminated by the physician or provider on or before the 30th day after the date the physician or provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) A physician or provider who receives information under Subsection (a) may only:

(1) use or disclose the information for the purpose of practice management, billing activities, and other business operations; and

(2) disclose the information to a governmental agency

involved in the regulation of health care or insurance.

(c) The health maintenance organization shall, on request of the physician or provider, provide the name, edition, and model version of the software that the health maintenance organization uses to determine bundling and unbundling of claims.

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

Added by Acts 2003, 78th Leg., ch. 214, Sec. 5, eff. June 17, 2003.

Renumbered from Insurance Code, Section 843.319 by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(60), eff. September 1, 2005.

Sec. 843.323. CONTRACT PROVISIONS PROHIBITING REJECTION OF BATCHED CLAIMS. (a) If requested by a participating physician or provider, a health maintenance organization shall include a provision in the physician's or provider's contract providing that the health maintenance organization or the health maintenance organization's clearinghouse may not refuse to process or pay an electronically submitted clean claim, as defined by Subchapter J, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim.

(b) In accordance with Chapters 82 and 84, the commissioner may issue a cease and desist order against or impose sanctions on a health maintenance organization that violates this section or a contract provision adopted under this section.

Added by Acts 2005, 79th Leg., Ch. 668 (S.B. 50), Sec. 1, eff. September 1, 2005.

#### SUBCHAPTER J. PAYMENT OF CLAIMS TO PHYSICIANS AND PROVIDERS

Sec. 843.336. DEFINITION. (a) In this subchapter, "clean claim" means a claim that complies with this section.

(b) A nonelectronic claim by a physician or provider, other than an institutional provider, is a clean claim if the claim is submitted using the Centers for Medicare and Medicaid Services Form 1500 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or its successor. An electronic claim by a physician or provider, other

than an institutional provider, is a clean claim if the claim is submitted using the Professional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(c) A nonelectronic claim by an institutional provider is a clean claim if the claim is submitted using the Centers for Medicare and Medicaid Services Form UB-92 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Billing Committee or its successor. An electronic claim by an institutional provider is a clean claim if the claim is submitted using the Institutional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or its successor.

(d) The commissioner may adopt rules that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

(e) The commissioner may not require any data element for an electronic claim that is not required in an electronic transaction set needed to comply with federal law.

(f) A health maintenance organization and a physician or provider may agree by contract to use fewer data elements than are required in an electronic transaction set needed to comply with federal law.

(g) An otherwise clean claim submitted by a physician or provider that includes additional fields, data elements, attachments, or other information not required under this section is considered to be a clean claim for the purposes of this section. Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 214, Sec. 6, eff. June 17, 2003.

Sec. 843.337. TIME FOR SUBMISSION OF CLAIM; DUPLICATE CLAIMS; ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A physician or provider must submit a claim to a health maintenance organization not later than the 95th day after the date the physician or provider provides the health care services for which the claim is made. A



health maintenance organization shall accept as proof of timely filing a claim filed in compliance with Subsection (e) or information from another health maintenance organization or insurer showing that the physician or provider submitted the claim to the health maintenance organization or insurer in compliance with Subsection (e).

(b) If a physician or provider fails to submit a claim in compliance with this section, the physician or provider forfeits the right to payment.

(c) The period for submitting a claim under this section may be extended by:

(1) contract;

(2) notice published by the commissioner allowing an extension of prompt payment deadlines to a later date chosen by the commissioner due to a catastrophic event; or

(3) the department's approval of a physician's or provider's request for an extension due to a catastrophic event that substantially interferes with the normal business operations of the physician or provider.

(c-1) The commissioner may adopt rules to implement Subsection (c), including rules establishing requirements for a request made under Subsection (c)(3).

(d) A physician or provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted. The commissioner shall adopt rules under which a health maintenance organization may determine whether a claim is a duplicate claim.

(e) Except as provided by Chapter [1213](#), a physician or provider may, as appropriate:

(1) mail a claim by United States mail, first class, or by overnight delivery service;

(2) submit the claim electronically;

(3) fax the claim; or

(4) hand deliver the claim.

(f) If a claim for health care services provided to a patient is mailed, the claim is presumed to have been received by the health maintenance organization on the fifth day after the date

the claim is mailed or, if the claim is mailed using overnight service or return receipt requested, on the date the delivery receipt is signed. If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the health maintenance organization or the health maintenance organization's clearinghouse. If the health maintenance organization or the health maintenance organization's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or provider, the physician's or provider's clearinghouse shall provide the confirmation. The physician's or provider's clearinghouse must be able to verify that the filing contained the correct payor identification of the entity to receive the filing. If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment. If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 7, eff. June 17, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.049, eff. April 1, 2009.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. 1286), Sec. 1, eff. September 1, 2023.

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections 843.3385 and 843.339, not later than the 45th day after the date on which a health maintenance organization receives a clean claim from a participating physician or provider in a nonelectronic format or the 30th day after the date the health maintenance organization receives a clean claim from a participating physician or provider that is electronically submitted, the health maintenance organization shall make a determination of whether the claim is payable and:

(1) if the health maintenance organization determines the entire claim is payable, pay the total amount of the claim in

accordance with the contract between the physician or provider and the health maintenance organization;

(2) if the health maintenance organization determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) if the health maintenance organization determines that the claim is not payable, notify the physician or provider in writing why the claim will not be paid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 8, eff. June 17, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. [2292](#)), Sec. 2, eff. September 1, 2011.

Sec. 843.3385. ADDITIONAL INFORMATION. (a) If a health maintenance organization needs additional information from a treating participating physician or provider to determine payment, the health maintenance organization, not later than the 30th calendar day after the date the health maintenance organization receives a clean claim, shall request in writing that the physician or provider provide an attachment to the claim that is relevant and necessary for clarification of the claim.

(b) The request must describe with specificity the clinical information requested and relate only to information the health maintenance organization can demonstrate is specific to the claim or the claim's related episode of care. The participating physician or provider is not required to provide an attachment that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a participating physician or provider.

(c) A health maintenance organization that requests an attachment under this section shall determine whether the claim is payable on or before the later of the 15th day after the date the health maintenance organization receives the requested attachment or the latest date for determining whether the claim is payable

under Section 843.338 or 843.339.

(d) A health maintenance organization may not make more than one request under this section in connection with a claim. Sections 843.337(e) and (f) apply to a request for and submission of an attachment under Subsection (a).

(e) If a health maintenance organization requests an attachment or other information from a person other than the participating physician or provider who submitted the claim, the health maintenance organization shall provide notice containing the name of the physician or provider from whom the health maintenance organization is requesting information to the physician or provider who submitted the claim. The health maintenance organization may not withhold payment pending receipt of an attachment or information requested under this subsection. If on receiving an attachment or information requested under this subsection the health maintenance organization determines that there was an error in payment of the claim, the health maintenance organization may recover any overpayment under Section 843.350.

(f) The commissioner shall adopt rules under which a health maintenance organization can easily identify an attachment or other information submitted by a physician or provider under this section.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 9, eff. June 17, 2003.

Sec. 843.339. DEADLINE FOR ACTION ON PRESCRIPTION CLAIMS; PAYMENT. (a) A health maintenance organization, or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, that affirmatively adjudicates a pharmacy claim that is electronically submitted shall pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated.

(b) A health maintenance organization, or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, that affirmatively adjudicates a pharmacy claim that is not electronically submitted shall pay the total amount of the claim not later than the 21st day after the date

on which the claim was affirmatively adjudicated.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 10, eff. June 17, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. [2292](#)), Sec. 3, eff. September 1, 2011.

Sec. 843.340. AUDITED CLAIMS. (a) Except as provided by Section [843.3385](#), if a health maintenance organization intends to audit a claim submitted by a participating physician or provider, the health maintenance organization shall pay the charges submitted at 100 percent of the contracted rate on the claim not later than the 30th day after the date the health maintenance organization receives the clean claim from the participating physician or provider if submitted electronically or if submitted nonelectronically not later than the 45th day after the date on which the health maintenance organization receives the clean claim from a participating physician or provider. The health maintenance organization shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule that the clean claim is being paid at 100 percent of the contracted rate, subject to completion of the audit.

(b) If the health maintenance organization requests additional information to complete the audit, the request must describe with specificity the clinical information requested and relate only to information the health maintenance organization in good faith can demonstrate is specific to the claim or episode of care. The health maintenance organization may not request as a part of the audit information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a participating physician or provider.

(c) If the participating physician or provider does not supply information reasonably requested by the health maintenance organization in connection with the audit, the health maintenance organization may:

(1) notify the physician or provider in writing that

the physician or provider must provide the information not later than the 45th day after the date of the notice or forfeit the amount of the claim; and

(2) if the physician or provider does not provide the information required by this section, recover the amount of the claim.

(d) The health maintenance organization must complete the audit on or before the 180th day after the date the clean claim is received by the health maintenance organization, and any additional payment due a participating physician or provider or any refund due the health maintenance organization shall be made not later than the 30th day after the completion of the audit.

(e) If a participating physician or provider disagrees with a refund request made by a health maintenance organization based on the audit, the health maintenance organization shall provide the physician or provider with an opportunity to appeal, and the health maintenance organization may not attempt to recover the payment until all appeal rights are exhausted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 11, eff. June 17, 2003.

Sec. 843.3405. INVESTIGATION AND DETERMINATION OF PAYMENT. The investigation and determination of payment, including any coordination of other payments, does not extend the period for determining whether a claim is payable under Section [843.338](#) or [843.339](#) or for auditing a claim under Section [843.340](#).

Added by Acts 2003, 78th Leg., ch. 214, Sec. 12, eff. June 17, 2003.

Sec. 843.341. CLAIMS PROCESSING PROCEDURES. (a) A health maintenance organization shall provide a participating physician or provider with copies of all applicable utilization review policies and claim processing policies or procedures.

(b) A health maintenance organization's claims payment processes shall:

(1) use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines,

including all relevant modifiers; and

(2) be consistent with nationally recognized, generally accepted bundling edits and logic.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 13, eff. June 17, 2003.

Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; PENALTIES. (a) Except as provided by this section, if a clean claim submitted to a health maintenance organization is payable and the health maintenance organization does not determine under this subchapter that the claim is payable and pay the claim on or before the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay the physician or provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of:

(1) 50 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate; or

(2) \$100,000.

(b) If the claim is paid on or after the 46th day and before the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay a penalty in the amount of the lesser of:

(1) 100 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate; or

(2) \$200,000.

(c) If the claim is paid on or after the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay a penalty computed under Subsection (b) plus 18 percent annual interest on that amount. Interest under this subsection accrues beginning on the date the health maintenance organization was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(d) Except as provided by this section, a health maintenance

organization that determines under this subchapter that a claim is payable, pays only a portion of the amount of the claim on or before the date the health maintenance organization is required to make a determination or adjudication of the claim, and pays the balance of the contracted rate owed for the claim after that date shall pay to the physician or provider, in addition to the contracted amount owed, a penalty on the amount not timely paid in the amount of the lesser of:

- (1) 50 percent of the underpaid amount; or
- (2) \$100,000.

(e) If the balance of the claim is paid on or after the 46th day and before the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay a penalty on the balance of the claim in the amount of the lesser of:

- (1) 100 percent of the underpaid amount; or
- (2) \$200,000.

(f) If the balance of the claim is paid on or after the 91st day after the date the health maintenance organization is required to make a determination or adjudication of the claim, the health maintenance organization shall pay a penalty on the balance of the claim computed under Subsection (e) plus 18 percent annual interest on that amount. Interest under this subsection accrues beginning on the date the health maintenance organization was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(g) For the purposes of Subsections (d) and (e), the underpaid amount is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate.

(h) A health maintenance organization is not liable for a penalty under this section:

(1) if the failure to pay the claim in accordance with this subchapter is a result of a catastrophic event and:

(A) the commissioner published a notice allowing an extension of the applicable prompt payment deadlines due to the



catastrophic event; or

(B) the department approved the health maintenance organization's request for an extension due to the substantial interference of the catastrophic event with the normal business operations of the health maintenance organization; or

(2) if the claim was paid in accordance with this subchapter, but for less than the contracted rate, and:

(A) the physician or provider notifies the health maintenance organization of the underpayment after the 270th day after the date the underpayment was received; and

(B) the health maintenance organization pays the balance of the claim on or before the 30th day after the date the health maintenance organization receives the notice.

(i) Subsection (h) does not relieve the health maintenance organization of the obligation to pay the remaining unpaid contracted rate owed the physician or provider.

(j) A health maintenance organization that pays a penalty under this section shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

(k) In addition to any other penalty or remedy authorized by this code or another insurance law of this state, a health maintenance organization that violates Section 843.338, 843.339, or 843.340 in processing more than two percent of clean claims submitted to the health maintenance organization is subject to an administrative penalty under Chapter 84. For each day an administrative penalty is imposed under this subsection, the penalty may not exceed \$1,000 for each claim that remains unpaid in violation of Section 843.338, 843.339, or 843.340.

(l) In determining whether a health maintenance organization has processed physician and provider claims in compliance with Section 843.338, 843.339, or 843.340, the commissioner shall consider paid claims, other than claims that have been paid under Section 843.340, and shall compute a compliance percentage for physician and provider claims, other than institutional provider claims, and a compliance percentage for

institutional provider claims.

(m) Notwithstanding any other provision of this section, this subsection governs the payment of a penalty under this section. For a penalty under this section relating to a clean claim submitted by a physician or provider other than an institutional provider, the health maintenance organization shall pay the entire penalty to the physician or provider, except for any interest computed under Subsection (c), which shall be paid to the Texas Health Insurance Risk Pool. For a penalty under this section relating to a clean claim submitted by an institutional provider, the health maintenance organization shall pay 50 percent of the total penalty amount computed under this section, including interest, to the institutional provider and the remaining 50 percent of that amount to the Texas Health Insurance Risk Pool.

(n) In this section, "institutional provider" means a hospital or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in an evidence of coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 14, eff. June 17, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.212, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 435 (S.B. [1884](#)), Sec. 1, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 265 (H.B. [2064](#)), Sec. 1, eff. January 1, 2010.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. [1286](#)), Sec. 2, eff. September 1, 2023.

Sec. 843.343. ATTORNEY'S FEES. A physician or provider may recover reasonable attorney's fees and court costs in an action to recover payment under this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 15, eff. June 17, 2003.

Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter applies to a person, including a pharmacy benefit manager, with whom a health maintenance organization contracts to:

- (1) process or pay claims;
- (2) obtain the services of physicians and providers to provide health care services to enrollees; or
- (3) issue verifications or preauthorizations.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 16, eff. June 17, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. [2292](#)), Sec. 5, eff. September 1, 2011.

Sec. 843.345. EXCEPTION. This subchapter does not apply to a capitated payment required to be made to a physician or provider under an agreement to provide health care services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 17, eff. June 17, 2003.

Sec. 843.346. PAYMENT OF CLAIMS. Except as provided by this subchapter, a health maintenance organization shall pay a physician or provider for health care services and benefits provided to an enrollee not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or provider and the health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by Acts 2003, 78th Leg., ch. 214, Sec. 18, eff. June 17, 2003.

Sec. 843.347. VERIFICATION. (a) In this section,

"verification" means a reliable representation by a health maintenance organization to a physician or provider that the health maintenance organization will pay the physician or provider for proposed health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, and any other term that would be a reliable representation by a health maintenance organization to a physician or provider and includes preauthorization only when preauthorization is a condition for the verification.

(b) On the request of a physician or provider for verification of a particular health care service the participating physician or provider proposes to provide to a particular patient, the health maintenance organization shall inform the physician or provider without delay whether the service, if provided to that patient, will be paid by the health maintenance organization and shall specify any deductibles, copayments, or coinsurance for which the enrollee is responsible.

(c) A health maintenance organization shall have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. A health maintenance organization must have a telephone system capable of accepting or recording incoming phone calls for verifications after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls on or before the second calendar day after the date the call is received.

(d) A health maintenance organization may decline to determine eligibility for payment if the insurer notifies the physician or preferred provider who requested the verification of the specific reason the determination was not made.

(e) A health maintenance organization may establish a specific period during which the verification is valid of not less than 30 days.

(f) A health maintenance organization that declines to provide a verification shall notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(g) If a health maintenance organization has provided a verification for proposed health care services, the health maintenance organization may not deny or reduce payment to the physician or provider for those health care services if provided to the enrollee on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services.

(h) A health maintenance organization providing routine vision services as a single health care service plan or providing dental health care services as a single health care service plan is not required to comply with Subsection (c) with respect to those services. For purposes of this subsection, "routine vision services" means a routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(i) A health maintenance organization described by Subsection (h) shall:

(1) have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 8 a.m. and 5 p.m. central time Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming phone calls for verifications after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and legal holidays; and

(3) respond to calls accepted or recorded on the telephone system described by Subdivision (2) not later than the next business day after the date the call is received.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 3, eff. September 1, 2005.

Sec. 843.348. PREAUTHORIZATION OF HEALTH CARE SERVICES.

(a) In this section, "preauthorization" means a determination by a health maintenance organization that health care services proposed to be provided to a patient are medically necessary and appropriate.

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the fifth business day after the date a request is made, a list of health care services that require preauthorization and information concerning the preauthorization process.

(c) If proposed health care services require preauthorization as a condition of the health maintenance organization's payment to a participating physician or provider, the health maintenance organization shall determine whether the health care services proposed to be provided to the enrollee are medically necessary and appropriate.

(d) On receipt of a request from a participating physician or provider for preauthorization, the health maintenance organization shall review and issue a determination indicating whether the health care services are preauthorized. The determination must be issued and transmitted not later than the third calendar day after the date the request is received by the health maintenance organization.

(e) If the proposed health care services involve inpatient care and the health maintenance organization requires preauthorization as a condition of payment, the health maintenance organization shall review the request and issue a length of stay for the admission into a health care facility based on the recommendation of the patient's physician or provider and the health maintenance organization's written medically accepted screening criteria and review procedures. If the proposed health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed, the health maintenance organization shall review the request and issue a determination indicating whether proposed services are

preauthorized within 24 hours of the request by the physician or provider.

(f) A health maintenance organization shall have appropriate personnel reasonably available at a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. A health maintenance organization must have a telephone system capable of accepting or recording incoming phone calls for preauthorizations after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls not later than 24 hours after the call is received.

(g) If the health maintenance organization has preauthorized health care services, the health maintenance organization may not deny or reduce payment to the physician or provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services.

(h) This section applies to an agent or other person with whom a health maintenance organization contracts to perform, or to whom the health maintenance organization delegates the performance of, preauthorization of proposed health care services.

(i) A health maintenance organization providing routine vision services as a single health care service plan or providing dental health care services as a single health care service plan is not required to comply with Subsection (f) with respect to those services. For purposes of this subsection, "routine vision services" means a routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(j) A health maintenance organization described by Subsection (i) shall:

(1) have appropriate personnel reasonably available at a toll-free telephone number to respond to requests for preauthorization under this section between 8 a.m. and 5 p.m.

central time Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming phone calls for preauthorizations after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and legal holidays; and

(3) respond to calls accepted or recorded on the telephone system described by Subdivision (2) not later than the next business day after the date the call is received.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 4, eff. September 1, 2005.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.01, eff. September 1, 2019.

Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

(a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) except as provided by Subsection (c) or (d), conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) except for the screening criteria under Subdivision (4)(C), be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;

(3) include a detailed description of the



preauthorization process and procedure; and

(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the health maintenance organization requires from the physician or provider ordering or requesting the service to approve a request for that service;

(C) the applicable screening criteria, which may include Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding preauthorization approval and denial rates for the service in the preceding calendar year, including statistics in the following categories:

(i) physician or provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned by an independent review organization; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(c) This section may not be construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. To comply with a posting requirement described by Subsection (b), a health maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, supply a summary of the withheld information sufficient to allow a licensed physician or provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the health maintenance organization's

medical necessity or appropriateness determinations.

(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the health maintenance organization has received from a third party with which the health maintenance organization has contracted, to comply with a posting requirement described by Subsection (b), the health maintenance organization may, instead of making that information publicly available on the health maintenance organization's Internet website, provide the material to a physician or provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.02, eff. September 1, 2019.

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

(a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any, and on the health maintenance organization's Internet website.

(b) For a change in a preauthorization requirement or process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance organization shall provide notice of the change in the preauthorization requirement and disclose the change in the health maintenance organization's newsletter or network bulletin, if any, and on the health maintenance organization's Internet website not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization shall update its Internet website to

disclose the change to the health maintenance organization's preauthorization requirements or process and the date and time the change is effective.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.02, eff. September 1, 2019.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any health care service affected by the violation.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.02, eff. September 1, 2019.

Sec. 843.349. COORDINATION OF PAYMENT. (a) A health maintenance organization may require a physician or provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the health maintenance organization on the applicable form described by Section 843.336. Except as provided by this section, a health maintenance organization may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of other payment under this section does not extend the period for determining whether a service is eligible for payment under Section 843.338 or 843.339 or for auditing a claim under Section 843.340.

(c) A participating physician or provider who submits a claim for particular health care services to more than one health maintenance organization or insurer shall provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) On receipt of notice under Subsection (c), a health maintenance organization shall coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or provider.

(e) Except as provided by Subsection (f), if a health maintenance organization is a secondary payor and pays a portion of a claim that should have been paid by the health maintenance organization or insurer that is the primary payor, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary health maintenance organization was also paid by the primary health maintenance organization or insurer, the secondary health maintenance organization may recover the amount of the overpayment under Section 843.350 from the physician or provider who received the payment. A health maintenance organization processing an electronic claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. Primary payor information may be submitted electronically by the primary payor to the secondary payor.

(g) A health maintenance organization may share information with another health maintenance organization or an insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Sec. 843.350. OVERPAYMENT. (a) A health maintenance organization may recover an overpayment to a physician or provider if:

(1) not later than the 180th day after the date the physician or provider receives the payment, the health maintenance organization provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds; and

(2) the physician or provider does not make arrangements for repayment of the requested funds on or before the 45th day after the date the physician or provider receives the

notice.

(b) If a physician or provider disagrees with a request for recovery of an overpayment, the health maintenance organization shall provide the physician or provider with an opportunity to appeal, and the health maintenance organization may not recover the overpayment until all appeal rights are exhausted.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Sec. 843.351. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND PROVIDERS. The provisions of this subchapter relating to prompt payment by a health maintenance organization of a physician or provider and to verification of health care services apply to a physician or provider who:

(1) is not included in the health maintenance organization delivery network; and

(2) provides to an enrollee:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other health care services at the request of the health maintenance organization or a physician or provider who is included in the health maintenance organization delivery network because the services are not reasonably available within the network.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Sec. 843.352. CONFLICT WITH OTHER LAW. To the extent of any conflict between this subchapter and Subchapter C, Chapter 1204, this subchapter controls.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.050, eff. April 1, 2009.

Sec. 843.353. WAIVER PROHIBITED. Except as provided by Sections 843.336(f) and 843.337(c), the provisions of this subchapter may not be waived, voided, or nullified by contract.

Added by Acts 2003, 78th Leg., ch. 214, Sec. 19, eff. June 17, 2003.

Sec. 843.354. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding payment of claims to providers who are pharmacists or pharmacies apply to all health maintenance organizations and pharmacy benefit managers unless otherwise prohibited by federal law.

Added by Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 6, eff. September 1, 2011.

#### SUBCHAPTER K. RELATIONS BETWEEN ENROLLEE AND PHYSICIAN OR PROVIDER

Sec. 843.361. ENROLLEES HELD HARMLESS. A contract or other agreement between a health maintenance organization and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the health maintenance organization does not pay the physician or provider for those services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.362. CONTINUITY OF CARE; OBLIGATION OF HEALTH MAINTENANCE ORGANIZATION. (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, life-threatening illness, or who is past the 24th week of pregnancy.

(b) Each contract between a health maintenance organization and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the health maintenance organization from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence. Subject to Subsections (d) and (e),

the health maintenance organization must provide continued reimbursement at not less than the contract rate in exchange for the enrollee's continued receipt of ongoing treatment from the physician or provider.

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

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

(2) agree not to seek payment from the enrollee of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the health maintenance organization delivery network.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a health maintenance organization 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, a health maintenance organization's obligation to reimburse a terminated physician or provider or, if applicable, an enrollee extends through delivery of the child and applies to immediate postpartum care and a follow-up checkup within the six-week period after delivery.

(f) A contract between a health maintenance organization 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 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.363. PROTECTED PHYSICIAN OR PROVIDER COMMUNICATIONS WITH PATIENTS. (a) A health maintenance

organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to

prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(2) information or opinions regarding the terms, requirements, or services of the health care plan as they relate to the medical needs of the patient;

(3) the termination of the physician's, dentist's, or provider's contract with the health care plan or the fact that the physician, dentist, or provider will otherwise no longer be providing medical care, dental care, or health care services under the health care plan; or

(4) information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the patient's medical condition.

(a-1) A health maintenance organization may not, as a condition of payment with a physician, dentist, or provider, or in any other manner, require a physician, dentist, or provider to provide a notification form stating that the physician, dentist, or provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

(b) A health maintenance organization may not in any manner penalize, terminate, or refuse to compensate for covered services a physician, dentist, or provider for communicating in a manner protected by this section with a current, prospective, or former patient, or a person designated by a patient.

(c) A contract provision that violates this section is void.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 3, eff. September 1, 2015.



SUBCHAPTER L. FINANCIAL REGULATION OF HEALTH MAINTENANCE  
ORGANIZATIONS

Sec. 843.401. FIDUCIARY RESPONSIBILITY. A director, officer, member, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in a fiduciary relationship to the enrollees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.402. OFFICERS' AND EMPLOYEES' BOND. (a) A health maintenance organization shall maintain in force in its own name a fidelity bond on its officers and employees in an amount of at least \$100,000 or another amount prescribed by the commissioner.

(b) The fidelity bond must be issued by an insurer that holds a certificate of authority in this state. If, after notice and hearing, the commissioner determines that a fidelity bond is not available from an insurer that holds a certificate of authority in this state, the health maintenance organization may obtain a fidelity bond procured by a surplus lines agent resident in this state in compliance with Chapter 981.

(c) The fidelity bond must obligate the surety to pay any loss of money or other property the health maintenance organization sustains because of an act of fraud or dishonesty by an employee or officer of the health maintenance organization, acting alone or in concert with others, while employed or serving as an officer of the health maintenance organization.

(d) Instead of a fidelity bond, a health maintenance organization may deposit cash with the comptroller. The deposit must be maintained in the amount and is subject to the same conditions required for a fidelity bond under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.403. MINIMUM NET WORTH. (a) A health maintenance organization authorized to provide basic health care services shall

maintain a minimum net worth of \$1.5 million.

(b) A health maintenance organization authorized to provide limited health care services shall maintain a minimum net worth of \$1 million.

(c) A health maintenance organization authorized to offer only a single health care service plan shall maintain a minimum net worth of \$500,000.

(d) The minimum net worth required by this section may consist only of:

(1) money of the United States;

(2) bonds of this state;

(3) bonds or other evidences of indebtedness of the United States that are guaranteed as to principal and interest by the United States; or

(4) bonds or other interest-bearing evidences of indebtedness of a county or municipality of this state.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.404. ADDITIONAL NET WORTH REQUIREMENTS. (a) The commissioner may adopt rules or by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on:

(1) the nature and kind of risks the health maintenance organization underwrites or reinsures;

(2) the premium volume of risks the health maintenance organization underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio;

(4) fluctuations in the market value of securities the health maintenance organization holds;

(5) the adequacy of the health maintenance organization's reserves;

(6) the number of individuals enrolled by the health maintenance organization; or

(7) other business risks.

(b) Rules adopted or guidelines established under this section must be designed to ensure the financial solvency of health

maintenance organizations for the protection of enrollees. The rules or guidelines may provide for a health maintenance organization to comply with a risk-based net worth requirement established under this section in stages over a two-year period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.405. DEPOSIT WITH COMPTROLLER. (a) Unless otherwise provided by this section, a health maintenance organization shall deposit with the comptroller cash or securities, or any combination of cash, securities, and other guarantees that are acceptable to the commissioner, in the amount prescribed by this section.

(b) The amount of a health maintenance organization's initial deposit or other guarantee must be \$100,000 for a health maintenance organization offering basic health care services, \$75,000 for a health maintenance organization offering limited health care services, and \$50,000 for a health maintenance organization offering a single health care service plan.

(c) On or before March 15 of the year following the year in which the health maintenance organization receives a certificate of authority, it shall deposit with the comptroller an amount equal to the difference between the initial deposit and 100 percent of its estimated uncovered health care expenses for the first 12 months of operation.

(d) On or before March 15 of each subsequent year, a health maintenance organization shall deposit the amount of the difference between its total uncovered health care expenses, based on its annual statement from the previous year, and the total amount previously deposited and not withdrawn from the state treasury. For any subsequent year in which the amount of the difference specified by this subsection is zero or less, the commissioner may not require the health maintenance organization to make any additional deposit under this subsection.

(e) If, on application made not more than once in each calendar year by a health maintenance organization, the commissioner determines that the amount previously deposited by the health maintenance organization has exceeded the amount required to

be on deposit by more than \$50,000 for a continuous 12-month period, the commissioner shall allow the health maintenance organization to withdraw the portion of the deposit that exceeds by more than \$50,000 the amount required to be on deposit, unless the commissioner determines that the release of a portion of the deposit could be hazardous to enrollees, creditors, or the public.

(f) If, on application, the commissioner determines that the amount previously deposited by a health maintenance organization continues to exceed the amount required to be on deposit, the commissioner shall allow the health maintenance organization to withdraw the portion of the deposit that exceeds the amount required to be on deposit, unless the commissioner determines that the release of that portion of the deposit could be hazardous to enrollees, creditors, or the public.

(g) On application by a health maintenance organization operating for more than one year under a certificate of authority, the commissioner may waive some or all of the requirements imposed by Subsection (b), (c), or (d) for any period if the commissioner determines that the waiver is justified because:

(1) the total amount of the deposit or other guarantee is equal to at least 25 percent of the health maintenance organization's estimated uncovered expenses for the next calendar year;

(2) the health maintenance organization's net worth is equal to at least 25 percent of its estimated uncovered expenses for the next calendar year;

(3) the health maintenance organization has a net worth of at least \$5 million; or

(4) the health maintenance organization's sponsoring organization has a net worth of at least \$5 million for each health maintenance organization whose uncovered expenses the sponsoring organization guarantees.

(h) If one or more of the requirements imposed by Subsection (b), (c), or (d) is waived, any amount previously deposited shall remain on deposit until released in whole or in part by the comptroller on order of the commissioner under Subsection (g).

(i) A health maintenance organization that has made a

deposit with the comptroller may, at its option, withdraw the deposit or any part of the deposit after substituting a deposit of cash or securities of equal amount and value to the withdrawn deposit or portion of deposit. The commissioner must first approve any securities being substituted.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.406. HAZARDOUS FINANCIAL CONDITION. (a) If the financial condition of a health maintenance organization indicates that the continued operation of the health maintenance organization could be hazardous to its enrollees or creditors or the public, the commissioner may, after notice and opportunity for hearing:

(1) suspend or revoke the health maintenance organization's certificate of authority; or

(2) order the health maintenance organization to take action reasonably necessary to correct the condition, including by:

(A) reducing by reinsurance the total amount of present and potential liability for benefits;

(B) reducing the volume of new business being accepted;

(C) reducing expenses by specified methods;

(D) suspending or limiting for a period the writing of new business; or

(E) increasing the health maintenance organization's capital and surplus by contribution.

(b) In a manner consistent with the purposes of this section, the commissioner by rule may establish:

(1) uniform standards and criteria for early warning that the continued operation of a health maintenance organization could be hazardous to the health maintenance organization's enrollees or creditors or the public; and

(2) standards for evaluating the financial condition of a health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.407. RECEIVERSHIP AND DELINQUENCY PROCEEDINGS.

(a) In addition to all other remedies available by law, if the

commissioner believes that a health maintenance organization or another person is insolvent or does not maintain the net worth required under Sections 843.403, 843.4031, and 843.404, the commissioner may bring an action in a Travis County district court to be named receiver in accordance with Section 843.157 and Chapter 443.

(b) The court may:

(1) find that a receiver should take charge of the assets of the health maintenance organization; and

(2) name the commissioner as the receiver of the health maintenance organization in accordance with Section 843.157 and Chapter 443.

(c) The operations and business of a health maintenance organization represent the business of insurance for purposes of Section 843.157 and Chapters 441 and 443.

(d) Exclusive venue of receivership and delinquency proceedings for a health maintenance organization is in Travis County.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.051, eff. April 1, 2009.

Sec. 843.408. INSOLVENCY AND ALLOCATION TO OTHER HEALTH MAINTENANCE ORGANIZATIONS. (a) If a health maintenance organization becomes insolvent, the commissioner shall equitably allocate the insolvent health maintenance organization's group contracts and nongroup enrollees among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area. The commissioner shall allocate the group contracts by order. In making allocations, the commissioner shall consider the resources of each health maintenance organization.

(b) A successor health maintenance organization to which one or more groups are allocated shall offer each group the successor health maintenance organization's coverage at rates determined in accordance with the successor health maintenance

organization's existing methodology or in accordance with that methodology as adjusted by the commissioner.

(c) A successor health maintenance organization to which nongroup enrollees are allocated shall offer each nongroup enrollee the successor health maintenance organization's existing coverage for individual or conversion coverage, as determined by the nongroup enrollee's type of coverage from the insolvent health maintenance organization, at rates determined in accordance with the successor health maintenance organization's existing methodology or in accordance with that methodology as adjusted by the commissioner. A successor health maintenance organization that does not offer direct nongroup enrollment shall provide coverage at rates that reflect the average group rate of the successor health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.409. EXAMINATION EXPENSES. (a) A credit against the amount of premium taxes to be paid by a health maintenance organization in a taxable year may not be allowed on:

(1) an examination fee or expense paid to another state; or

(2) an examination expense:

(A) directly attributable to an examination of the books, records, accounts, or principal offices of a health maintenance organization located outside this state; or

(B) paid in a different taxable year.

(b) The limitations provided by Subsections (a)(1) and (a)(2)(B) apply to foreign health maintenance organizations.

Added by Acts 2003, 78th Leg., ch. 209, Sec. 9A, eff. Jan. 1, 2004; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.207, eff. Sept. 1, 2003.

Sec. 843.410. ASSESSMENTS. (a) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, conservatorship, or seizure of a health maintenance organization in this state that is placed under supervision or in conservatorship under Chapter 441 or against which a delinquency proceeding is commenced under Chapter

443 and that is found by the commissioner to have insufficient funds to pay the total amount of health care claims and the administrative expenses incurred by the commissioner regarding the rehabilitation, liquidation, supervision, conservatorship, or seizure, the commissioner shall assess each health maintenance organization in the proportion that the gross premiums of the health maintenance organization that were written in this state during the preceding calendar year bear to the aggregate gross premiums that were written in this state by all health maintenance organizations, as found after review of annual statements and other reports the commissioner considers necessary.

(b) The commissioner may abate or defer an assessment in whole or in part if, in the opinion of the commissioner, payment of the assessment would endanger the ability of a health maintenance organization to fulfill its contractual obligations. If an assessment is abated or deferred in whole or in part, the amount of the abatement or deferral may be assessed against the remaining health maintenance organizations in a manner consistent with the calculations made by the commissioner under Subsection (a).

(c) The total of all assessments on a health maintenance organization may not exceed one-fourth of one percent of the health maintenance organization's gross premiums in any one calendar year.

(d) Notwithstanding any other provision of this subchapter, funds derived from an assessment made under this section may not be used for more than 180 consecutive days for the expenses of administering the affairs of a health maintenance organization the surplus of which is impaired and that is in supervision or conservatorship. The commissioner may extend the period during which the commissioner makes assessments for the administrative expenses.

Transferred, redesignated and amended from Insurance Code, Section 843.441 by Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 2.002, eff. September 1, 2011.

#### SUBCHAPTER N. ENFORCEMENT

Sec. 843.461. ENFORCEMENT ACTIONS. (a) After notice and



opportunity for a hearing, the commissioner may:

- (1) suspend or revoke a certificate of authority issued to a health maintenance organization under this chapter;
- (2) impose sanctions under Chapter 82;
- (3) issue a cease and desist order under Chapter 83;

or

- (4) impose administrative penalties under Chapter 84.

(b) The commissioner may take an enforcement action listed in Subsection (a) against a health maintenance organization if the commissioner finds that the health maintenance organization:

- (1) is operating in a manner that is:

- (A) significantly contrary to its basic organizational documents or health care plan; or

- (B) contrary to the manner described in and reasonably inferred from other information submitted under Section 843.078, 843.079, or 843.080;

- (2) issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 843.346, 1271.001-1271.005, 1271.007, 1271.151, 1271.152, and 1271.156, and Subchapters B, C, E, F, and G, Chapter 1271;

- (3) does not meet the requirements of Section 843.082(1);

- (4) provides a health care plan that does not provide or arrange for basic health care services, provides a limited health care service plan that does not provide or arrange for the plan's limited health care services, or provides a single health care service plan that does not provide or arrange for a single health care service;

- (5) cannot fulfill its obligation to provide:

- (A) health care services as required under its health care plan;

- (B) limited health care services as required under its limited health care service plan; or

- (C) a single health care service as required under its single health care service plan;

- (6) is no longer financially responsible and may

reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(7) has not implemented the complaint system required by Section [843.251](#) in a manner to resolve reasonably valid complaints;

(8) has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner or a person on behalf of the health maintenance organization has advertised or merchandised the health maintenance organization's services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) would be hazardous to its enrollees if it continued in operation;

(10) has not complied substantially with:

(A) this chapter or a rule adopted under this chapter; or

(B) Section [1367.053](#), Subchapter [A](#), Chapter [1452](#), Subchapter [B](#), Chapter [1507](#), Chapter [222](#), [251](#), or [258](#), as applicable to a health maintenance organization, or Chapter [1271](#) or [1272](#) or a rule adopted under one of those provisions; or

(11) has not taken corrective action the commissioner considers necessary to correct a failure to comply with this chapter, any applicable provision of this code, or any applicable rule or order of the commissioner not later than the 30th day after the date of notice of the failure or within any longer period specified in the notice and determined by the commissioner to be reasonable.

(c) The commissioner may suspend or revoke a certificate of authority only after complying with this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2E.052, eff. April 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 161 (S.B. [1093](#)), Sec. 11.001, eff. September 1, 2013.

Sec. 843.462. OPERATIONS DURING SUSPENSION OR AFTER

REVOCAATION OF CERTIFICATE OF AUTHORITY. (a) During the period a certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not:

(1) enroll additional enrollees except newborn children or other newly acquired dependents of existing enrollees; or

(2) advertise or solicit in any way.

(b) After a certificate of authority of a health maintenance organization is revoked, the health maintenance organization:

(1) shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs;

(2) may not conduct further business except as essential to the orderly conclusion of its affairs; and

(3) may not advertise or solicit in any way.

(c) Notwithstanding Subsection (b), the commissioner may, by written order, permit the further operation of the health maintenance organization to the extent that the commissioner finds necessary to serve the best interest of enrollees and to provide enrollees with the greatest practical opportunity to obtain continuing health care coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Sec. 843.463. INJUNCTIONS. If the commissioner believes that a health maintenance organization or another person is violating or has violated this chapter or a rule adopted under this chapter or Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272 or a rule adopted under one of those provisions, the commissioner may bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.053, eff. April 1, 2009.

Sec. 843.464. CRIMINAL PENALTY. (a) A person, including an

agent or officer of a health maintenance organization, commits an offense if the person:

(1) wilfully violates this chapter or a rule adopted under this chapter or Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272 or a rule adopted under one of those provisions; or

(2) knowingly makes a false statement with respect to a report or statement required under this chapter or Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapter 222, 251, or 258, as applicable to a health maintenance organization, or Chapter 1271 or 1272.

(b) An offense under this section is a Class B misdemeanor.  
Added by Acts 2001, 77th Leg., ch. 1419, Sec. 1, eff. June 1, 2003.  
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2E.054, eff. April 1, 2009.