A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
THE LICENSURE OF INSURERS AND RELATED ENTITIES,
LIFE INSURANCE, AND CERTAIN GROUP BENEFIT PROGRAMS
FOR GOVERNMENTAL EMPLOYEES

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V.T.I.C. Article 3.39. In 1985, V.T.I.C. Article 3.33 was enacted to govern investments of most types of insurers. Section 1 of Article 3.33 states that Article 3.39 is applicable only to specified types of insurers listed by that section. Accordingly, the revised law includes a reference to Article 3.33.

Revised Law

Sec. 828.057. PROHIBITION ON USE OF PURCHASING COMPANY'S CAPITAL, SURPLUS, OR RESERVES. Amounts actually paid by the purchasing company for the purchase of shares acquired or obtained under this subchapter may not include the minimum capital, minimum surplus, and policy reserves required by law for the purchasing company. (V.T.I.C. Art. 21.26, Sec. 1 (part).)

Source Law

Sec. 1. . . . [The provisions contained in Article 3.39 of the Insurance Code limiting investments in the purchase of the corporate shares of another corporation shall not apply to such purchase or contract to purchase provided that:]

. . .

(g) In no event shall any sums actually paid out by the purchasing corporation for the purchase of stock acquired or obtained hereunder include the minimum capital, minimum surplus, and policy reserves required by law for such corporation.

[Chapters 829-840 reserved for expansion]

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CHAPTER 841. LIFE, HEALTH, OR ACCIDENT INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 841.001. DEFINITIONS. (1) "Accident insurance company" means a corporation authorized under a charter to engage in business involving the payment of money or another thing of value in the event of an injury to or the disablement or death of an individual as a result of travel or a general accident by land or water.

(2) "Alien company" means a life, accident, or health insurance company organized under the laws of a foreign country.

(3) "Beneficiary" is the person to whom an insurance policy is payable.

(4) "Domestic insurance company," in this chapter and another law described by Section 841.002, means an insurance company organized under the laws of this state as:

(A) a life insurance company;

(B) an accident insurance company;

(C) a life and accident insurance company;

(D) a health and accident insurance company; or

(E) a life, health, and accident insurance company.

(5) "Foreign company" means a life, accident, or health insurance company organized under the laws of another state.

(6) "Health insurance company" means a corporation authorized under a charter to engage in business involving the payment of money or another thing of value in the event of loss resulting from disability incurred as a result of sickness or ill health.

(7) "Home office," with respect to an insurance company, means the principal office of the company in the state or country under whose laws the company is organized.

(8) "Insurance company" and "company" include all corporations engaged as a principal in the business of life, accident, or health insurance.

(9) "Life insurance company" means a corporation authorized under a charter to engage in business involving the payment of money or another thing of value conditioned on the continuance or cessation of human life or involving an insurance, guaranty, or contract for the payment of an endowment or annuity.

(10) "Policyholder" and "insured" mean the individual on whose life an insurance policy is effected.

(11) "Profits," with respect to an insurance company, means the portion of the company's funds that are not:

(A) required for the payment of losses and expenses; or

(B) set aside for any other purpose required by law.

(12) "United States branch" means:

(A) the business unit through which business is transacted within the United States by an alien company;

(B) the assets and liabilities of the company within the United States pertaining to the business;

(C) the management powers pertaining to the business and to the assets and liabilities; or

(D) any combination of the items described by Paragraphs (A)-(C).

(13) The definitions of "company" and "insurance company" apply to this chapter and another law described by Section 841.002 unless a different meaning is plainly required by the context in which the term appears. (V.T.I.C. Art. 3.01, Secs. 1, 2, 3, 4, 5, 6, 7, 7A, 8, 9, 11, 13.)

Source Law

Art. 3.01

Sec. 1. A life insurance company shall be deemed to be a corporation doing business under any charter involving the payment of money or other thing of value, conditioned on the continuance or cessation of human life, or involving an insurance, guaranty, contract or pledge for the payment of endowments or annuities.

Sec. 2. An accident insurance company shall be deemed to be a corporation doing business under any charter involving the payment of money or other thing of value, conditioned upon the injury, disablement or death of persons resulting from traveling or general accidents by land or water.

Sec. 3. A health insurance company shall be deemed to be a corporation doing business under any charter involving the payment of any amount of money, or other thing of value, conditioned upon loss by reason of disability due to sickness or ill-health.

Sec. 4. When consistent with the context and not obviously used in a different sense, the term "company," or "insurance company," as used herein, includes all corporations engaged as principals in the business of life, accident or health insurance.

Sec. 5. The term "domestic" company, as used herein, designates those life, accident or life and accident, health and accident, or life, health and accident insurance companies incorporated and formed in this State.

Sec. 6. The term "foreign company" means any life, accident or health insurance company organized under the laws of any other state or territory of the United States.

Sec. 7. The term "home office" of a company means its

principal office within the state or country in which it is incorporated and formed.

Sec. 7A. The term "alien company" means any life, accident, or health insurance company organized under the laws of any foreign country.

Sec. 8. The "insured" or "policyholder" is the person on whose life a policy of insurance is effected.

Sec. 9. The "beneficiary" is the person to whom a policy of insurance effected is payable.

Sec. 11. The "profits" of a company are that portion of its funds not required for the payment of losses and expenses, nor set apart for any other purpose required by law.

Sec. 13. The "United States branch" means:

(a) the business unit through which business is transacted within the United States by an alien insurer;

(b) the assets and liabilities of the insurer within the United States pertaining to such business;

(c) the management powers pertaining to such business and to the assets and liabilities; or

(d) any combination of the foregoing.

Revisor's Note

(1) Section 1, V.T.I.C. Article 3.01, defines "life insurance company" to include a corporation doing business involving an "insurance, guaranty, contract or pledge" for payment of an endowment or annuity. The revised law omits "pledge" as unnecessary because it is included within the meaning of "guaranty."

(2) Sections 5 and 7, V.T.I.C. Article 3.01, refer to insurance companies "incorporated and formed" in this state and to the state or country in which a company is "incorporated and formed." The revised law substitutes "organized" for "incorporated and formed" for consistency with terminology used in other chapters of this code.

(3) Section 6, V.T.I.C. Article 3.01, refers to "any other state or territory of the United States." The revised law omits "territory" as unnecessary because Section 311.005, Government Code (Code Construction Act), which applies to the revised law, provides that "state," when referring to a part of the United States, includes any state or territory of the United States.

Revised Law

Sec. 841.002. APPLICABILITY OF CHAPTER AND OTHER LAW. Except as otherwise expressly provided by this code, each insurance company incorporated or engaging in business in this state as a life insurance company, an accident insurance company, a life and accident insurance company, a health and accident insurance company, or a life, health, and accident insurance company is subject to:

(1) this chapter;

(2) Chapter 3; and

(3) Title 7. (V.T.I.C. Art. 3.02, Sec. 3.)

Source Law

Sec. 3. Every life insurance company, or accident insurance company, or life and accident, health and accident, or life, health and accident insurance company incorporated or transacting such business in this State is subject to the capital and surplus requirements imposed by this article and is subject to the other provisions of this chapter unless otherwise expressly provided by this Code.

Revisor's Note

(1) Section 3, V.T.I.C. Article 3.02, provides that certain companies are subject to "the capital and surplus requirements" imposed by Article 3.02 and to "the other provisions of this chapter." The revised law omits the reference to "the capital and surplus requirements" as unnecessary because "the capital and surplus requirements" are included within the meaning of "provisions of this chapter."

(2) Section 3, V.T.I.C. Article 3.02, refers to "the other

provisions of this chapter," meaning Chapter 3, Insurance Code, portions of which are revised as this chapter. This chapter contains primarily portions of V.T.I.C. Chapter 3 that are derived from law originally derived from Chapter 108, General Laws, Acts of the 31st Legislature, Regular Session, 1909. V.T.I.C. Chapter 3 also contains law that is derived from law that was added to the Revised Statutes after 1909, but before the enactment of the Insurance Code of 1951, and provisions added to Chapter 3 after 1951. In addition, V.T.I.C. Chapter 3 includes provisions of law that are published by the publishing company as part of Chapter 3, but which were never formally added to the Insurance Code by the legislature.

Portions of Chapter 3 of the Insurance Code of 1951 remain as a part of Chapter 3. It is appropriate, therefore, to state in this section that the companies described by this section are subject to Chapter 3.

Portions of V.T.I.C. Chapter 3 are revised as part of Title 7 of this code. While portions of Title 7 are not derived from Chapter 3 of the Insurance Code of 1951, those provisions either apply to the insurance companies described by this section by their own terms or cannot be interpreted to apply to these companies. It is appropriate, therefore, to state in this section that the companies described by this section are subject to Title 7.

Portions of Chapter 3 of the Insurance Code of 1951 are revised as part of Chapter 982 of this code. The provisions of Chapter 982 that are derived from Chapter 3 clearly state the scope of their applicability and it is not necessary to repeat that applicability in this section.

Portions of V.T.I.C. Chapter 3 are revised in Subtitle H of Title 8 of this code. To the extent that the provisions of Subtitle H, Title 8, that are derived from Chapter 3 of the Insurance Code of 1951 apply to companies described by this section, those provisions clearly state the scope of their applicability and it is not necessary to repeat that applicability in this section. The revised law is drafted

accordingly.

Revised Law

Sec. 841.003. APPLICABILITY OF LAW GOVERNING CORPORATIONS. An insurance company operating under this chapter is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and any other law of this state that governs corporations in general to the extent those laws are not inconsistent with this chapter or another law described by Section 841.002. (V.T.I.C. Art. 3.69.)

Source Law

Art. 3.69. The laws governing corporations in general shall apply to and govern insurance companies organized or operating under this Chapter 3 in so far as same are not inconsistent with the provisions of this chapter.

Revisor's Note

(1) V.T.I.C. Article 3.69 refers to "laws governing corporations in general." For the convenience of the reader, the revised law adds references to the Texas Business Corporation Act and the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), which are laws that govern corporations in general.

(2) V.T.I.C. Article 3.69 refers to "insurance companies organized or operating under" this chapter. Throughout this chapter, the revised law refers only to a company "operating" under this chapter because a company "organized" under this chapter is also "operating" under this chapter.

Revised Law

Sec. 841.004. NET ASSETS DEFINED; RULES. (a) A company's "net assets" consist of the company's funds that are available for the payment of a company's obligations in this state, including:

(1) uncollected premiums that are not more than three months past due and deferred premiums on policies actually in

force, after the deduction of:

(A) all unpaid losses and claims;

(B) all claims for losses; and

(C) all other debts, exclusive of capital stock; and

(2) if the total value of the equipment exceeds $2,000, the value of all electronic machines that comprise a data processing system or systems and of all other office equipment, furniture, machines, and labor-saving devices purchased for and used in connection with the business of the insurance company to the extent that the total actual cash market value of those assets is less than 10 percent of the other admitted assets of the company.

(b) The commissioner may adopt rules defining electronic machines and systems, office equipment, furniture, machines, and labor-saving devices described by Subsection (a) and stating the maximum period for which each class of equipment may be amortized. (V.T.I.C. Art. 3.01, Sec. 10 (part).)

Source Law

Sec. 10. By the term "net assets" is meant the funds of the company available for the payment of its obligations in this state, including but not limited to:

(a) Uncollected premiums not more than three (3) months past due and deferred premiums on policies actually in force, after deducting from such funds all unpaid losses and claims and claims for losses, and all other debts, exclusive of capital stock; and

(b) All electronic machines, constituting a data-processing system or systems, and all other office equipment, furniture, machines and labor-saving devices heretofore or hereafter purchased for and used in connection with the business of an insurance company to the extent that the total actual cash market value of all of such systems, equipment, furniture, machines and devices constitute not more than ten percent (10%) of the otherwise admitted assets of such company;

and provided further, that the total value of all such property of a company must exceed Two Thousand Dollars ($2,000), to qualify hereunder.

(c) The Commissioner of Insurance may adopt regulations defining electronic machines and systems, office equipment, furniture, machines and labor-saving devices as used in subsection (b), and provide for the maximum period for which each such class of equipment may be amortized.

Revisor's Note

Section 10(c), V.T.I.C. Article 3.01, refers to the authority of the commissioner of insurance to adopt "regulations" defining certain equipment. Throughout this chapter, the revised law substitutes "rules" for "regulations" because, in this context, the terms are synonymous and because under Section 311.005, Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 841.005-841.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF DOMESTIC COMPANIES

Revised Law

Sec. 841.051. FORMATION OF COMPANY. (a) Three or more residents of this state may form:

(1) a life insurance company;

(2) an accident insurance company;

(3) a life and accident insurance company;

(4) a health and accident insurance company; or

(5) a life, health, and accident insurance company.

(b) To form a domestic insurance company:

(1) each incorporator must sign and acknowledge the articles of incorporation of the company; and

(2) the incorporators must file the articles of incorporation with the department. (V.T.I.C. Art. 3.02, Sec. 1(a) (part).)

Source Law

Art. 3.02

Sec. 1. (a) Any three or more citizens of this State may associate themselves for the purpose of forming a life insurance company, or accident insurance company, or life and accident, health and accident, or life, health and accident insurance company. . . . In order to form such a company, the incorporators shall sign and acknowledge its articles of incorporation and file the same in the office of the State Board of Insurance. . . .

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.02, refers to "citizens of this State." The revised law substitutes "resident" for "citizen" because, in context, "citizen" and "resident" are synonymous, and "resident" is more commonly used.

(2) Section 1(a), V.T.I.C. Article 3.02, refers to "such a company," meaning a life insurance company, accident insurance company, life and accident insurance company, health and accident insurance company, or life, health, and accident insurance company formed in accordance with V.T.I.C. Article 3.02. The revised law substitutes the term "domestic insurance company" because that is the defined term that describes a company organized under this chapter. Similar changes are made throughout this chapter, as appropriate.

(3) Section 1(a), V.T.I.C. Article 3.02, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished that board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 841.052. ARTICLES OF INCORPORATION. (a) Articles of incorporation of a proposed domestic insurance company must state:

(1) the name of the company;

(2) the location of the company's home office;

(3) the kinds of insurance business in which the company proposes to engage;

(4) the name and place of residence of each incorporator;

(5) the amount of the company's capital stock;

(6) the number of shares of the company's capital stock;

(7) the amount of the company's surplus; and

(8) the period of the company's duration, which may be perpetual.

(b) The incorporators of a domestic insurance company may include in the articles of incorporation other provisions that are not inconsistent with law. (V.T.I.C. Art. 3.02, Sec. 1(a) (part).)

Source Law

(a) . . . Such articles shall specify:

1. The name and place of residence of each of the incorporators;

2. The name of the proposed company . . .;

3. The location of its home office;

4. The kind or kinds of insurance business it proposes to transact;

5. The amount of its capital stock and its surplus . . . ;

6. The period of time it is to exist, which may be perpetual;

7. The number of shares of such capital stock;

8. Such other provisions not inconsistent with the law as the incorporators may deem proper to insert therein.

Revised Law

Sec. 841.053. COMPANY NAME. (a) The name of a domestic insurance company must contain the words "Insurance Company."

(b) A domestic insurance company's name may not be so similar to the name of another domestic insurance company as to likely mislead the public. (V.T.I.C. Art. 3.02, Sec. 1(a) (part).)

Source Law

(a) . . . [Such articles shall specify:]

. . .

2. The name of the proposed company, which shall contain the words "Insurance Company" as a part thereof, and the name selected shall not be so similar to that of any other insurance company as to be likely to mislead the public;

. . .

Revised Law

Sec. 841.054. CAPITAL STOCK AND SURPLUS REQUIREMENTS. (a) A domestic insurance company must have capital stock in an amount of at least $700,000 and surplus in an amount of at least $700,000.

(b) All of the capital stock required by Subsection (a) must be fully subscribed and paid up and delivered to the incorporators before the articles of incorporation are filed.

(c) At the time of incorporation, the required capital and surplus shall consist only of:

(1) United States currency;

(2) bonds of the United States, this state, or a county or municipality of this state; or

(3) government insured mortgage loans that are authorized by this chapter or Chapter 3, with not more than 50 percent of the required capital invested in first mortgage real property loans. (V.T.I.C. Art. 3.02, Sec. 1(a) (part).)

Source Law

(a) . . . [Such articles shall specify:]

. . .

5. The amount of its capital stock and its surplus, that in no case may be less than Seven Hundred Thousand ($700,000.00) Dollars capital and Seven Hundred Thousand ($700,000.00) Dollars surplus; all of which capital stock must be fully subscribed and fully paid up and in the hands of the incorporators before said articles of incorporation are filed. Such minimum capital and surplus shall, at the time of incorporation, consist only of lawful money of the United States or bonds of the United States or of this State or of any county or incorporated municipality thereof, or government insured mortgage loans which are otherwise authorized by this chapter, and shall not include any real estate; provided, however, that fifty (50%) per cent of the minimum capital may be invested in first mortgage real estate loans. . . .

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.02, refers to an "incorporated municipality" of this state. The revised law omits "incorporated" because under the Local Government Code all municipalities must be incorporated.

(2) Section 1(a), V.T.I.C. Article 3.02, refers to "government insured mortgage loans . . . authorized by this chapter." The revised law includes a reference to Chapter 3, Insurance Code, which contains provisions applicable to investments of insurance companies that are not revised in this chapter.

(3) Section 1(a), V.T.I.C. Article 3.02, provides that the minimum capital and surplus "shall not include any real estate." The revised law omits the quoted language as unnecessary because the revised law expressly sets out all of the forms that capital and surplus may take, which do not include real property.

Revised Law

Sec. 841.055. SHARES OF STOCK. (a) The shares of stock of an insurance company operating under this chapter may be divided or converted into shares of stock with a par value or shares of stock without par value or into a combination of shares with or without par value.

(b) Each issued share of stock must be fully paid for and nonassessable.

(c) The insurance company by an amendment to its charter may increase or decrease the total number of shares of stock the company is authorized to issue if:

(1) shares representing at least 50 percent of the total par value of the authorized shares with a par value, if any, have been in good faith subscribed and fully paid for; and

(2) shares representing at least 50 percent of the total number of the authorized shares without a par value, if any, have been in good faith subscribed and fully paid for.

(d) Authorized but unissued shares of stock of an insurance company are not considered capital, stock, or capital stock of the company.

(e) This section and Sections 841.056 and 841.057 do not impair the charter rights of an insurance company authorized to issue shares of stock with or without a par value before September 6, 1955. (V.T.I.C. Art. 3.02a, Subsecs. (a) (part), (d).)

Source Law

Art. 3.02a. (a) The shares of any life, health or accident insurance company organized or operating under the provisions of this Chapter may be divided or converted into shares of either par value or no par value, or some of each, and all issued shares shall be fully paid and nonassessable. . . . The aggregate number of shares which the company has authority to issue may be increased or decreased from time to time by lawful charter amendment so long as at least fifty per cent (50%) of the aggregate number of the authorized shares to be issued without

nominal or par value is in good faith subscribed and paid for and so long as shares representing at least fifty per cent (50%) of the aggregate par value of the shares authorized to be issued with a nominal or par value has been in good faith subscribed and paid for in full; provided that authorized but unissued shares shall not constitute capital or stock or capital stock of such company.

(d) Nothing herein contained shall be construed to impair the charter rights of companies heretofore authorized to issue stock of no par value or par value.

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 3.02a, provides for a change in the number of authorized shares by "lawful charter amendment." The revised law omits "lawful" as unnecessary because it does not add to the clear meaning of the law.

(2) Subsection (a), V.T.I.C. Article 3.02a, refers to shares with a "nominal or par value." The revised law omits "nominal" because, in context, the terms are synonymous, and "par value" is more commonly used.

(3) Subsection (d), V.T.I.C. Article 3.02a, refers to the effect of that article on charter rights of companies "heretofore" authorized to issue stock with or without a par value. That article was enacted by Chapter 363, Acts of the 54th Legislature, Regular Session, 1955, which took effect after midnight of September 5, 1955 (90 days after June 7, 1955). The revised law substitutes "before September 6, 1955," for "heretofore."

Revised Law

Sec. 841.056. REQUIREMENTS FOR SHARES OF STOCK WITH PAR VALUE. (a) The shares of stock of an insurance company operating under this chapter that are divided or converted into par value shares, if any, must have a par value of not less than $1 or more than $100.

(b) Each par value share of stock must be fully paid for

before issuance in an amount that is not less than the share's par value.

(c) When an application for charter or an amendment to the charter authorizing the issuance of shares of stock with a par value is filed, the insurance company shall file with the department a statement under oath stating:

(1) the total number of par value shares subscribed; and

(2) the actual total consideration the company received for those shares.

(d) The shareholders of an insurance company authorizing par value shares of stock must in good faith subscribe and fully pay for shares representing at least 50 percent of the total par value of the authorized shares with a par value before the company:

(1) is granted a charter; or

(2) amends its charter to authorize the issuance of par value shares.

(e) If all of the authorized par value shares of stock are not subscribed and paid for when the charter is granted or the amendment is filed, respectively, the insurance company shall file with the department a certificate authenticated by a majority of the directors stating the total number of par value shares issued and the actual total consideration received for those shares. The company shall file the certificate not later than the 90th day after the date of issuance of those remaining shares. The company is not required to file an amendment to its charter or take further action to effect the increase in the capital and surplus of the company.

(f) The actual consideration received by an insurance company for a par value share constitutes capital to the extent of its par value and the remainder, if any, constitutes surplus. (V.T.I.C. Art. 3.02a, Subsecs. (a) (part), (b) (part), (c) (part).)

Source Law

(a) . . . If divided or converted into shares of par value, each share shall be for not less than One Dollar ($1) nor more than One Hundred Dollars ($100) and the stockholders of any such company authorizing the issuance of its stock with a nominal or par value shall be required in good faith to subscribe and fully pay for shares representing at least fifty per cent (50%) of the aggregate par value of the shares authorized to be issued with a nominal par value before said company shall be chartered or have its charter amended so as to authorize the issuance of shares with a nominal or par value. At the time of filing of an original charter or any amendment of an existing charter authorizing the issuance of stock with a nominal or par value, the company shall file a statement under oath with the State Board of Insurance setting forth the aggregate number of shares with a nominal or par value subscribed and the actual aggregate consideration received by the company for such shares. . . .

(b) . . . The consideration received for shares with a nominal or par value shall constitute capital to the extent of the par value of such shares, and the excess, if any, of such consideration shall constitute surplus. . . . All shares with a nominal or par value issued by the company shall be fully paid for prior to issuance at a rate of not less than the par value thereof. In no event shall the capital or surplus be less than the minimum required by this Chapter.

(c) . . . In the event all of the shares with a nominal or par value, authorized by the original charter or any amendment, are not subscribed and paid for at the time the original charter is granted, or the amendment is filed, then when such remaining shares with a nominal or par value are sold and issued, the company shall file with the Board, within ninety (90) days after the issuance of such shares, a certificate authenticated by a majority of the directors setting forth the aggregate number of shares so issued and the actual aggregate consideration received by the company for such shares. In the case of the issuance by a

company of any of its authorized shares having a nominal or par value, the consideration received therefor shall constitute capital to the extent of the par value of such shares, and the excess, if any, of such consideration shall constitute surplus. . . . All shares with a nominal or par value issued by the company shall be fully paid for prior to issuance at a rate of not less than the par value thereof. No further action on the part of the company and no charter amendment shall be necessary to effect the increase in capital or surplus, or both, of the company.

Revisor's Note

(1) Subsections (a), (b), and (c), V.T.I.C. Article 3.02a, refer to shares with a "nominal or par value." The revised law omits "nominal" for the reason stated in Revisor's Note (2) to Section 841.055.

(2) Subsection (b), V.T.I.C. Article 3.02a, provides that "[i]n no event shall the capital or surplus be less than the minimum required by this Chapter." The revised law omits the quoted language as unnecessary because it duplicates the minimum capital and surplus requirements of Section 1(a), V.T.I.C. Article 3.02, revised in relevant part as Section 841.054.

Revised Law

Sec. 841.057. REQUIREMENTS FOR SHARES OF STOCK WITHOUT PAR VALUE. (a) The shares of stock of an insurance company operating under this chapter that are divided or converted into shares without par value, if any, must be equal in all respects.

(b) An insurance company may issue and dispose of authorized shares without par value for money or for notes, mortgages, and stocks in the form authorized by law for capital stock of insurance companies. Each share of stock without par value must be fully paid before issuance. After the company receives payment for a share of stock issued under this section, the share is not subject to additional call or assessment, and the subscriber or holder of the share is not required to make an additional payment with respect to the share.

(c) The shareholders of an insurance company authorizing shares of stock without par value must in good faith subscribe and pay for shares representing at least 50 percent of the authorized shares without par value before the company is granted a charter or has its charter amended to authorize the issuance of shares without par value. The total amount paid for the shares must be at least $250,000.

(d) When an application for charter or an amendment to the charter authorizing the issuance of shares without par value is filed, the insurance company shall file with the department a statement under oath stating:

(1) the number of shares without par value subscribed; and

(2) the actual consideration the company received for those shares.

(e) If all of the authorized shares of stock without par value are not subscribed and paid for when the charter is granted or the amendment is filed, respectively, the insurance company shall file with the department a certificate authenticated by a majority of the directors stating the number of shares without par value issued and the consideration received for those shares.

(f) The insurance company shall file the certificate required by Subsection (e) not later than the 90th day after the date of issuance of those remaining shares. The portion of the consideration received for shares without par value that is designated as capital by the company's directors, or by the company's shareholders if the charter or articles of incorporation reserve the right to make that determination to the shareholders, constitutes capital and the remainder, if any, constitutes surplus. The company is not required to file an amendment to its charter or take further action to effect the increase in the capital and surplus of the company. (V.T.I.C. Art. 3.02a, Subsecs. (a) (part), (b) (part), (c) (part).)

Source Law

(a) . . . If divided or converted into shares of no par value, every such share shall be equal in all respects to every other such share. At the time of filing of an original charter or any amendment of an existing charter authorizing the issuance of stock with no par value, the company shall file a statement under oath with the State Board of Insurance setting forth the number of shares without par value subscribed and the actual consideration received by the company for such shares. Provided, however, that the stockholders of any such company authorizing the issuance of its stock without nominal or par value, shall be required in good faith to subscribe and pay for at least fifty per cent (50%) of the authorized shares to be issued without nominal or par value, before said corporation shall be chartered or have its charter amended so as to authorize the issuance of shares without nominal or par value; and provided further, that in no event shall the amount so paid be less than Two Hundred Fifty Thousand Dollars ($250,000). . . .

(b) Such companies may issue and dispose of their authorized shares having no nominal or par value for money or those notes, mortgages and stocks of which the law requires that capital stock of insurance companies shall consist. Any and all shares without nominal or par value issued for the consideration prescribed or fixed in accordance with the provisions of this Article shall be fully paid stock and not liable to any further call or assessment thereon, nor shall the subscriber or holder be liable for any further payments. . . . In the case of issuance of shares without a nominal or par value, that portion of the consideration fixed by the Board of Directors, unless the charter or the articles of incorporation reserve to the shareholders the right to fix the consideration, shall constitute capital and the excess, if any, of such consideration shall constitute surplus. . . .

(c) In the event all of the shares without nominal or par value, authorized by the original charter or any amendment, are

not subscribed and paid for at the time the original charter is granted, or the amendment is filed, then when such remaining shares without nominal or par value are sold and issued, the company shall file with the State Board of Insurance within ninety (90) days after the issuance of such shares, a certificate authenticated by a majority of the directors setting forth the number of such shares so issued and the actual consideration received by the company for such shares. . . . In case of the issuance by a company of any of its authorized shares without a nominal or par value, that portion of the consideration fixed by the Board of Directors, unless the charter or articles of incorporation of the company reserve to the shareholders the right to fix the consideration, shall constitute capital, and the excess, if any, shall constitute surplus. . . . No further action on the part of the company and no charter amendment shall be necessary to effect the increase in capital or surplus, or both, of the company.

Revised Law

Sec. 841.058. APPLICATION FOR CHARTER. (a) To obtain a charter for a domestic insurance company, the incorporators must pay to the department the charter fee in an amount determined under Article 4.07 and file with the department:

(1) an application for charter on the form and containing the information prescribed by the commissioner;

(2) the company's articles of incorporation; and

(3) an affidavit made by two or more of the incorporators that states that:

(A) the minimum capital and surplus requirements of Section 841.054 are satisfied;

(B) the capital and surplus are the bona fide property of the company; and

(C) the information in the articles of incorporation is true and correct.

(b) The commissioner may require that the incorporators provide at their expense additional evidence of a matter required

in the affidavit before the commissioner takes further action on the application for charter. (V.T.I.C. Art. 3.04, Sec. 1.)

Source Law

Art. 3.04

Sec. 1. As a condition precedent to the granting of a charter of any such company, the incorporators shall file with the State Board of Insurance the following:

1. An application for charter on such form and including therein such information as may be prescribed by the Board;

2. The articles of incorporation as provided in this Code;

3. An affidavit made by two (2) or more of its incorporators that all of the stock has been subscribed in good faith and fully paid for, as required by law, in the amount as required by law, in addition to its capital; which affidavit shall state that the facts set forth in the application and the articles of incorporation are true and correct and that the capital and surplus is the bona fide property of such company. The State Board of Insurance may, in its discretion, at the expense of the incorporators, require other and additional satisfactory evidence of the matters required to be set forth in said affidavit before it shall be required to file the articles of incorporation, application for charter or follow the procedure hereinafter set forth;

4. A charter fee prescribed by law.

Revisor's Note

Section 1, V.T.I.C. Article 3.04, provides that a domestic insurance company must deposit with the Texas Department of Insurance "[a] charter fee prescribed by law" when it files an application to obtain a charter. V.T.I.C. Article 4.07 is a comprehensive fee provision that authorizes the Texas Department of Insurance to set the amounts of various fees, including a charter fee, subject to statutorily specified limits.

Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

Revised Law

Sec. 841.059. ACTION BY COMMISSIONER AND DEPARTMENT AFTER FILING. (a) After the charter fee is paid and all items required for a charter under Section 841.058 are filed with the department:

(1) the commissioner may set a date for a hearing on the application; and

(2) the department shall make or cause to be made a full and thorough examination of the domestic insurance company before the hearing.

(b) The domestic insurance company shall pay for the examination under Subsection (a)(2). (V.T.I.C. Art. 3.04, Sec. 2 (part); Art. 3.06 (part).)

Source Law

[Art. 3.04]

Sec. 2. When such application for charter, articles of incorporation, affidavit, and charter fee are filed with the State Board of Insurance, the Board may set a date for a public hearing of the same, ...

Art. 3.06. When the application for charter, articles of incorporation, affidavit, and charter fee are filed with the State Board of Insurance and before the hearing required by Article 3.04 of this Code, the Board shall make, or cause to be made, at the expense of the company, a full and thorough examination thereof. . . .

Revisor's Note

Section 2, V.T.I.C. Article 3.04, refers to a "public hearing" of the former State Board of Insurance. Throughout this chapter, the revised law omits "public" as unnecessary. In context, "hearing" means a hearing open to the public.

Revised Law

Sec. 841.060. APPLICATION PROCESS. (a) The date for a hearing on an application for charter may not be before the 11th day or later than the 30th day after the date notice is provided under Subsection (b).

(b) The commissioner shall:

(1) provide written notice of the date of a hearing to:

(A) the person or persons who filed the application; and

(B) any interested party, including any other party who had previously requested a copy of the notice; and

(2) publish, at the expense of the incorporators, a copy of the notice in a newspaper of general circulation in the county in which the domestic insurance company's home office is proposed to be located.

(c) The department shall make a record of the proceedings of a hearing under this section.

(d) An interested party is entitled to oppose or support the granting or denial of the application and may intervene and participate fully and in all respects in any hearing or other proceeding on the application. An intervenor has the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel. (V.T.I.C. Art. 3.04, Sec. 2 (part).)

Source Law

Sec. 2. . . . the Board may set a date for a public hearing . . ., which date shall be not less than ten (10) nor more than thirty (30) days after the date of notice thereof. The Board shall notify in writing the person or persons submitting such application of the date for such hearing and shall furnish a copy of such notice to all interested parties including any parties who have theretofore requested a copy of such notice. The Board shall, at the expense of the incorporators, publish a copy of such notice in any newspaper of general circulation in the county

of the proposed home office of said company. In all such public hearings on such applications, a record shall be made of such proceedings, and . . . . Any interested party shall have the right to oppose or support the granting or denial of such application and may intervene and participate fully and in all respects in any hearing or other proceeding had on any such application. Any such intervenor shall have and enjoy all the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel.

Revised Law

Sec. 841.061. ACTION ON APPLICATION. (a) In considering the application, the commissioner, not later than the 30th day after the date a hearing under Section 841.060 is completed, shall determine if:

(1) the minimum capital and surplus required by Section 841.054 are the bona fide property of the domestic insurance company;

(2) the proposed officers, directors, and managing executive of the company have sufficient insurance experience, ability, and standing to make success of the proposed company probable; and

(3) the applicants are acting in good faith.

(b) If the commissioner determines by an affirmative finding any of the issues under Subsection (a) adversely to the applicants, the commissioner shall reject the application in writing, giving the reason for the rejection. An application may not be granted unless it is adequately supported by competent evidence.

(c) If the commissioner does not reject the application under Subsection (b), the commissioner shall approve the application. On approval of an application, the department shall record the information required by Section 841.058 in records maintained for that purpose. On receipt of a fee in the amount determined under Article 4.07, the commissioner shall provide to

the incorporators a certified copy of the application, articles of incorporation, and submitted affidavit. (V.T.I.C. Art. 3.04, Secs. 2 (part), 3, 4 (part).)

Source Law

Sec. 2. . . . no such application shall be granted except when same is adequately supported by competent evidence. . . .

Sec. 3. In considering any such application, the Board shall, within thirty (30) days after public hearing, determine whether or not:

(a) The minimum capital and surplus, as required by law, is the bona fide property of the company;

(b) The proposed officers, directors and managing executive have sufficient insurance experience, ability and standing to render success of the proposed company probable;

(c) The applicants are acting in good faith.

Sec. 4. If the Board shall determine by an affirmative finding any of the above issues adversely to the applicants, it shall reject the application in writing giving the reason therefor. Otherwise, the Board shall approve the application, whereupon all such documents shall be deposited with the Board. The Board shall record the documents in a log kept for that purpose; and upon receipt of the prescribed fee, it shall furnish a certified copy of the same to the incorporators, . . .

Revisor's Note

Section 4, V.T.I.C. Article 3.04, refers to "receipt of the prescribed fee" for providing a certified copy of the application, articles of incorporation, and affidavit to the incorporators. V.T.I.C. Article 4.07 is a comprehensive fee provision that authorizes the Texas Department of Insurance to set the amounts of various fees, including a fee for making copies of any paper or record in the Texas Department of Insurance. Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

Revised Law

Sec. 841.062. BEGINNING OF CORPORATE EXISTENCE. On receipt of the certified copy of documents under Section 841.061(c), the domestic insurance company becomes a body politic and corporate, and the incorporators may complete organization of the company under Section 841.063. (V.T.I.C. Art. 3.04, Sec. 4 (part).)

Source Law

Sec. 4. . . . [whereupon all such documents shall be deposited with the Board. The Board shall . . . furnish a certified copy of the same to the incorporators,] upon which they shall become a body politic and corporate and may proceed to complete the organization of the company, ...

Revised Law

Sec. 841.063. ORGANIZATION MEETING. (a) After receipt of the certified copy of documents under Section 841.061(c), the incorporators shall promptly call a meeting of the domestic insurance company's shareholders. The shareholders shall:

(1) adopt bylaws to govern the company; and

(2) elect the company's initial board of directors.

(b) The directors elected under this section serve until directors are first elected under Section 841.153. (V.T.I.C. Art. 3.04, Sec. 4 (part).)

Source Law

Sec. 4. [. . . the incorporators . . . may proceed to complete the organization of the company,] for which purpose they shall forthwith call a meeting of the stockholders who shall adopt bylaws for the government of the company, and elect a board of directors . . . . The board of directors so elected shall serve until the fourth Tuesday in April thereafter, ...

[Sections 841.064-841.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 841.101. CERTIFICATE OF AUTHORITY REQUIRED. A domestic insurance company may not engage in the business of insurance in this state, except for the lending of money, without first obtaining from the commissioner a certificate of authority that:

(1) shows that the company has fully complied with the laws of this state; and

(2) authorizes the company to engage in the business of insurance in this state. (V.T.I.C. Art. 3.57 (part).)

Source Law

Art. 3.57. No . . . domestic insurance company shall transact any insurance business in this State, other than the lending of money, unless it shall first procure from the Board of Insurance Commissioners a certificate of authority, stating that the laws of this State have been fully complied with by it, and authorizing it to do business in this State. . . .

Revised Law

Sec. 841.102. SCHEDULE OF ASSETS. Two or more officers of the domestic insurance company shall execute and file with the department:

(1) a sworn schedule of each of the assets of the company exhibited to the department during the examination under Section 841.059 showing the value of the assets; and

(2) a sworn statement that the assets are the bona fide, unconditional, and unencumbered property of the company and are worth the amount stated in the schedule. (V.T.I.C. Art. 3.06 (part).)

Source Law

Art. 3.06. . . . not less than two (2) officers of such company shall execute and file with the State Board of Insurance a sworn schedule of all the assets of the company exhibited to the Board upon such examination showing the value thereof,

together with a sworn statement that the same are bona fide, the unconditional and unencumbered property of the company, and are worth the amount stated in such schedule.

Revised Law

Sec. 841.103. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) If the commissioner makes a determination favorable to the applicants on all issues under Section 841.061(a), the commissioner, on compliance with the requirements of Section 841.102, shall issue to the domestic insurance company a certificate of authority authorizing the company to engage in the kinds of business authorized by the company's charter.

(b) On written request of a domestic insurance company, the commissioner shall provide a certified copy of the company's certificate of authority to the company for each of the company's agents in this state. (V.T.I.C. Arts. 3.06 (part), 3.09.)

Source Law

Art. 3.06. . . . After the hearing under Article 3.04 of this Code, if the Board finds that all of the capital of the company, as required by law, has been fully paid up and that the capital and surplus is in the custody of the officers, in cash or securities of the class authorized by Article 3.02 of this Code as amended, and if the Board makes the other findings required by Section 3 of Article 3.04 of this Code favorably to the applicant, on compliance with the other requirements of this article and Article 3.04 of this Code, the Board shall issue to such company a certificate of authority to transact such kind or kinds of insurance business within this State as such officers may apply for and as may be authorized by its charter. Before such certificate is issued, . . . [officers of such company shall . . . file with the State Board of Insurance a sworn schedule of all the assets of the company . . . together with a sworn statement . . . .]

Art. 3.09. Any such company organized under the laws of this

State, having received authority from the Board of Insurance Commissioners to transact business in this State, shall receive from such Board, upon written request therefor, a certified copy of its certificate of authority for each of its agents in this State.

Revisor's Note
(End of Subchapter)

V.T.I.C. Article 3.08 provides a procedure for obtaining a renewal certificate of authority, and V.T.I.C. Article 3.57 refers to the expiration and annual renewal of a certificate of authority. The revised law omits these provisions as repealed. Under Section 1, V.T.I.C. Article 1.14, revised in relevant part as Section 801.053, a certificate of authority is valid until it is suspended or revoked. Section 2, Chapter 194, Acts of the 56th Legislature, Regular Session, 1959, amending Article 1.14, repealed "[a]ll laws and parts of laws in conflict herewith . . . including . . . [Articles] 3.08, 3.57 . . . to the extent that they require periodic renewal of certificates of authority." The omitted law reads:

Art. 3.08. Whenever any such company, transacting insurance business in this State, shall have filed its annual statement in accordance with the preceding article, showing a condition which entitles it to transact business in this State in accordance with the provisions of this chapter, the State Board of Insurance shall, upon a receipt of the prescribed fee, issue a renewal certificate of authority to such company for a period of not more than fifteen (15) months, and not extending more than ninety (90) days beyond the last day of February next after the date of its issuance, on which date such certificate shall expire by its terms unless revoked or suspended according to law.

Art. 3.57. . . . Such certificate of authority shall expire on the day fixed by the Board under Articles 3.06 and 3.08 of this code and shall be renewed annually so long as the company

shall continue to comply with the laws of the State, such renewals to be granted upon the same terms and considerations as the original certificate.

[Sections 841.104-841.150 reserved for expansion]

SUBCHAPTER D. MANAGEMENT OF COMPANY

Revised Law

Sec. 841.151. CONDUCTING SHAREHOLDERS' MEETING. (a) At a meeting of a domestic insurance company's shareholders, each shareholder is entitled to one vote for each fully paid up share of stock appearing in the shareholder's name on the company's books, except to the extent that the articles of incorporation increase, limit, or deny voting rights to the holders of the shares of a class of stock as authorized by the Texas Business Corporation Act.

(b) A shareholder may vote in person or by written proxy.

(c) At a shareholders' meeting, a quorum is any number of shareholders whose cumulative stock ownership in the domestic insurance company represents a majority of the company's paid up capital stock. (V.T.I.C. Art. 3.04, Sec. 4 (part).)

Source Law

Sec. 4. . . . At all meetings of the stockholders, each stockholder shall be entitled to one vote for each share of stock fully paid up appearing in his name on the books of the company, except to the extent that the voting rights of the shares of any class or classes of stock are increased, limited or denied by the articles of incorporation as authorized or permitted by the Texas Business Corporation Act, which vote may be given in person or by written proxy. The majority of the paid up capital stock at any meeting of the stockholders shall be a quorum.

Revised Law

Sec. 841.152. BOARD OF DIRECTORS. (a) Subject to the bylaws of the domestic insurance company, as adopted or amended by the shareholders or directors, the board of directors has full

management and control of the company.

(b) The board consists of not fewer than five directors. A director is not required to be a shareholder unless such a qualification is required by the articles of incorporation or bylaws of the company.

(c) The directors shall keep a full and correct record of the board's transactions. The shareholders may inspect those records during business hours.

(d) The directors shall fill a vacancy that occurs on the board or in any office of the company.

(e) A majority of the board is a quorum. (V.T.I.C. Art. 3.04, Sec. 4 (part).)

Source Law

Sec. 4. . . . [elect a board of directors] of not less than five (5) members; which board shall have full control and management of the affairs of the corporation, subject to the bylaws thereof as adopted or amended from time to time by the stockholders or directors, and to the laws of this state. . . . Neither directors [nor officers] need be stockholders unless the articles of incorporation or bylaws so require. . . . The directors shall keep a full and correct record of their transactions to be open during business hours to the inspection of stockholders. The directors shall fill any vacancy which occurs in the board or in any office of such company. A majority of the board shall be a quorum for the transaction of such business. . . .

Revisor's Note

(1) Section 4, V.T.I.C. Article 3.04, provides that the board's control of a company is subject "to the laws of this state." The revised law omits that provision as unnecessary because the provisions of state law require compliance without an express statement to that effect.

(2) Section 4, V.T.I.C. Article 3.04, provides that a majority of the board is a quorum "for the transaction of such

business." The revised law omits the quoted phrase as unnecessary. "Quorum" means the number of persons or votes necessary for a body to act.

Revised Law

Sec. 841.153. ELECTION OF DIRECTORS. (a) After a domestic insurance company completes the organization of the company under Section 841.063, the company shall hold an annual meeting of the company's shareholders on the fourth Tuesday in April at the home office of the company to elect the company's board of directors.

(b) After the directors are first elected under this section, the annual meeting must be before May 1 of each year as established by the company's bylaws. The directors serve one-year terms beginning immediately after the election, except as provided by Section 841.154.

(c) If the shareholders do not elect directors at an annual meeting, the shareholders may elect the directors at a special shareholders' meeting called for that purpose. (V.T.I.C. Art. 3.04, Sec. 4 (part).)

Source Law

Sec. 4. . . . [The board of directors so elected shall serve until the fourth Tuesday in April thereafter,] on which date, there shall be held a meeting of the stockholders at the home office, and a board of directors elected for the ensuing year; provided, however, that . . . Annual meetings of the stockholders, after the first meeting, shall be held at the home office of the company on or before April 30 of each year as may be prescribed in the bylaws of the corporation. If the stockholders fail to elect directors at any annual meeting, directors may be elected at a special meeting of the stockholders called for that purpose. . . .

Revised Law

Sec. 841.154. STAGGERED TERMS FOR LARGE BOARD OF DIRECTORS. (a) This section applies only to a domestic insurance company whose board of directors consists of at least nine members.

(b) The bylaws of a domestic insurance company may provide that the company's directors, other than initial directors, may be elected to serve staggered terms as provided by this section.

(c) The company's directors shall be divided into two or three classes, with each class consisting of an equal number of directors to the extent possible. After the directors are divided into classes:

(1) the terms of the directors in the first class expire on the first annual meeting date after their initial election;

(2) the terms of the directors in the second class expire on the second annual meeting date after their initial election; and

(3) the terms of the directors in the third class, if any, expire on the third annual meeting date after their initial election.

(d) At each annual meeting after the directors are first elected, the shareholders shall elect the number of directors whose terms expire on that date. Directors are elected for:

(1) staggered two-year terms, if the board is divided into two classes; or

(2) staggered three-year terms, if the board is divided into three classes. (V.T.I.C. Art. 3.04, Sec. 4 (part).)

Source Law

Sec. 4. . . . when the board of directors shall consist of nine (9) or more members, in lieu of electing the whole number of directors annually, the bylaws may provide that the directors be divided into either two or three classes, each class to be as nearly equal in number as possible, the terms of office of directors of the first class to expire at the first annual meeting of stockholders after their election, that of the second class to expire at the second annual meeting after their election, and that of the third class, if any, to expire at the third annual meeting after their election. At each annual meeting after such classification the number of directors equal

to the number of the class whose term expires at the time of such meeting shall be elected to hold office until the second succeeding annual meeting, if there be two classes, or until the third succeeding annual meeting, if there be three classes. No classification of directors shall be effective prior to the first annual meeting of stockholders. . . .

Revised Law

Sec. 841.155. OFFICERS. (a) A domestic insurance company's directors shall choose one of the directors to serve as the company's president.

(b) Other officers of the domestic insurance company shall be chosen in accordance with the company's bylaws. An officer is not required to be a shareholder unless such a qualification is required by the company's articles of incorporation or bylaws. An officer other than the president is not required to be a director unless such a qualification is required by the company's bylaws.

(c) The duties and compensation of a domestic insurance company's officers are as stated in the company's bylaws. If the bylaws do not state the duties or compensation of the officers, the directors shall establish the duties or compensation. (V.T.I.C. Art. 3.04, Sec. 4 (part).)

Source Law

Sec. 4. . . . Neither [directors] nor officers need be stockholders unless the articles of incorporation or bylaws so require. The directors shall choose a president from their own number, and all other officers shall be chosen in accordance with the bylaws of the company, and none of such other officers need be a director except as required by the bylaws of such company. The duties and compensation of officers of such company shall be in accordance with the bylaws of the company, or, to the extent of the absence of provisions governing the same in the bylaws, then the duties and compensation of officers shall be defined and fixed by the directors. . . .

Revised Law

Sec. 841.156. AMENDMENT OF CHARTER OR ARTICLES. (a) The shareholders of a domestic insurance company by resolution may amend the company's charter or articles of incorporation at any shareholders' meeting.

(b) The amendment and a copy of the resolution certified by the president and secretary of the domestic insurance company shall be filed and recorded in the same manner as the charter.

(c) An amendment of the charter or articles takes effect when it is recorded. (V.T.I.C. Art. 3.05, Subsec. (a) (part).)

Source Law

Art. 3.05. (a) At any regular or called meeting of the stockholders, they may, by resolution, provide for any lawful amendment to the charter or articles of incorporation; and such amendment, accompanied by a copy of such resolution duly certified by the president and secretary of the company, shall be filed and recorded in the same manner as the original charter, and shall thereupon become effective. . . .

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 3.05, authorizes any "lawful" amendment to a charter or to articles of incorporation. The revised law omits "lawful" for the reason stated in Revisor's Note (1) to Section 841.055.

(2) Subsection (a), V.T.I.C. Article 3.05, provides for the amendment of a company's charter or articles at "any regular or called meeting." The revised law omits "regular or called" as unnecessary because a meeting is either "regular" or "called."

[Sections 841.157-841.200 reserved for expansion]

SUBCHAPTER E. CAPITAL AND SURPLUS

Revised Law

Sec. 841.201. FORM OF REQUIRED CAPITAL AND SURPLUS. Notwithstanding any other provision of this code, after a charter is granted under this chapter, the domestic insurance company:

(1) shall maintain the company's minimum capital at

all times in a form described by Section 841.054(c); and

(2) may invest the company's surplus as provided by this code. (V.T.I.C. Art. 3.02, Sec. 1(a) (part).)

Source Law

(a) . . .

5. . . . After the granting of charter the surplus may be invested as otherwise provided in this Code. Notwithstanding any other provisions of this Code, such minimum capital shall at all times be maintained in cash or in the classes of investments described in this article;

. . .

Revised Law

Sec. 841.202. AUTHORIZED SHARES. (a) At any shareholders' meeting, shareholders of a domestic insurance company whose cumulative stock ownership represents a majority of the capital stock of the company by resolution may increase or decrease the amount of the company's capital stock, subject to this section.

(b) Capital stock may never be decreased to an amount that is less than the minimum amount of paid-up stock required by Section 841.054.

(c) Two officers of the domestic insurance company must sign and acknowledge a statement of the increase or decrease. The acknowledged statement and a certified copy of the resolution shall be filed and recorded in the same manner as the charter.

(d) For an increase or decrease of capital stock, the domestic insurance company may require the return of the original certificates evidencing the stock in exchange for new certificates. An issuance of new certificates that results in a transfer of stock is subject to Section 841.254. (V.T.I.C. Art. 3.05, Subsec. (a) (part).)

Source Law

[(a) At any regular or called meeting of the stockholders, they may, by resolution, provide for . . . .] Stockholders representing a majority of the capital stock of any such company may in such manner also increase or reduce the amount of its capital stock. The capital stock shall in no case be reduced to less than the minimum amount of fully paid up capital stock required by applicable provisions of law. A statement of any such increase or reduction shall be signed and acknowledged by two officers of the company and filed and recorded along with the certified copy of the resolution of the stockholders provided therefor in the same manner as the charter or amendment thereto. For any such increase or reduction, the company may require the return of the original certificates as other evidence of stock in exchange for new certificates issued in lieu thereof. . . .

Revisor's Note

The part of Subsection (a), V.T.I.C. Article 3.05, that follows the part of the law revised in this section is revised as Section 841.254 of this code. The revised law adds a cross-reference to Section 841.254 for the reader's convenience.

Revised Law

Sec. 841.203. COMPANY'S REPURCHASE OF STOCK. (a) A legal reserve life insurance company may purchase in the name of the company outstanding shares of the company's capital stock as provided by the Texas Business Corporation Act.

(b) A purchase of stock under this section is not considered an investment and does not violate the provisions of this code relating to eligible investments for a legal reserve life insurance company.

(c) A legal reserve life insurance company that purchases stock under this section shall file with the department not later than the 10th day after the date of the purchase a statement that contains:

(1) the name of each shareholder from whom the shares

were purchased; and

(2) the sum of money paid for those shares. (V.T.I.C. Art. 3.05, Subsec. (b).)

Source Law

(b) Any legal reserve life insurance company may purchase in the name of such company, issued and outstanding shares of the capital stock of such company in accordance with the provisions of the Texas Business Corporation Act. Purchases of stock under this paragraph shall not be deemed an investment nor shall such purchases be held in violation of the provisions of the Texas Insurance Code governing eligible investments for such company. Any such company, immediately or within ten days after such purchase, shall file a statement with the Commissioner of Insurance, which statement shall set forth the name of the shareholder or shareholders from whom such shares have been purchased and the sum of money paid for such shares.

Revised Law

Sec. 841.204. EXEMPTION FROM REQUIRED INCREASE OF CAPITAL AND SURPLUS. (a) Except as otherwise provided by this chapter, a domestic insurance company that after September 1, 1991, had less than the minimum amount of capital and surplus required for a newly incorporated company under Section 841.054 may continue to transact the kinds of business for which it holds a certificate of authority.

(b) The insurance company shall immediately increase the amount of its capital to the required amount of capital under Section 841.054 if there is:

(1) a change in the control of at least 50 percent of the voting securities of the insurance company;

(2) a change in the control of at least 50 percent of the voting securities of a holding company controlling the insurance company; or

(3) a change in control of at least 50 percent by any other method of control if the insurance company or holding

company is not controlled by voting securities.

(c) For purposes of Subsection (b), a transfer of ownership that occurs because of death, regardless of whether the decedent died testate or intestate, may not be considered a change in the control of an insurance company or holding company if ownership is transferred solely to one or more individuals, each of whom would be an heir of the decedent if the decedent had died intestate. (V.T.I.C. Art. 3.02, Sec. 2(a).)

Source Law

Sec. 2. (a) If an insurance company subject to this chapter and doing business in this state as an authorized insurer has less than the minimum capital and surplus required for a newly incorporated company under Section 1 of this article, it may continue to transact the kind or kinds of insurance business for which it holds a Texas certificate of authority. However, the insurance company must increase its capital to at least the minimum required by Section 1 of this article immediately after any change of control of the insurance company or any holding company controlling the insurance company if, after September 1, 1991, there has been a change of control of at least 50 percent of the voting securities of the insurance company or holding company or other means of control if the insurance company or holding company is not controlled by voting securities. The insurance company is not required to increase its surplus. For the purposes of this section, a transfer of ownership that occurs because of death, regardless of whether the decedent died testate or intestate, may not be considered a change of control of an insurance company or change of control of a holding company, if ownership is transferred solely to one or more natural persons, each of whom would be an heir of the decedent if the decedent had died intestate.

Revisor's Note

Section 2(a), V.T.I.C. Article 3.02, refers to "an insurance company subject to this chapter and doing business in this state

as an authorized insurer." The revised law substitutes "domestic insurance company" for the quoted phrase because the applicability of these capital and surplus requirements to foreign and alien insurance companies, the other insurance companies that are engaging in business in this state as authorized insurers, is established clearly under V.T.I.C. Article 3.22, revised as part of Chapter 982. Similar changes in this context have been made throughout this chapter.

Revised Law

Sec. 841.205. COMMISSIONER MAY REQUIRE LARGER CAPITAL AND SURPLUS AMOUNTS. (a) The commissioner by rule or guideline may require a domestic insurance company that writes or assumes a life insurance or annuity contract or assumes liability on or indemnifies one person for any risk under an accident and health insurance policy, or a combination of these policies, in an amount that exceeds $10,000, to maintain capital and surplus in amounts that exceed the minimum amounts required by this chapter because of:

(1) the nature and kind of risks the company underwrites or reinsures;

(2) the premium volume of risks the company underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the company's investment portfolio;

(4) fluctuations in the market value of securities the company holds; or

(5) the adequacy of the company's reserves.

(b) A rule adopted under Subsection (a) must be designed to ensure the financial solvency of an insurance company for the protection of policyholders but may not require that the total admitted assets of a company exceed 106 percent of its total liabilities.

(c) A fraternal benefit society operating under Chapter 885 and a mutual life insurance company operating under Chapter 882 are subject to a rule adopted under this section. (V.T.I.C. Art. 3.02, Secs. 2A(a)(part), (b); 3A.)

Source Law

Sec. 2A. (a) In addition to the requirements for capital and surplus provided by this article, the board may adopt rules, regulations, and guidelines requiring any company subject to this chapter . . . that writes or assumes life insurance, annuity contracts or liability on, or indemnifies any one person for, any risk under a health, accident, sickness, or hospitalization policy, or any combination of those policies, in an amount in excess of $10,000, to maintain capital and surplus levels in excess of the minimum levels required by either Section 1 or Section 2 of this article for that company based upon any of the following factors:

1. the nature and type of risks a company underwrites or reinsures;
2. the premium volume of risks a company underwrites or reinsures;
3. the composition, quality, duration, or liquidity of a company's investment portfolio;
4. fluctuations in the market value of securities a company holds; or
5. the adequacy of a company's reserves.

(b) The rules adopted under this section shall be designed to ensure the financial solvency of companies for the protection of policyholders, but may not, according to the dates specified below, require that the total admitted assets of a company exceed the following percentages of its total liabilities:

1. as of December 31, 1992, 103 percent;
2. as of December 31, 1993, 103 percent;
3. as of December 31, 1994, 103 percent;
4. as of December 31, 1995, 104 percent;
5. as of December 31, 1996, 105 percent; and
6. as of December 31, 1997, 106 percent.

Sec. 3A. Fraternal benefit societies organized or operating under the provisions of Chapter 10 of this code and mutual life

insurance companies organized or operating under the provisions of Chapter 11 of this code shall be subject to the risk capital rules and regulations adopted by the board under Section 2A of this article.

Revisor's Note

(1) Section 2A(a), V.T.I.C. Article 3.02, refers to the application of that subsection to "any alien or foreign company." The revised law omits the quoted language as unnecessary because the applicability of these capital and surplus requirements to foreign and alien insurance companies is established clearly under V.T.I.C. Article 3.22, revised as part of Chapter 982. The omitted law reads:

. . . or any alien or foreign company admitted in this state to do the types of business authorized by this chapter, ...

(2) Section 2A(a), V.T.I.C. Article 3.02, refers to a "health, accident, sickness, or hospitalization policy." Throughout this code, the term "accident and health insurance policy" is used when referring to that type of policy, and that term has been substituted for "health, accident, sickness, or hospitalization policy" throughout this chapter.

(3) Section 2A(b), V.T.I.C. Article 3.02, provides a series of limits for admitted assets based on percentages of liabilities for the years 1992 to 1997. The revised law omits the series as executed.

Revised Law

Sec. 841.206. IMPAIRMENT OF CAPITAL AND SURPLUS. (a) A domestic insurance company may not have:

(1) the company's required capital impaired;

(2) more than 90 percent of the company's required minimum surplus impaired; or

(3) the surplus required under Section 841.205 impaired.

(b) If the commissioner determines that an insurance company's capital or surplus is impaired in violation of this

section, the commissioner shall:

(1) order the company to immediately reduce the level of impairment to an acceptable level of impairment as specified by the commissioner or prohibit the company from engaging in the business of insurance in this state; and

(2) begin proceedings as necessary to determine any further actions with respect to the impairment. (V.T.I.C. Art. 3.60.)

Source Law

Art. 3.60. No impairment of capital shall be permitted for companies either incorporated or authorized to do the lines of business authorized in this chapter. No impairment of more than 90 percent of the statutory minimum surplus required of a company under Article 3.02 of this code shall be permitted, and no impairment of a company's surplus required by the board promulgated risk-based capital and surplus regulations shall be permitted. If the commissioner determines that either the capital is impaired or the surplus of a company is impaired in excess of such permissible amount, the commissioner shall order the company to immediately reduce the impairment to acceptable levels specified by the commissioner or to cease to do business within this state. The commissioner shall thereupon institute such proceedings as may be necessary to determine what further actions shall be taken in the matter.

Revisor's Note

V.T.I.C. Article 3.60 refers to impairment of a company's surplus "required by the board promulgated risk-based capital and surplus regulations." The revised law substitutes for the quoted language a reference to the surplus "required under Section 841.205" for the convenience of the reader. The quoted language refers to the provisions of Section 2A(a), V.T.I.C. Article 3.02, giving the Texas Department of Insurance the authority to require capital and surplus amounts after taking into account certain risks. The relevant parts of Section 2A are revised in Section

841.205.

Revised Law

Sec. 841.207. ACTIONS OF COMMISSIONER WHEN CAPITAL AND SURPLUS REQUIREMENTS NOT SATISFIED. If an insurance company does not comply with the capital and surplus requirements of this chapter, the commissioner may order the insurance company to cease writing new business and may:

(1) place the insurance company under state supervision or conservatorship;

(2) declare the insurance company to be in a hazardous condition as provided by Article 1.32;

(3) declare the insurance company to be impaired as provided by Section 841.206; or

(4) apply to the insurance company any other applicable sanction provided by this code. (V.T.I.C. Art. 3.02, Sec. 1(b).)

Source Law

(b) The commissioner may order an insurer subject to the minimum capital and surplus requirements of this article that fails to comply with those requirements to cease writing new business, and the commissioner may also:

1. place the insurer under state supervision or conservatorship;

2. determine the insurer to be in a hazardous condition as provided by Article 1.32 of this Code;

3. determine the insurer to be impaired as provided by Article 3.60 of this Code; or

4. make the insurer subject to any other applicable sanctions provided by this Code.

[Sections 841.208-841.250 reserved for expansion]

SUBCHAPTER F. GENERAL POWERS, DUTIES, AND LIMITATIONS

Revised Law

Sec. 841.251. EVIDENCE OF EXPENDITURES. (a) A domestic insurance company may not make an expenditure of $100 or more unless the expenditure is evidenced by a voucher that:

(1) is signed by or on behalf of the individual, firm, or corporation that receives the money; and

(2) describes the consideration received for the payment correctly.

(b) For an expenditure for both services and disbursements, the voucher must state the services rendered and disbursement made.

(c) For an expenditure related to a matter pending before a legislature or public body or a department or officer of a state or government, the voucher must describe both the nature of the matter and the interest of the company in the matter correctly.

(d) If the domestic insurance company cannot obtain a voucher as required by this section, the expenditure must be evidenced by:

(1) a paid check; or

(2) an affidavit that:

(A) describes the nature and purpose of the expenditure; and

(B) states the reason the voucher was not obtained. (V.T.I.C. Art. 3.13.)

Source Law

Art. 3.13. No "domestic" company shall make any disbursement of One Hundred ($100.00) Dollars or more, unless the same be evidenced by a voucher signed by, or on behalf of, the person, firm or corporation receiving the money and correctly describing the consideration for the payment. If the expenditure be for both services and disbursements, the voucher shall set forth the service rendered and statement of the disbursement made. If the expenditure be in connection with any matter pending before any

legislature or public body, or before any department or officer of any state or government, the voucher shall correctly describe, in addition, the nature of the matter and of the interest of such company therein. When such voucher cannot be obtained, the expenditure shall be evidenced by a paid check or an affidavit describing the character and object of the expenditure, and stating the reason for not obtaining such voucher.

Revised Law

Sec. 841.252. PAYMENTS TO OFFICERS, DIRECTORS, AND EMPLOYEES. (a) Unless first authorized by a vote of a domestic insurance company's board of directors or a committee of the board that has the duty to authorize the payments, the company may not pay any compensation or emolument in an amount that, when added to any compensation or emolument paid to the person by an affiliated domestic insurance company, exceeds $100,000 in any year to an individual, firm, or corporation, including an officer or director of the company.

(b) Subsection (a) does not prevent a domestic insurance company from contracting with its agents for the payment of renewal commissions.

(c) The shareholders of a domestic insurance company may authorize the creation of one or more plans for the payment of pensions, retirement benefits, or group insurance for the company's officers and employees. The shareholders may delegate to the company's board of directors the power and duty to prepare, effect, finally approve, administer, and amend a plan.

(d) A mutual insurance company, acting through the company's policyholders, may exercise the same discretion, and has the same powers, privileges, and rights, as are conferred on a domestic insurance company under Subsection (c). (V.T.I.C. Art. 3.12.)

Source Law

Art. 3.12. (a) A "domestic" company may not pay any salary, compensation or emolument which, together with any salary,

compensation or emolument from an affiliated "domestic" company, amounts in any year to more than $100,000 to any officer, trustee or director of the "domestic" company, or to any person, firm or corporation, unless such payment be first authorized by a vote of the board of directors of such company, or by a committee of such board charged with the duty of authorizing such payments. The limitation as to time contained in this article does not prevent a "domestic" company from entering into contracts with its agents for the payment of renewal commissions.

(b) The stockholders of any such "domestic" company may authorize the inauguration of a plan or plans for the payment of pensions, retirement benefits or group insurance to its officers and employees. The stockholders may delegate to the board of directors authority and responsibility for the preparation, inauguration, putting into effect, final approval and administration of any such plan or plans or any amendments thereof.

(c) Mutual companies, acting through their policyholders, may exercise the same discretion and shall have the same authority, privileges and rights as are conferred upon "domestic" companies under Subparagraph (b) next above.

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 3.12, refers to "salary, compensation or emolument." The references to "salary" are omitted from the revised law because "salary" is included within the meaning of "compensation."

(2) Subsection (a), V.T.I.C. Article 3.12, refers to a company's "trustee." A domestic insurance company is governed by directors rather than trustees. The revised law omits the reference as unnecessary.

(3) Subsection (b), V.T.I.C. Article 3.12, refers to "the preparation, inauguration, putting into effect, final approval and administration of any such plan or plans." The revised law omits the reference to "inauguration" because in this context it is included in the action of "putting into effect."

Revised Law

Sec. 841.253. LIFE INSURANCE COMPANY'S PAYMENT OF DIVIDENDS. (a) A life insurance company may declare or pay a dividend to its:

(1) policyholders only from the expense loading and profits made by the company; and

(2) shareholders only from the company's earned surplus, as defined by the commissioner.

(b) A life insurance company that is not showing a profit may pay a dividend on its participating policies from the expense loading on those policies.

(c) A life insurance company may not discriminate between policyholders in paying a dividend from the expense loading under this section. (V.T.I.C. Art. 3.11 (part).)

Source Law

Art. 3.11. No life insurance company shall declare or pay any dividends to its policyholders, except from the expense loading and profits made by such company; provided, however, any such company not showing a profit may pay dividends on its participating policies from the expense loading on such policies; and provided further, that any payment of dividends from the expense loading shall not be discriminatory as between policyholders. . . . No such company shall declare or pay any dividends to its stockholders, except from the company's earned surplus as defined by the State Board of Insurance. . . .

Revised Law

Sec. 841.254. TRANSFER OF STOCK. (a) A domestic insurance company's shares of stock are transferrable on the company's books, in accordance with law and the bylaws of the company, by the owner or the owner's authorized agent.

(b) Each person who becomes a shareholder by a transfer of shares succeeds to all rights of the former holder of those shares, by reason of that ownership. (V.T.I.C. Art. 3.05, Subsec. (a) (part).)

Source Law

(a) . . . The shares of stock of such company shall be transferable on its books, in accordance with law and the by-laws of the company, by the owner in person or his authorized agent. Every person becoming a stockholder by such transfer shall succeed to all rights of the former holder of the stock transferred, by reason of such ownership.

Revised Law

Sec. 841.255. ANNUAL STATEMENT; FILING FEE. (a) Not later than March 1 of each year, a domestic insurance company shall:

(1) prepare a statement showing the condition of the company on December 31 of the preceding year; and

(2) deliver the statement to the department accompanied by a filing fee in the amount determined under Article 4.07.

(b) The statement must be under oath of two of the domestic insurance company's officers and show in detail:

(1) the character of the company's assets and liabilities on December 31 of the preceding year;

(2) the amount and character of business transacted and money received during the preceding year;

(3) how money was spent during the preceding year;

(4) the number and amount of the company's policies in force in this state on that date; and

(5) the total amount of the company's policies in force on that date. (V.T.I.C. Art. 3.07.)

Source Law

Art. 3.07. Each "domestic" company shall, after the first day of January of each year and before the first day of March following, and before the renewal of its certificate of authority to transact business, prepare, under oath of two of its officers, and deposit in the office of the State Board of Insurance, a statement, accompanied with the prescribed fee for filing annual

statements, showing the condition of the company on the thirty-first day of December the next preceding, which shall include a statement in detail showing the character of its assets and liabilities on that date, the amount and character of business transacted, moneys received and how expended during the year, and the number and amount of its policies in force on that date in Texas, and the total amount of its policies in force.

Revisor's Note

(1) V.T.I.C. Article 3.07 requires a domestic insurance company to file an annual statement "before the renewal of its certificate of authority." The revised law omits the reference to the renewal of a certificate for the reason stated in the revisor's note at the end of Subchapter C.

(2) V.T.I.C. Article 3.07 refers to "the prescribed fee for filing annual statements." V.T.I.C. Article 4.07 is a comprehensive provision that authorizes the Texas Department of Insurance to set the amount of various fees, including fees for annual statements. Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

(3) V.T.I.C. Article 3.07 refers to "the next preceding" December 31. The revised law omits "next" as unnecessary because "the preceding" means "the next preceding."

Revised Law

Sec. 841.256. BUSINESS IN SEPARATE DEPARTMENTS OF DOMESTIC INSURANCE COMPANY. A domestic insurance company may not transact more than one of the kinds of insurance business described by Section 841.051(a) unless the company establishes separate departments to transact each kind of business. (V.T.I.C. Art. 3.02, Sec. 1(a) (part).)

Source Law

(a) . . . [for the purpose of forming a life insurance company, or accident insurance company, or life and accident, health and accident, or life, health and accident insurance

company.] No such company shall transact more than one of the foregoing classes of business except in separate and distinct departments. . . .

Revisor's Note

Section 1(a), V.T.I.C. Article 3.02, refers to "separate and distinct" departments of an insurance company. The revised law omits "distinct" as unnecessary because, in context, "distinct" is included within the meaning of "separate."

Revised Law

Sec. 841.257. KINDS OF BUSINESS LIMITED. An insurance company authorized to engage in the business of insurance under this chapter may not accept a risk or write an insurance policy in this state or any other state or country other than:

(1) a life, accident, or health insurance policy;

(2) reinsurance under Article 5.75-1 by a life insurance company authorized to engage in the business of insurance in this state; or

(3) reinsurance under Article 5.75-3 by a domestic insurance company. (V.T.I.C. Art. 3.54.)

Source Law

Art. 3.54. It shall be unlawful for any insurance company incorporated or licensed under the provisions of this chapter to take any kind of risks or issue any policies of insurance, except those of life, accident or health or those risks reinsured under Article 5.75-1 or 5.75-3 of this code; nor shall the business of life insurance in this State be in anywise conducted or transacted by any company which, in this or any other State or country, is engaged or concerned in writing any kinds of insurance other than life, health and accident insurance, reinsurance under Article 5.75-1 of this code by a life insurance company authorized to do business in this State, or reinsurance under Article 5.75-3 of this code by a domestic company as defined in Section 5 of Article 3.01 of this code.

Revisor's Note

V.T.I.C. Article 3.54 refers to an insurance company "licensed" under V.T.I.C. Chapter 3. The revised law substitutes "authorized to engage in the business of insurance" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 841.258. AGENTS FOR COMPANY THAT CEASES WRITING NEW BUSINESS. A domestic insurance company that ceases to write new business in this state may maintain in this state agents to collect renewal premiums on outstanding policies the company has written under its certificate of authority. (V.T.I.C. Art. 3.58.)

Source Law

Art. 3.58. Any company which shall fail to renew its certificate of authority or continue to write new business in this State, shall, nevertheless, have the right to maintain agents in Texas for the purpose of collecting renewal premiums on outstanding business written by it under certificate of authority, and also for the purpose of making investments as provided by this chapter.

Revisor's Note

(1) V.T.I.C. Article 3.58 addresses in part a company that fails to "renew its certificate of authority." The revised law omits the reference to the renewal of a certificate of authority for the reason stated in the revisor's note at the end of Subchapter C.

(2) V.T.I.C. Article 3.58 provides that certain insurance companies may maintain agents in this state "for the purpose of making investments as provided by this chapter." The revised law omits the quoted language because the provisions of V.T.I.C. Chapter 3 to which it refers have been repealed. Article 3.58 is derived from Section 9, Chapter 122, General Laws, Acts of the

31st Legislature, Regular Session, 1909, which established requirements for life insurance companies to maintain investments in Texas securities (see former V.T.I.C. Article 3.34). The requirements relating to investments of insurance companies in Texas securities were repealed by Chapter 31, Acts of the 68th Legislature, 2nd Called Session, 1984, and investments of insurance companies are now governed by V.T.I.C. Articles 3.33, 3.39, and 3.40-1.

Revised Law

Sec. 841.259. ACTIVITIES OF DIRECTORS AND OFFICERS. (a) A director or officer of an insurance company may not:

(1) receive money or another valuable thing for negotiating, procuring, recommending, or aiding in a purchase or sale of property by or a loan from the company; or

(2) have a pecuniary interest, as a principal, coprincipal, agent, or beneficiary, in a purchase, sale, or loan described by Subdivision (1).

(b) This section does not prohibit:

(1) a life insurance company from making a loan to a policyholder in an amount that is not greater than the reserve value of the policy; or

(2) a transaction, purchase, sale, or loan approved by the commissioner under Subchapter A of Chapter 805 or Chapter 823. (V.T.I.C. Art. 3.67.)

Source Law

Art. 3.67. No director or officer of any insurance company transacting business in or organized under the laws of this State, shall receive any money or valuable thing for negotiating, procuring, recommending or aiding in any purchase or sale by such company of any property, or any loan from such company, nor be pecuniarily interested, either as principal, co-principal, agent or beneficiary in any such purchase, sale or loan. Nothing in this article shall prevent a life insurance corporation from making a loan upon a policy held therein, by the borrower, not in excess of the reserve value thereof. Provided, however, that

nothing in this article shall prevent any transaction, purchase, sale or loan which is approved by the commissioner of insurance under the provisions of either Article 1.29 or Article 21.49-1 of this code, as amended.

Revisor's Note

V.T.I.C. Article 3.67 refers to "Article 1.29 or Article 21.49-1 of this code, as amended." V.T.I.C. Articles 1.29 and 21.49-1 are revised as Chapters 805 and 823, respectively, and the revised law is drafted accordingly. The revised law omits the reference to "as amended" as unnecessary because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, provides that unless expressly provided otherwise, a reference to any portion of a statute applies to all reenactments, revisions, or amendments of the statute.

Revised Law

Sec. 841.260. PROHIBITED COMMISSIONS. (a) In this section, "contingent compensation" means a commission or other compensation an insurance company pays to a person that is contingent on:

(1) the writing or procurement of an insurance policy in the company;

(2) the procurement of an application for an insurance policy in the company;

(3) the payment of a renewal premium; or

(4) the assumption of an insurance risk by the company.

(b) A life insurance company that engages in the business of insurance in this state may not, directly or indirectly, pay or contract to pay a contingent compensation to:

(1) the president, vice president, secretary, or treasurer of the company;

(2) any other officer of the company, other than an agent or solicitor;

(3) an actuary of the company; or

(4) a medical director or other physician of the

company whose duty is to examine risks or applications for insurance for the company.

(c) This section does not prohibit a plan of compensation to a marketing officer according to the total amount of insurance the insurance company writes or to the total amount of insurance in force with the insurance company during a specified period if:

(1) the commissioner approves the plan under Subchapter A, Chapter 805;

(2) the marketing officer is not responsible for underwriting, rating, or otherwise approving the acceptability of insurance risks; and

(3) the plan does not compensate the marketing officer according to commissions on individual sales of any insurance product. (V.T.I.C. Art. 3.68 (part).)

Source Law

Art. 3.68. No life insurance company transacting business in this State shall pay, or contract to pay, directly or indirectly, to its president, vice president, secretary, treasurer, actuary, medical director or other physician charged with the duty of examining risks or applications for insurance or to any officer of the company other than an agent or solicitor, any commission or other compensation contingent upon the writing or procuring of any policy of insurance in such company, or procuring an application therefor by any person whomsoever, or contingent upon the payment of any renewal premium, or upon the assumption of any insurance risk by such company. . . . Provided, however, that nothing in this article shall prevent any plan of compensation to a marketing officer based on the aggregate amount of insurance that is issued by or that is in force with the company during any specified period, which is approved under the provisions of Article 1.29 of this code, as amended, so long as such officer is not responsible for underwriting, rating, or otherwise approving the acceptability of insurance risks. Further provided, this exception shall not allow such a plan of compensation to be based on commissions for individual sales of insurance products.

Revisor's Note

(1) V.T.I.C. Article 3.68 provides that an insurance company may have its certificate of authority revoked for a violation of the article. The revised law omits the provision because it duplicates V.T.I.C. Article 3.55, revised as Section 841.701, which provides for revocation of a certificate of authority for any violation of V.T.I.C. Chapter 3. The omitted law reads:

Art. 3.68. . . . Should any company violate any provision of this article, the Board may revoke its certificate of authority to transact business in this State. . . .

(2) V.T.I.C. Article 3.68 refers to "Article 1.29 of this code, as amended." The revised law omits the reference to "as amended" for the reason stated in the revisor's note to Section 841.259.

Revised Law

Sec. 841.261. CAUSES OF ACTION. (a) A domestic insurance company may bring an action against any person, including a policyholder or shareholder of the company, for any cause related to the company's business.

(b) A policyholder or an heir or legal representative of a policyholder may bring an action against a domestic insurance company for a loss that accrues on a policy.

(c) An action enjoining, restraining, or interfering with the prosecution of a domestic insurance company's business may be brought only by the department. (V.T.I.C. Art. 3.63.)

Source Law

Art. 3.63. Actions may be maintained by a company organized under the laws of this State against any of its policyholders, stockholders, or other person for any cause relating to the business of such company. Suits may also be prosecuted and maintained by any policyholder or his heirs or his legal representatives against the company for losses which accrue on any policy. No action shall be brought or maintained by any

person other than the Board of Insurance Commissioners for the enjoining, restraining or interfering with the prosecution of the business of the company.

[Sections 841.262-841.300 reserved for expansion]

SUBCHAPTER G. PROHIBITIONS AND RESTRICTIONS ON ISSUANCE OF POLICIES

Revised Law

Sec. 841.301. LIMITS ON AMOUNT OF ACCIDENT AND HEALTH INSURANCE POLICIES. (a) A domestic insurance company may not assume liability on or indemnify one person for any risk under one or more accident, health, or hospitalization insurance policies, or a combination of those policies, in an amount that exceeds $10,000, unless the amount of the issued, outstanding, and stated capital of the company is at least equal to the minimum amount of capital required for a newly incorporated company under Section 841.054.

(b) A domestic insurance company that before January 1, 2002, ceases to write or assume liability on, or indemnify any risk under, a policy described by Subsection (a) in the amount specified by Subsection (a) and notifies the commissioner of that action is exempt from the requirements of Subsection (a) until the date the company resumes writing those policies. A company that resumes assuming liability on or indemnifying risks under those policies shall comply with Subsections (a) and (c).

(c) A domestic insurance company that is exempt under Subsection (b) shall maintain its issued, outstanding, and stated capital in an amount that is at least $100,000 and is at least:

(1) the amount of capital held by the company on December 31, 1991, plus 10 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1993;

(2) the amount of capital held by the company on

December 31, 1991, plus 20 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1994;

(3) the amount of capital held by the company on December 31, 1991, plus 30 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1995;

(4) the amount of capital held by the company on December 31, 1991, plus 40 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1996;

(5) the amount of capital held by the company on December 31, 1991, plus 50 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1997;

(6) the amount of capital held by the company on December 31, 1991, plus 60 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1998;

(7) the amount of capital held by the company on December 31, 1991, plus 70 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 1999;

(8) the amount of capital held by the company on

December 31, 1991, plus 80 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 2000; and

(9) the amount of capital held by the company on December 31, 1991, plus 90 percent of the difference between that amount and an amount equal to the minimum amount of capital required for a newly incorporated company under Section 841.054, if the last date that the company writes a policy described by Subsection (a) is during 2001. (V.T.I.C. Art. 3.02, Secs. 2(c), (d).)

Source Law

[(a) If an insurance company subject to this chapter and doing business in this state as an authorized insurer . . . .]

(c) In addition to increases under Subsection (a) of this section, after December 31, 1991, an insurance company subject to this chapter may not assume risk of liability on, or indemnify any one person for, any risk under any health, accident, sickness, or hospitalization policy, or any combination of those policies, in an amount in excess of $10,000, unless the issued, outstanding, and stated capital of the insurer is at least $100,000 as of December 31, 1991, and:

1. not later than December 31, 1992, the company's capital must have increased by at least 10 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

2. not later than December 31, 1993, the company's capital must have increased by at least 20 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

3. not later than December 31, 1994, the company's

capital must have increased by at least 30 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

4. not later than December 31, 1995, the company's capital must have increased by at least 40 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

5. not later than December 31, 1996, the company's capital must have increased by at least 50 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

6. not later than December 31, 1997, the company's capital must have increased by at least 60 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

7. not later than December 31, 1998, the company's capital must have increased by at least 70 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

8. not later than December 31, 1999, the company's capital must have increased by at least 80 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991;

9. not later than December 31, 2000, the company's capital must have increased by at least 90 percent of the difference between the minimum capital level established by Section 1 of this article for a newly incorporated company and the company's capital on December 31, 1991; and

10. not later than December 31, 2001, and thereafter, the company must have capital of at least the minimum capital

level established by Section 1 of this article for a newly incorporated company.

(d) If an insurer subject to Subsection (c) of this section ceases to write or assume risk of liability on, or to indemnify any one person for, any risk under any health, accident, sickness, or hospitalization policy in an amount in excess of $10,000, and so notifies the Commissioner, the insurer is not thereafter required to meet the requirements of Subsection (c) of this section relating to increase in minimum capital. If the insurer should thereafter resume writing or assuming such risk of liability on, or indemnifies any one person for, any risk under any health, accident, sickness, or hospitalization policy in an amount in excess of $10,000, the insurer shall be subject to and comply with Subsection (c) of this section at the amount of capital required as of the date of such resumed writing or assumption of such risks.

Revised Law

Sec. 841.302. LIMITS ON LIFE OR ACCIDENTAL DEATH INSURANCE. (a) Until the amount of the capital and surplus of a domestic insurance company is at least $100,000, the company may not insure any one life for more than $20,000 in the event of death from natural causes or more than $40,000 in the event of death from accidental causes.

(b) If the net capital and surplus of a domestic insurance company is at least $75,001 but less than $100,000, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds $4,000 in the event of death from natural causes and the amount of the benefit that exceeds $8,000 in the event of death from accidental causes.

(c) If the net capital and surplus of a domestic insurance company is at least $50,001 but less than $75,001, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds $3,000 in the event of death from natural causes and the amount of the benefit that exceeds $6,000 in the event of death from accidental causes.

(d) If the net capital and surplus of a domestic insurance company is at least $35,001 but less than $50,001, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds $2,000 in the event of death from natural causes and the amount of the benefit that exceeds $4,000 in the event of death from accidental causes.

(e) If the net capital and surplus of a domestic insurance company is $35,000 or less, the company, for any policy issued by the company, shall reinsure the amount of the benefit that exceeds $1,000 in the event of death from natural causes and the amount of the benefit that exceeds $2,000 in the event of death from accidental causes.

(f) Benefits under this section must be reinsured with a legal reserve company that is authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 3.02, Sec. 2(b).)

Source Law

(b) Until the capital and surplus of such company is at least One Hundred Thousand ($100,000.00) Dollars, no such company shall insure any life for more than Twenty Thousand ($20,000.00) Dollars in the event of death from natural causes nor more than Forty Thousand ($40,000.00) Dollars in the event of death from accidental causes. Provided, however, that when the net capital and surplus of any such company is not more than Thirty-five Thousand ($35,000.00) Dollars, the excess over One Thousand ($1,000.00) Dollars natural death benefit and Two Thousand ($2,000.00) Dollars accidental death benefit under any policy issued by it shall be reinsured in some legal reserve company licensed in Texas; that when the net capital and surplus is Thirty-five Thousand and One ($35,001.00) Dollars to Fifty Thousand ($50,000.00) Dollars, the natural death benefit over Two Thousand ($2,000.00) Dollars and accidental death benefit over Four Thousand ($4,000.00) Dollars shall be so reinsured; that when the net capital and surplus is Fifty Thousand and One ($50,001.00) Dollars to Seventy-five Thousand ($75,000.00)

Dollars, the natural death benefit over Three Thousand ($3,000.00) Dollars and accidental death benefit over Six Thousand ($6,000.00) Dollars shall be so reinsured; and when the net capital and surplus is Seventy-five Thousand and One ($75,001.00) Dollars to less than One Hundred Thousand ($100,000.00) Dollars, the natural death benefit over Four Thousand ($4,000.00) Dollars and accidental death benefit over Eight Thousand ($8,000.00) Dollars shall be so reinsured.

Revisor's Note

Section 2(b), V.T.I.C. Article 3.02, refers to a legal reserve company "licensed" in Texas. The revised law substitutes "authorized to engage in the business of insurance" for "licensed" for the reason stated in the revisor's note to Section 841.257.

[Sections 841.303-841.350 reserved for expansion]

SUBCHAPTER H. DEPOSIT OF SECURITIES

Revised Law

Sec. 841.351. DEPOSIT WITH COMPTROLLER. (a) A domestic insurance company may, at its option, deposit with the comptroller either:

(1) securities in which the company's capital stock is invested; or

(2) securities in an amount equal to the amount of the company's capital stock.

(b) Securities deposited under Subsection (a) must be securities of a class authorized by the laws of this state for investments of a domestic insurance company's capital stock.

(c) A domestic insurance company may, at its option, withdraw a deposit made under Subsection (a), or any portion of the deposit, after substituting a deposit of securities of a like class and of an amount and value equal to the withdrawn deposit or portion of deposit.

(d) The commissioner must first approve any securities deposited or being substituted under this section. (V.T.I.C. Art. 3.15, Subsec. (a) (part).)

Source Law

Art. 3.15. (a) Any "domestic" company may, at its option, deposit with the comptroller, securities in which its capital stock is invested, or securities equal in amount to its capital stock, of the class in which the law of this State permits such insurance companies to invest their capital stock, and may, at its option, withdraw the same or any part thereof, first having deposited with the comptroller, in lieu thereof, other securities of like class and equal amount and value to those withdrawn. Any such securities, before being so originally deposited or substituted, shall be approved by the Board of Insurance Commissioners. . . .

Revised Law

Sec. 841.352. ISSUANCE OF RECEIPT FOR DEPOSIT. When a domestic insurance company deposits securities under this subchapter, the comptroller shall issue to the company a receipt that:

(1) describes the deposit in a manner that identifies the securities; and

(2) states that the securities are held on deposit as capital stock investments of the company. (V.T.I.C. Art. 3.15, Subsec. (a) (part).)

Source Law

(a) . . . When any such deposit is made, the comptroller shall execute to the company making such deposit a receipt therefor, giving such description of said stock or securities as will identify the same, and stating that the same are held on deposit as the capital stock investments of such company; and . . . .

Revised Law

Sec. 841.353. ADVERTISEMENT OF DEPOSIT. A domestic insurance company that makes a deposit under this subchapter may:

(1) advertise the fact that a deposit has been made; or

(2) print a copy of the receipt for the deposit on any policy the company issues. (V.T.I.C. Art. 3.15, Subsec. (a) (part).)

Source Law

(a) . . . such company shall have the right to advertise such fact or print a copy of the comptroller's receipt on the policies it may issue; and . . . .

Revised Law

Sec. 841.354. ACCESS TO DEPOSIT. In accordance with reasonable rules adopted by the comptroller and the commissioner, the proper officer or agent of a domestic insurance company making a deposit of securities under this subchapter may at a reasonable time:

(1) examine the deposit;

(2) detach coupons from the securities; and

(3) collect interest on the deposit. (V.T.I.C. Art. 3.15, Subsec. (a) (part).)

Source Law

(a) . . . the proper officer or agent of each insurance company making such deposit shall be permitted at all reasonable times to examine such securities and to detach coupons therefrom, and to collect interest thereon, under such reasonable rules and regulations as may be prescribed by the comptroller and the Board of Insurance Commissioners. . . .

Revised Law

Sec. 841.355. WITHDRAWAL OF DEPOSIT AFTER MERGER, CONSOLIDATION, OR TOTAL REINSURANCE. (a) When two or more domestic insurance companies that have two or more deposits of securities under this subchapter merge, consolidate, or enter into a total reinsurance contract by which the ceding company is

dissolved and its assets and liabilities are acquired or assumed by the surviving company, the new, surviving, or reinsuring insurance company, on approval of the commissioner, may withdraw all of the deposits, except for the deposit of the greatest amount and value. The new, surviving, or reinsuring insurance company must demonstrate to the commissioner that the company is the owner of the deposited securities before the commissioner approves the withdrawal of those securities.

(b) In accordance with an order of the commissioner approving a withdrawal of securities under this section, the comptroller shall release, transfer, and deliver the withdrawn securities to their owner. (V.T.I.C. Art. 3.15, Subsec. (b).)

Source Law

(b) When two or more companies merge or consolidate or enter a total reinsurance contract by which the ceding company is dissolved and its assets acquired and liabilities assumed by the surviving company, and the companies have on deposit with the comptroller two or more deposits made under Article 3.15 of the Texas Insurance Code, as amended, all such deposits, except the deposit of greatest amount and value may be withdrawn by the new, surviving or reinsuring company upon proper showing before the Commissioner that the company is the owner thereof. The comptroller shall release, transfer and deliver such deposit or deposits to the owner as directed by order of the Commissioner.

Revisor's Note

Subsection (b), V.T.I.C. Article 3.15, refers to "Article 3.15 of the Texas Insurance Code, as amended." The revised law omits "as amended" for the reason stated in the revisor's note to Section 841.259.

Revised Law

Sec. 841.356. SITUS OF DEPOSIT FOR TAX PURPOSES. For purposes of state, county, or municipal taxation, the situs of deposited securities is the municipality and county in which the depositing company's home office is located. (V.T.I.C. Art. 3.15,

Subsec. (a) (part).)

Source Law

(a) . . . For the purpose of state, county and municipal taxation, the situs of securities deposited with the comptroller by domestic insurance companies shall be in the city and county where the principal business office of such company is fixed by its charter.

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 3.15, refers to the "city" where a company's business office is located. The revised law substitutes "municipality" for "city" because that is the term used in the Local Government Code.

(2) Subsection (a), V.T.I.C. Article 3.15, refers to an insurance company's "principal business office." The revised law substitutes "home office" for the quoted term for consistency of terminology used in this chapter. Section 7, V.T.I.C. Article 3.01, revised as Section 841.001(7), defines "home office" to mean "the principal office" of a company.

Revised Law

Sec. 841.357. MAINTENANCE OF DEPOSIT. A domestic insurance company must maintain a deposit of securities under this subchapter as long as the company has outstanding any liability to a policyholder in this state. (V.T.I.C. Art. 3.15, Subsec. (a) (part).)

Source Law

(a) . . . The deposit herein provided for, when made by any company, shall thereafter be maintained so long as said company shall have outstanding any liability to its policyholders in this State. . . .

[Sections 841.358-841.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT AND INTERVENTION

Revised Law

Sec. 841.701. REVOCATION OF CERTIFICATE OF AUTHORITY. (a) If the commissioner determines that an insurance company that holds a certificate of authority does not comply with this chapter or another law described by Section 841.002, the commissioner shall notify the company that the commissioner intends to revoke its certificate of authority on the expiration of the 30-day period after the date actual notice is delivered or mailed under this section.

(b) Notice under this section must:

(1) be in writing; and

(2) be delivered to an executive officer of the company by personal service or by registered mail.

(c) If an insurance company receiving notice under this section does not fully comply before the expiration of the period prescribed by Subsection (a), the commissioner shall revoke the company's certificate of authority.

(d) An insurance company whose certificate of authority is revoked under this section is not entitled to receive another certificate of authority for a period of one year and until the company has fully and in good faith complied with this chapter. (V.T.I.C. Art. 3.55 (part).)

Source Law

Art. 3.55. If any such insurance company, while holding a certificate of authority to transact business in this State, shall fail or refuse to comply with any of the provisions or requirements of this chapter, the Board of Insurance Commissioners upon ascertaining such fact, shall notify such company by actual notice in writing delivered to an executive officer of such company, of its intention to revoke its certificate of authority to transact business in this State at the expiration of thirty (30) days after the mailing of such registered letter, or the date upon which such actual notice is

served. If such provisions or requirements are not fully complied with upon the expiration of said thirty (30) days, it shall be the duty of said Board to revoke the certificate of authority of such company. In case of such revocation, such company shall not be entitled to receive another certificate of authority for a period of one (1) year, and until it shall have fully and in good faith complied with all such provisions and requirements of this chapter. . . .

Revisor's Note

V.T.I.C. Article 3.55 refers to the "Board of Insurance Commissioners." Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the Board of Insurance Commissioners and the State Board of Insurance have been changed appropriately.

Revised Law

Sec. 841.702. APPEAL OF DETERMINATION TO REVOKE CERTIFICATE. A domestic insurance company aggrieved by an order of the commissioner to revoke the company's certificate of authority under Section 841.701 may file suit in a court in Travis County to vacate the order. (V.T.I.C. Art. 3.55 (part).)

Source Law

Art. 3.55. . . . Any company feeling itself aggrieved by the action of the Board in revoking its certificate of authority to do business in this State may bring suit against said Board in

Travis County to annul and vacate the order revoking such certificate.

Revisor's Note

V.T.I.C. Article 3.55 provides that a suit may be brought to "annul and vacate" certain orders of the commissioner. The revised law omits the reference to "annul" because, in context, "annul" is included within the meaning of "vacate."

Revised Law

Sec. 841.703. CERTIFICATE OF AUTHORITY VOID ON FAILURE TO SATISFY JUDGMENT. (a) If an officer holding an execution issued on a final judgment rendered against an insurance company demands payment of the judgment from an officer or attorney of record of the company and the company does not fully satisfy the judgment before the 31st day after the date the demand is made, the officer shall certify the demand and failure to the commissioner, regardless of whether the demand is made in this state.

(b) On receipt of a certification under Subsection (a), the commissioner shall declare void the certificate of authority issued to the company under this chapter.

(c) An insurance company whose certificate of authority is declared void under this section may not engage in the business of insurance in this state until:

(1) the judgment is fully satisfied and discharged; and

(2) the commissioner renews the company's certificate of authority. (V.T.I.C. Art. 3.61.)

Source Law

Art. 3.61. If any life insurance company, accident insurance company, life and accident, health and accident, or life, health and accident insurance company fails to pay off and satisfy any execution that may lawfully issue on any final judgment against said company within thirty (30) days after the officer holding such execution has demanded payment thereof from any officer or attorney of record of such company, in this State, or out of it,

such officer shall immediately certify such demand and failure to the Board of Insurance Commissioners; and thereupon the Board shall forthwith declare null and void the certificate of authority of such company; and such company shall be prohibited from transacting any business in this State until such execution shall be fully satisfied and discharged, and until such Board shall renew its certificate of authority to such company.

Revisor's Note

(1) V.T.I.C. Article 3.61 provides for voiding a certificate of authority of a company that fails "to pay off and satisfy" an execution. The revised law omits "to pay off" as unnecessary because, in context, "pay off" is included within the meaning of "satisfy."

(2) V.T.I.C. Article 3.61 refers to an execution issued "lawfully." The revised law omits "lawfully" as unnecessary because the authority to issue the execution on a judgment is sufficient to make the issuance lawful.

(3) V.T.I.C. Article 3.61 provides that under certain circumstances a company's certificate of authority shall be declared "null and void." The revised law omits "null" as unnecessary because it is included within the meaning of "void."

Revised Law

Sec. 841.704. FALSE STATEMENT, REPORT, OR OTHER DOCUMENT; CRIMINAL PENALTY. (a) A person commits an offense if the person executes or causes to be executed a statement, report, or other document required by law to be filed with the commissioner that contains a material statement or fact that the person knows to be false.

(b) A person commits an offense if the person is an officer of an insurance company that is not organized under the laws of this state and the person files a statement, report, or other document required by law to be filed with the commissioner that contains a material statement or fact that the person knows to be false.

(c) An offense under this section is punishable by

imprisonment in the institutional division of the Texas Department of Criminal Justice for a term of not less than one year. (V.T.I.C. Art. 3.56-1.)

Source Law

Art. 3.56-1. Any officer of any insurance company not organized under the laws of this State, who shall file with the Commissioner of Insurance any statement, report or other paper required or provided for by law to be so filed, which shall contain any material statement or fact known to be false by the person filing the same, or any person who shall execute or cause to be executed any such false statement, report or other paper to be so filed, shall be imprisoned in the penitentiary for a term of not less than one year.

Revisor's Note

V.T.I.C. Article 3.56-1 refers to imprisonment in the "penitentiary." The revised law substitutes "institutional division of the Texas Department of Criminal Justice" for "penitentiary" to conform to the changes in law made by Chapter 785, Acts of the 71st Legislature, Regular Session, 1989, which transferred to that division the powers and duties that were previously those of the Texas Department of Corrections, the state agency with jurisdiction over penitentiaries in this state.

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SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 842.001. DEFINITIONS. In this chapter:

(1) "Group hospital service corporation" means a corporation organized under this chapter to establish and operate a nonprofit hospital service plan, under which hospital care may be provided by the corporation through one or more hospitals and sanitariums with which the corporation has contracted for the provision of that care.

(2) "Health care provider" means a person, association, partnership, corporation, or other entity that provides a service or supplies to prevent, alleviate, cure, or heal human illness or injury. (V.T.I.C. Arts. 20.01 (part); 20.11 (part).)

Source Law

[Art. 20.01. Any seven (7) or more persons, a majority of whom are superintendents of hospitals or physicians or surgeons licensed by the State Board of Medical Examiners, upon

application to the Secretary of State of the State of Texas for a corporate charter may be incorporated] for the purpose of establishing, maintaining and operating a nonprofit hospital service plan, whereby hospital care may be provided by said corporation through an established hospital or hospitals, and sanitariums with which it has contracted for such care, as is hereinafter defined.

[Art. 20.11]

. . . Health care provider means any person, association, partnership, corporation, or other entity furnishing or providing any services or supplies for the purpose of preventing, alleviating, curing, or healing human illness or injury.

Revisor's Note

(1) V.T.I.C. Article 20.01 refers to "establishing, maintaining and operating" a nonprofit hospital service plan. The revised law omits the reference to "maintaining" because, in context, "maintaining" is included within the meaning of "operating."

(2) V.T.I.C. Article 20.11 refers to "furnishing or providing" any services or supplies. The revised law omits the reference to "furnishing" because, in context, "furnishing" is included within the meaning of "providing."

Revised Law

Sec. 842.002. APPLICABILITY OF OTHER LAWS. (a) Except as otherwise required by this chapter, a state agency may not require a group hospital service corporation to post a bond or place a deposit with the agency or another agency of this state to begin or maintain operations authorized under this chapter.

(b) The group hospital service corporation is exempt from a provision of this code that is not expressly made applicable to the corporation. (V.T.I.C. Art. 20.09.)

Source Law

Art. 20.09. Such corporations organized and operated under the provisions of this chapter shall not be required by any department of this State to post bond, or place deposits with any department of this State to begin and/or operate under this chapter, except as may be otherwise required in this chapter, and the provisions of the other chapters of this code which are not expressly made applicable to corporations organized and operating under this chapter are hereby declared inapplicable.

Revised Law

Sec. 842.003. CORPORATION SUBJECT TO REGULATION BY COMMISSIONER AND DEPARTMENT. Each group hospital service corporation is subject to regulation by the department and the commissioner. (V.T.I.C. Art. 20.02 (part).)

Source Law

Art. 20.02. All corporations organized under the provisions of this chapter shall be under the direct supervision of the Board of Insurance Commissioners of the State of Texas, and . . . .

Revisor's Note

(1) V.T.I.C. Article 20.02 refers to the "direct supervision" of the former Board of Insurance Commissioners. The revised law substitutes "regulation" for "direct supervision" because the terms are synonymous and the use of "regulation" in this context is consistent with terminology used throughout this code.

(2) V.T.I.C. Article 20.02 refers to the "Board of Insurance Commissioners of the State of Texas." Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to the State Board of Insurance.

Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished that board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the Board of Insurance Commissioners and the State Board of Insurance have been changed appropriately.

[Sections 842.004-842.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF GROUP HOSPITAL SERVICE CORPORATION

Revised Law

Sec. 842.051. APPLICATION FOR CORPORATE CHARTER; NONPROFIT STATUS REQUIRED. (a) Seven or more persons, a majority of whom are superintendents of hospitals or physicians licensed by the Texas State Board of Medical Examiners, may apply to the secretary of state for a corporate charter to operate a group hospital service corporation.

(b) A group hospital service corporation must be governed and operated as a nonprofit organization. (V.T.I.C. Arts. 20.01 (part); 20.10 (part).)

Source Law

Art. 20.01. Any seven (7) or more persons, a majority of whom are superintendents of hospitals or physicians or surgeons licensed by the State Board of Medical Examiners, upon application to the Secretary of State of the State of Texas for a corporate charter may be incorporated . . . .

Art. 20.10. Such corporations shall be governed and conducted as nonprofit organizations; and provided that . . . .

Revisor's Note

(1) V.T.I.C. Article 20.01 refers to "physicians or surgeons" licensed by the State Board of Medical Examiners. Section 151.002(12), Occupations Code, defines a person licensed to practice medicine in this state as a "physician." Section 151.002(b), Occupations Code, provides that the terms "physician" and "surgeon" are synonyms. The revised law omits the use of the term "surgeon" because a surgeon is covered by the use of the term "physician."

(2) V.T.I.C. Article 20.01 refers to the "Secretary of State of the State of Texas." The revised law substitutes the term "secretary of state" because, under Chapter 405, Government Code, that is the official title of that officer.

Revised Law

Sec. 842.052. MINIMUM MEMBERSHIP REQUIREMENTS. (a) Before a group hospital service corporation may be incorporated, the corporation must have collected in advance from at least 500 applicants for membership:

(1) the application fee; and

(2) an amount at least equal to the amount charged by the corporation for one month's premium for coverage.

(b) A group hospital service corporation must maintain a membership of at least 500 as a condition of continued operation. (V.T.I.C. Art. 20.02 (part).)

Source Law

. . .

(a) Upon incorporation, and as a condition thereof, they shall have collected in advance from at least five hundred (500) applicants the application fee and at least one (1) month's payment for insurance. It shall be a condition of continued operation that a minimum membership of five hundred (500) be maintained;

. . . .

[Sections 842.053-842.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 842.101. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The department shall issue to a group hospital service corporation a certificate of authority that authorizes the corporation to engage in the business of a group hospital service corporation if the corporation:

(1) files a statement acceptable to the department showing solvency; and

(2) complies with this chapter.

(b) The department shall charge the fee prescribed by law for the issuance of the certificate of authority. (V.T.I.C. Arts. 20.02 (part); 20.08 (part).)

Source Law

[Art. 20.02. . . .]

(d) If any such corporation files an acceptable statement showing solvency, and otherwise complies with this chapter, the Board shall issue it a certificate authorizing it to transact business . . . .

Art. 20.08. The State Board of Insurance shall charge the fee prescribed by law for . . . the issuance of each certificate of authority to such corporation.

Revisor's Note

V.T.I.C. Article 20.02(d) refers to the term of a certificate of authority issued under that article. The revised law omits this reference as repealed. Under Section 1, V.T.I.C. Article 1.14, revised in relevant part as Section 801.053, a certificate of authority is valid until it is suspended or revoked. Section 2, Chapter 194, Acts of the 56th Legislature, Regular Session, 1959, amending Article 1.14, Insurance Code, provided that Article 20.02 was repealed "to the extent that [it requires] periodic renewal of certificates of authority." The omitted law reads:

[(d) If any such corporation files an acceptable statement showing solvency, and otherwise complies with this chapter, the Board shall issue it a certificate authorizing it to transact business] for a period of not more than fifteen (15) months, and not extending beyond May 31, next following the date of said certificate;

. . .

[Sections 842.102-842.150 reserved for expansion]

SUBCHAPTER D. BOARD OF DIRECTORS; PERSONNEL

Revised Law

Sec. 842.151. BOARD OF DIRECTORS. (a) Each group hospital service corporation is governed by a board of directors that has full control over its management affairs.

(b) A board of directors must be composed of at least 12 but not more than 20 directors. A majority of the directors must be persons who:

(1) are not health care providers or employees of health care providers; and

(2) do not have a financial interest in a health care provider. (V.T.I.C. Art. 20.13.)

Source Law

Art. 20.13. Such corporation shall have not fewer than 12 nor more than 20 directors who shall have full control over its management affairs. A majority of the directors shall not be health care providers or employees of or have a financial interest in a health care provider as defined in this chapter.

Revised Law

Sec. 842.152. COMPENSATION OF DIRECTORS. A director of a group hospital service corporation may not receive compensation for the director's services but is entitled to receive reimbursement for reasonable and necessary expenses incurred in attending a meeting called to manage or direct the affairs of the

corporation. (V.T.I.C. Art. 20.20 (part).)

Source Law

Art. 20.20. No director of any corporation created under this chapter shall receive any salary, wages or compensation for his services, but shall be allowed reasonable and necessary expenses incurred in attending any meeting called for the purpose of managing or directing the affairs of said corporation. . . .

Revisor's Note

V.T.I.C. Article 20.20 refers to the "salary, wages or compensation" of a director. The revised law omits the references to salary and wages because, in context, salary and wages are included within the meaning of "compensation."

Revised Law

Sec. 842.153. BOARD MEETINGS. The board of directors of a group hospital service corporation may not meet more frequently than once a month. A meeting may not last more than five days. (V.T.I.C. Art. 20.20 (part).)

Source Law

. . . Provided, however, that the directors may not have more than one (1) meeting per month, which meeting shall not last more than five (5) days.

Revised Law

Sec. 842.154. BOND REQUIREMENTS FOR CERTAIN OFFICERS AND EMPLOYEES. (a) Each group hospital service corporation shall post a bond for the officer or employee responsible for the handling of the corporation's money. The bond must be:

(1) issued by a surety company licensed by the department to do business in this state; and

(2) at all times in an amount at least equal to $25,000.

(b) In addition to the bond required under Subsection (a), the corporation shall post a separate bond or a blanket bond for

all employees who have access to the money of the corporation. The bond must be in a reasonable amount set by the commissioner in the amount of at least $500, not to exceed $10,000.

(c) A bond required by this section must be payable to the commissioner for the use and benefit of the corporation. (V.T.I.C. Art. 20.04.)

Source Law

Art. 20.04. Each such corporation shall furnish a bond for the officer or employee responsible for the handling of the funds, the bond to be in some Surety company licensed by the Board of Insurance Commissioners to do business in Texas, and the bond to be in a minimum amount of One Thousand ($1,000.00) Dollars, to be at all times at least equal to the assets on hand, with a maximum bond of Twenty-five Thousand ($25,000.00) Dollars. In addition, it shall furnish on all employees who have access to any of its funds, separate bonds, or a blanket bond, in amounts to be reasonably fixed by the Board, with a minimum of Five Hundred ($500.00) Dollars, and a maximum of Ten Thousand ($10,000.00) Dollars. All such bonds shall be made payable to the Board of Insurance Commissioners for the use and benefit of the corporation.

Revisor's Note

V.T.I.C. Article 20.04 requires a bond equal to the "assets on hand," in a minimum amount of $1,000 and a maximum amount of $25,000. Under V.T.I.C. Article 20.15, revised as Section 842.206, a group hospital service corporation must maintain a surplus of at least $100,000. As a result, the amount of assets on hand for the corporation must always exceed $25,000. The revised law is drafted accordingly.

Revised Law

Sec. 842.155. TREASURER'S BOND. The treasurer of each group hospital service corporation shall post a fidelity bond with a corporation surety. The bond must be in the amount determined by the officers of the corporation as necessary to secure the

faithful handling of the corporation's money. (V.T.I.C. Art. 20.17 (part).)

Source Law

Art. 20.17. The treasurer of such corporation shall be required to give a fidelity bond with corporation surety in such sum as may be determined by the officers of said corporation for the faithful handling of the funds of said corporation and . . . .

Revised Law

Sec. 842.156. COMPENSATION OF CERTAIN OFFICERS AND EMPLOYEES. A paid officer or employee of a group hospital service corporation may not receive more than $20,000 annually as compensation for the officer's or employee's services unless a higher amount is first authorized by a vote of:

(1) the board of directors of the corporation; or

(2) a committee of the board of directors that is charged with the duty of authorizing that compensation. (V.T.I.C. Art. 20.10 (part).)

Source Law

. . . no paid officer or employee of said corporations shall receive more than Twenty Thousand Dollars ($20,000.00) per annum for his services, unless such payment be first authorized by a vote of the board of directors of such company, or by a committee of such board charged with the duty of authorizing such payments. . . .

[Sections 842.157-842.200 reserved for expansion]

SUBCHAPTER E. REGULATION OF GROUP HOSPITAL SERVICE CORPORATIONS

Revised Law

Sec. 842.201. ANNUAL STATEMENT; FILING FEE. (a) Not later than March 1 of each year, each group hospital service

corporation shall file with the department an annual statement that covers the operations for the preceding calendar year.

(b) The statement must be in the form prescribed by and provide the information required by the commissioner.

(c) The department shall charge a fee in an amount determined under Article 4.07 for filing the statement. (V.T.I.C. Arts. 20.02 (part); 20.08 (part).)

Source Law

[Art. 20.02. . . .]

(b) They shall file a statement of their operations for the year ending December 31 each year, said statement to reach the Board of Insurance Commissioners not later than March 1 of the succeeding year. The statements shall be on such forms and shall reveal such information as shall be required by the Board;

. . .

Art. 20.08. The State Board of Insurance shall charge the fee prescribed by law for filing the annual statement of each corporation operating under this chapter, and for . . . .

Revisor's Note

V.T.I.C. Article 20.08 provides that the former State Board of Insurance must charge "the charter fee prescribed by law" for filing an annual statement. Article 4.07 is a comprehensive fee provision that authorizes the Texas Department of Insurance to set the amounts of various fees, including the fee for an annual statement. Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

Revised Law

Sec. 842.202. RESERVE REQUIREMENTS. (a) Each group hospital service corporation shall maintain reserves sufficient to cover liability for claims incurred but not yet paid and the expenses incurred in settling those claims.

(b) A group hospital service corporation shall estimate the

amount necessary to satisfy the reserve requirements using a method submitted to the commissioner for approval. The estimate method used by the corporation is considered approved on the 30th day after the date filed with the commissioner unless the commissioner affirmatively approves or disapproves the method before that date. (V.T.I.C. Art. 20.02 (part).)

Source Law

. . .

(c) They shall maintain reserves to cover the liability for claims incurred but not yet paid and for the expenses of settlement on those claims; provided that the reserves shall be estimated using a method which has been submitted to the Commissioner of Insurance for approval; and provided further that the method shall be deemed approved thirty (30) days after filing unless earlier affirmatively approved or disapproved by the Commissioner of Insurance;

. . .

Revised Law

Sec. 842.203. FINAL JUDGMENT DEPOSIT. (a) For each 1,000 members and fraction of 1,000 members, a group hospital service corporation shall deposit $100 with the comptroller through the commissioner. The total deposit required under this subsection may not exceed $2,000.

(b) The deposit required under Subsection (a) shall be used to pay any judgment entered against the group hospital service corporation and is subject to garnishment after a final judgment is entered.

(c) The group hospital service corporation shall immediately replenish the amount on deposit if the amount is impounded or impaired. If the amount is not replenished immediately on the demand of the commissioner, the corporation may be regarded as insolvent and treated accordingly. (V.T.I.C. Art. 20.03.)

Source Law

Art. 20.03. Each such corporation shall place with the comptroller through the Board of Insurance Commissioners a deposit equal to One Hundred ($100.00) Dollars for each one thousand (1,000) of its members and fractional part of such number, provided that the maximum deposit shall be Two Thousand ($2,000.00) Dollars. The deposit shall be liable for the payment of all judgments against the corporation and subject to garnishment after final judgment against the corporation. When such deposit becomes impounded or impaired, it shall at once be replenished by the corporation; and if not replenished immediately on demand by the Board, the corporation may be regarded as insolvent and dealt with accordingly.

Revised Law

Sec. 842.204. INVESTMENT LIMITATIONS. The investment limitations that apply to a life, health, and accident insurance company apply to the investments of a group hospital service corporation. (V.T.I.C. Art. 20.10 (part).)

Source Law

. . . Such corporation's investments shall be subject to the limitations applicable to insurance companies operating under the provisions of Chapter 3 of this code. . . .

Revisor's Note

V.T.I.C. Article 20.10 refers to "Chapter 3 of this code," meaning Chapter 3 of the Insurance Code of 1951. That chapter applies only to life, health, and accident insurance companies. The revised law substitutes a reference to those companies for the convenience of the reader.

Revised Law

Sec. 842.205. INCURRED EXPENSES. (a) In this section, "general expenses" means expenses incurred by a group hospital service corporation in the operation of its business other than:

(1) a tax;

(2) a license fee;

(3) a commission; or

(4) an expense incurred in the performance of a contract:

(A) made directly or indirectly with this state or the United States; and

(B) under which the corporation does not assume an insurance risk.

(b) Subject to Subsection (c), a group hospital service corporation may not incur during a calendar year general expenses that exceed 20 percent of the premiums earned in that calendar year.

(c) For a group hospital service corporation earning $500 million or more in premiums in a calendar year, the maximum percentage of general expenses that may be incurred during a calendar year is reduced by one-half percent for each $50 million of premiums earned to a maximum percentage of 15 percent. (V.T.I.C. Art. 20.10 (part).)

Source Law

. . . No corporation operating under this chapter may incur general expenses during a calendar year in excess of twenty percent (20%) of premiums earned in that calendar year; provided further that the maximum expense shall be reduced by one-half percent (1/2%) for each Fifty Million Dollars ($50,000,000) of premium earned to fifteen percent (15%) for corporations earning Five Hundred Million Dollars ($500,000,000) or more of premium in a calendar year. "General expenses" means the expenses incurred by a corporation in the operation of its business except that the term shall not be deemed to include taxes, license fees, commissions, or any expenses incurred in the performance of contracts made directly or indirectly with the government of this state or of the United States under which the corporation does not assume an insurance risk.

Revised Law

Sec. 842.206. MINIMUM SURPLUS REQUIREMENT. Each group hospital service corporation shall maintain a surplus of at least $100,000 to meet adverse contingencies. (V.T.I.C. Art. 20.15.)

Source Law

Art. 20.15. Such corporation shall maintain a surplus of at least $100,000 to meet adverse contingencies.

Revised Law

Sec. 842.207. CONTRACTS; REINSURANCE; OTHER AGREEMENTS. (a) Subject to Subsection (b), a group hospital service corporation may:

(1) contract with another organization similar in character for joint participation through:

(A) a mutualization contract agreement;

(B) a reinsurance treaty; or

(C) another arrangement; and

(2) cede or accept risks from an insurer on all or part of a risk.

(b) Each document used for a purpose described by Subsection (a) must be filed with the department and approved by the commissioner for use in that purpose. (V.T.I.C. Art. 20.19.)

Source Law

Art. 20.19. Such corporations shall be authorized to contract with other organizations similar in character for joint participation through mutualization contract agreements, re-insurance treaties or otherwise and cede or accept risks from any insurance company or insurer upon the whole or any part of any risks, provided that such contract forms, documents, treaties or agreement forms are filed with and approved by the State Board of Insurance for such purposes.

Revisor's Note

V.T.I.C. Article 20.19 refers to "contract forms, documents, treaties or agreement forms." The revised law omits the references to contract forms, treaties, and agreement forms because, in context, those terms are included within the meaning of "document."

Revised Law

Sec. 842.208. BOOKS AND RECORDS. Each group hospital service corporation shall keep complete books and records. (V.T.I.C. Art. 20.21(a).)

Source Law

Art. 20.21. (a) Every Such Corporation Shall Keep Complete Books and Records.

Revised Law

Sec. 842.209. EXAMINATIONS. Articles 1.15 and 1.16 apply to a group hospital service corporation. (V.T.I.C. Art. 20.21(b).)

Source Law

(b) Articles 1.15 and 1.16 of this code apply to corporations regulated under this article.

Revised Law

Sec. 842.210. LIQUIDATION, REHABILITATION, OR CONSERVATION OF GROUP HOSPITAL SERVICE CORPORATION. The dissolution, liquidation, rehabilitation, or conservation of a group hospital service corporation is subject to Articles 21.28 and 21.28-A. (V.T.I.C. Art. 20.06.)

Source Law

Art. 20.06. Any dissolution, liquidation, rehabilitation, or conservation of any such corporation shall be handled as provided in Articles 21.28, 21.28-A, and 21.28-B of this code.

Revisor's Note

V.T.I.C. Article 20.06 refers to "Articles 21.28, 21.28-A, and 21.28-B of this code." The revised law omits the reference to Article 21.28-B because that article was repealed by Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989.

[Sections 842.211-842.250 reserved for expansion]

SUBCHAPTER F. PLAN OF OPERATION; PROVISION OF BENEFITS TO MEMBERS

Revised Law

Sec. 842.251. PLAN OF OPERATION. (a) Before accepting applications for membership in its hospital service plan, a group hospital service corporation must submit to the commissioner a plan of operation. The plan of operation must be accompanied by a schedule of the dues to be charged to members and a statement of the amount of hospital services that the corporation contracts to provide.

(b) The commissioner must approve the plan of operation as fair and reasonable before the corporation may engage in business. (V.T.I.C. Art. 20.14.)

Source Law

Art. 20.14. Every such corporation shall, before accepting applications for membership in said nonprofit hospital service plan, submit to the Board of Insurance Commissioners a plan of operation, together with a schedule of its dues to be charged and the amount of hospital service contracted to be rendered; which plan shall first be approved by the Board as fair and reasonable before said corporation shall engage in business.

Revised Law

Sec. 842.252. MEMBERSHIP CERTIFICATE; CONTRACT. (a) A group hospital service corporation shall issue to each member a membership certificate that states the benefits to which the member is or may become entitled.

(b) The department must approve the form of:

(1) the membership certificate; and

(2) any contract made between the group hospital service corporation and the member's employer or group representative. (V.T.I.C. Art. 20.16.)

Source Law

Art. 20.16. Every such corporation shall issue to its members certificates of membership setting forth the benefits to which they are or may become entitled. Such certificates, and the contracts made between the corporation and the member's employer or group representative shall be in form approved by the State Board of Insurance.

Revised Law

Sec. 842.253. POLICY, CERTIFICATE, AND APPLICATION FORMS. A policy, certificate, or application form used by a group hospital service corporation is subject to Article 3.42. (V.T.I.C. Art. 20.02(e).)

Source Law

(e) Policy, certificate, and application forms shall be subject to the provisions of Article 3.42 of this code, as amended.

Revised Law

Sec. 842.254. DEPOSIT REQUIREMENTS. A group hospital service corporation shall deposit in the account of the corporation in a bank money collected by the corporation from a member or subscriber. The bank must be a state depository. (V.T.I.C. Art. 20.17 (part).)

Source Law

. . . all funds collected from members or subscribers of said corporation shall be deposited to the account of said corporation in a bank, which is a State depository.

Revised Law

Sec. 842.255. ADVANCE PAYMENTS TO HOSPITAL PROHIBITED. A group hospital service corporation may not pay to a hospital any money collected by the corporation from a member or subscriber before the hospital provides necessary care to that member or subscriber. (V.T.I.C. Art. 20.18.)

Source Law

Art. 20.18. Such corporation shall not pay any of the funds collected from members or subscribers to any hospital until after said hospitals shall have rendered the necessary hospital care to such subscriber or member.

Revised Law

Sec. 842.256. CONTRACTS WITH HEALTH CARE PROVIDERS. (a) A group hospital service corporation may contract with health care providers as necessary to ensure to each member or subscriber the provision of services and supplies covered by the membership certificate or policy of the corporation.

(b) A group hospital service corporation may not be required to contract with any particular health care provider.

(c) This section does not authorize a group hospital service corporation to contract with a health care provider in a manner prohibited by a licensing law of this state under which that health care provider operates. (V.T.I.C. Art. 20.11 (part).)

Source Law

Art. 20.11. Such corporations shall have authority to contract with health care providers in such manner as to assure to each person holding a policy or certificate of said corporation the furnishing of such services and supplies as may be agreed upon in the policy, with . . . such corporations shall not be required to contract with any particular health care provider; and provided further that this Article shall not be deemed to authorize such corporation to contract with any health

care provider in any manner which is prohibited by any licensing law of this state under which the health care provider operates. . . .

Revised Law

Sec. 842.257. MAY LIMIT BENEFITS. A policy or certificate issued by a group hospital service corporation may limit the types of disease for which benefits are provided. (V.T.I.C. Art. 20.11 (part).)

Source Law

. . . the right to said corporation to limit in the policy the types of disease for which it shall furnish benefits; provided that . . . .

Revisor's Note

V.T.I.C. Article 20.11 refers to the "policy" of the corporation. Most provisions revised in this chapter refer to a policy or contract. The revised law is drafted accordingly.

Revised Law

Sec. 842.258. LIMITATIONS ON CONTRACTS FOR MEDICAL SERVICES. (a) A group hospital service corporation may not:

(1) contract to provide to a member a physician or any medical services;

(2) contract to practice medicine in any manner;

(3) control or attempt to control the relations existing between a member and the member's physician; or

(4) restrict the right of a patient to obtain the services of any licensed physician.

(b) This section does not prohibit a group hospital service corporation from contracting with:

(1) a health organization certified under Chapter 162, Occupations Code; or

(2) a physician or other health care provider under rules adopted for preferred provider plans. (V.T.I.C. Art. 20.12 (part).)

Source Law

Art. 20.12. Such corporations shall not contract to furnish to the member a physician or any medical services, nor shall said corporation contract to practice medicine in any manner, nor shall said corporation control or attempt to control the relations existing between said member and his or her physician, nor restrict the right of the patient to obtain the services of any licensed doctor of medicine; provided that nothing in this article shall prohibit a corporation from contracting with a health organization certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), or with physicians or other health care providers under rules promulgated for preferred provider plans. . . .

Revisor's Note

(1) V.T.I.C. Article 20.12 refers to a "licensed doctor of medicine." The revised law substitutes the term "physician" for the reason stated in Revisor's Note (1) to Section 842.051.

(2) V.T.I.C. Article 20.12 refers to Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). That statute was codified in 1999 as Chapter 162, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 842.259. USE OF INDEMNITY PLAN AUTHORIZED. A group hospital service corporation may provide benefits for medical care, surgical care, or both medical and surgical care on the basis of indemnity payments for incurred expenses. (V.T.I.C. Art. 20.12 (part).)

Source Law

. . . In addition, such corporations are hereby authorized to provide benefits for medical and/or surgical care on the basis of indemnity payments for expenses incurred.

Revised Law

Sec. 842.260. PAYMENT OF CLAIM; PROOF OF CLAIM. (a) After receipt of due proof of claim, a group hospital service corporation shall pay each claim presented under a membership certificate in full not later than the 60th day after the date on which the applicable services prescribed in the certificate have been provided.

(b) Written notice of a claim given to a group hospital service corporation is considered due proof of claim under this section if the corporation does not provide the claimant with the forms usually provided by the corporation for filing a claim before the 16th day after the date notice is received. (V.T.I.C. Art. 20.05 (part).)

Source Law

Art. 20.05. All claims under certificates shall be paid in full within sixty (60) days after the services called for by the particular certificate have been rendered, and after receipt of due proof of claim. Written notice of claim given to the corporation shall be deemed due proof in the event the corporation fails, upon receipt of notice, to furnish the claimant within fifteen (15) days such forms as are usually furnished by it for filing such claims. . . .

[Sections 842.261-842.300 reserved for expansion]

SUBCHAPTER G. DISCIPLINARY PROCEDURES

Revised Law

Sec. 842.301. REVOCATION OF CERTIFICATE OF AUTHORITY. The commissioner shall revoke the certificate of authority of a group hospital service corporation that:

(1) is determined to be:

(A) operating fraudulently; or

(B) improperly contesting claims; or

(2) fails to pay valid claims in accordance with this chapter. (V.T.I.C. Art. 20.05 (part).)

Source Law

. . . The Board of Insurance Commissioners shall cancel the certificate of authority of any corporation found to be operating fraudulently or improperly contesting its claims, or which fails to pay its valid claims in accordance with the provisions of this article.

Revisor's Note

V.T.I.C. Article 20.05 states that the former Board of Insurance Commissioners "shall cancel" the certificate of authority of a group hospital service corporation in certain circumstances. The revised law substitutes "revoke" for "cancel" because, in context, the terms are synonymous and "revoke" is more frequently used.

Revisor's Note

(End of Chapter)

V.T.I.C. Article 20.02 contains introductory language that provides that a group hospital service corporation is "subject to the following requirements." The revised law omits the language as unnecessary since the referenced requirements are revised as various sections of this chapter. The omitted law reads as follows:

[Art. 20.02. All corporations organized under the provisions of this chapter . . .] shall be subject to the following requirements:

. . .

CHAPTER 843. HEALTH MAINTENANCE ORGANIZATIONS

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CHAPTER 843. HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 843.001. SHORT TITLE. This chapter may be cited as the Texas Health Maintenance Organization Act. (V.T.I.C. Art. 20A.01.)

Source Law

Art. 20A.01. This Act may be cited as the Texas Health Maintenance Organization Act.

Revised Law

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, including, at a minimum, services designated as basic health services under Section 1302, Title XIII, Public Health Service Act (42 U.S.C. Section 300e-1(1)).

(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 or comparable 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.

(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 mental retardation, 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 Article 1.39, 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, mental retardation center, mental health and mental retardation 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 registered optician; 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 Article 20A.09. 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. (V.T.I.C. Art. 20A.02, Subdivs. (b); (c); (e); (f); (g); (h); (i); (j); (k) as amended Acts 75th Leg., R.S., Ch. 1023; (k) as amended Acts 75th Leg., R.S., Ch. 1026; (l) as amended Acts 75th Leg., R.S., Ch. 1023; (l) as amended Acts 75th Leg., R.S., Ch. 1026; (m); (n); (o); (p); (q); (r); (s); (t); (u); (v); (w) as amended Acts 75th Leg., R.S., Ch. 1023; (w) as amended Acts 75th Leg., R.S., Ch. 1026; (x); (y); (z); (aa) as added Acts 76th Leg., R.S., Ch. 273; (aa) as added Acts 76th Leg., R.S., Ch. 1380; Art. 20A.12A, Sec. (a)(1).)

Source Law

Art. 20A.02. For the purposes of this Act:

(b) "Basic health care services" means health care services which the commissioner determines an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, services designated as basic health services under Section 1302, Title XIII, Public Health Service Act (42 U.S.C. Section 300e-1(1)).

(c) "Capitation" means a method of compensation to a physician or provider based on a predetermined payment per

enrollee for a specified period of time for certain enrollees in exchange for arranging for or providing a defined set of covered health care services to such enrollees for a specified period of time, regardless of the amount of services actually provided.

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

(f) "Complaint" means any dissatisfaction expressed by a complainant orally or in writing to the health maintenance organization with any aspect of the health maintenance organization's operation, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination, as that term is defined by Section 12A of this Act; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions, expressed by a complainant. The term does not include 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 and does not include a provider's or enrollee's oral or written dissatisfaction or disagreement with an adverse determination.

(g) "Emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or

part;

(4) serious disfigurement; or

(5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(h) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(i) "Evidence of coverage" means any certificate, agreement, or contract, including a blended contract, issued to an enrollee setting out the coverage to which the enrollee is entitled.

(j) "Group hospital service corporation" means a nonprofit corporation organized and operating under Chapter 20 of the Insurance Code.

(k) [as amended Acts 75th Leg., R.S., Ch. 1023] "Limited health care services" means:

(1) services for mental health, chemical dependency, or mental retardation, or any combination of mental health, chemical dependency, or mental retardation; or

(2) 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.

(k) [as amended Acts 75th Leg., R.S., Ch. 1026] "Health care" means prevention, maintenance, rehabilitation, pharmaceutical, and chiropractic services provided by qualified persons other than medical care.

(l) [as amended Acts 75th Leg., R.S., Ch. 1023] "Limited health care service plan" means a plan under which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of limited health care services, if a part of the plan consists of arranging for, or the provision of, limited health care services, as distinguished from an indemnification against the cost of those services, on a prepaid basis through insurance or otherwise.

(l) [as amended Acts 75th Leg., R.S., Ch. 1026]

"Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services; provided, however, a part of such plan consists of arranging for or the provision of health care services, as distinguished from indemnification against the cost of such service, on a prepaid basis through insurance or otherwise.

(m) "Health care services" means any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, or dental care, or hospitalization or incident to the furnishing of such services, care, or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury a limited health care service plan, or a single health care service plan.

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

(o) "Life threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(p) "Medical care" means furnishing those services defined as practicing medicine under Section 1.03(8), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes).

(q) "Person" means any natural or artificial person, including, but not limited to, individuals, partnerships, associations, organizations, trusts, hospital districts, community mental health, mental retardation, or mental health and mental retardation centers, limited liability companies, limited liability partnerships, corporations, or the rural community health care system under Chapter 20C, Insurance Code.

(r) "Physician" means:

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

(2) a professional association organized under

the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes);

(3) a medical school or medical and dental unit, as 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

(4) another person wholly owned by physicians.

(s) "Prospective enrollee" means:

(1) in the case of an individual who is a member of a group, an individual eligible for enrollment in a health maintenance organization purchased through that individual's group; or

(2) in the case of 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 plan, an individual who has expressed an interest in purchasing individual health maintenance organization coverage and who is eligible for coverage by the health maintenance organization.

(t) "Provider" means:

(1) any person other than a physician, including a licensed doctor of chiropractic, registered nurse, pharmacist, optometrist, registered optician, pharmacy, hospital, or other institution or organization or person that is licensed or otherwise authorized to provide a health care service in this state;

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

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

(u) "Sponsoring organization" means a person who guarantees the uncovered expenses of the health maintenance

organization and who is financially capable, as determined by the commissioner, of meeting the obligations resulting from those guarantees.

(v) "Uncovered expenses" means the estimated 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. Health care services may be considered covered if the physician or provider agrees in writing that enrollees shall in no way be liable, assessible, or in any way subject to payment for services except as described in the evidence of coverage issued to the enrollee under Section 9 of this Act. The amount due on loans in the next calendar year will be considered uncovered expenses unless specifically subordinated to uncovered medical and health care expenses or unless guaranteed by the sponsoring organization.

(w) "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 providers and physicians.

(w) "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.

(x) "Single health care service" means a health care service that an enrolled population may reasonably require in order to be maintained in good health with respect to a particular health care need for the purpose of preventing, alleviating, curing, or healing human illness or injury of a single specified nature and that is to be provided by one or more persons each of whom is licensed by the state to provide that specific health care service.

(y) "Single health care service plan" means a plan under which any person undertakes to provide, arrange for, pay

for, or reimburse any part of the cost of a single health care service, provided that a part of the plan consists of arranging for or the provision of the single health care service, as distinguished from an indemnification against the cost of that service, on a prepaid basis through insurance or otherwise and that no part of that plan consists of arranging for the provision of more than one health care need of a single specified nature.

(z) "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 providers and physicians.

(aa) [as added Acts 76th Leg., R.S., Ch. 273] "Net worth" means the excess of total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Article 1.39, Insurance Code.

(aa) [as added Acts 76th Leg., R.S., Ch. 1380] "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

Art. 20A.12A. (a) In this section:

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

Revisor's Note

(1) Subdivision (a), V.T.I.C. Article 20A.02, defines "adverse determination." The term is defined differently by V.T.I.C. Article 20A.12A, which is revised in pertinent part in this section. The term is used only in Article 20A.12A and in V.T.I.C. Article 20A.02(f), which specifically references the definition contained in Article 20A.12A. As a result, the

revised law omits the definition of "adverse determination" contained in Subdivision (a), V.T.I.C. Article 20A.02 as unnecessary. The omitted law reads:

(a) "Adverse determination" means a determination by a health maintenance organization or a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary.

(2) Subdivision (d), V.T.I.C. Article 20A.02, defines "commissioner." The revised law omits the definition as unnecessary because Section 31.001 of this code contains a definition of "commissioner" that is applicable throughout this code and all other insurance laws of this state. The omitted law reads:

(d) "Commissioner" means the commissioner of insurance.

(3) Subdivisions (f) and (g), V.T.I.C. Article 20A.02, refer to dissatisfaction and medical conditions, "including but not limited to" certain types of dissatisfaction and medical conditions. Subdivision (q), V.T.I.C. Article 20A.02, refers to any natural or artificial person, "including, but not limited to," various kinds of persons. Throughout this chapter, the revised law omits "but not limited to" as unnecessary because under Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, "includes" and "including" are terms of enlargement and not of limitation and use of the terms does not create a presumption that components not expressed are excluded.

(4) Subdivision (p), V.T.I.C. Article 20A.02, refers to "services defined as practicing medicine under Section 1.03(8) [meaning Section 1.03(a)(8)], Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes)." The Medical Practice Act was codified in 1999 as Subtitle B, Title 3, Occupations Code. Immediately before codification, Section 1.03(a)(8) of the Medical Practice Act in fact defined "Open Records Law," and

Section 1.03(a)(12) of the Medical Practice Act defined "practicing medicine." Section 1.03(a)(12) was codified in 1999 as a part of Section 151.002, Occupations Code, and the revised law is drafted accordingly.

(5) Subdivision (q), V.T.I.C. Article 20A.02, defines "person" to include "the rural community health care system under Chapter 20C, Insurance Code," revised in this code as Chapter 845. The revised law substitutes "statewide rural health care system" for "rural community health care system" to provide for consistent use of terminology with Chapter 845.

(6) Subdivision (r), V.T.I.C. Article 20A.02, refers to "a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes)." That statute was codified in 1999 as Chapter 162, Occupations Code, and the revised law is drafted accordingly.

(7) Subdivision (t), V.T.I.C. Article 20A.02, refers to a "licensed doctor of chiropractic." The revised law substitutes "chiropractor" for "licensed doctor of chiropractic" because "chiropractor" is the defined term under Chapter 201, Occupations Code, which is the chapter under which chiropractors are regulated. Under Section 201.001 of that code, "chiropractor" is defined as a person licensed to practice chiropractic by the Texas Board of Chiropractic Examiners.

Revised Law

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. (V.T.I.C. Art. 20A.16.)

Source Law

Art. 20A.16. (a) An insurance company licensed in this state, pursuant to Chapter 2, 3, or 15 of the Insurance Code, or a group hospital service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Act. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies or group hospital service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization under the provisions of this Act.

(b) Notwithstanding any provision of insurance or group hospital service corporation laws, an insurer or group hospital service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided by a health maintenance organization and to provide coverage in the event of failure of a health maintenance organization to meet its obligations. Among other things, under such contracts, the insurer or group hospital service corporation may make benefit payments to a health maintenance organization for health care services rendered by

physicians or providers pursuant to health care plans.

Revisor's Note

(1) Section (a), V.T.I.C. Article 20A.16, refers to an insurance company "licensed" in this state. Throughout this chapter, the revised law substitutes "authorized" for "licensed" in this context because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(2) Section (a), V.T.I.C. Article 20A.16, refers to Chapter 3 of the Insurance Code. The relevant portions of Chapter 3, relating to organization of entities that may write insurance, are revised in Chapters 841 and 982. The revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 20A.07.)

Source Law

Art. 20A.07. The governing body of any health maintenance organization may include physicians, providers, or other individuals, or any combination of the above.

Revised Law

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. (V.T.I.C. Art. 20A.14, Sec. (d).)

Source Law

(d) No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

Revised Law

Sec. 843.006. PUBLIC DOCUMENTS. (a) Except as provided by Subsection (b), each application, filing, and report required under this chapter or Chapter 20A 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. (V.T.I.C. Art. 20A.27.)

Source Law

Art. 20A.27. All applications, filings, and reports required under this Act shall be treated as public documents, except that examination reports shall be considered confidential documents which may be released if, in the opinion of the commissioner, it is in the public interest.

Revised Law

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 Chapter 20A;

(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. (V.T.I.C. Art. 20A.25.)

Source Law

Art. 20A.25. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any physician or provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act; or upon the express consent of the enrollee or applicant; or pursuant to a statute or court order for the production of evidence or to discovery therefor; or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. The health maintenance organization shall be entitled to claim such statutory privilege against such disclosure which the physician or provider who furnishes such information to the health maintenance organization is entitled to claim.

Revised Law

Sec. 843.008. COSTS OF ADMINISTERING HEALTH MAINTENANCE ORGANIZATION LAWS. Money collected under this chapter and Article 20A.33 must be sufficient to administer this chapter and Chapter 20A. (V.T.I.C. Art. 20A.03, Sec. (d).)

Source Law

(d) Funds collected under this Act shall be sufficient to administer this Act.

Revised Law

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. (V.T.I.C. Art. 20A.23, Secs. (a), (b), (c) (part).)

Source Law

Art. 20A.23. (a) Any person who is affected by any rule, ruling, or decision of the Texas Department of Insurance or the commissioner shall have the right to have such rule, ruling, or decision reviewed by the commissioner by making an application to the commissioner. Such application shall state the identities of the person, the rule, ruling, or decision complained of, the interest of the person in such rule, ruling, or decision, the grounds of such objection, the action sought of the commissioner, and the reasons and grounds for such action by the commissioner. The original shall be filed with the chief clerk of the Texas Department of Insurance together with a certification that a true and correct copy of such application has been filed with the commissioner. Within 30 days after the application is filed, and after 10 days' written notice to all parties of record, the commissioner shall review the action complained of in a public hearing and render its decision at the earliest possible date thereafter. The commissioner shall make such other rules and regulations with respect to such applications and their consideration as it considers to be advisable, not inconsistent with this Act. Said application shall have precedence over all other business of a different nature pending before said commissioner.

(b) In the public hearing, any and all evidence and matters pertinent to the appeal may be submitted to the commissioner

whether included in the application or not.

(c) If any person who is affected by any rule, ruling, or decision of the commissioner be dissatisfied with any rule, ruling, or decision adopted by the commissioner, that person, after failing to get relief from the commissioner, may file a petition seeking review of the rule, ruling, or decision and . . . . The action shall have precedence over all other causes on the docket of a different nature. The proceedings on appeal shall be tried and determined as provided by Article 1.04, Insurance Code. . . .

Revisor's Note

(1) Section (a), V.T.I.C. Article 20A.23, refers to the "Texas Department of Insurance." In this section and throughout this chapter, the revised law refers to the "department" because Section 31.001 of this code defines "department" to mean the Texas Department of Insurance throughout this code.

(2) V.T.I.C. Article 20A.23 refers to a "public hearing." Throughout this chapter, the revised law omits "public" as unnecessary. In context, "hearing" means a hearing open to the public.

(3) Section (a), V.T.I.C. Article 20A.23, refers to "rules and regulations." Throughout this chapter, the reference to "regulations" is omitted from the revised law in this context because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(4) Section (c), V.T.I.C. Article 20A.23, provides that Article 1.04, Insurance Code (revised in 1999 as Subchapter D, Chapter 36), applies to the judicial review of a rule, ruling, or decision of the commissioner and then duplicates various provisions covered by that subchapter. The revised law omits the duplicative provisions as unnecessary. The omitted law reads:

(c) . . . [that person . . . may file a petition seeking review of the rule, ruling, or decision and] setting forth the particular objection to such rule, ruling, or decision, or either

or all of them, in a district court of Travis County, Texas, and not elsewhere, against the commissioner as defendant. . . . Either party to the action may appeal to the appellate court having jurisdiction of the cause and the appeal shall at once be returnable to the appellate court having jurisdiction of the cause and the action so appealed shall have precedence in the appellate court over all causes of a different character therein pending. The commissioner is not required to give any appeal bond in any cause arising hereunder.

[Sections 843.010-843.050 reserved for expansion]

SUBCHAPTER B. APPLICABILITY OF AND CONSTRUCTION WITH OTHER LAWS

Revised Law

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, Articles 21.21, 21.21A, 21.21-2, 21.21-5, and 21.21-6, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995, and the Unauthorized Insurers False Advertising Process Act (Article 21.21-1, Vernon's Texas Insurance Code) 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) Section 3B, Article 3.51-6;

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

(3) Article 21.49-8.

(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 Articles 21.07-6 and 21.58A, 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 Section 3, Article 21.58A. (V.T.I.C. Art. 20A.14, Sec. (b); Art. 20A.26, Secs. (a), (f)(4), (h) (part), (i).)

Source Law

[Art. 20A.14]

(b) Articles 21.21, 21.21A, 21.21-2, 21.21-3, and 21.21-5, Insurance Code, Article 21.21-6, Insurance Code, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995, and Chapter 122, Acts of the 57th Legislature, Regular Session, 1961 (Article 21.21-1, Vernon's Texas Insurance Code), apply to health maintenance organizations that offer basic, limited, and single health care coverages and to basic, limited, and single health care plans and the evidence of coverage under those plans, except to the extent that the commissioner determines that the nature of health maintenance organizations and health care plans and evidence of coverage renders any provision of those articles clearly inappropriate.

Art. 20A.26. (a) Except as otherwise provided in this Act, provisions of the insurance law and provisions of the group hospital service corporation laws shall not be applicable to any

health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurance company or a group hospital service corporation licensed and regulated pursuant to the insurance laws or the group hospital service corporation laws of this state except with respect to its health maintenance organization's activities authorized and regulated pursuant to this Act.

[(f)]

(4) Except for Articles 21.07-6 and 21.58A, Insurance Code, the insurance laws, including the group hospital service corporation law, do not apply to physicians and providers; however, a physician or provider who conducts utilization review during the ordinary course of treatment of patients pursuant to a joint or delegated review agreement or agreements with a health maintenance organization on services rendered by the physician or provider shall not be required to obtain certification under Section 3, Article 21.58A, Insurance Code.

(h) Activities permitted under authority of Chapter 491, Acts of the 52nd Legislature, 1951, as amended, shall not be considered subject to the provisions of this Act . . . .

(i) A health maintenance organization authorized under this Act is subject to:

(1) Article 21.49-2C, Insurance Code, and is an authorized insurer for the purposes of that article;

(2) Article 21.49-8, Insurance Code; and

(3) Article 3.51-6, Section 3B, Insurance Code.

Revisor's Note

(1) Section (b), V.T.I.C. Article 20A.14, refers to Article 21.21-3, Insurance Code. The revised law omits the reference because Article 21.21-3 was repealed by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995.

(2) Section (a), V.T.I.C. Article 20A.26, provides that the insurance laws and group hospital service corporation laws do not

apply to a health maintenance organization except as provided in the Texas Health Maintenance Organization Act. The revised law states that the insurance laws and group hospital service corporation laws do not apply to a health maintenance organization except as otherwise provided by "this chapter or other law" to reflect the fact that many other insurance laws and group hospital service corporation laws expressly apply to a health maintenance organization.

(3) Section (h), V.T.I.C. Article 20A.26, in part refers to the general inapplicability of Chapter 491, Acts of the 52nd Legislature, 1951 (the Insurance Code of 1951), to health maintenance organizations. The revised law omits the reference as duplicative of Section (a), V.T.I.C. Article 20A.26, revised as Subsection (c) of this section, which provides that the insurance laws are generally inapplicable to health maintenance organizations. The omitted law reads:

(h) . . . nor shall the provisions of Chapter 491, Acts of the 52nd Legislature, 1951, be applicable to organizations permitted under the authority of this Act.

Revised Law

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. (V.T.I.C. Art. 20A.26, Secs. (b), (d).)

Source Law

(b) Solicitation of enrollees by health maintenance organizations granted a certificate of authority, or their representatives or agents, shall not be construed to violate any provision of law relating to solicitation or advertising by providers or physicians.

(d) The provision of factually accurate information regarding coverage, rates, location and hours of service, and names of affiliated institutions, physicians, and providers by health maintenance organizations or its personnel to potential enrolled participants shall not be construed to be violative of any provision of law relating to solicitation or advertising by physicians or providers. Such information with respect to providers or physicians shall in no manner be contrary to or in conflict with any law or ethics regulating the practice of practitioners of any professional service rendered through or in connection with such providers or physicians.

Revisor's Note

Section (d), V.T.I.C. Article 20A.26, refers to "potential enrolled participants." The revised law substitutes the equivalent term "prospective enrollee" because that is the defined term used in this chapter.

Revised Law

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. (V.T.I.C. Art. 20A.26, Secs. (e), (f)(3).)

Source Law

(e) Any health maintenance organization authorized under this Act which contracts with a health facility or enters into an independent contractual arrangement with physicians or providers organized on a group practice or individual practice basis shall not by virtue of any contracts or arrangements be deemed to have entered into a conspiracy in restraint of trade in violation of Sections 15.01 through 15.34 of the Business & Commerce Code.

[(f)]

(3) Notwithstanding any other law, any physician who conducts activities permitted by law but which do not require a certificate of authority under this Act, and in the process contracts with one or more physicians, shall not, by virtue of such contract or arrangement, be deemed to have entered into a conspiracy in restraint of trade in violation of Sections 15.01 through 15.34 of the Business & Commerce Code.

Revisor's Note

Sections (e) and (f)(3), V.T.I.C. Article 20A.26, refer to "Sections 15.01 through 15.34 of the Business & Commerce Code." Section 15.27, Business & Commerce Code, is reserved for expansion. Sections 15.28-15.34, Business & Commerce Code, were repealed by Chapter 519, Acts of the 68th Legislature, Regular Session, 1983. The revised law accordingly substitutes a reference to Sections 15.01-15.26, Business & Commerce Code.

Revised Law

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. (V.T.I.C. Art. 20A.26, Sec. (g).)

Source Law

(g)(1) No health maintenance organization shall be 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.

(2) If the proposed plan of operation of the health maintenance organization includes the provision of any facility and/or service that makes the health maintenance organization subject to the statute mentioned in Subdivision (1) of this subsection, 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 agency responsible for the issuance of the

certificate of need.

Revised Law

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. (V.T.I.C. Art. 20A.26, Sec. (c).)

Source Law

(c) Nothing in this Act shall be construed as permitting the practice of medicine as defined by the laws of this state. Nothing in this Act shall be construed to repeal, modify, or amend Section 3.08, Medical Practice Act (Article 4495b Vernon's Texas Civil Statutes), and no health maintenance organization shall be exempt from same.

Revisor's Note

Section (c), V.T.I.C. Article 20A.26, refers to Section 3.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). That statute was codified in 1999 as Sections 164.051, 164.052, 164.053, 164.054, and 164.056, Occupations Code, and the revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 20A.05, Sec. (e).)

Source Law

(e) By applying for and receiving a certificate of authority to do business in this state, the health maintenance

organization agrees and admits that it is not subject to the United States Bankruptcy Code and is not eligible to proceed under the United States Bankruptcy Code.

[Sections 843.057-843.070 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

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 Chapter 20A; and

(2) holds a certificate of authority under this chapter. (V.T.I.C. Art. 20A.03, Sec. (a) (part); Art. 20A.14, Sec. (f).)

Source Law

Art. 20A.03. (a) . . . No person shall establish 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 Act. . . .

[Art. 20A.14]

(f) Only those persons who comply with the provisions of this Act and are issued a certificate of authority by the commissioner may use the phrase "health maintenance organization" or "HMO" in the course of operation.

Revised Law

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. (V.T.I.C. Art. 20A.03, Secs. (e), (f), (g).)

Source Law

(e) A person, physician, or provider may not perform any of the acts of a health maintenance organization, as defined in this Act, except as provided by and in accordance with the specific authorization of this Act or other law.

(f) A person, physician, or provider who performs any of the acts of a health maintenance organization that require a certificate of authority under this Act without having first obtained a certificate of authority from the Texas Department of Insurance is subject to all enforcement processes and procedures available against an unauthorized insurer under Articles 1.14-1 and 1.19-1, Insurance Code.

(g) Subsections (e) and (f) of this section do not apply to an activity exempt from regulation under Section 26(f) of this Act.

Revised Law

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 Chapter 20A and is required to obtain a certificate of authority under this chapter. (V.T.I.C. Art. 20A.26, Secs. (f)(1), (2).)

Source Law

(f)(1) This Act shall not be applicable to:

(A) any physician, so long as that physician is engaged in the delivery of care that is within the definition of medical care; or

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

(2) Except as provided by Section 6(a)(3) of this Act or Subdivision (5) of this subsection, any physician or provider that employs or enters into a contractual arrangement with a provider or group of providers to furnish basic, limited, or single health care services as defined in Section 2 of this Act is subject to the provisions of this Act and shall be required to obtain a certificate of authority from the commissioner.

Revisor's Note

Sections (f)(1) and (2), V.T.I.C. Article 20A.26, state that the Texas Health Maintenance Organization Act does not apply to a physician, as long as the physician is engaged in the delivery of care that is within the definition of medical care, or to a provider that is engaged in the delivery of health care services

other than medical care as part of a health maintenance organization delivery network. The revised law clarifies this provision to reflect the clear intent of the legislature. In context, the purpose of the provision is to exempt physicians and providers providing only certain care and services from the requirement of obtaining a certificate of authority and from application of the regulatory provisions in the Texas Health Maintenance Organization Act that apply to a health maintenance organization. The blanket statement in Section (f)(1) that the act does not apply to such a physician or provider, if read literally, does not reflect the intent of the legislature. Large portions of the act, such as the provisions revised in Subchapter I (concerning relations between a health maintenance organization and physicians and providers) and in Subchapter K (concerning relations between an enrollee and a physician or provider) explicitly apply to physicians and providers.

Revised Law

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. (V.T.I.C. Art. 20A.26, Sec. (j).)

Source Law

(j) This Act applies to a medical school and medical and dental unit as defined by Section 61.003, 61.501, or 74.601, Education Code, except when such a medical school and medical and dental unit contracts to deliver medical care within a health maintenance organization delivery network.

Revisor's Note

Section (j), V.T.I.C. Article 20A.26, states that the Texas Health Maintenance Organization Act applies to a medical school or medical and dental unit except when the medical school or medical and dental unit contracts to deliver medical care within a health maintenance organization delivery network. The revised law clarifies this provision to reflect the clear intent of the legislature. In context, the purpose of the provision is to exempt a medical school or medical and dental unit in the described circumstance from the requirement of obtaining a certificate of authority and from application of the regulatory provisions in the Texas Health Maintenance Organization Act that apply to a health maintenance organization. The blanket statement in Section (j) that a medical school and medical and dental unit are exempted from the act when contracting to deliver medical care within a health maintenance organization delivery network, if read literally, does not reflect the intent of the legislature. A medical school or medical and dental unit that contracts to provide medical care within a health maintenance organization delivery network is a physician as defined by Section 843.002, and consequently the provisions of the act that explicitly apply to a physician will apply to the medical school or medical and dental unit.

Revised Law

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. (V.T.I.C. Art. 20A.03, Sec. (c) (part).)

Source Law

(c) Notwithstanding any other law of this state or provision of this Act, a health maintenance organization may be organized, established, operated, and issued a certificate of authority by the commissioner of insurance for the sole purpose of providing a single health care service plan. . . .

Revised Law

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. (V.T.I.C. Art. 20A.03, Sec. (a) (part); Art. 20A.04, Sec. (a) (part).)

Source Law

Art. 20A.03. (a) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. . . .

Art. 20A.04. (a) Each application for a certificate of authority shall be on a form prescribed by rule of the commissioner and shall be verified by the applicant, an officer, or other authorized representative of the applicant, and . . . .

Revised Law

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. (V.T.I.C. Art. 20A.03, Secs. (a) (part), (c) (part).)

Source Law

(a) . . . A foreign corporation may qualify under this Act, subject to its registration to do business in this state as a foreign corporation under the Texas Business Corporation Act and compliance with all provisions of this Act and other applicable Texas statutes.

(c) . . . [a health maintenance organization may be organized, established, operated, and issued a certificate of authority by the commissioner of insurance for the sole purpose of providing a single health care service plan.] A foreign corporation may qualify under this Act, subject to its regulation to do business in the state as a foreign corporation under the Texas Business Corporation Act and in compliance with this Act and other applicable state laws.

Revised Law

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 Chapter 20A.

(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.

(l) 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 Article 20A.09Z.

(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 Chapter 20A. (V.T.I.C. Art. 20A.04, Sec. (a) (part).)

Source Law

Art. 20A.04. (a) Each application for a certificate of authority . . . shall set forth or be accompanied by the following:

(1) a copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) a copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing body or committee, the principal officer in the case of a corporation, and the partnership or members in the case of a partnership or association;

(4) a copy of any independent or other contract made or to be made between any provider, physician, or persons listed in Paragraph (3) hereof and the applicant;

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

(6) a copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) a current financial statement that includes:

(A) the sources and application of funds;

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

(C) a balance sheet beginning as of the date of

the expected start of operations;

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

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

(8) the schedule of charges to be used during the first 12 months of operation;

(9) a statement acknowledging that all lawful process in any 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 Article 1.36, Insurance Code;

(10) a statement reasonably describing the geographic area or areas to be served;

(11) a description of the complaint procedures to be utilized;

(12) a description of the procedures and programs to be implemented to meet the quality of health care requirements set forth herein;

. . .

(13) [as added Acts 75th Leg., R.S., Ch. 1026] a written description of health care plan terms and conditions made available to any current or prospective group contract holder or current or prospective enrollee of the health maintenance organization pursuant to the requirements of Section 11 of this Act;

(14) network configuration information, including an explanation of the adequacy of the physician and other provider network configuration; the information provided must include the names of physicians, specialty physicians, and other providers by zip code or zip code map and indicate whether each physician or other provider is accepting new patients from the health maintenance organization;

(15) 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; such compensation arrangements shall be confidential and not subject to the open records law, Chapter 552, Government Code;

(16) documentation demonstrating that the health maintenance organization will [pay for emergency care services performed by non-network physicians or providers at the negotiated or usual and customary rate and that the health care plan contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement with the entity to provide items or services to covered individuals, the following provisions and procedures for coverage of emergency care services:

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

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

(C) services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition will be provided to covered enrollees as approved by the health maintenance organization, provided that the health maintenance organization is required to approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from the time of the request; the health maintenance organization must respond to inquiries from the treating physician or provider in compliance with this provision in the health maintenance organization's plan; and]

(17) such other information as the commissioner may require to make the determinations required by this Act.

Revisor's Note

(1) Section (a)(10), V.T.I.C. Article 20A.04, refers to the "geographic area" of a health maintenance organization. For consistent use of terminology throughout this chapter, the revised law substitutes "service area."

(2) Section (a)(13), V.T.I.C. Article 20A.04, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refers to "terms and conditions." Throughout this chapter, the revised law omits "conditions" in this context as unnecessary because it is included within the meaning of "terms."

(3) Section (a)(15), V.T.I.C. Article 20A.04, refers to "the open records law, Chapter 552, Government Code." Section 1, Chapter 1035, Acts of the 74th Legislature, Regular Session, 1995, changed the heading of Chapter 552, Government Code, from "Open Records" to "Public Information." The revised law is drafted accordingly throughout this chapter.

Revised Law

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. (V.T.I.C. Art. 20A.04, Sec. (a) (part).)

Source Law

(a) Each application for a certificate of authority . . . shall set forth or be accompanied by the following:

. . .

(13) [as added Acts 75th Leg., R.S., Ch. 1023] for a limited health care service plan, a specific description of the health care services to be provided; and

. . .

Revised Law

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. (V.T.I.C. Art. 20A.04, Sec. (b).)

Source Law

(b) The commissioner may promulgate such reasonable rules and regulations as the commissioner deems necessary to the proper administration of this Act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the modifications or amendments to the operations or documents described in Subsection (a) of this section to the commissioner, either for his approval or for information only, prior to the effectuation of 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. As soon as reasonably possible after any filing for approval required by this subsection is

made, the commissioner shall in writing approve or disapprove it. Any modification or amendment for which the commissioner's approval is required shall be considered approved unless disapproved within 30 days; provided that the commissioner may postpone the action for such further time, not exceeding an additional 30 days, as necessary for proper consideration.

Revised Law

Sec. 843.081. DEADLINE FOR ACTION ON APPLICATION. (a) After receipt by the department of a completed application for a certificate of authority, the department shall provide notice and an opportunity for a hearing regarding the matter. Not later than the 75th day after the date the department receives the completed application:

(1) the department shall schedule the matter for a hearing; or

(2) the commissioner shall issue or deny a certificate of authority to the person filing the application.

(b) Notwithstanding Subsection (a), the commissioner may grant to an applicant a delay of final action on the application. (V.T.I.C. Art. 20A.05, Sec. (a) (part).)

Source Law

Art. 20A.05. (a) The commissioner shall, after notice and hearing, issue or deny a certificate of authority to any person filing an application pursuant to Section 4 of this Act, within 75 days of the receipt of a completed application; provided, however, that if notice and the opportunity for a hearing is involved in a particular issuance or denial, then the matter must be scheduled for a hearing within 75 days of the receipt of a completed application. In any event, the commissioner may grant a delay of final action on the application to an applicant. . . .

Revised Law

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. (V.T.I.C. Art. 20A.05, Sec. (a) (part).)

Source Law

(a) . . . Issuance of the certificate of authority shall be granted upon payment of the application fee prescribed in Section 32 of this Act if the commissioner is satisfied that:

(1) the applicant for a certificate of authority, with respect to health care services to be furnished:

(A) has demonstrated the willingness and potential ability to assure that such health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities, in a manner enhancing availability, accessibility, quality of care, and continuity of services;

(B) has arrangements, established in accordance with rules and regulations promulgated by the commissioner, for an ongoing quality of health care assurance program concerning health care processes and outcome; and

(C) has a procedure, established by rules and regulations of the commissioner to develop, compile, evaluate,

and report statistics relating to the cost of operation, the pattern of utilization of its services, and availability and accessibility of its services;

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

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

(4) the health maintenance organization is fully responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner shall consider:

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

(B) the adequacy of working capital;

(C) any agreement with an insurer, 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 the provision for automatic applicability of an alternative coverage in the event of discontinuance of plan;

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

(E) any deposit of cash or securities submitted in accordance with Section 13 of this Act as a guarantee that the obligations will be duly performed; and

(5) nothing in the proposed method of operation, as shown by the information submitted pursuant to Section 4 of this Act, or by independent investigation, is contrary to Texas law.

Revised Law

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. (V.T.I.C. Art. 20A.05, Sec. (b).)

Source Law

(b) If the commissioner shall certify that the health maintenance organization's proposed plan of operation does not meet the requirements of this section, the commissioner shall not issue the certificate of authority. The commissioner shall notify the applicant that it is deficient and shall specify in what respects it is deficient.

Revised Law

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 Chapter 20A; or

(2) until the commissioner suspends or revokes the certificate or the commissioner terminates the certificate at the request of the certificate holder. (V.T.I.C. Art. 20A.05, Sec. (c) (part).)

Source Law

(c) A certificate of authority shall continue in force as long as the person to whom it is issued meets the requirements of this Act or until suspended or revoked by the commissioner or terminated at the request of the certificate holder. . . .

Revised Law

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. (V.T.I.C. Art. 20A.05, Sec. (c) (part).)

Source Law

(c) . . . Any change in control, as defined by Article 21.49-1 of the Insurance Code of Texas, of the health maintenance organization, shall be subject to the approval of the commissioner.

Revisor's Note
(End of Subchapter)

Section (b), V.T.I.C. Article 20A.03, contains special provisions for the treatment of health maintenance organizations that were in existence on the effective date of the Texas Health Maintenance Organization Act, which was enacted in 1975 by the 64th Legislature and which took effect December 1, 1975. The revised law omits the provisions as executed law. The omitted law reads:

(b) Within 90 days of the effective date of this Act, every existing health maintenance organization shall submit an application for a certificate of authority. Each such applicant may continue to operate until the commissioner acts on the application. In the event that an application is denied, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

[Sections 843.086-843.100 reserved for expansion]

SUBCHAPTER D. GENERAL POWERS AND DUTIES OF HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

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 under contract with or are employed by the health maintenance organization; 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.

(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. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(3) the furnishing of or arranging for medical care services only through other health maintenance organizations or physicians or groups of physicians who have independent contracts with the health maintenance organizations; the furnishing of or arranging for the delivery of health care services only through other health maintenance organizations or providers or groups of providers who are under contract with or employed by the health maintenance organization or through other health maintenance organizations or physicians or providers who have contracted for health care services with those other health maintenance organizations or physicians or providers, except for the furnishing of or authorization for emergency services, services by referral, and services to be provided outside of the service area as approved by the commissioner; provided, however, that a health maintenance organization is not authorized to employ or contract with other health maintenance organizations or physicians or providers in any manner which is prohibited by any licensing law of this state under which such health maintenance organizations or physicians or providers are licensed; however . . . .

Revised Law

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. (V.T.I.C. Art. 20A.37.)

Source Law

Art. 20A.37. (a) A health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, quality, and continuity of care.

(b) A health maintenance organization shall have an ongoing 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 contexts. The commissioner by rule may establish minimum standards and requirements for ongoing internal quality assurance programs for health maintenance organizations, including but not limited to standards for assuring availability, accessibility, quality, and continuity of care.

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

(d) A health maintenance organization shall establish and maintain a physician review panel to assist in reviewing medical guidelines or criteria and to assist in determining the prescription drugs to be covered by the health maintenance organization, if the health maintenance organization offers a prescription drug benefit.

(e) A health maintenance organization shall ensure the use and maintenance of an adequate patient record system that will facilitate documentation and retrieval of clinical information for the purpose of 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.

(f) Enrollees' clinical records shall be available to the commissioner for examination and review to determine compliance. Such records are confidential and privileged, and are not subject to the open records law, Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this article.

(g) A health maintenance organization shall establish a mechanism for the periodic reporting of quality assurance program

activities to its governing body, providers, and appropriate organization staff.

Revised Law

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. (V.T.I.C. Art. 20A.06, Secs. (a) (part), (b).)

Source Law

Art. 20A.06. (a) The powers of a health maintenance organization include, but are not limited to, the following:

(1) the purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities,

or both, and ancillary equipment and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the health maintenance organization;

(2) the making of loans to a medical group, under an independent contract with it in furtherance of its program, or corporations under its control, for the purpose of acquiring or constructing medical facilities and hospitals, or in the furtherance of a program providing health care services to enrollees;

. . .

(b)(1) The health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in Subdivision (1) or (2) of Subsection (a) of this section if the exercise of that power involves an affiliate, as that term is defined by Article 21.49-1, Insurance Code. The commissioner shall disapprove such exercise of powers which, in his or her opinion, would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations or would impair the interests of the general public or the organization's enrollees or creditors in this state. If the commissioner does not disapprove within 30 days of filing, it shall be deemed approved; provided that the commissioner may, by official order, postpone action for such further time, not exceeding 30 days, as may be necessary for proper consideration.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirements of this subdivision those activities having a de minimis effect.

Revised Law

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. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

> (a) The powers of a health maintenance organization include, but are not limited to, the following:
>
> . . .
>
> (4) the contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;
>
> . . .

Revised Law

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. (V.T.I.C. Art. 20A.18.)

Source Law

Art. 20A.18. (a) No health maintenance organization may enter into a management contract or an exclusive agency contract unless the contract is first filed with the commissioner and approved under this section within 30 days after filing or such reasonable extended period as the commissioner may specify by notice given within the 30 days.

(b) The commissioner shall disapprove a contract submitted under Subsection (a) of this section if he finds that:

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

(2) the contract extends for an unreasonable period of time;

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

(4) the persons empowered under the contract to manage the health maintenance organization 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 its enrollees, creditors, or the public; or

(5) the contract contains provisions which impair the interests of the organization's enrollees, creditors, or the public in this state.

(c) The commissioner shall disapprove a

management contract submitted under Subsection (a) of this section unless the commissioner finds that the entity with which the health maintenance organization proposes to contract has in force in its own name a fidelity bond on its officers and employees in an amount not less than $100,000 or in any other amount prescribed by the commissioner.

(d) Except as otherwise provided by this subsection, the bond required under Subsection (c) of this section must be issued by an insurance company that holds a certificate of authority in this state. If, after notice and hearing, the commissioner determines that the fidelity bond required by this section is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed Texas surplus lines agent resident in this state in compliance with Article 1.14-2, Insurance Code, satisfies the requirements of this section.

(e) 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 on the part of an employee or officer of the management contractor during the period that the management contract is in effect.

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

Revised Law

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. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(5) the contracting with an insurance company licensed in this state, or with a group hospital service corporation authorized to do business in the state, for the provision of insurance, reinsurance, indemnity, or reimbursement against the cost of health care and medical care services provided by the health maintenance organization;

. . .

Revised Law

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 Article 3.64; or

(4) a point-of-service rider under Section 843.108.

(V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(6) the offering of:

(A) indemnity benefits covering out-of-area emergency services;

(B) indemnity benefits in addition to those relating to out-of-area and emergency services, provided through insurers or group hospital service corporations;

(C) a point-of-service plan under Article 3.64, Insurance Code; or

(D) a point-of-service rider under Subsection (c) of this section;

. . .

Revisor's Note

Subdivision (bb), V.T.I.C. Article 20A.02, defines "point-of-service plan." The revised law revises the portion of the definition that concerns a point-of-service rider as part of Section 843.108. The revised law omits the remainder of the definition as unnecessary. The term is used in the Texas Health Maintenance Organization Act only in Section (a)(6), V.T.I.C. Article 20A.06 (revised as this section), in the context of authorizing a health maintenance organization to offer a point-of-service plan under V.T.I.C. Article 3.64. Article 3.64 has its own definition of the term, which is substantively identical to the portion of the definition omitted from this chapter. The omitted law reads:

[(bb) "Point-of-service plan" means an arrangement under which:]

(1) an enrollee may choose to obtain benefits or services, or both benefits and services, through either a health maintenance organization delivery network, including a limited provider network, or through a non-network delivery system outside the health maintenance organization's health care delivery network, including a limited provider network, and that are administered through an indemnity benefit arrangement for the cost of health care services; or

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

Revised Law

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. (V.T.I.C. Art. 20A.02, Subdiv. (bb) (part); Art. 20A.06, Sec. (c).)

Source Law

[Art. 20A.02]

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

. . .

(2) . . . indemnity benefits for the cost of the health care services provided by a health maintenance organization through a point-of-service rider as provided by Section 6(a)(6)(D) of this Act in conjunction with corresponding benefits arranged or provided by a health maintenance organization.

[Art. 20A.06]

(c) A health maintenance organization may offer a point-of-service rider for out-of-network coverage without obtaining a separate insurance carrier license 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. If the expenses incurred by a health maintenance organization under a point-of-service rider exceed 10 percent of the total medical and

hospital expenses incurred for all health plan products sold, the health maintenance organization shall cease issuing new point-of-service riders until those expenses fall below 10 percent or until the health maintenance organization obtains an insurance carrier license under this Act. Indemnity benefits and 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 limited provider networks, higher cost sharing may be imposed only when obtaining benefits or services outside the health maintenance organization delivery network. A health maintenance organization that issues a point-of-service rider under this section must meet the net worth requirements promulgated by the commissioner based on the actuarial relation of the amount of insurance risk assumed through the issuance of the point-of-service rider in relation to the amount of solvency and reserve requirements already required of the health maintenance organization.

Revisor's Note

Section (c), V.T.I.C. Article 20A.06, refers to an "insurance carrier license." The revised law substitutes "certificate of authority as an insurer" for consistency with other terminology used throughout this code.

Revised Law

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. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(7) receiving and accepting from government or private agencies payments covering all or part of the cost of the services provided or arranged for by the organization;

. . .

Revisor's Note

Section (a)(7), V.T.I.C. Article 20A.06, refers to "receiving and accepting . . . payments." The revised law omits "receiving" because, in this context, the meaning of that term is included within the meaning of "accepting."

Revised Law

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. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(8) all powers given to corporations (including professional corporations and associations), partnerships, and associations pursuant to their organizational documents which are not in conflict with provisions of this Act, or other applicable law.

Revised Law

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. (V.T.I.C. Art. 20A.06A.)

Source Law

Art. 20A.06A. (a) Unless this section and the powers specified in Section 6(a) of this Act are specifically amended by law, a law, whether enacted before or after this enactment of this section, may not be construed to prohibit or restrict a group model health maintenance organization from:

(1) selectively contracting with or declining to contract with any or all providers as the 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 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 health maintenance organization who wish to obtain the services covered by the health maintenance organization to use the providers specified by the health maintenance organization.

(b) For purposes of 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 Texas, state-supported, public college or

university.

Revised Law

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. (V.T.I.C. Art. 20A.38.)

Source Law

Art. 20A.38. (a) Each dental health maintenance organization or other single service health maintenance organization that provides dental benefits is subject to this section. This section does not apply to a health maintenance organization with 10,000 or fewer enrollees in this state enrolled in dental benefit plans based on a provider panel.

(b) If an employer, association, or other private group arrangement that employs or has 25 or more employees or 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.

(c) 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.

(d) 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 either 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.

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

(f) 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.

(g) For purposes of this section:

(1) "Point-of-service option" means a plan provided through a contractual arrangement under which 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 under which an enrollee may choose to obtain benefits or services under either the indemnity plan or the health maintenance organization plan in accordance with specific provisions of a point-of-service contract.

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

Revised Law

Sec. 843.113. SPECIFIED POWERS NOT EXCLUSIVE. The powers of a health maintenance organization are not limited to the powers specified by this subchapter. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

> Art. 20A.06. (a) The powers of a health maintenance organization include, but are not limited to, the following:
>
> . . .

[Sections 843.114-843.150 reserved for expansion]

SUBCHAPTER E. REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

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

(1) implement this chapter and Chapter 20A, 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. (V.T.I.C. Art. 20A.22, Secs. (a), (b) (part), (c).)

Source Law

> Art. 20A.22. (a) The commissioner may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of this Act.
>
> (b) The commissioner is specifically authorized to promulgate rules to prescribe authorized investments for health maintenance organizations for all investments for which provision is not otherwise made in this Act; to ensure that enrollees have adequate access to health care services; and to establish minimum physician/patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting times for obtaining appointments. . . .

(c) The commissioner may promulgate such reasonable rules and regulations as are necessary and proper to meet the requirements of federal law and regulations.

Revisor's Note

Section (b), V.T.I.C. Article 20A.22, states that the rulemaking authority provided by that section does not limit the rulemaking authority granted to the commissioner under Section (a) of that article. The revised law omits that provision as unnecessary because nothing in Section (b) acts to limit the authority granted under Section (a). The omitted law reads:

(b) . . . The rulemaking authority provided by this subsection does not limit in any manner the rulemaking authority granted to the commissioner under Subsection (a) of this section.

Revised Law

Sec. 843.152. SUBPOENA AUTHORITY. In implementing this chapter and Chapter 20A, the commissioner may exercise subpoena authority in accordance with Subchapter C, Chapter 36. (V.T.I.C. Art. 20A.03, Sec. (h).)

Source Law

(h) The commissioner may exercise subpoena authority in accordance with Article 1.19-1, Insurance Code, in implementing this Act.

Revised Law

Sec. 843.153. AUTHORITY TO CONTRACT. In performing duties under this chapter and Chapter 20A, 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. (V.T.I.C. Art. 20A.28.)

Source Law

Art. 20A.28. The commissioner, in carrying out the commissioner's obligations under this Act, may contract with other state agencies or, after notice and opportunity for hearing, with other qualified persons to make recommendations concerning the determinations

to be made by the commissioner.

Revised Law

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) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

(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. (V.T.I.C. Art. 20A.32, Sec. (a) (part).)

Source Law

Art. 20A.32. (a)(1) Every organization subject to this chapter shall pay to the commissioner the following fees:

(A) for filing and review of its original application for a certificate of authority, a fee in an amount not to exceed $18,000 as determined by the commissioner;

(B) for filing each annual report pursuant to Section 10 of this Act, a fee in an amount not to exceed $500 as

determined by the commissioner;

(C) the expenses of all examinations of health maintenance organizations made on behalf of the State of Texas by the commissioner or under the commissioner's authority in such amounts as the commissioner shall certify to be just and reasonable;

(D) the expenses of an examination under Section 17(a) of this Act incurred by the commissioner or under the commissioner's authority, provided that:

(i) examination expenses are the expenses attributable directly to a specific examination including the actual salaries and expenses of the examiners directly attributable to that examination as determined under rules adopted by the commissioner; and

(ii) the expenses shall be assessed by the commissioner and paid in accordance with rules adopted by the commissioner;

. . .

(F) for filing an evidence of coverage which requires approval, a fee not to exceed $200 as determined by the commissioner; and

(G) for filings required by rule but which do not require approval, a fee not to exceed $100 as determined by the commissioner.

(2) The commissioner shall, within the limits fixed by this subsection, prescribe the fees to be charged under this subsection.

(3) Fees collected under this subsection must be deposited in the State Treasury to the credit of the Texas Department of Insurance operating fund.

(4) Notwithstanding Subdivision (1) of this subsection, the comptroller shall collect the annual report filing fee prescribed by Subdivision (1)(B) of this subsection.

Revisor's Note

Section (a)(1)(E), V.T.I.C. Article 20A.32, refers to "the licensing, appointment, and examination fees pursuant to Section 15 of this Act." The revised law omits that provision because Section 15 of

the Texas Health Maintenance Organization Act (V.T.I.C. Article 20A.15) was repealed effective January 1, 2000, by Section 17(a), Chapter 716, Acts of the 75th Legislature, Regular Session, 1997. The omitted law reads:

[(a)(1) Every organization subject to this chapter shall pay to the commissioner the following fees:]

. . .

(E) the licensing, appointment, and examination fees pursuant to Section 15 of this Act;

. . .

Revised Law

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.

(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 this chapter and Chapter 20A.

(c) Chapter 802 and Article 1.11 apply to the annual report of a health maintenance organization. (V.T.I.C. Art. 20A.10.)

Source Law

Art. 20A.10. (a) Each health maintenance organization shall annually, on or before the 1st day of March, file a report, verified by at least two principal officers, with the commissioner, with a copy to the board, covering the preceding calendar

year.

(b) Such report shall be on forms prescribed by the State Board of Insurance and shall include:

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

(2) the number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(3) updated financial projections for the next calendar year of the type described in Section 4(a)(7) of this Act, until the organization has had a net income for 12 consecutive months; and

(4) such other information relating to the performance of the health maintenance organization as is necessary to enable the commissioner to carry out the duties under this Act.

(c) Article 1.11 of the Insurance Code applies to the annual report of a health maintenance organization.

Revisor's Note

Section (a), V.T.I.C. Article 20A.10, refers to providing a copy of the annual report to "the board," meaning the State Board of Insurance. Section (b), V.T.I.C. Article 20A.10, refers to forms "prescribed by the State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the State Board of Insurance have been changed appropriately.

Revised Law

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 and Chapter 20A, 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 or Chapter 20A. 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) Articles 1.04A, 1.15, 1.16, and 1.19 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, Chapter 82, and Article 1.12 apply to a health maintenance organization. (V.T.I.C. Art. 20A.17.)

Source Law

Art. 20A.17. (a) The commissioner may make an examination concerning the quality of health care services and of the affairs of any applicant for a certificate of authority or any health maintenance organization as often as the commissioner deems necessary, but not less frequently than once every three years.

(b)(1) Every health maintenance organization shall make its books and records relating to its operation available for such examinations and in every way facilitate the examinations. Every physician and provider with whom a health maintenance organization has a contract, agreement, or other arrangement need only make available for examination that portion of its books and records relevant to its relationship with the health maintenance organization.

(2) A copy of any contract, agreement, or other arrangement between a health maintenance organization and a physician or provider shall be provided to the commissioner by the health maintenance organization on the request of the commissioner. Such documentation provided to the commissioner under this subsection shall be deemed confidential and not subject to the open records law, Chapter 552, Government Code.

(3) Medical, hospital, and health records of enrollees and records of physicians and providers providing service under independent contract with a health

maintenance organization shall only be subject to such examination as is necessary for an ongoing quality of health assurance program concerning health care procedures and outcome in accordance with an approved plan as provided for in this Act. Said plan shall provide for adequate protection of confidentiality of medical information and shall only be disclosed in accordance with applicable law and this Act and shall only be subject to subpoena upon a showing of good cause.

(4) 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 that term is used in Section 1.03, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), as necessary to carry out the purposes of this Act, including an enforcement action under Section 20 of this Act. That information is confidential and privileged and is not subject to the open records law, Chapter 552, Government Code, or to subpoena except as necessary for the commissioner to enforce this Act.

(5) For the purpose of examinations, the commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of such physicians and providers concerning their business.

(c) Articles 1.04A, 1.15, 1.16, and 1.19, as amended, of the Insurance Code shall be construed to apply to health maintenance organizations, except to the extent that the commissioner determines that the nature of the examination of a health maintenance organization renders such clearly inappropriate.

(d) Articles 1.12, 1.24, and 1.30, and Section 7 of Article 1.10, Insurance Code, apply to health maintenance organizations.

Revisor's Note

Section (b)(4), V.T.I.C. Article 20A.17, refers to "a medical peer review committee as

that term is used in Section 1.03, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes)." The relevant part of Section 1.03 was codified in 1999 as a part of Section 151.002, Occupations Code, and the revised law is drafted accordingly.

Revised Law

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 Article 21.28 or 21.28-A, 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. (V.T.I.C. Art. 20A.21.)

Source Law

Art. 20A.21. All rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be considered to be rehabilitation, liquidation, supervision, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to Articles 21.28, as amended, 21.28-A, and 21.28-B of the Insurance Code. The commissioner may also order the supervision, conservation, liquidation, or rehabilitation of a health maintenance organization if the commissioner is of the opinion that the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of the state.

Revisor's Note

V.T.I.C. Article 20A.21 refers to Article 21.28-B, Insurance Code. That provision was repealed by Section 6.21, Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989, and the revised law accordingly omits the reference.

[Sections 843.158-843.200 reserved for expansion]

SUBCHAPTER F. RELATIONS WITH ENROLLEES AND GROUP CONTRACT HOLDERS

Revised Law

Sec. 843.201. DISCLOSURE OF INFORMATION ABOUT HEALTH CARE PLAN TERMS. (a) A health maintenance organization shall provide an accurate written 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 description must:

(1) be in a 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 description prescribed by the commissioner; and

(2) the current list of physicians and providers is also provided. (V.T.I.C. Art. 20A.11, Sec. (b).)

Source Law

(b) A health maintenance organization shall provide an accurate written description of health care plan terms and conditions, including restrictions or limitations related to limited provider networks or delegated networks within a health care plan, to allow any current or prospective group contract holder and current or prospective enrollee eligible for enrollment in a health care plan to make comparisons and informed decisions before selecting among health care plans. The written description must be in a readable and understandable format as prescribed by the commissioner and shall include a current list of physicians and providers, including delineation of limited provider networks and delegated networks. The health maintenance organization may provide its handbook to satisfy this requirement provided the handbook's content is substantially similar to and achieves the same level of disclosure

as the written description prescribed by the commissioner and the current list of physicians and providers is also provided.

Revised Law

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. (V.T.I.C. Art. 20A.11B.)

Source Law

Art. 20A.11B. (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 promulgated by the commissioner.

(b) The commissioner shall adopt a disclosure form informing prospective enrollees in a Medicare-contracting health maintenance organization of the effect of enrollment in a Medicare-contracting health maintenance organization on the prospective enrollee's opportunity to purchase Medicare supplement insurance and of any differences in the benefits and costs between the health care plan offered to Medicare recipients and Medicare supplement insurance.

Revised Law

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. (V.T.I.C. Art. 20A.11, Sec. (a).)

Source Law

> Art. 20A.11. (a) Each plan application form shall prominently include a space in which the enrollee at the time of application or enrollment shall make a selection of a primary care physician or primary care provider. 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. However, a health maintenance organization may limit an enrollee's request to change physicians or providers to no more than four changes in any 12-month period.

Revised Law

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 and Chapter 20A, 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 and Chapter 20A, 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. (V.T.I.C. Art. 20A.11, Sec. (d); Art. 20A.14, Sec. (a).)

Source Law

[Art. 20A.11]

(d) No health maintenance organization, or representative thereof, may cause or knowingly permit the use or distribution of prospective enrollee information which is untrue or misleading.

Art. 20A.14. (a) No health maintenance organization, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For the purposes of this Act:

(1) a statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

(2) a statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which said

statement is made or such item of information is communicated, such statement or items of information may be reasonably understood by a reasonable person, not possessing special knowledge, regarding health care coverage, as indicating any benefit or advantage or absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist;

(3) an evidence of coverage shall be deemed to be deceptive if the evidence of coverage, taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans, and evidence of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

Revised Law

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. (V.T.I.C. Art. 20A.11A.)

Source Law

Art. 20A.11A. (a) Each health maintenance organization or approved nonprofit health corporation certified under

Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and holding a certificate of authority issued by the commissioner shall establish procedures to 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. A major population is defined as a group comprising 10 percent or more of the health maintenance organization's enrolled population.

(b) Each health maintenance organization and approved nonprofit health corporation certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and holding a certificate of authority issued by the commissioner shall establish procedures to provide access to a member handbook and the complaint and appeals process to an enrollee who has a disability affecting the enrollee's ability to communicate or to read.

Revisor's Note

V.T.I.C. Article 20A.11A refers to and imposes a duty on an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner. The revised law omits the references as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844, provides that an approved nonprofit health corporation has all the powers granted to and duties imposed on a health maintenance organization under the Texas Health Maintenance Organization Act.

Revised Law

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. (V.T.I.C. Art. 20A.11, Sec. (c).)

Source Law

(c) A health maintenance organization shall notify a group contract holder within 30 days of any substantive changes to the payment arrangements between the health

maintenance organization and health care physicians or providers.

Revised Law

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. (V.T.I.C. Art. 20A.11, Sec. (e).)

Source Law

(e) Every health maintenance organization shall provide to its enrollees reasonable notice of any material adverse change in the operation of the organization that will affect them directly.

Revised Law

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. (V.T.I.C. Art. 20A.14, Sec. (c).)

Source Law

(c) An enrollee may not be canceled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner.

[Sections 843.209-843.250 reserved for expansion]

SUBCHAPTER G. DISPUTE RESOLUTION

Revised Law

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. (V.T.I.C. Art. 20A.12, Secs. (a), (b), (r).)

Source Law

Art. 20A.12. (a) Every health maintenance organization shall implement and maintain a complaint system to provide reasonable procedures for the resolution of oral and written complaints initiated by enrollees or providers concerning health care services, including a process for the notice and appeal of complaints.

(b) The commissioner may adopt reasonable rules as necessary or proper to implement and administer this section.

(r) The commissioner may examine the complaint system for compliance with this Act and may require the health maintenance organization to make corrections as considered necessary by the commissioner.

Revisor's Note

Section (a), V.T.I.C. Article 20A.12, refers to complaints initiated by "enrollees or providers" concerning health care services. The revised law substitutes "complainant" for "enrollees or providers" for consistency of terminology and to reflect the clear intent of the legislature. All similar references in V.T.I.C. Article 20A.12 refer to a complainant, and Subdivision (e), V.T.I.C. Article 20A.02, revised as Section 843.002(4), defines "complainant" to mean an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint.

Revised Law

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. (V.T.I.C. Art. 20A.12, Secs. (c), (e), (f).)

Source Law

(c) If a complainant notifies the health maintenance organization orally or in writing of a complaint, the health maintenance organization, not later than the fifth business day after the date of the receipt of the complaint, shall send to the complainant a letter acknowledging the date of receipt of the complaint that includes a description of the organization's complaint procedures and time frames. If the complaint is received orally, the health maintenance organization shall also enclose a one-page complaint form. The one-page complaint form must prominently and clearly state that the complaint form must be returned to the health maintenance organization for prompt resolution of the complaint.

(e) The total time for acknowledgment, investigation, and resolution of the complaint by the health maintenance organization may not exceed 30 calendar days after the date the health maintenance organization receives the written complaint or one-page complaint form from the complainant.

(f) Subsections (c) and (e) of this section do not apply to complaints concerning emergencies or denials of continued stays for hospitalization. Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case and may not exceed one business day from receipt of the complaint.

Revisor's Note

Section (c), V.T.I.C. Article 20A.12, refers to notification of a complaint made "orally or in writing." In this section and the following sections of this subchapter, the revised law omits "orally and in writing" and similar references in this context as unnecessary. Subdivision (f), Article 20A.02, revised as Section 843.002(6), defines "complaint" to mean any dissatisfaction expressed orally or in writing. In addition, Section (a), V.T.I.C. Article 20A.12, revised as Section 843.251, makes clear that this subchapter applies to both oral and written complaints.

Revised Law

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. (V.T.I.C. Art. 20A.12, Secs. (d), (g).)

Source Law

(d) The health maintenance organization shall investigate each oral and written complaint received in accordance with its own policies and in compliance with this Act.

(g) After the health maintenance organization has investigated a complaint, the health maintenance organization shall issue a response letter to the complainant explaining the health maintenance organization's resolution of the complaint within the time frame set forth in Subsection (e) of this section. The letter must include a statement of the specific medical and contractual reasons for the resolution and the specialization of any physician or other provider consulted. The response letter must contain a full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.

Revised Law

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. (V.T.I.C. Art. 20A.12, Secs. (h), (i).)

Source Law

(h) If the complaint is not resolved to the satisfaction of the complainant, the health maintenance organization shall provide

an appeals process that includes the right of the complainant either to appear in person before a complaint appeal panel where the enrollee normally receives health care services, unless another site is agreed to by the complainant, or to address a written appeal to the complaint appeal panel. The health maintenance organization shall complete the appeals process under this section not later than the 30th calendar day after the date of the receipt of the written request for appeal.

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

Revised Law

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.
(V.T.I.C. Art. 20A.12, Sec. (j).)

Source Law

(j) The health maintenance organization shall appoint members to the complaint appeal panel, which shall advise the health maintenance organization on the resolution of the dispute. The complaint appeal panel shall be composed of equal numbers of health maintenance organization staff, physicians or other providers, and enrollees. A member of

the complaint appeal panel may not have been previously involved in the disputed decision. The physicians or other providers must have experience in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination. If specialty care is in dispute, the appeal panel must include a person who is a specialist in the field of care to which the appeal relates. The enrollees may not be employees of the health maintenance organization.

Revised Law

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. (V.T.I.C. Art. 20A.12, Sec. (k).)

Source Law

(k) Not later than the fifth business day before the scheduled meeting of the panel, 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 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 panel.

Revised Law

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. (V.T.I.C. Art. 20A.12, Sec. (l).)

Source Law

(l) The complainant, or designated representative if the enrollee is a minor or 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 prior determination that resulted in the appeal.

Revised Law

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. (V.T.I.C. Art. 20A.12, Sec. (m).)

Source Law

> (m) Investigation and resolution of appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed one business day after the complainant's request for appeal. Due to the ongoing emergency or continued hospital stay, and at the request of the complainant, the health maintenance organization shall provide, in lieu of a complaint appeal panel, a review by a physician or provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal. The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three days. Investigation and resolution of appeals after emergency care has been provided shall be conducted in accordance with the process established under this section, including the right to a review by an appeal panel.

Revised Law

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. (V.T.I.C. Art. 20A.12, Sec. (n).)

Source Law

(n) Notice of the final decision of the health maintenance organization on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice must also include the toll-free telephone number and the address of the Texas Department of Insurance.

Revised Law

Sec. 843.260. RECORD OF COMPLAINTS. (a) A health maintenance organization shall maintain a complaint and appeal log regarding each complaint.

(b) A health maintenance organization shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on a complaint 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) regarding a complaint and action taken on the complaint. (V.T.I.C. Art. 20A.12, Secs. (o), (p), (q).)

Source Law

(o) The health maintenance organization shall maintain a record of each complaint and any complaint proceeding and any actions taken on a complaint for three years from the date of the receipt of the complaint. A complainant is entitled to a copy of the record on the applicable complaint and any complaint proceeding.

(p) Each health maintenance organization shall maintain a complaint and appeal log regarding each complaint.

(q) Each health maintenance organization shall maintain documentation on each complaint received and the action taken on the complaint until the third anniversary of the date of receipt of the complaint. The Texas Department of Insurance may review documentation maintained under this subsection during any investigation of the health maintenance organization.

Revised Law

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 Article 21.58A.

(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 Article 21.58A.

(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 Article 21.58A. (V.T.I.C. Art. 20A.12A, Secs. (b), (c), (d).)

Source Law

(b) A health maintenance organization shall implement and maintain an internal appeal system that provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination that is initiated by an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record. The appeal system must include procedures for notification, review, and appeal of an adverse determination, as defined by this section, in accordance with Article 21.58A, Insurance Code.

(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 regard the expression of dissatisfaction or disagreement as an appeal of the adverse determination, as defined by this section, and shall review and resolve the appeal in accordance with Article 21.58A, Insurance Code.

(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 12 of this Act only if the procedures related to adverse determinations comply with this section and Article 21.58A, Insurance Code.

Revisor's Note

Sections (a)(2) and (3), V.T.I.C. Article 20A.12A, define "independent review organization" and "life-threatening condition." However, the 1999 amendments to V.T.I.C. Article 20A.12A deleted those terms from the text of the article. The revised law omits the definitions as no longer necessary. The omitted law reads:

(2) "Independent review organization" means an organization selected as provided under Article 21.58C, Insurance Code.

(3) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A, Insurance Code.

[Sections 843.262-843.280 reserved for expansion]

SUBCHAPTER H. GENERAL PROVISIONS REGARDING COMPLAINTS

Revised Law

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. (V.T.I.C. Art. 20A.14, Sec. (j), as added Acts 75th Leg., R.S., Ch. 1026; Sec. (k).)

Source Law

(j) A health maintenance organization shall not engage in any retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or enrollee because the group, enrollee, or 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.

(k) A health maintenance organization shall not engage in any retaliatory action, including termination of or refusal to renew 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 has appealed a decision of the health maintenance organization.

Revised Law

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 this chapter or Chapter 20A.

(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. (V.T.I.C. Art. 20A.12B.)

Source Law

Art. 20A.12B. (a) Any person, including persons who have attempted to resolve complaints through a health maintenance organization's complaint system process who are dissatisfied with the resolution, may report an alleged violation of this Act to the Texas Department of Insurance.

(b) The commissioner shall investigate a complaint against a health maintenance organization to determine compliance with this Act within 60 days after the Texas Department of Insurance's receipt of the complaint and all information necessary for the department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

(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.

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (i), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(i) A contract between a health maintenance organization and a physician or a 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 Texas Department of Insurance's toll-free telephone number for filing complaints.

[Sections 843.284-843.300 reserved for expansion]

SUBCHAPTER I. RELATIONS WITH PHYSICIANS AND PROVIDERS

Revised Law

Sec. 843.301. PRACTICE OF MEDICINE NOT AFFECTED. This chapter and Chapter 20A 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. (V.T.I.C. Art. 20A.29.)

Source Law

Art. 20A.29. This Act shall not be construed to:

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

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

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (a) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

Art. 20A.18A. (a) A health maintenance organization shall, on request, make

available and disclose to physicians and providers written application procedures and qualification requirements for contracting with the health maintenance organization. . . .

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (a) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(a) . . . Each physician and provider who initially applies to contract with a health maintenance organization for the provision of health care services on behalf of the health maintenance organization and who is denied a contract with the health maintenance organization must be provided written notice of the reasons the initial application was denied. Unless otherwise limited by Article 21.52B, Insurance Code, this subsection does not prohibit a health maintenance organization plan from rejecting an application from a physician or provider based on the determination that the plan has sufficient qualified physicians or providers.

Revised Law

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. (V.T.I.C. Art. 20A.06, Sec. (a) (part); Art. 20A.14, Sec. (g).)

Source Law

Art. 20A.06. (a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(3) . . . 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, the health maintenance organization shall be required to accept such certification or accreditation;

. . .

[Art. 20A.14]

(g) No type of provider licensed or otherwise authorized to practice in this state may be denied participation to provide health care services which are delivered by the health maintenance organization and which are within the scope of licensure or authorization of the type of provider on the sole basis of type of license or

authorization. However, 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, the health maintenance organization shall be required to accept such certification or accreditation. This section may not be construed to (1) require a health maintenance organization to utilize a particular type of provider in its operation; (2) require, except as provided by Article 21.52B of this code, that a health maintenance organization accept each provider of a category or type; or (3) require that health maintenance organizations contract directly with such providers. Notwithstanding any other provision nothing herein shall be construed to limit the health maintenance organization's authority to set the terms and conditions under which health care services will be rendered by providers. All providers must comply with the terms and conditions established by the health maintenance organization for the provision of health services and for designation as a provider.

Revised Law

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. (V.T.I.C. Art. 20A.14, Sec. (h).)

Source Law

(h) A health maintenance organization that provides coverage for health care services or medical care through one or more providers or physicians who are not partners or employees of the health maintenance organization or one or more providers or physicians that are not owned or operated by the health maintenance organization shall provide a (20) twenty calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in providing health care services or medical care under the terms and conditions established by the health maintenance organization for the provision of such services and the designation of such providers and physicians. A health maintenance organization will notify, in writing, such provider or physician of the reason for non-acceptance to participate in providing health care services or medical care. This section may not be construed to (1) require that a health maintenance organization utilize a particular type of provider or physician in its operation; (2) require that a health maintenance organization accept a provider or physician of a category or type that does not meet the practice standards and qualifications established by the health maintenance organizations; or (3) require that a health maintenance organization contract directly with such providers or physicians.

Revisor's Note

Section (h), V.T.I.C. Article 20A.14, refers to "health care services or medical care." The revised law omits the reference to "medical care" in this context as unnecessary because Subdivision (m), V.T.I.C. Article 20A.02, revised as Section 843.002(12), includes medical care within the definition of "health care services." Similar changes are made throughout this chapter, except where helpful for clarity.

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (b), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(b) Before terminating a contract with a physician or provider, the health

maintenance organization shall provide a written explanation to the physician or provider of the reasons for termination. On request and before the effective date of the termination, but within a period not to exceed 60 days, a physician or provider shall be entitled to a review of the health maintenance organization's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health or an action by a state medical or dental board, other medical or dental licensing board, or other licensing board or other government agency, that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession, or in a case of fraud or malfeasance. The advisory review panel shall be composed of physicians and providers, including at least one representative in the physician's or provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of the health maintenance organization. The decision of the advisory review panel must be considered but is not binding on the health maintenance organization. The health maintenance organization shall provide to the affected physician or provider, on request, a copy of the recommendation of the advisory review panel and the health maintenance organization's determination.

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (d) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(d) A physician or provider who is terminated or deselected shall be entitled to an expedited review process by the health

maintenance organization on request by the physician or provider. . . .

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (d) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(d) . . . If the physician or provider is deselected for reasons other than at the physician's or provider's request, the health maintenance organization may not notify patients of the physician's or provider's deselection until the effective date of the termination or the time a review panel makes a formal recommendation. If a physician or provider is deselected for reasons related to imminent harm, the health maintenance organization may notify patients immediately.

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (c) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(c) Each contract between a health maintenance organization and a physician or provider of health care services must provide that reasonable advance notice be given to an enrollee of the impending termination from the plan of a physician or provider who is

currently treating the enrollee. . . .

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (f), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(f) A contract between a health maintenance organization and a physician or provider may not contain any clause purporting to indemnify the health maintenance organization for any tort liability resulting from acts or omissions of the health maintenance organization.

Revised Law

Sec. 843.311. CONTRACTS WITH PODIATRISTS. A contract between a health maintenance organization and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners 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. (V.T.I.C. Art. 20A.18A, Sec. (j), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(j) A contract between a health maintenance organization and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request, and the insurer 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 insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

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

Revisor's Note

Section (j), V.T.I.C. Article 20A.18A, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, specifically applies by its terms to contracts between podiatrists and health maintenance organizations but, in Subdivisions (1) and (2) of Section (j), refers to an "insurer" rather than to a "health maintenance organization." The revised law substitutes "health maintenance organization" for "insurer" because it is clear in this context that the legislature intended to refer to health maintenance organizations.

Revised Law

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. (V.T.I.C. Art. 20A.14, Sec. (i), as added Acts 75th Leg., R.S., Ch. 1260.)

Source Law

(i) If an advanced practice nurse or

physician assistant is authorized to provide care under Section 3.06(d)(5) or (6), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), by a physician participating in a health maintenance organization's provider network, the health maintenance organization may not refuse a request made by the physician and physician assistant or advanced practice nurse to have the physician assistant or advanced practice nurse identified as a provider in the provider network unless the physician assistant or advanced practice nurse fails to meet the quality of care standards previously established by the health maintenance organization for participation in the network by advanced practice nurses and physician assistants.

Revisor's Note

Section (i), V.T.I.C. Article 20A.14, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, refers to Section 3.06(d)(5) or (6), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). Those provisions were codified in 1999 as Subchapter B, Chapter 157, Occupations Code, and the revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (h), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(h) A health maintenance organization that conducts or uses economic profiling of physicians or providers within the health maintenance organization shall make available to a network physician or provider on request

the economic profile of that physician or provider, including the standards by which the physician or provider is measured. 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.

Revised Law

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. (V.T.I.C. Art. 20A.14, Sec. (l).)

Source Law

(l) A health maintenance organization may not use any financial incentive or make any payment to a physician or provider that acts directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the use of capitation as a method of payment.

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (e) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) The following applies to any health maintenance organization that to any extent uses capitation as a method of compensation:

(1) The health maintenance organization shall begin payment of capitated amounts to the enrollee's primary care physician or primary care provider, calculated from the date of enrollment, no later than the 60th day following the date an enrollee has selected or has been assigned a primary care physician or primary care provider. If selection or assignment does not occur at the time of enrollment, capitation which would otherwise have been paid to a selected primary care physician or

primary care provider had a selection been made shall be reserved as a capitation payable until such time as an enrollee makes a selection or the plan assigns a primary care physician or primary care provider.

(2) 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 an enrollee to a primary care physician or primary care provider. If a health maintenance organization elects to assign an enrollee to a primary care physician or primary care provider, the assignment shall be made to a primary care physician or primary care provider located within the zip code nearest the enrollee's residence or place of employment and, to the extent practicable given the zip code limitation, shall be done in a manner that results in a fair and equal distribution of enrollees among the plan's primary care physicians or primary care providers. The health maintenance organization shall inform an enrollee of the name, address, and telephone number of the primary care physician or primary care provider to whom the enrollee has been assigned and of the enrollee's right to select a different primary care physician or primary care provider. An enrollee shall have the right at any time to reject the physician or provider assigned and to select another physician or provider from the list of primary care physicians or primary care providers for the health maintenance organization network. An election by an enrollee to reject an assigned physician or provider shall not be counted as a change in providers for purposes of the limitation described in Section 11(a) of this Act.

(3) A health maintenance organization shall notify a physician or provider of the selection of the physician or provider as a primary care physician or primary care provider by an enrollee within 30 working days of the selection or assignment of an enrollee to that physician

or provider by the health maintenance organization.

. . .

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (e) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) The following applies to any health maintenance organization that to any extent uses capitation as a method of compensation:

. . .

(4) As an alternative to the provisions of Subdivisions (1), (2), and (3) of this subsection, a health maintenance organization may seek approval from the Texas Department of Insurance of a different capitation payment scheme that assures:

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

(B) payment to the primary care physician or primary care provider of a capitation amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk being assumed.

Revised Law

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. (V.T.I.C. Art. 20A.14, Sec. (e).)

Source Law

(e) No physician or health care provider or group of physicians or providers or health care facility or institution may exclude any other physician or provider from staff privileges, facilities, or institutions solely on the ground that such physician or provider is associated with a health maintenance organization issued a certificate of authority under this Act.

Revised Law

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 authorized by this section within a health maintenance organization delivery network.

(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. (V.T.I.C. Art. 20A.26, Secs. (f)(5), (6), (7), (8), (9).)

Source Law

(5) This Act and the Insurance Code may not be construed to prohibit a physician or provider who is participating in a health maintenance organization delivery network, whether contracting with a health maintenance organization under Section 6(a)(3) of this Act or 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 under Subdivisions (6)-(9) of this subsection.

(6) 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 other providers any services that are ancillary to the practice of medicine, other than hospital or other institutional or inpatient provider services.

(7) A provider may contract to provide, or arrange to provide through subcontracts with similarly licensed providers, any health care services that those providers are licensed to provide, other than medical care.

(8) A provider may contract to provide, or arrange to provide through subcontracts with other providers, 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 to be provided by that provider or arranged to be provided for by that provider.

(9) A contract or subcontract authorized under Subdivision (6), (7), or (8) of this subsection may provide for compensation based on a fee-for-service arrangement, a risk-sharing arrangement, or a capitated risk arrangement under which a

fixed predetermined payment is made in exchange for the provision of, or the arrangement to provide and the guaranty of the provision of, a defined set of covered services to the covered persons for a specified period, regardless of the amount of services actually provided.

Revisor's Note
(End of Subchapter)

Section (j), V.T.I.C. Article 20A.14, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, provides that a health maintenance organization may not take various actions against an advanced practice nurse or physician assistant solely because the advanced practice nurse or physician assistant is not identified under Section 3, V.T.I.C. Article 21.52. The revised law omits Section (j) as unnecessary because Section 3, V.T.I.C. Article 21.52, as amended by Chapter 428, Acts of the 76th Legislature, Regular Session, 1999, includes advanced practice nurses and physician assistants. The omitted law reads:

(j) A health maintenance organization may not refuse to contract with an advanced practice nurse or physician assistant to be included in the organization's provider network, refuse to reimburse the advanced practice nurse or physician assistant for covered services, or otherwise discriminate against the advanced practice nurse or physician assistant solely because the advanced practice nurse or physician assistant is not identified under Section 3, Article 21.52, Insurance Code.

[Sections 843.319-843.335 reserved for expansion]

SUBCHAPTER J. PAYMENT OF CLAIMS TO PHYSICIANS AND PROVIDERS

Revised Law

Sec. 843.336. DEFINITION. In this subchapter, "clean claim" means a completed claim, as determined under department rules, submitted by a physician or provider for health care services under a health care plan. (V.T.I.C. Art. 20A.18B, Sec. (a).)

Source Law

Art. 20A.18B. (a) In this section, "clean claim" means a completed claim, as determined under Texas Department of Insurance rules, submitted by a physician or provider for medical care or health care services under a health care plan.

Revised Law

Sec. 843.337. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A physician or provider for health care services under a health care plan may obtain acknowledgment of receipt of a claim for health care services under a health care plan by submitting the claim by United States mail, return receipt requested.

(b) A health maintenance organization or the contracted clearinghouse of the health maintenance organization that receives a claim electronically shall acknowledge receipt of the claim by an electronic transmission to the physician or provider and is not required to acknowledge receipt of the claim in writing. (V.T.I.C. Art. 20A.18B, Sec. (b).)

Source Law

(b) A physician or provider for medical care or health care services under a health care plan may obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim by United States mail, return receipt requested. A health maintenance organization or the contracted clearinghouse of the health maintenance organization that receives a claim electronically shall acknowledge receipt of the claim by an electronic transmission to the physician or provider and is not required to acknowledge receipt of the claim by the health maintenance organization in writing.

Revised Law

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not later than the 45th day after the date on which a health maintenance organization receives a clean claim from a physician or provider, the health maintenance organization shall:

(1) pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) 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) notify the physician or provider in writing why the claim will not be paid. (V.T.I.C. Art. 20A.18B, Sec. (c).)

Source Law

(c) Not later than the 45th day after the date that the health maintenance organization receives a clean claim from a physician or provider, the health maintenance organization shall:

(1) pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) 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) notify the physician or provider in writing why the claim will not be paid.

Revised Law

Sec. 843.339. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION BENEFIT CLAIMS. If a health maintenance organization or its designated agent authorizes treatment, a prescription benefit claim that is electronically adjudicated and electronically paid shall be paid not later than the 21st day after the date on which the treatment is authorized. (V.T.I.C. Art. 20A.18B, Sec. (d).)

Source Law

(d) If a prescription benefit claim is electronically adjudicated and electronically paid, and the health maintenance organization or its designated agent authorizes treatment, the claim must be paid not later than the 21st day after the treatment is authorized.

Revised Law

Sec. 843.340. AUDITED CLAIMS. A health maintenance organization that acknowledges coverage of an enrollee under a health care plan but intends to audit a claim submitted by a physician or provider shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date on which the health maintenance organization receives the claim from a physician or provider.

Following completion of the audit, any additional payment due a physician or provider or any refund due the health maintenance organization shall be made not later than the 30th day after the later of the date that:

(1) the physician or provider receives notice of the audit results; or

(2) any appeal rights of the enrollee are exhausted. (V.T.I.C. Art. 20A.18B, Sec. (e).)

Source Law

> (e) If the health maintenance organization acknowledges coverage of an enrollee under the health care plan but intends to audit the physician or provider claim, the health maintenance organization shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the health maintenance organization receives the claim from the physician or provider. Following completion of the audit, any additional payment due a physician or provider or any refund due the health maintenance organization shall be made not later than the 30th day after the later of the date that:
>
> (1) the physician or provider receives notice of the audit results; or
>
> (2) any appeal rights of the enrollee are exhausted.

Revised Law

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, including required data elements and claim formats.

(b) A health maintenance organization may, by contract with a participating physician or provider, add or change the data elements that must be submitted with a claim from the physician or provider.

(c) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in a health maintenance organization's claim processing and payment procedures, the health maintenance organization shall provide written notice of the addition or change to each participating physician or provider. (V.T.I.C. Art. 20A.18B, Secs. (i), (j), (k).)

Source Law

(i) The health maintenance organization shall provide a participating physician or provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(j) A health maintenance organization may, by contract with a physician or provider, add or change the data elements that must be submitted with the physician or provider claim.

(k) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in a health maintenance organization's claim processing and payment procedures, the health maintenance organization shall provide written notice of the addition or change to each participating physician or provider.

Revised Law

Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; ADMINISTRATIVE PENALTY. (a) A health maintenance organization that violates Section 843.338 or 843.340 is liable to a physician or provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health care plan.

(b) In addition to any other penalty or remedy authorized by this code, a health maintenance organization that violates Section 843.338 or 843.340 is subject to an administrative penalty under Chapter 84. The administrative penalty imposed under that chapter may not exceed $1,000 for each day the claim remains unpaid in violation of Section 843.338 or 843.340. (V.T.I.C. Art. 20A.18B, Secs. (f), (h).)

Source Law

(f) A health maintenance organization that violates Subsection (c) or (e) of this section is liable to a physician or provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health

care plan.

(h) In addition to any other penalty or remedy authorized by the Insurance Code or another insurance law of this state, a health maintenance organization that violates Subsection (c) or (e) of this section is subject to an administrative penalty under Article 1.10E, Insurance Code. The administrative penalty imposed under that article may not exceed $1,000 for each day the claim remains unpaid in violation of Subsection (c) or (e) of this section.

Revisor's Note

Section (h), V.T.I.C. Article 20A.18B, refers to a "penalty or remedy authorized by the Insurance Code or another insurance law of this state." The revised law omits the reference to "another insurance law of this state" as unnecessary because all insurance laws of this state that authorize a penalty or remedy are now included in the Insurance Code.

Revised Law

Sec. 843.343. ATTORNEY'S FEES. A physician or provider may recover reasonable attorney's fees in an action to recover payment under Section 843.342. (V.T.I.C. Art. 20A.18B, Sec. (g).)

Source Law

(g) A physician or provider may recover reasonable attorney's fees in an action to recover payment under this section.

Revised Law

Sec. 843.344. APPLICABILITY TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. Sections 843.336-843.343 apply to a person with whom a health maintenance organization contracts to:

(1) process claims; or

(2) obtain the services of physicians and providers to provide health care services to enrollees. (V.T.I.C. Art. 20A.18B, Sec. (n).)

Source Law

(n) This section applies to a person with whom a health maintenance organization contracts to process claims or to obtain the

services of physicians and providers to provide health care services to health care plan enrollees.

Revised Law

Sec. 843.345. EXCEPTIONS. Sections 843.336-843.344 do not apply to:

(1) a capitated payment required to be made to a physician or provider under an agreement to provide health care services, including medical care, under a health care plan; or

(2) a claim submitted by a physician or provider who is a member of the legislature. (V.T.I.C. Art. 20A.18B, Secs. (l), (m).)

Source Law

(l) This section does not apply to a claim made by a physician or provider who is a member of the legislature.

(m) This section does not apply to a capitation payment required to be made to a physician or provider under an agreement to provide medical care or health care services under a health care plan.

Revised Law

Sec. 843.346. PAYMENT OF CLAIMS. Subject to Sections 843.336-843.345, a health maintenance organization shall pay a physician or provider for health care services and benefits provided to an enrollee under the evidence of coverage and to which the enrollee is entitled under the terms of the evidence of coverage 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. (V.T.I.C. Art. 20A.09, Sec. (j) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(j) . . . A health maintenance organization shall make payment to a physician or provider for covered services rendered to enrollees of the health maintenance organization not later than the 45th day after the date a claim for payment is received with documentation reasonably necessary for the health maintenance

organization to process the claim or, if applicable, within the number of calendar days specified by written agreement between the physician or provider and the health maintenance organization. For purposes of this subsection, "covered services" means health care services and benefits to which enrollees are entitled under the terms of an applicable evidence of coverage.

Revisor's Note

Section (j), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, prescribes certain conditions relating to payment for covered services. V.T.I.C. Chapter 20A was amended by the addition of Article 20A.18B by Chapter 1343, Acts of the 76th Legislature, Regular Session, 1999. Article 20A.18B, which is revised as Sections 843.336-843.345, provides for payment of certain "clean claims" submitted by a physician or provider. Section 312.014(a), Government Code, provides that "[i]f statutes enacted at . . . different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails." Thus, as the later enactment, Article 20A.18B prevails over Section (j), Article 20A.09, to the extent of any conflict. Accordingly, the revised law includes a reference to Sections 843.336-843.345.

Revisor's Note

(End of Subchapter)

Section (o), V.T.I.C. Article 20A.18B, authorizes the commissioner of insurance to adopt rules as necessary to implement Article 20A.18B, revised in this subchapter. The revised law omits that provision as unnecessary because V.T.I.C. Article 20A.22, revised as Section 843.151, authorizes the commissioner of insurance to adopt rules to implement the Texas Health Maintenance Organization Act, including Article 20A.18B. The omitted law reads:

(o) The commissioner may adopt rules as necessary to implement this section.

[Sections 843.347-843.360 reserved for expansion]

SUBCHAPTER K. RELATIONS BETWEEN ENROLLEE AND PHYSICIAN OR PROVIDER

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (g), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (g) All contracts or other agreements between a health maintenance organization and a physician or provider shall specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services in the event the health maintenance organization fails to pay the provider for health care services.

Revised Law

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. (V.T.I.C. Art. 20A.18A, Sec. (c) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (c) . . . Each contract must also provide that the termination of the physician or provider contract, except for reason of medical competence or professional behavior, does not release the health maintenance organization from the obligation to reimburse the physician or provider who is treating an enrollee of special circumstance, such as a person who has a disability, acute condition, or life-threatening illness or is past the twenty-fourth week of pregnancy, at no less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of an enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence. For purposes of this subsection, "special circumstance" means a condition such that the treating physician or provider reasonably believes that discontinuing care by the treating physician or provider could cause

harm to the patient. The special circumstance shall be identified by the treating physician or provider, who must request that the enrollee be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still on the health maintenance organization network. Contracts between a health maintenance organization and physicians or providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. This section does not extend the obligation of the health maintenance organization to reimburse the terminated physician or provider for ongoing treatment of an enrollee beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the health maintenance organization to reimburse the terminated physician or provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

Revised Law

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; or

(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.

(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.

(V.T.I.C. Art. 20A.14, Sec. (i), as added Acts 75th Leg., R.S., Ch. 1026; Art. 20A.18A, as added Acts 75th Leg., R.S., Ch. 735.)

Source Law

[Art. 20A.14]

(i)(1) A health maintenance organization shall not, as a condition of a contract with a physician or provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from:

(A) discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the patient's health care, including but not limited to the patient's medical condition or treatment options; or

(B) discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient.

(2) A health maintenance organization shall not in any way penalize, terminate, or refuse to compensate, for covered services, a physician or provider for discussing or communicating with a current, prospective, or former patient, or a party designated by a patient, pursuant to this section.

Art. 20A.18A. (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 to a current, prospective, or former patient, or a party 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 provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient; or

(3) the fact that the physician's, dentist's, or provider's contract with the health care plan has terminated or 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.

(b) A health maintenance organization may not in any way penalize, terminate, or refuse to compensate, for covered services, a physician, dentist, or provider for communicating with a current, prospective, or former patient, or a party designated by a patient, in any manner protected by this section.

(c) A contract provision that violates this section is hereby declared void.

Revisor's Note

(1) Section (i), V.T.I.C. Article 20A.14, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, is substantively identical to Sections (a)(1), (a)(2), and (b), V.T.I.C. Article 20A.18A, as added by Chapter 735, Acts of the 75th Legislature, Regular Session, 1997, except that Section (i)(1)(A), V.T.I.C. Article 20A.14, protects communications regarding a patient's medical condition or treatment

options without explicitly requiring that the communications be made in good faith, while Section (a)(1), V.T.I.C. Article 20A.18A, explicitly requires good faith in order for the communications to be protected. V.T.I.C. Article 20A.18A also provides that a contract provision that violates that article is void. Subchapter C, Chapter 311, Government Code (Code Construction Act), Section 312.014, Government Code, and general rules of statutory construction indicate that different amendments to a statute regarding the same subject should be reconciled whenever possible. The revised law includes the requirement that communications be made in good faith and includes the provision that voids a contract provision in violation of this section because the amendments are reconcilable in this manner. Also, there is no indication that the legislature in enacting Section (i), V.T.I.C. Article 20A.14, intended to override the applicable provisions of V.T.I.C. Article 20A.18A.

(2) Section (i)(1)(B), V.T.I.C. Article 20A.14, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, and Section (a)(2), V.T.I.C. Article 20A.18A, as added by Chapter 735, Acts of the 75th Legislature, Regular Session, 1997, refer to "provisions, terms, requirements, or services." The revised law omits "provisions" as unnecessary because it is included within the meaning of "terms [and] requirements."

[Sections 843.364-843.400 reserved for expansion]

SUBCHAPTER L. FINANCIAL REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

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. (V.T.I.C. Art. 20A.08.)

Source Law

Art. 20A.08. Any director, officer, member, employee, or partner of a health

maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

Revised Law

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. (V.T.I.C. Art. 20A.30.)

Source Law

Art. 20A.30. (a) A health maintenance organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than $100,000 or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that holds a certificate of authority in this state. If, after notice and hearing, the State Board of Insurance determines that the fidelity bond required by this section is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed Texas surplus lines agent resident in this state in

compliance with Article 1.14-2, Insurance Code, satisfies the requirements of this section.

(b) The fidelity bond shall obligate the surety to pay a loss of money or other property the health maintenance organization sustains through acts of fraud or dishonesty on the part of any employee or officer of the health maintenance organization acting either alone or in concert with others, while employed or serving as an officer of a health maintenance organization.

(c) Instead of a bond, a health maintenance organization may deposit cash with the comptroller. Such a deposit must be maintained in the amount and subject to the same conditions required for a bond under this section.

Revised Law

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. (V.T.I.C. Art. 20A.13A.)

Source Law

Art. 20A.13A. (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 shall consist only of the following:

(1) lawful money of the United States of America;

(2) bonds of this state;

(3) bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America; or

(4) bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state.

Revisor's Note

V.T.I.C. Article 20A.13A refers to bonds or other evidences of indebtedness "of the United States of America or any of its agencies." The reference to "its agencies" is omitted from the revised law because under Section 311.005(9), Government Code (Code Construction Act), "United States" includes an agency of the United States.

Revised Law

Sec. 843.4031. PHASE-IN PERIOD FOR MINIMUM NET WORTH. (a) Notwithstanding Section 843.403(a), a health maintenance organization authorized to provide basic health care services that holds a certificate of authority under this chapter issued before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $500,000 not later than December 31, 2000;

(2) $1 million not later than December 31, 2001; and

(3) $1.5 million not later than December 31, 2002.

(b) Notwithstanding Section 843.403(b), a health maintenance organization authorized to provide limited health care services that holds a certificate of authority under this chapter issued before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $300,000 not later than December 31, 2000;

(2) $600,000 not later than December 31, 2001; and

(3) $1 million not later than December 31, 2002.

(c) Notwithstanding Section 843.403(c), a health

maintenance organization authorized to offer only a single health care service plan that holds a certificate of authority under this chapter issued before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $150,000 not later than December 31, 2000;

(2) $300,000 not later than December 31, 2001; and

(3) $500,000 not later than December 31, 2002.

(d) This section expires January 1, 2003. (V.T.I.C. Art. 20A.13B.)

Source Law

Art. 20A.13B. (a) A health maintenance organization authorized to provide basic health care services that was licensed before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $500,000 not later than December 31, 2000;

(2) $1 million not later than December 31, 2001; and

(3) $1.5 million not later than December 31, 2002.

(b) A health maintenance organization authorized to provide limited health care services that was licensed before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $300,000 not later than December 31, 2000;

(2) $600,000 not later than December 31, 2001; and

(3) $1 million not later than December 31, 2002.

(c) A health maintenance organization authorized to offer only a single health care service plan that was licensed before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $150,000 not later than December 31, 2000;

(2) $300,000 not later than December 31, 2001; and

(3) $500,000 not later than December 31, 2002.

(d) This section expires January 1, 2003.

Revised Law

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. (V.T.I.C. Art. 20A.13C.)

Source Law

Art. 20A.13C. (a) The commissioner may adopt rules or by rule establish guidelines requiring any health maintenance organization that holds a certificate of authority under this Act to maintain a specified net worth based on:

(1) the nature and type 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 Subsection (a) of this section must be designed to ensure the financial solvency of health maintenance organizations for the protection of enrollees. The rules and guidelines may provide for a health maintenance organization to comply with a risk-based net worth requirement established under Subsection (a) of this section in stages over a two-year period.

Revisor's Note

Section (a), V.T.I.C. Article 20A.13C, refers to actions the commissioner of insurance may take in relation to a health maintenance organization "that holds a certificate of authority under this Act." Throughout this chapter, the revised law omits the quoted language and similar language as unnecessary in any context in which it is clear the law refers to health maintenance organizations engaging in business in Texas. All health maintenance organizations engaging in business in Texas are required to hold a certificate of authority under this chapter, and the descriptive phrase referring to the certificate is unnecessary.

Revised Law

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. (V.T.I.C. Art. 20A.13, Secs. (a), (b) (part), (d), (e), (f), (g), (h).)

Source Law

Art. 20A.13. (a) Unless otherwise provided by this section, each health maintenance organization shall deposit with the comptroller cash or securities, or any combination of these or other guarantees that are acceptable to the commissioner, in an amount as set forth in this section.

(b) For a health maintenance organization . . . :

(1) the amount of the initial deposit or other guarantee shall be $100,000 for an organization offering basic health care services, $75,000 for an organization offering limited health care services, and $50,000 for an organization offering a single health care service plan;

(2) 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;

(3) on or before March 15 of each subsequent year, it shall deposit 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; and

(4) in any year in which the amount determined in accordance with Subdivision (3) of this subsection is zero or less than zero, the commissioner may not require the health maintenance organization to make any additional deposit under this subsection.

(d) If, on application made not more than once in each calendar year by a health maintenance organization under this subsection, the commissioner determines that the amount previously deposited by the organization under this section has exceeded the amount required under this section by more than $50,000 for a continuous 12-month period, the commissioner shall allow the organization to withdraw the portion of the deposit that exceeds by more than $50,000 the amount required to be on deposit for that organization, unless the commissioner considers that the release of a portion of the deposit could be hazardous to enrollees, creditors, or the general public.

(e) On application made not sooner than the 24th month after the effective date of this subsection, if the commissioner determines that the amount previously deposited by an organization under this section continues to exceed the amount required under this section, the commissioner shall allow the organization to withdraw the portion of the deposit that exceeds the amount required to be on deposit for that organization, unless the commissioner considers that the release of the deposit could be hazardous to enrollees, creditors, or the general public.

(f) Upon application by a health maintenance organization operating for more than one year under a certificate of authority issued by the State Board of Insurance or the commissioner, the commissioner may waive some or all of the requirements of Subsection (b) or (c) of this section for any period of time it shall deem proper whenever it finds that one or more of

the following conditions justifies such waiver:

(1) the total amount of the deposit or other guarantee is equal to 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; or

(3) either the health maintenance organization has a net worth of $5,000,000 or its sponsoring organization has a net worth of at least $5,000,000 for each health maintenance organization whose uncovered expenses it guarantees.

(g) If one or more of the requirements is waived, any amount previously deposited shall remain on deposit until released in whole or in part by the comptroller upon order of the commissioner pursuant to Subsection (f) of this section.

(h) A health maintenance organization that has made a deposit with the comptroller may, at its option, withdraw the deposit or any part thereof, first having deposited with the comptroller, in lieu thereof, a deposit of cash or securities of equal amount and value to that withdrawn. Any securities shall be approved by the commissioner before being substituted.

Revisor's Note

(1) V.T.I.C. Article 20A.13 distinguishes, for purposes of security deposit requirements, between health maintenance organizations that received certificates of authority before September 1, 1987, and health maintenance organizations that received certificates of authority on or after that date. Health maintenance organizations that received a certificate of authority before that date were required to make initial deposits not later than March 15, 1988. The revised law omits those provisions as executed. The omitted law reads:

(b) [For a health maintenance organization] which has not received a certificate of authority from the State Board of Insurance or the commissioner prior to September 1, 1987:

. . .

(c) For a health maintenance organization which has received a certificate of authority from the State Board of Insurance prior to September 1, 1987:

(1) on or before March 15, 1988, the organization shall deposit an amount equal to the sum of:

(A) $100,000 for an organization offering basic health care services or $50,000 for an organization offering a single health care service plan; and

(B) 100 percent of the uncovered health care expenses for the preceding 12 months of operation;

(2) on or before March 15 of each subsequent year, the organization shall make additional deposits 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; and

(3) in any year in which the amount determined in accordance with Subdivision (2) of this subsection is zero or less than zero, the commissioner may not require the health maintenance organization to make any additional deposit under this subsection.

(2) Section (e), V.T.I.C. Article 20A.13, refers to an application "made not sooner than the 24th month after the effective date of this subsection." The relevant version of Section (e) was added by Chapter 567, Acts of the 70th Legislature, Regular Session, 1987, and took effect September 1, 1987. The revised law omits the quoted language as executed.

Revised Law

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. (V.T.I.C. Art. 20A.19.)

Source Law

Art. 20A.19. (a) Whenever the financial condition of any health maintenance organization indicates a condition such that the continued operation of the health maintenance organization might be hazardous to its enrollees, creditors, or the general public, then the commissioner may, after notice and opportunity for hearing, order the health maintenance organization to take such action as may be reasonably necessary to rectify the existing condition, including but not necessarily limited to one or more of the following steps:

(1) to reduce the total amount of present and potential liability for benefits by reinsurance;

(2) to reduce the volume of new business being accepted;

(3) to reduce expenses by

specified methods;

(4) to suspend or limit the writing of new business for a period of time;

(5) to increase the health maintenance organization's capital and surplus by contribution; or

(6) to suspend or revoke the certificate of authority.

(b) The commissioner is authorized, by rules and regulations, to fix uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public, and to fix standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in Subsection (a) of this section.

Revised Law

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 Article 21.28.

(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 Article 21.28.

(c) The operations and business of a health maintenance organization represent the business of insurance for purposes of Section 843.157 and Articles 21.28 and 21.28-A.

(d) Exclusive venue of receivership and delinquency proceedings for a health maintenance organization is in Travis County. (V.T.I.C. Art. 20A.31, Secs. (b), (c), (d), (e).)

Source Law

(b) In addition to all other remedies available by law, when it appears to the commissioner that a health maintenance organization or other person is insolvent or does not possess the surplus required by

Section 13 of this Act, the commissioner may bring suit in a district court of Travis County to be named receiver in accordance with Section 21 of this Act and Article 21.28, Insurance Code.

(c) A court of competent jurisdiction may find that a receiver should take charge of the assets of a health maintenance organization and name the commissioner as the receiver of the health maintenance organization in accordance with Section 21 of this Act and Article 21.28, Insurance Code.

(d) The operations and business of a health maintenance organization represent the business of insurance for purposes of Section 21 of this Act and Articles 21.28 and 21.28-A, Insurance Code.

(e) Exclusive venue of receivership and delinquency proceedings for a health maintenance organization shall be in Travis County.

Revisor's Note

(1) Section (b), V.T.I.C. Article 20A.31, refers to a requirement that a health maintenance organization or other person "possess the surplus required by Section 13 of this Act." Section 13 of the Texas Health Maintenance Organization Act (V.T.I.C. Article 20A.13) is revised as Section 843.405. However, in 1999 the legislature substantially revised Article 20A.13. Section 3, Chapter 273, Acts of the 76th Legislature, Regular Session, 1999, repealed the provisions of Article 20A.13 that established surplus requirements for health maintenance organizations. Section 2, Chapter 273, Acts of the 76th Legislature, Regular Session, 1999, added Sections 13A, 13B, and 13C to the Texas Health Maintenance Organization Act. The added sections, revised as Sections 843.403, 843.4031, and 843.404, require health maintenance organizations to maintain a minimum net worth in the form of cash or certain government debt and authorize the commissioner to prescribe additional net worth provisions designed to ensure solvency. It is clear that the legislature intended the

net worth requirements to perform the function of the repealed surplus requirements. Therefore, the revised law references the net worth requirements of Sections 843.403, 843.4031, and 843.404 instead of the repealed surplus requirements.

(2) Section (c), V.T.I.C. Article 20A.31, refers to a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

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. (V.T.I.C. Art. 20A.13, Sec. (m).)

Source Law

(m) In the event of the insolvency of a health maintenance organization and on order of the commissioner, the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the resources of each health maintenance organization. Each health maintenance organization to which a group or groups are allocated shall offer such group or groups the health maintenance organization's coverage at rates determined in accordance with the successor health maintenance organization's existing methodology or as adjusted by the commissioner. In addition, the commissioner shall allocate equitably among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area the insolvent health maintenance organization's nongroup enrollees, taking into consideration the resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer each such nongroup enrollee that health maintenance organization's existing coverage for individual or conversion coverage as determined by the nongroup enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology or as adjusted by the commissioner. The successor health maintenance organizations that do not offer direct nongroup enrollment shall provide coverage at rates that reflect the average group rate of the successor health maintenance organization.

[Sections 843.409-843.434 reserved for expansion]

SUBCHAPTER M. HEALTH MAINTENANCE ORGANIZATION SOLVENCY SURVEILLANCE COMMITTEE

Revised Law

Sec. 843.435. DEFINITION. In this subchapter, "committee" means the Health Maintenance Organization Solvency Surveillance Committee. (New.)

Revisor's Note

The revised law adds a definition of "Health Maintenance Organization Solvency Surveillance Committee" for the convenience of the reader and to avoid frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 843.436. COMPOSITION AND ADMINISTRATION. (a) The Health Maintenance Organization Solvency Surveillance Committee exists under the direction of the commissioner.

(b) The committee is composed of nine members appointed by the commissioner. Each member must be a health maintenance organization that holds a certificate of authority under this chapter or a public representative. If a member is a health maintenance organization or its holding company system, the commissioner shall appoint an officer or employee of the member to represent the member on the committee. No two individuals on the committee may be employees or officers of the same health maintenance organization or holding company system.

(c) Five of the members shall represent health maintenance organizations or their holding company systems. Of the health maintenance organization members, one shall represent a limited health care service plan and one shall represent a single health care service plan. The commissioner shall select the remaining health maintenance organization members after considering appropriate factors such as the varying categories of premium income and geographic location.

(d) A public representative may not:

(1) be an officer, director, or employee of a health maintenance organization, a health maintenance organization agent, or any other business entity regulated by the commissioner;

(2) be a person required to register under Chapter 305, Government Code; or

(3) be related to a person described by Subdivision (1) or (2) within the second degree by affinity or consanguinity.

(e) Qualifications for membership, terms of office, and reimbursement of expenses shall be governed by the approved plan of operation required under Section 843.437. (V.T.I.C. Art. 20A.36, Sec. (a) (part), as amended Acts 75th Leg., R.S.,

Ch. 1023; Sec. (a) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

Art. 20A.36. (a) [as amended Acts 75th Leg., R.S., Ch. 1023] The Health Maintenance Organization Solvency Surveillance Committee is created under the direction of the commissioner. . . . The committee is composed of nine members appointed by the commissioner of insurance. No two members may be employees or officers of the same health maintenance organization or holding company system. The qualifications for membership, terms of office, and reimbursement of expenses shall be as provided by the plan of operation approved by the commissioner. A "member" is a Texas licensed health maintenance organization as defined in Section 2(j) of this Act or a public representative. The commissioner of insurance shall appoint the member along with the officer or employee of the member who shall serve on the committee if the member is a representative of a Texas licensed health maintenance organization or its holding company system. Five of the members shall represent health maintenance organizations or their holding company system. Of the health maintenance organization members, one shall be a limited health care service plan as defined in Section 2(l) of this Act, if one exists at the time of appointment, and one shall be a single health care service plan as defined in Section 2(u) of this Act. The remaining health maintenance organization members shall be selected by the commissioner of insurance with due consideration of factors deemed appropriate including, but not limited to, the varying categories of premium income and geographical location.

A public representative may not be:

(1) an officer, director, or employee of a health maintenance organization, a health maintenance organization agent, or any other business entity regulated by the commissioner;

(2) a person required to register

as a lobbyist under Chapter 305, Government Code; or

(3) related to a person described by Subdivision (1) or (2) of this subsection within the second degree of affinity or consanguinity.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] The Health Maintenance Organization Solvency Surveillance Committee is created under the direction of the commissioner. . . . The committee is composed of nine members appointed by the commissioner. No two members may be employees or officers of the same health maintenance organization or holding company system. The qualifications for membership, terms of office, and reimbursement of expenses shall be as provided by the plan of operation approved by the commissioner. A "member" is a Texas licensed health maintenance organization as defined in Section 2(n) of this Act or a public representative. The commissioner of insurance shall appoint the member along with the officer or employee of the member who shall serve on the committee if the member is a representative of a Texas licensed health maintenance organization or its holding company system. Five of the members shall represent health maintenance organizations or their holding company system. Of the health maintenance organization members, one shall be a single health care service plan as defined in Section 2(y) of this Act. The remaining health maintenance organization members shall be selected by the commissioner with due consideration of factors deemed appropriate including, but not limited to, the varying categories of premium income and geographical location.

A public representative may not be:

(1) an officer, director, or employee of a health maintenance organization, a health maintenance organization agent, or any other business entity regulated by the commissioner;

(2) a person required to register with the Texas Ethics Commission under

Chapter 305, Government Code; or

(3) related to a person described by Subdivision (1) or (2) of this subsection within the second degree of affinity or consanguinity.

Revisor's Note

Section (a), V.T.I.C. Article 20A.36, as amended by Chapter 1023, Acts of the 75th Legislature, Regular Session, 1997, refers to "a person required to register as a lobbyist under Chapter 305, Government Code." Section (a), V.T.I.C. Article 20A.36, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refers to "a person required to register with the Texas Ethics Commission under Chapter 305, Government Code." The revised law omits the reference to registration as a "lobbyist" because that term is not used in Chapter 305, Government Code. The revised law also omits the reference to registration "with the Texas Ethics Commission" as unnecessary because Chapter 305, Government Code, provides for registration only with that agency.

Revised Law

Sec. 843.437. PLAN OF OPERATION. (a) The committee shall perform its functions under a plan of operation. The plan takes effect on the written approval of the commissioner.

(b) If the committee fails to submit a suitable plan of operation or if, after adoption of a plan, the committee fails to submit suitable amendments to the plan, the commissioner may, after notice and hearing, adopt rules as necessary to implement this subchapter. The rules continue in effect until modified by the commissioner or superseded by a plan submitted by the committee and approved by the commissioner. (V.T.I.C. Art. 20A.36, Sec. (a) (part), as amended Acts 75th Leg., R.S., Ch. 1023; Sec. (a) (part), as amended Acts 75th Leg., R.S., Ch. 1026; Sec. (e).)

Source Law

(a) [as amended Acts 75th Leg., R.S., Ch. 1023] . . . The committee shall perform its functions under a plan of operation approved by the commissioner. . . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . . The committee shall perform its functions under a plan of operation

approved by the commissioner. . . .

(e) Not later than the 180th day after the date on which the final member of the committee is appointed, the committee shall submit to the commissioner a plan of operation. The plan of operation takes effect on approval in writing by the commissioner. If the committee fails to submit a suitable plan of operation within the period set by this subsection, or if, after the adoption of a plan, the committee fails to submit suitable amendments to the plan, the commissioner may, after notice and hearing, adopt rules as necessary to implement this Act. Those rules continue in effect until modified by the commissioner or superseded by a plan submitted by the committee and approved by the commissioner.

Revisor's Note

Section (e), V.T.I.C. Article 20A.36, refers to an action required to be taken by the Health Maintenance Organization Solvency Surveillance Committee "[n]ot later than the 180th day after the date on which the final member of the committee is appointed" and "within the period set by this subsection." The revised law omits those provisions as executed.

Revised Law

Sec. 843.438. EXAMINATION AND REGULATION. The committee is subject to examination and regulation by the commissioner. Not later than May 1 of each year, the committee shall submit to the commissioner:

(1) a financial report for the preceding calendar year in a form approved by the commissioner; and

(2) a report of its activities during the preceding calendar year. (V.T.I.C. Art. 20A.36, Sec. (f).)

Source Law

(f) The committee is subject to examination and regulation by the commissioner. Not later than May 1 of each year, the committee shall submit to the commissioner a financial report for the preceding calendar year in a form approved by the commissioner and a report of its

activities during the preceding calendar year.

Revised Law

Sec. 843.439. IMMUNITY FROM LIABILITY. A health maintenance organization or its agents or employees, the committee or its agents, employees, or members, or the commissioner or the commissioner's representatives are not liable in a civil action for any act taken or not taken in good faith in the performance of powers and duties under this subchapter. (V.T.I.C. Art. 20A.36, Sec. (g).)

Source Law

(g) A licensed health maintenance organization or its agents or employees, the committee or its agents, employees, or members, or the commissioner or the commissioner's representatives are not liable in a civil action for any act taken or not taken in good faith in the performance of powers and duties under this section.

Revised Law

Sec. 843.440. GENERAL POWERS AND DUTIES. (a) The committee shall assist and advise the commissioner regarding:

(1) the detection and prevention of insolvency problems in health maintenance organizations; and

(2) any health maintenance organization placed in rehabilitation, liquidation, supervision, or conservation.

(b) The method of providing assistance and advice to the commissioner shall be in accordance with the committee's approved plan of operation.

(c) The committee shall file a record of its proceedings with the commissioner.

(d) In performing its duties, the committee may:

(1) enter into contracts as necessary or proper to implement this subchapter;

(2) take legal action as necessary to recover any unpaid assessments owed under Section 843.441;

(3) employ staff as necessary to conduct the financial transactions of the committee;

(4) assess each health maintenance organization for funds necessary to:

(A) enable the committee to perform its duties and other necessary or proper functions; and

(B) reimburse committee members for their actual expenses incurred in performing the functions of the committee; and

(5) perform other functions as necessary or proper under this subchapter.

(e) Reports regarding the financial condition of health maintenance organizations and the financial condition, administration, and status of health maintenance organizations in rehabilitation, liquidation, supervision, or conservation shall be provided to committee members at meetings. With regard to any person examined by the committee, committee members may not reveal:

(1) the condition of the examined person; or

(2) any information obtained in the course of a committee meeting that relates to the examined person. (V.T.I.C. Art. 20A.36, Secs. (b), (d).)

Source Law

(b)(1) The committee shall assist and advise the commissioner relating to the detection and prevention of insolvency problems regarding health maintenance organizations. The committee shall also assist and advise the commissioner regarding any health maintenance organization placed in rehabilitation, liquidation, supervision, or conservation. The method of providing this assistance and advice shall be as contained in the plan of operation approved by the commissioner.

(2) Reports regarding the financial condition of Texas licensed health maintenance organizations and regarding the financial condition, administration, and status of health maintenance organizations in rehabilitation, liquidation, supervision, or conservation shall be provided to the committee members at meetings. Committee members shall not reveal the condition of nor any information secured in the course of any meeting of the Solvency Surveillance Committee with regard to any corporation, form or person examined by the committee. Committee proceedings shall be filed with the commissioner.

(d) In performing its duties under this section, the committee may:

(1) enter into contracts as necessary or proper to implement this section;

(2) take legal action as necessary to recover any unpaid assessments owed under Subsection (c) of this section;

(3) employ staff as necessary to handle the financial transactions of the committee;

(4) assess each health maintenance organization that has a certificate of authority issued under this Act to operate in this state for funds necessary to carry out its duties and perform other functions as necessary or proper under this section and to reimburse committee members for their actual expenses in carrying out the functions of the committee; and

(5) perform other functions as necessary or proper under this section.

Revisor's Note

Section (b)(2), V.T.I.C. Article 20A.36, refers to "any corporation, form or person" examined by the Health Maintenance Organization Solvency Surveillance Committee. The revised law omits the references to "corporation" and "form" as unnecessary. In context, "form" is clearly intended to be "firm," and Subdivision (q), V.T.I.C. Article 20A.02, revised as Section 843.002(20), defines "person" broadly to include corporations and other artificial persons such as firms.

Revised Law

Sec. 843.441. ASSESSMENTS. (a) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, or conservation of an impaired health maintenance organization in this state, the committee, at the commissioner's direction, 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 provided to the committee by the commissioner after review of annual statements and other reports the commissioner considers necessary.

(b) Assessments to supplement or pay for administrative expenses of rehabilitation, liquidation, supervision, or conservation may be made only after the commissioner determines that:

(1) adequate assets of the impaired health maintenance organization are not immediately available for those administrative expenses; or

(2) use of those assets could be detrimental to rehabilitation, liquidation, supervision, or conservation.

(c) 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 basis for assessments provided by the approved plan of operation.

(d) 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.

(e) Notwithstanding any other provision of this subchapter, funds derived from an assessment made under this section may not be used for the expenses of administering the affairs of an impaired health maintenance organization while in supervision, rehabilitation, or conservation for more than 150 days. The committee may extend the period during which it makes assessments for the administrative expenses of an impaired health maintenance organization as it considers appropriate. (V.T.I.C. Art. 20A.36, Secs. (c), (h).)

Source Law

(c) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, or conservation of an impaired health maintenance organization in this state, the committee, at the commissioner's direction, shall assess each health maintenance organization licensed in this state in the proportion that the gross premiums of that health maintenance organization written in this state during the preceding calendar year bear to the aggregate gross premiums written in this state by all health maintenance organizations, as furnished to the committee by the commissioner after review of annual statements and other reports the commissioner considers necessary. Assessments to supplement or pay for administrative expenses

of rehabilitation, liquidation, supervision, or conservation may be made only after the commissioner determines that adequate assets of the health maintenance organization are not immediately available for those purposes or that use of those assets could be detrimental to rehabilitation, liquidation, supervision, or conservation. The commissioner may abate or defer the assessments, either 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, either in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the remaining licensed health maintenance organizations in a manner consistent with the basis for assessments provided by the plan of operation approved by the commissioner. The total of all assessments on a health maintenance organization may not exceed one-quarter of one percent of the health maintenance organization's gross premiums in any one calendar year.

(h) Notwithstanding any other provision of this section, funds derived from an assessment made under this section may not be used for the expenses of administering the affairs of a health maintenance organization while in supervision, rehabilitation, or conservation for a period longer than 150 days. The committee may extend the period during which it makes assessments for the administrative expenses of an impaired organization as it considers appropriate.

[Sections 843.442-843.460 reserved for expansion]

SUBCHAPTER N. ENFORCEMENT

Revised Law

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 Article 20A.09;

(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 untrue manner;

(9) would be hazardous to its enrollees if it continued in operation;

(10) has not complied substantially with this chapter or Chapter 20A or a rule adopted under this chapter or Chapter 20A; 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. (V.T.I.C. Art. 20A.20, Secs. (a), (b).)

Source Law

Art. 20A.20. (a) The commissioner may after notice and opportunity for hearing (i) suspend or revoke any certificate of authority issued to a health maintenance organization under this Act; (ii) impose sanctions under Section 7, Article 1.10, Insurance Code; (iii) impose administrative penalties under Article 1.10E, Insurance Code; or (iv) issue a cease and desist order under Article 1.10A, Insurance Code, if the commissioner finds that any of the following conditions exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational documents, or its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under Section 4 of this Act.

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which does not comply with the requirements of Section 9 of this Act.

(3) The health care plan does not provide or arrange for basic health care services, the limited health care service plan does not provide or arrange for its limited health care services, or the single health care service plan does not provide or arrange for a single health care service.

(4) The health maintenance organization does not meet the requirements of Section 5(a)(1) of this Act.

(5) The health maintenance

organization is unable to fulfill its obligation to furnish health care services as required under its health care plan, to furnish the limited health care services as required under its limited health care service plan, or to furnish a single health care service as required under its single health care service plan.

(6) The health maintenance organization is no longer financially responsible and may be reasonably expected to be unable to meet its obligations to enrollees or prospective enrollees.

(7) The health maintenance organization has failed to implement the complaint system required by Section 12 of this Act in a manner to resolve reasonably valid complaints.

(8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(10) The health maintenance organization has otherwise failed to comply substantially with this Act, and any rule and regulation thereunder.

(11) The health maintenance organization has failed to carry out corrective action the commissioner considers necessary to correct a failure to comply with this Act, any applicable provision of the Insurance Code, or any applicable rule or order of the commissioner within 30 days after the date of notice of a deficiency or within any longer period of time that the commissioner determines to be reasonable and specifies in the notice.

(b) A certificate of authority shall be suspended or revoked only after compliance with this section.

Revised Law

Sec. 843.462. OPERATIONS DURING SUSPENSION OR AFTER REVOCATION 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. (V.T.I.C. Art. 20A.20, Secs. (c), (d).)

Source Law

(c) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children, or newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(d) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization, as he may find to be in the best interest of the enrollees, to the end that the enrollees will be afforded the greatest practical opportunity to obtain continuing health care

coverage.

Revised Law

Sec. 843.463. INJUNCTIONS. If the commissioner believes that a health maintenance organization or another person is violating or has violated this chapter or Chapter 20A or a rule adopted under this chapter or Chapter 20A, the commissioner may bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate. (V.T.I.C. Art. 20A.31, Sec. (a).)

Source Law

Art. 20A.31. (a) When it appears to the commissioner that a health maintenance organization or other person is violating or has violated this Act or any rule or regulation issued pursuant to this Act, the commissioner may bring suit in a district court of Travis County to enjoin the violation and for such other relief as the court may deem appropriate.

Revised Law

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 Chapter 20A or a rule adopted under this chapter or Chapter 20A; or

(2) knowingly makes a false statement with respect to a report or statement required under this chapter or Chapter 20A.

(b) An offense under this section is a Class B misdemeanor. (V.T.I.C. Art. 20A.24.)

Source Law

Art. 20A.24. A person or an agent or an officer of a health maintenance organization who wilfully violates this Act or the rules promulgated pursuant to this Act or who knowingly makes a false statement with respect to a report or a statement required by this Act is guilty of a Class B misdemeanor.

Revisor's Note
(End of Chapter)

(1) V.T.I.C. Article 20A.34 states the effective date of the Texas Health

Maintenance Organization Act. The revised law omits the provision as executed. The omitted law reads:

Art. 20A.34. This Act shall take effect on the first day of December, 1975.

(2) V.T.I.C. Article 20A.35 is a severability clause. The revised law omits the provision because it duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law, and Section 312.013, Government Code. Those sections state that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

Art. 20A.35. If any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of this Act which can be given effect without the invalid provisions or application. To this end, all provisions of the Texas Health Maintenance Organization Act are declared to be severable.

CHAPTER 844. CERTIFICATION OF CERTAIN NONPROFIT HEALTH CORPORATIONS

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