CHAPTER 567

S.B. No. 1132

AN ACT

relating to the regulation of health maintenance organizations and their agents.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Subsections (k) and (*o*), Section 2, Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code), are amended to read as follows:

(k) "Medical care" means furnishing those services defined as *practicing* [~~the practice of~~] medicine *under Section 1.03(8), Medical Practice Act (Article 4495b* [~~in Section 11, Chapter 426, Acts of the 53rd Legislature, Regular Session, 1953 (Article 4510a~~], Vernon's Texas Civil Statutes).

(*o*) "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.*

SECTION 2. Section 4, Texas Health Maintenance Organization Act (Article 20A.04, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 4. APPLICATION FOR CERTIFICATE OF AUTHORITY. (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 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 statement generally describing the health maintenance organization, its health care plan or plans, facilities, and personnel;~~

[~~(6)~~] a copy of the form of evidence of coverage to be issued to the enrollee;

(6) [~~(7)~~] 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;

[~~(8) a financial statement showing the applicant's assets, liabilities, and sources of financial support; if the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the commissioner~~

~~directs that additional or more recent financial information is required for the proper administration of this Act;~~

[~~(9) a description of the proposed method of marketing the plan, a financial plan which includes a projection of the initial operating results anticipated until the organization has had a net income for 12 consecutive months, and a statement as to the sources of working capital, as well as any other sources of funding, provided that updated projections for the next calendar year must be filed by December 31 of each year until the organization has had a net income for 12 consecutive months;~~]

(9) [~~(10)~~] a power of attorney duly executed by such applicant, if not domiciled in this state, appointing the commissioner and his successors in office, or a duly authorized deputy, as the true and lawful attorney of such applicant in and for the state upon whom all lawful processes in any legal action or proceedings against the health maintenance organization on a cause of action arising in this state may be served;

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

(11) [~~(12)~~] a description of the complaint procedures to be utilized;

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

(13) [~~(14) a description of the mechanisms by which enrollees will be afforded the opportunity to participate in matters of policy and operation; and~~

[~~(15)~~] such other information as the commissioner may require to make the determinations required by this Act.

(b) The State Board of Insurance may promulgate such reasonable rules and regulations as it 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 both the board and 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.

SECTION 3. Subsection (b), Section 5, Texas Health Maintenance Organization Act (Article 20A.05, Vernon's Texas Insurance Code), is amended to read as follows:

(b) 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 the certification of the board; provided, however, that the commissioner may grant a delay of final action on the application to an applicant [~~who has demonstrated a need therefor, including any delay occasioned by an application to the federal government~~]. Issuance of the certificate of authority shall be granted upon payment of the application fee prescribed in Section 32 of this Act if:

(1) the board certifies that the health maintenance organization's proposed plan of operation meets the requirements of Subsection (a)(2) of this section; and

(2) the commissioner is satisfied that:

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

(B) the health care 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 or single health care service on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payment;

(C) 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:

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

(ii) the adequacy of working capital;

(iii) 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;

(iv) any agreement which provides for the provision of health care services; and

(v) any [~~surety bond or~~] deposit of cash or securities submitted in accordance with Section 13 of this Act as a guarantee that the obligations will be duly performed;

(D) [~~the enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Section 7(b) of this Act;~~

[~~(E)~~] 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.

SECTION 4. Section 6, Texas Health Maintenance Organization Act (Article 20A.06, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 6. POWERS OF HEALTH MAINTENANCE ORGANIZATION. (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;

(3) the furnishing of or arranging for medical care services only through 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 providers or groups of providers who are under contract with or employed by the health maintenance organization *or through physicians or providers who have contracted for health care services with those 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 physicians or providers in any manner which is prohibited by any licensing law of this state under which such physicians or providers are licensed;

(4) the contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(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, indemnity, or reimbursement against the cost of health care and medical care services provided by the health maintenance organization;

(6) the offering of:

(A) indemnity benefits covering out-of-area emergency services; and

(B) indemnity benefits in addition to those relating to out-of-area and emergency services, provided through insurers or group hospital service corporations;

(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;

(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.

(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 [~~considered~~] 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.

SECTION 5. Section 7, Texas Health Maintenance Organization Act (Article 20A.07, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 7. GOVERNING BODY. [~~(a)~~] The governing body of any health maintenance organization may include physicians, providers, or other individuals, or any combination of the above.

[~~(b) The governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.~~]

SECTION 6. Subsections (a), (b), and (c), Section 9, Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code), are amended to read as follows:

(a)(1) Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(3) An evidence of coverage shall contain:

(A) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act; and

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:

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

(ii) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or co-payment feature;

(iii) where and in what manner information is available as to how services may be obtained; *and*

(iv) [~~the total amount of payment for health care services or single health care service and the indemnity or service benefits, if any, which the enrollee is obligated to pay with~~

~~respect to individual contracts, or indication whether the plan is contributory or noncontributory with respect to group certificates; and~~

[~~(v)~~] a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints. Any subsequent changes may be evidenced in a separate document issued to the enrollee.

(4) Any form of the evidence of coverage or group contract to be used in this state, and any amendments thereto, are subject to the filing and approval requirements of Subsection (c) of this section, unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or group hospital service corporations, in which event the filing and approval provisions of such law shall apply. To the extent, however, that such provisions do not apply to the requirements of Subdivision (3), Subsection (a) of this section, the requirements of Subdivision (3) shall be applicable.

(b) *The formula or method for calculating the schedule of charges for enrollee coverage for medical services or health care services must be filed with the commissioner before it is used in conjunction with any health care plan. The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. The charges resulting from the application of the formula or method may not be altered for an individual enrollee based on the status of that enrollee's health. The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and benefits must be reasonable with respect to the rates produced by the formula or method. A statement by a qualified actuary that certifies the appropriateness of the formula or method must accompany the filing together with supporting information considered adequate by the commissioner.* [~~(1) No schedule of charges for enrollee coverage for medical services or health care services or amendments thereto may be used in conjunction with any health care plan until a copy of such schedule or amendments thereto has been filed with the commissioner.~~

[~~(2) Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his or her health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory, and the benefits shall be reasonable with respect to the rates charged. A certification, by a qualified actuary, to the appropriateness of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.~~]

(c) The commissioner shall, within a reasonable period, approve any form of the evidence of coverage or group contract, or amendment thereto, if the requirements of this section are met. *After notice and hearing, the commissioner may withdraw previous approval of any form, if the commissioner determines that it violates or does not comply with this Act or a rule adopted by the State Board of Insurance.* It shall be unlawful to issue such form until approved. If the commissioner disapproves such form, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reason for the disapproval. A hearing shall be granted within 30 days after a request in writing by the person filing. If the commissioner does not disapprove any form within 30 days after the filing of such form it shall be considered approved; provided that the commissioner may by written notice extend the period for approval or disapproval of any filing for such further time, not exceeding an additional 30 days, as necessary for proper consideration of the filing.

SECTION 7. Subsection (b), Section 10, Texas Health Maintenance Organization Act (Article 20A.10, Vernon's Texas Insurance Code), is amended to read as follows:

(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* [~~a summary of the information compiled pursuant to Section 12 of this Act in such form as required by the State Board of Insurance~~]; 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.

SECTION 8. Subsection (a), Section 12, Texas Health Maintenance Organization Act (Article 20A.12, Vernon's Texas Insurance Code), is amended to read as follows:

(a)[~~(1)~~] Every health maintenance organization shall establish and maintain a complaint system [~~which has been approved by the commissioner after consultation with the board~~] to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

[~~(2) Every health maintenance organization shall submit to the commissioner and to the board an annual report in a form prescribed by rule of the State Board of Insurance after consultation with the board.~~]

SECTION 9. Section 13, Texas Health Maintenance Organization Act (Article 20A.13, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 13. PROTECTION AGAINST INSOLVENCY. (a) Unless otherwise provided by this section, each health maintenance organization shall [~~furnish a surety bond, or~~] deposit with the State Treasurer cash or securities, or any combination of these or other guarantees that are acceptable to the State Board of Insurance, in an amount as set forth in this section.

(b) For a health maintenance organization which has not received a certificate of authority from the State Board of Insurance prior to September 1, *1987* [~~1981~~]:

(1) the amount of the initial [~~surety bond,~~] deposit[~~,~~] or other guarantee shall be *$100,000 for an organization offering basic health care services and $50,000 for an organization offering a single health care service plan;* [~~equal to five percent of its estimated uncovered expenses for the first 12 months of operation, but in no event less than $100,000; and~~]

(2) on or before March 15 of *the* [~~each~~] year following the year in which the health maintenance organization receives a certificate of authority, *it* [~~the health maintenance organization~~] shall deposit with the State Treasurer an amount equal to *the difference between the initial deposit and 100* [~~four~~] 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 State Board of Insurance may not require the health maintenance organization to make any additional deposit under this subsection [~~the dues or premium revenue collected during the previous calendar year~~].

(c) For a health maintenance organization which has received a certificate of authority from the State Board of Insurance prior to September 1, *1987* [~~1981~~]:

(1) on or before March 15, *1988* [~~1982~~], 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 [~~one percent of the dues or premium revenue collected during the previous calendar year~~]; [~~and~~]

(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 State Board of Insurance may not require the health maintenance organization to make any additional deposit under this subsection [~~two percent of dues or premium revenue collected during the previous calendar year shall be deposited on or before March 15, 1983, three percent of dues or premium revenue collected during the previous calendar year shall be deposited on or before March 15, 1984, and four percent of dues or premium revenue collected during the previous calendar year shall be deposited on or before March 15, 1985, and on or before March 15 of each subsequent year until the requirement is waived by the State Board of Insurance~~].

(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, the State Board of Insurance may waive some or all of *the* [~~these~~] 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 [~~surety bond,~~] 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 been in operation for at least 10 years and~~] has a net worth of at least $5,000,000 *for each health maintenance organization whose uncovered expenses it guarantees.*

(g) [~~(e)~~] 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 State Treasurer upon order of the State Board of Insurance pursuant to [~~the same standards specified in~~] Subsection *(f)* [~~(d)~~] of this section.

(h) [~~(f)~~] A health maintenance organization that has made a deposit with the State Treasurer may, at its option, withdraw the deposit or any part thereof, first having deposited with the State Treasurer, in lieu thereof, a deposit of cash or securities of equal amount and value to that withdrawn. Any securities shall be approved by the State Board of Insurance before being substituted.

(i) [~~(g)~~] Each health maintenance organization offering basic health care services shall maintain a minimum surplus of not less than *$500,000* [~~$200,000~~], net of accrued uncovered liabilities. *Each health maintenance organization offering only a single care service shall maintain a minimum surplus of not less than $125,000, net of*

accrued uncovered liabilities. The *minimum* surplus *shall* [~~may~~] consist only of cash, bonds of the United States, bonds of this state, or a combination of these. If a health maintenance organization fails to comply with the surplus requirement of this subsection or Subsection *(j)* [~~(h)~~] of this section, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

(j) [~~(h)~~] The minimum surplus for a health maintenance organization authorized to operate on the effective date of Subsection *(i)* [~~(g)~~] of this section and having a surplus of less than *$500,000* [~~$200,000~~] shall be as follows:

(1) $200,000 by December 31, 1987;

(2) $250,000 by December 31, 1988;

(3) $300,000 by December 31, 1989;

(4) $350,000 by December 31, 1990;

(5) $400,000 by December 31, 1991;

(6) $450,000 by December 31, 1992; and

(7) $500,000 by December 31, 1993.

[~~(1) $50,000 by December 31, 1984;~~

[~~(2) $100,000 by December 31, 1985;~~

[~~(3) $150,000 by December 31, 1986; and~~

[~~(4) $200,000 by December 31, 1987.~~]

(k) [~~(i)~~] Notwithstanding any other provision of this article, a health maintenance organization authorized to offer only a single health care service plan *authorized to operate on September 1, 1987, and having a surplus of less than $125,000 shall be as follows:*

(1) $50,000 by December 31, 1987;

(2) $62,500 by December 31, 1988;

(3) $75,000 by December 31, 1989;

(4) $87,500 by December 31, 1990;

(5) $100,000 by December 31, 1991;

(6) $112,500 by December 31, 1992; and

(7) $125,000 by December 31, 1993 [~~providing a single health care service that is owned by residents of this state must have a minimum surplus of $50,000.~~

[~~(j) A health maintenance organization authorized to offer only a single health care service plan providing a single health care service that is owned by persons who are not residents of this state must have a minimum surplus of $150,000~~].

SECTION 10. Subsection (b), Section 14, Texas Health Maintenance Organization Act (Article 20A.14, Vernon's Texas Insurance Code), is amended to read as follows:

(b) *Articles 21.21, 21.21A, 21.21-2, and 21.21-3, Insurance Code, and Chapter 122, Acts of the 57th Legislature, Regular Session, 1961 (Article 21.21-1, Vernon's Texas* [~~Article 21.21, as amended, and Article 21.21-2, of the~~] Insurance Code*)*, [~~shall be construed to~~] apply to health maintenance organizations *that offer both basic and single health care coverages* and *to basic 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* [~~provisions~~] of *those articles* [~~such sections~~] clearly inappropriate.

SECTION 11. Section 15, Texas Health Maintenance Organization Act (Article 20A.15, Vernon's Texas Insurance Code), is amended by amending Subsection (a) and by adding Subsections (n) through (u) to read as follows:

(a) A health maintenance organization agent is anyone who represents any health maintenance organization in the solicitation, negotiation, procurement, or effectuation of

health maintenance organization membership or holds himself or herself out as such. No person or other legal entity may perform the acts of a health maintenance organization agent within this state unless such person or legal entity has a valid health maintenance organization agent's license issued pursuant to this Act. The term "health maintenance organization agent" shall not include:

(1) any regular salaried officer or employee of a health maintenance organization or of a licensed health maintenance organization agent, who devotes substantially all of his or her time to activities other than the solicitation of applications for health maintenance organization membership and receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

(2) employers or their officers or employees or the trustees of any employee benefit plan to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits involving the use of membership in a health maintenance organization; provided that such employers, officers, employees, or trustees are not in any manner compensated directly or indirectly by the health maintenance organization issuing such health maintenance organization membership;

(3) banks or their officers and employees to the extent that such banks, officers, and employees collect and remit charges by charging same against accounts of depositors on the orders of such depositors; *or*

(4) any person or the employee of any person who has contracted to provide administrative, management, or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income, or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this section.

(n) The State Board of Insurance shall issue a license to a corporation if it finds that:

(1) the corporation is organized or existing under the Texas Business Corporation Act, has its principal place of business in this state, and has as one of its purposes the authority to act as an agent under this section; and

(2) each officer, director, and shareholder of the corporation is individually licensed under this section.

(o) This section may not be construed to permit any employee, agent, or corporation to perform any act of an agent under this section without obtaining a license.

(p) If, at any time, a corporation that holds an agent's license does not maintain the qualifications necessary to obtain a license, the State Board of Insurance shall cancel or revoke the license of that corporation to act as an agent. If a person who is not a licensed agent under this section acquires shares in such a corporation by devise or descent, that person must either obtain a license or dispose of the shares to a person licensed under this section not later than the 90th day after the date on which the person acquires the shares.

(q) If an unlicensed person acquires shares in a corporation and does not dispose of the shares within the 90-day period, the shares must be purchased by the corporation for the value of the shares as reflected by the regular books and records of the corporation as of the date of the acquisition of the shares by the unlicensed person. If the corporation fails or refuses to purchase the shares, the State Board of Insurance shall cancel its license.

(r) A corporation may redeem the shares of any shareholder or the shares of a deceased shareholder on terms agreed to by the board of directors and the shareholder or the shareholder's personal representative or at a price and on terms provided in the articles of incorporation, the bylaws of the corporation, or an existing contract entered into by the shareholders of the corporation.

(s) With the application for a license or a license renewal, each corporation licensed as an agent under this section must file a sworn statement listing the names and addresses of all of its officers, directors, and shareholders.

(t) Each corporation shall notify the State Board of Insurance of any change in its officers, directors, or shareholders not later than the 30th day after the date on which the change takes effect.

(u) Another corporation may not own an interest in a corporation licensed under this section. Each owner of an interest in a corporation licensed under this section must be a natural person who holds a valid license issued under this section.

SECTION 12. Section 18, Texas Health Maintenance Organization Act (Article 20A.18, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 18. MANAGEMENT *CONTRACT* AND EXCLUSIVE *AGENCY* CONTRACTS. (a) No health maintenance organization may enter into *a management contract or* an exclusive agency contract [~~or management 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 or is covered by 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 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.

(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 State Treasurer cash or securities acceptable to the State Board of Insurance. Such a deposit must be maintained in the amount and subject to the same conditions as required for a bond under this section.

SECTION 13. Subsection (a), Section 20, Texas Health Maintenance Organization Act (Article 20A.20, Vernon's Texas Insurance Code), is amended to read as follows:

(a) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this Act 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 or the single health care service plan does not provide or arrange for a single health care service.

(4) The board certifies to the commissioner that:

(A) the health maintenance organization does not meet the requirements of Section 5(a)(2) of this Act; or

(B) the health maintenance organization is unable to fulfill its obligation to furnish health care services as required under its health care plan or to furnish a single health care service as required under its single health care service plan.

(5) 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.

(6) [~~The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under Section 7(b) of this Act.~~

[~~(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.

(7) [~~(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.

(8) [~~(9)~~] The continued operation of the health maintenance organization would be hazardous to its enrollees.

(9) [~~(10)~~] The health maintenance organization has otherwise failed to comply substantially with this Act, and any rule and regulation thereunder.

SECTION 14. Sections 21 and 22, Texas Health Maintenance Organization Act (Articles 20A.21 and 20A.22, Vernon's Texas Insurance Code), are amended to read as follows:

Sec. 21. REHABILITATION, LIQUIDATION, *SUPERVISION,* OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATIONS. 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.

Sec. 22. RULES AND REGULATIONS. *(a)* The State Board of Insurance may[~~, after notice and hearing,~~] promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of this Act.

(b) The State Board of Insurance is specifically authorized to promulgate rules prescribing authorized investments for health maintenance organizations for all investments for which provision is not otherwise made in this Act. The rulemaking authority provided by this subsection does not limit in any manner the rulemaking authority granted to the State Board of Insurance under Subsection (a) of this section.

SECTION 15. Subsections (c) and (f), Section 26, Texas Health Maintenance Organization Act (Article 20A.26, Vernon's Texas Insurance Code), are amended to read as follows:

(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* [~~3, Chapter 627, Acts of the 62nd Legislature, Regular Session, 1971 (Article 4505~~], Vernon's Texas Civil Statutes), and no health maintenance organization shall be exempt from same.

(f)(1) This Act shall not be applicable to any person licensed to practice medicine in this state, nor to any professional association organized under the Texas Professional Association Act, as amended (Article 1528f, Vernon's Texas Civil Statutes), nor to any nonprofit corporation organized and complying with Section *5.01, Medical Practice Act (Article 4495b* [~~4, Chapter 627, Acts of the 62nd Legislature, Regular Session, 1971 (Article 4509a~~], Vernon's Texas Civil Statutes), so long as that person, professional association, or nonprofit corporation is engaged in the delivery of health or medical care that is within the definition of *practicing* [~~the practice of~~] medicine as defined in Section 2(k) of this Act.

(2) *Except as provided by Section 6(a)(3) of this Act, any* [~~Any~~] person, professional association, or nonprofit corporation referred to above, which shall employ or enter into a contractual arrangement with a provider or group of providers to furnish basic health care services [~~or a single health care service~~] as defined in *Section 2* [~~Sections 2(a) and (r)~~] of this Act, would be subject to the provisions of this Act, and shall be required to obtain a certificate of authority from the commissioner.

(3) Notwithstanding any other law, any person, professional association, or nonprofit corporation referred to above, which 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, professional associations, or nonprofit corporations referred to above, 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.

(4) Notwithstanding any other law, provisions of the insurance law and the provisions of the group hospital service corporation law shall not be applicable to the above persons, professional associations, or nonprofit corporations.

SECTION 16. Section 30, Texas Health Maintenance Organization Act (Article 20A.30, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 30. OFFICERS AND EMPLOYEES BOND. (a) A health maintenance organization shall maintain in force a fidelity bond *in its own name* [~~issued by an insurance company holding a certificate of authority to do business in this state,~~] 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) [~~A three-year discovery period applies in the event a health maintenance organization goes out of business, is sold, is voluntarily liquidated, or becomes bankrupt.~~

[~~(c) The fidelity bond must include a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, does not take effect before the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner, unless an earlier date of cancellation or termination is approved by the commissioner.~~

[~~(d)~~] 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 State Treasurer. Such a deposit must be maintained in the amount and subject to the same conditions required for a bond under this section.

SECTION 17. Section 31, Texas Health Maintenance Organization Act (Article 20A.31, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 31. INJUNCTIONS. 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.

SECTION 18. The Texas Health Maintenance Organization Act (Article 20A.01 et seq., Vernon's Texas Insurance Code) is amended by adding Section 36 to read as follows:

Sec. 36. HEALTH MAINTENANCE ORGANIZATION SOLVENCY SURVEILLANCE COMMITTEE. (a) The Health Maintenance Organization Solvency Surveillance Committee is created under the direction of the commissioner. The committee shall perform its functions under a plan of operation approved by the State Board of Insurance. The committee is composed of nine members appointed by the State Board of Insurance. Four members must be employees or officers from four of the 10 licensed health maintenance organizations that have the largest total direct premium income based on the latest financial statement on file, and the remaining members must be employees or officers of the remaining health maintenance organizations and chosen based on due consideration of their varying categories of premium income and geographical location and other factors considered appropriate by that board. 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, method of succession and reimbursement of expenses shall be as provided by the plan of operation approved by the State Board of Insurance.

(b) 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 State Board of Insurance.

(c) To provide funds for the administrative expenses of the State Board of Insurance 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 State Board of Insurance. 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.

(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; and

(4) perform other functions as necessary or proper under this section.

(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 State Board of Insurance a plan of operation. The plan of operation takes effect on approval in writing by the State Board of Insurance. 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 State Board of Insurance may, after notice and hearing, adopt rules as necessary to implement this Act. Those rules continue in effect until modified by the State Board of Insurance or superseded by a plan submitted by the committee and approved by the State Board of Insurance.

(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.

(g) A licensed health maintenance organization or its agents or employees, the committee or its agents, employees, or members, or the State Board of Insurance, the commissioner, or their 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.

(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.

SECTION 19. (a) This Act takes effect September 1, 1987.

(b) Section 30, Texas Health Maintenance Organization Act (Article 20A.30, Vernon's Texas Insurance Code), as amended by this Act, applies only to fidelity bonds that are purchased or renewed on or after the effective date of this Act. A fidelity bond purchased before the effective date of this Act is subject until its first renewal after the effective date of this Act to the law as it existed at the time the fidelity bond was purchased, and that law is continued in effect for that purpose.

SECTION 20. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

Passed the Senate on May 8, 1987, by a viva-voce vote. Passed the House on May 30, 1987, by a non-record vote.

Approved June 18, 1987.

Effective Sept. 1, 1987.