DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

September 1, 2022

Humana Insurance Company of Texas – Texas – HIOS # 63141
Humana Health Plan of Texas – Texas – HIOS # 32673

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Re: Final Determination Letter - Finding of Non-Compliance - Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitation (NQTL) Comparative Analysis Review – Provider Network Participation Requirements for Inpatient, In-Network Providers and Outpatient, In-Network Providers

Dear Ms. Daugherty and Ms. Maloney:

This notice is being sent to inform you that a review of the Corrective Action Plan (CAP) and additional comparative analyses submitted to address the instances of non-compliance noted in the MHPAEA NQTL Analysis Review (Review) is complete. This letter also identifies additional remediation and corrective action CMS identified as necessary to fully address the instances of non-compliance.

The purpose of the Review was to assess Humana Insurance Company of Texas' and Humana Health Plan of Texas' (Issuer) compliance with the following requirements under Title XXVII of the Public Health Service Act (PHS Act) for the specific NQTL comparative analyses reviewed:

> 42 U.S.C. § 300gg-26, 45 C.F.R. §§ 146.136 and 147.160 - Parity In Mental Health And Substance Use Disorder Benefits

The Review covered provider network participation requirements for inpatient, in-network providers and outpatient, in-network providers for the 2021 plan year.

CMS conducted this Review pursuant to PHS Act § 2726(a)(8)(A) and (B), as added by Section 203 of Title II of Division BB of the Consolidated Appropriations Act, 2021.[1] CMS contracted with Examination Resources, LLC to assist CMS with conducting this Review.

On September 16, 2021, CMS provided an initial determination letter of non-compliance to the Issuer and requested a CAP and additional comparative analysis to demonstrate compliance. After reviewing the CAP and additional comparative analysis, CMS is finalizing the determination of non-compliance with MHPAEA in the following areas:

I. Failures to Demonstrate Comparability as Written and in Operation.

45 C.F.R. § 146.136(c)(4)(i) states that "A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification **are comparable to, and are applied no more stringently than**, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." (emphasis added). CMS identified violations of this provision in the following instances:

1. Access and Adequacy Factors Used in the Design and Application of the Network Participation Requirements NQTL (Geographic Access Standards) are Not Comparable and Applied More Stringently to Mental Health/Substance Use Disorder (MH/SUD) Provider Types.

In the initial submission on May 19, 2021, the Issuer identified both access and adequacy as factors considered in the design and application of the network participation requirements NQTL (*NQTL_CompAnalyses_Admittance_and_Credentialing_TX 051821*, cells E7 and E10). In the supplemental submission on July 9, 2021 (*CMS MHPAEA CA Network Follow-Ups – HIC TX and HHP TX*, cells G6 & G16), the Issuer provided policy *NNO 702-044-15 Provider Network Availability and Access*, which further defines the access and adequacy factors to include "geographic accessibility of providers" (*NNO 702-044-15 Provider Network Availability and Access*, p. 3). The Issuer's supplemental submission (*CMS MHPAEA CA Network Follow-Ups – HIC TX and HHP TX*, cell G16) received on July 9, 2021 referenced the *Comm-Prov-Ntwrk-Avail-and-Access-Standards 2020.3.24* document, also received on July 9, 2021, which includes quantitative thresholds for the access and adequacy factors in the form of Geographic Access Standards on page 1 of the document. The Geographic Access Standards include a table listing the Distance (miles) and Time (minutes) standards for different provider types for which 90% of members should have access. The provider types include: "Primary Care," "Specialty Care (includes OBG)," "Hospital, Behavioral Health," "Behavioral Health Hospital," and "Inpatient Psych." Distance and Time standards are provided for Urban and Rural areas for all Provider Types. For medical/surgical (M/S) provider types, which includes Primary Care and Hospital provider types, the Distance and Time requirements are 30 miles/30 minutes for Urban Areas and 60 miles/60 minutes for Rural Areas.

[1] Pub. L. 116-260 (Dec. 27, 2020).

However, for MH/SUD Provider Types, which include "Behavioral Health," "Behavioral Health Hospital," and "Inpatient Psych," the Distance and Time standards are 60 miles/60 minutes for Urban Areas, and 90 miles/90 minutes for Rural Areas. The "Specialty Care" provider type (defined as "A physician or non-physician health care professional who focuses on a specific area of mental or behavioral health or a group of patients"), which could include both MH/SUD and M/S providers, also has a Distance and Time standard of 60 miles/60 minutes for Urban Areas, and 90 miles/90 minutes for Rural Areas (*Comm-Prov-Ntwrk-Avail-and-Access-Standards 2020.3.24,* pg. 3). The September 16, 2021 initial determination letter stated that insufficient information was provided regarding the sources and evidentiary standards used to determine and establish the variations in the Issuer's Geographic Access Standards identified by CMS.

On January 7, 2022, the Issuer provided the results of a network adequacy review as part of the CAP to support the processes, sources, and/or evidentiary standards considered in establishing variations in standards or guidelines utilized in the application of the NQTL. The Behavioral Health, Behavioral Health Hospital, and Inpatient Psych provider types that were included in the previous July 9, 2021 submission were updated to "MH/SUD" and "IP MH/SUD" provider types for both Urban and Rural areas. As part of the network adequacy review, the Issuer provided the minimum, average, maximum, and mode time and distance observations for different provider types currently in place and modified the standards for OBGYN and MH/SUD provider types in Urban areas based on those observations. As part of the network adequacy review performed by the Issuer and provided to CMS on January 7, 2022 as part of the CAP, the mileage portion of the Distance and Time requirements for the "MH/SUD" provider type was updated to 50 miles for Urban Areas and established as 50 miles/60 minutes for the "OBGYN" provider type (OBGYN was previously included in the "Specialty Care" provider type) (*Humana-Prov-Ntwrk-Avail-and-Access-Standards 2021.12.14*, page 1). However, the network adequacy review did not demonstrate that the factors used to establish the variation were consistent with parity requirements (*Access Standards Review Meeting Minutes Final (003)*, page 3). In a prior response received on July 9, 2021, the Issuer cited Texas Administrative Code to support "PCP," "SCP," "Hospital" and "Pharmacy" urban and rural standards contemplated in state regulations (*Texas Specific Standards*, page 1). No other information was provided to support the specific standards that were selected for each provider category. For example, no information was provided to support why a standard of 90 miles/90 minutes was selected for "Behavioral Health," "Behavioral Health Hospital," "Inpatient Psych" and "Specialty Care" providers in Rural areas. Although the time and distance observations in the network adequacy review supported the *modification* to "OBGYN" and "MH/SUD" Urban standards, it was unclear why the original standards were selected for all provider type categories. The time and distance observations included in the network adequacy review demonstrated *results* based on the preexisting standards selected by the Issuer but did not explain the underlying rationale for establishing each standard selected prior to the network adequacy review. Therefore, the observations alone did not provide a sufficient explanation of the process and factors used in setting each standard and the resulting variation in standards between MH/SUD and M/S provider types.

The quantitative thresholds for distance and time standards set for MH/SUD provider types, both before and after the network adequacy review, are not in parity with those for M/S providers. In

the initial submission provided on May 19, 2021, the Issuer states that networks may be "closed due to saturation of a specific specialty" (NQTL_CompAnalyses_Admittance_and_Credentialing_TX 051821, Network Admittance tab, cell E6). The June 22, 2021 Insufficient Data Request Item and September 16, 2021 initial determination letter requested information on how "saturation of a specific specialty" is measured. The Issuer's response provided on October 18, 2021 states that, along with a "qualitative determination," the "[c]losure of a network for a specific provider type is based on the quantitative network adequacy measures described" in the "Commercial Provider Network Availability and Access Standards" document provided on July 9th, which includes the Geographic Access Standards (Initial Determination Response to CMS_10182021, pages 5-6). The current standards could restrict MH/SUD provider admission to the network. Specifically, MH/SUD providers may be denied admission to a network based on analyses that there are sufficient numbers or "saturation" of "MH/SUD" or "IP MH/SUD" provider types within 50 or 60 miles/60 minutes (Urban) or 90 miles/90 minutes (Rural), whereas a M/S provider applying to participate in the same network may be granted admission under a standard of 30 miles/30 minutes (Urban) or 60 miles/60 minutes (Rural). In addition, the standards may make access to MH/SUD care a greater burden for members traveling a greater time and distance to access MH/SUD providers than to access M/S providers. Therefore, these standards, as quantitative thresholds for the access and adequacy factors utilized in the design and application of the NQTL, are not comparable and are more stringent with respect to MH/SUD providers. By using a non-comparable and more stringent threshold, as written and in operation, this NQTL is not comparable and is applied more stringently to MH/SUD benefits compared to M/S benefits in the same benefit classification, in violation of 45 C.F.R. § 146.136(c)(4)(i).

As such, the following corrective action is required:

i. Update the geographic access standards for MH/SUD and Inpatient MH/SUD providers to be comparable to and no more stringent than the standards for M/S provider types and provide supporting documentation showing completion of this action by September 21, 2022.

2. Access and Adequacy Factors Used in the Design and Application of the Network Participation Requirements NQTL (Access to Service/Waiting Time Standards) are Not Comparable and Applied More Stringently to MH/SUD Provider Types.

In the initial submission on May 19, 2021, the Issuer identified both access and adequacy as factors considered in the design and application of the network participation requirements NQTL (*NQTL_CompAnalyses_Admittance_and_Credentialing_TX 051821*, cells E7 and E10). In the supplemental submission on July 9, 2021 (*CMS MHPAEA CA Network Follow-Ups – HIC TX and HHP TX*, cells G6 & G16), the Issuer provided policy *NNO 702-044-15 Provider Network Availability and Access*, which further defines the access and adequacy factors to include "Waiting times for an appointment with participating providers" in their definition (*NNO 702-044-15 Provider Network Availability and Access*, p. 3). The Issuer's supplemental submission (*CMS MHPAEA CA Network Follow-Ups – HIC TX and HHP TX*, cell G16) received on July 9, 2021 referenced the *Comm-Prov-Ntwrk-Avail-and-Access-Standards 2020.3.24* document, also received on July 9, 2021, which includes quantitative thresholds for the access and adequacy

factors in the form of Access to Service/Waiting Time Standards (*Comm-Prov-Ntwrk-Avail-and-Access-Standards 2020.3.24*, p. 2). The September 16, 2021 initial determination letter stated that insufficient information was provided regarding the sources and evidentiary standards used to determine and establish the variations in the Issuer's Access to Service/Waiting Time Standards identified by CMS. In a supplemental CAP response provided on January 7, 2022, the Issuer provided an updated document, *Humana-Prov-Ntwrk-Avail-and-Access-Standards 2021.12.14*, which provides Humana's general and state-specific Access to Service/Waiting Time Standards, separated by Medical and Behavioral Standards. The general Medical Standard for Emergent appointments is "Immediately, 24 hours per day, 7 days per week" (*Humana-Prov-Ntwrk-Avail-and-Access-Standards 2021.12.14*, page 3). However, the general Behavioral Standard for Emergent appointments is categorized by "Life Threatening: Immediately and Non-Life Threatening: 6 hours" (*Humana-Prov-Ntwrk-Avail-and-Access-Standards 2021.12.14*, page 3). There are no Texas-specific Medical or Behavioral Standards for Emergent appointments set by the plan.

The Non-Life Threatening appointment access/waiting time standard is longer for MH/SUD appointments than for M/S appointments, likely limiting access to MH/SUD care. Further, there is no limitation for M/S appointments based on "Life Threatening" or "Non-Life Threatening" categorizations, which then results in a longer wait time for MH/SUD Non-Life Threatening appointments. Additionally, the Behavioral Standard does not specify that Emergent appointments are available 24 hours per day, 7 days a week, limiting the availability for MH/SUD appointments compared to M/S appointments.

In addition, the general Medical Standard for Urgent appointments is "Within 24 hours, 7 days per week" (*Humana-Prov-Ntwrk-Avail-and-Access-Standards 2021.12.14*, page 3) and the Texas-specific Behavioral Standard is "Within 24 hours" (page 2). There is no Texas-specific Medical Standard for Urgent appointments set by the plan. The Texas-specific Behavioral Standard does not specify that appointments are available 7 days a week, limiting the availability for MH/SUD appointments compares to M/S appointments.

On January 7, 2022, the Issuer provided the results of a network adequacy review to support the processes, sources, and/or evidentiary standards considered in establishing variations in standards or guidelines utilized in the application of the NQTL. The Issuer cited Texas Administrative Code to support the Texas-specific standard selections (*Texas Specific Standards*, page 1). Regarding the selected default standards, the analysis states, "The committee discussed differences between the medical standards and behavioral standards, and concluded that the relatively limited availability of specialized behavioral health providers necessitated differences in some circumstances" (*Access Standards Review Meeting Minutes Final (003)*, page 6). The network adequacy review did not demonstrate that the factors used to establish the variation were consistent with parity requirements for the following reasons. No other information was provided to support the specific default standards that were selected for each appointment category. No further context was provided to support the assertion of "limited availability of specialized behavioral health providers" and the extent to which this consideration impacted certain Access to Service/Waiting Time Standards. Further, it is unclear which specific standards the statement "limited availability of specialized behavioral health providers" refers to. For example, it is unclear why the Issuer set a different default standard for Life Threatening compared to Non-

Life Threatening Emergent MH/SUD appointments, or why a standard of 6 hours was selected as the standard for Non-Life Threatening MH/SUD appointments. The general statement regarding "limited availability of specialized behavioral health providers" did not provide a sufficient explanation of the process and factors used in setting each standard and the resulting variation in standards between MH/SUD and M/S appointment types.

In the initial submission provided on May 19th, 2021, the Issuer states that networks may be "closed due to saturation of a specific specialty" (NQTL_CompAnalyses_Admittance_and_Credentialing_TX 051821, Network Admittance tab, cell E6). The June 22, 2021 Insufficient Data Request Item and September 16, 2021 initial determination letter Item requested information on how "saturation of a specific specialty" is measured. The Issuer's response provided on October 18, 2021 states that, along with a "qualitative determination," "[c]losure of a network for a specific provider type is based on the quantitative network adequacy measures described" in the "Commercial Provider Network Availability and Access Standards" document provided on July 9th, which includes the Access to Service/Waiting Time Standards (Initial Determination Response to CMS_10182021, pages 5-6). The current standards could restrict MH/SUD provider admission to the network. Specifically, MH/SUD providers may be denied admission to a network based on analyses that there are sufficient numbers or "saturation" of these providers to meet the current Access to Service/Waiting Time Standards, which allow longer appointment wait times for MH/SUD appointments, whereas a M/S provider applying to participate in the same network may be granted admission in order to meet a shorter appointment availability and wait time standard. In addition, the standards may delay access to MH/SUD care for members waiting longer for appointments with MH/SUD providers. Therefore, these standards, as quantitative thresholds for the access and adequacy factors utilized in the design and application of the network participation requirements NQTL, are not comparable and are more stringent with respect to MH/SUD providers. By using a non-comparable and more stringent threshold, as written and in operation, this NQTL is not comparable and is applied more stringently to MH/SUD benefits compared to M/S benefits in the same benefit classification, in violation of 45 C.F.R. § 146.136(c)(4)(i). As such, the following corrective action is required:

i. Update the Behavioral Access to Service/Waiting Time Standards for Emergent and Urgent MH/SUD appointments to be comparable to and no more stringent than the standards for M/S provider types and provide supporting documentation showing completion of this action by September 21, 2022.

3. Access and Adequacy Factors Used in the Design and Application of the Network Participation Requirements NQTL (Provider to Member Ratio Availability Standards) are Not Comparable and Applied More Stringently to MH/SUD Provider Types.

In the initial submission on May 19, 2021, the Issuer identified both access and adequacy as factors considered in the design and application of the network participation requirements NQTL (*NQTL_CompAnalyses_Admittance_and_Credentialing_TX 051821*, cells E7 and E10). In the supplemental submission on July 9, 2021 (*CMS MHPAEA CA Network Follow-Ups – HIC TX and HHP TX*, cells G6 & G16), the Issuer provided policy *NNO 702-044-15 Provider Network*

Availability and Access which further defines the access and adequacy factors to include "Provider-covered person ratios by specialty" and "Primary care professional covered person ratios" in their definition (*NNO 702-044-15 Provider Network Availability and Access*, p. 3). The Issuer's supplemental submission (*CMS MHPAEA CA Network Follow-Ups – HIC TX and HHP TX*, cell G16) received on July 9, 2021 referenced the *Comm-Prov-Ntwrk-Avail-and-Access-Standards 2020.3.24* document, also received on July 9, 2021, which includes quantitative thresholds for the access and adequacy factors in the form of Availability Standards as provider-to-member ratios (*Comm-Prov-Ntwrk-Avail-and-Access-Standards 2020.3.24*, p. 1). The September 16, 2021 initial determination letter stated that insufficient information was provided regarding the sources and evidentiary standards used to determine and establish the variations in the Issuer's Availability Standards identified by CMS. In a supplemental CAP response provided on January 7, 2022, the Issuer provided an updated document, *Humana-Prov-Ntwrk-Avail-and-Access-Standards 2021.12.14*, which provides Humana's general and state-specific Availability Standards, categorized by Primary Care, Medical/Surgical Specialists, and Behavioral Health provider types. The provider to member ratio for a Behavioral Health Inpatient Psych Facility is 1 provider to 45,000 members (*Humana-Prov-Ntwrk-Avail-and-Access-Standards 2021.12.14*, page 1). The highest provider to member ratio for M/S provider types is "All Other" specialists, with a ratio of 1 provider to 26,000 members. The Behavioral Health Inpatient Psych Facility Availability Standard results in fewer MH/SUD providers for inpatient psychiatric facilities than M/S providers for all M/S specialties and provider types, limiting access to MH/SUD care.

The Issuer provided the results of a network adequacy review to support the processes, sources, and/or evidentiary standards utilized in establishing variations in standards or guidelines utilized in the application of the NQTL. The Issuer evaluated Medicare standards for different provider types and provided rationale for the selected ratios for OBGYN, MH/SUD, and "ALL OTHER" provider specialty types that deviated from the Medicare standards. However, regarding the Inpatient Psych Facility provider-to-member ratio standard, the analysis states, "there is not a standard for any other facility type. The requirement is [one] facility per county. Therefore, the committee agreed to keep its existing standard for inpatient psych facilities" (*Access Standards Review Meeting Minutes Final (003)*, page 5). Thus, the network adequacy review did not demonstrate that the factors used to establish the variation were consistent with parity requirements. The Issuer did not provide an explanation for why the specific standard of one provider to 45,000 members for an Inpatient Psych Facility was previously selected, or why the Issuer determined this standard (45,000 members) satisfied the cited requirement of one facility per county. The Issuer's response did not provide a sufficient explanation of the process and factors used in setting the Inpatient Psych Facility (MH/SUD) standard and the resulting variation between the Inpatient Psych Facility standard and other MH/SUD and M/S provider types.

In the initial submission provided on May 19th, 2021, the Issuer stated that networks may be "closed due to saturation of a specific specialty" (NQTL_CompAnalyses_Admittance_and_Credentialing_TX 051821, Network Admittance tab, cell E6). The June 22, 2021 Insufficient Data Request Item and September 16, 2021 initial determination letter Item requested information on how "saturation of a specific specialty" is measured. The Issuer's response provided on October 18, 2021 states that, along with a "qualitative determination," "[c]losure of a network for a specific provider type is based on the

quantitative network adequacy measures described" in the "Commercial Provider Network Availability and Access Standards" document provided on July 9th, which includes the Availability Standards in the form of provider-to-member ratios (Initial Determination Response to CMS_10182021, pages 5-6). The current Inpatient Psych Facility standard could restrict MH/SUD provider admission to the network. Specifically, MH/SUD providers may be denied admission to a network based on analyses that there are sufficient numbers or "saturation" of MH/SUD inpatient psychiatric facility providers to meet a standard of 1 provider to 45,000 members, whereas a M/S provider applying to participate in the same network may be granted admission under a standard of 1 provider to between 1,000-26,000 members, depending on specialty. Therefore, these standards, as quantitative thresholds for the access and adequacy factors utilized in the design and application of the NQTL, are not comparable and are more stringent with respect to MH/SUD providers. By using a non-comparable and more stringent threshold, as written and in operation, this NQTL is not comparable and is applied more stringently to MH/SUD benefits compared to M/S benefits in the same benefit classification, in violation of 45 C.F.R. § 146.136(c)(4)(i). As such, the following corrective action is required:

i. Update the Provider to Member Ratio Availability Standards for Behavioral Health Inpatient Psych Facility to be comparable to and no more stringent than the standards for M/S provider types and provide supporting documentation showing completion of this action by September 21, 2022.

4. No comparable MH/SUD clinical representation on the committee responsible for credentialing decisions.

In the initial submission received on May 19, 2021, the Issuer identified one of the criteria considered for the provider network participation NQTL, specifically for re-credentialing, is "quality," and practitioners are assessed on whether they can "demonstrate an acceptable performance record related to Humana members with no evidence of quality issues" (NQTL_CompAnalyses_Admittance_and_Credentialing_TX051821, cell E10). The June 22, 2021 Insufficient Data Request and September 16, 2021 initial determination letter requested the qualifications, including clinical specialty, of the individuals responsible for making a final decision regarding a denial based on quality. On October 18, 2021, the Issuer provided documentation titled *Initial Determination Response to CMS_10182021* which provided further details on the qualifications of the individuals on their Corporate Recommendation Review Committee on page 4. The Corporate Recommendation Review Committee ("CRRC") is "a subcommittee of the Corporate Quality Improvement Committee vested with the authority to make the final decision on all matters pertaining to participation rights determined under the quality review process. A majority of the CRRC must be physicians (M.D.s or D.O.s)" (*QM-2880-07 Quality Review Process,* page 2). The voting members of the CRRC include Medical Directors with clinical specialties in family medicine, internal medicine, pediatrics, as well as representation from RNs in the Quality Operations Compliance and Accreditation department, and a VP in Physician Strategy (*Initial Determination Response to CMS_10182021*, pg. 5). However, based on the information provided in *Initial Determination Response to CMS_10182021*, there is no comparable MH/SUD clinical representation included within the CRRC committee responsible for provider credentialing decisions.

Based on the documentation provided, the committee representation of MH/SUD providers is not comparable to committee representation of M/S providers as written or in operation, specifically for this committee involved in the process of application of the NQTL. Membership of a committee that makes decisions about provider admission or denial to a network is one of the sources used to apply this NQTL – provider network participation. If there is no MH/SUD provider representation on these committees, MH/SUD providers are being evaluated on their "quality" by individuals who are not qualified or trained in their work, whereas M/S providers are evaluated by peers with similar qualifications. Therefore, the committee's lack of any MH/SUD representation is a violation of 45 C.F.R. § 146.136(c)(4)(i). As such, the following corrective action is required:

i. Update committee members to include representation from MH/SUD clinical specialties that is comparable to representation for M/S clinical specialties and provide supporting documentation showing completion of this action by September 21, 2022.

II. Next Steps

Pursuant to PHS Act § 2726(a)(8)(B)(iii)(I)(bb), the Issuer must, within seven calendar days of the date of this letter, notify all individuals enrolled under a plan subject to this NQTL that it is not compliant with the requirements under MHPAEA. Please provide a copy of the letter, with the date(s) the letter was sent, and a list of recipients by September 6, 2022.

If the Issuer fails to complete the identified corrective actions, provide appropriate notice to its enrollees, or provide documentation of these actions to CMS, CMS may pursue further enforcement action, including the potential imposition of civil monetary penalties pursuant to 45 C.F.R. § 150.301.

CMS's findings detailed in this letter pertain only to the NQTL under review. These findings do not bind CMS in any subsequent or further review of other plan provisions or their application for compliance with governing law, including MHPAEA. If additional information is provided to CMS regarding these NQTLs or plan, CMS reserves the right to conduct an additional review for compliance with MHPAEA or other applicable PHS Act requirements.[2] CMS's findings pertain only to the specific plans to which the NQTL under review applies and is offered by the Issuer and do not apply to any other plan or issuer, including other plans or coverage for the Issuer acts as an Administrator.

CMS will include a summary of the comparative analyses, results of this Review, determination of non-compliance, and the identity of the Issuer in its annual report to Congress pursuant to PHS Act § 2726(a)(8)(B)(iv).

Sincerely,

[2] See PHS Act § 2726(a)(8)(B)(i). See also 45 C.F.R. § 150.303.

Mary M. Nugent -S

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Mary Nugent
Director, Compliance and Enforcement Division
Oversight Group
Center for Consumer Information and Insurance Oversight
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cc: Texas Department of Insurance