By: Schwertner

S.B. No. 1765

A BILL TO BE ENTITLED

1	AN ACT
2	relating to network adequacy standards and other requirements for
3	preferred provider benefit plans.
4	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
5	SECTION 1. Section 1301.001, Insurance Code, is amended by
6	adding Subdivision (6-a) to read as follows:
7	(6-a) "Post-emergency stabilization care" means health care
8	services that are furnished by an out-of-network provider,
9	including an out-of-network hospital, freestanding emergency
10	medical care facility or comparable emergency facility,
11	(regardless of the department of the hospital in which such
12	services or supplies are furnished) after the insured is stabilized
13	and as part of outpatient observation or an inpatient or outpatient
14	stay with respect to the visit in which the services defined by
15	Section 1301.155(a) are furnished.
16	SECTION 2. Section 1301.0046, Insurance Code, is amended to
17	read as follows:
18	Sec. 1301.0046. <u>COST-SHARING</u> [COINSURANCE] REQUIREMENTS
19	FOR SERVICES OF NONPREFERRED PROVIDERS. <u>(a)</u> The insured's
20	coinsurance applicable to payment to nonpreferred providers may not
21	exceed 50 percent of the total covered amount applicable to the
22	medical or health care services.

(b) An insurer shall credit a cost-sharing payment,
 including any copayment, coinsurance, or deductible, paid by or on

behalf of an insured for services furnished by an out-of-network 1 2 provider to any out-of-pocket maximum that applies to the insured. 3 The cost-sharing payment must be applied to the out-of-pocket maximum in the same manner as if it were made with respect to 4 services furnished by a preferred provider. 5 6 (c) An insurer may not have separate out-of-pocket maximums 7 for in-network and out-of-network services. (d) The commissioner by rule shall set a reasonable cap on 8 9 an out-of-pocket maximum under this section. 10 (e) This section does not apply to an exclusive provider 11 benefit plan. 12 SECTION 3. The heading to Section 1301.005, Insurance Code, 13 is amended to read as follows: Sec. 1301.005. AVAILABILITY OF 14 PREFERRED PROVIDERS; 15 SERVICE AREA LIMITATIONS. 16 SECTION 4. Section 1301.005, Insurance Code, is amended by amending Subsections (a) and adding Subsection (d) to read as 17 follows: 18 An insurer offering a preferred provider benefit plan 19 (a) 20 shall ensure that both preferred provider benefits and basic level benefits, including benefits for emergency care, as defined by 21 Section 1301.155 and post-emergency stabilization care, are 22 reasonably available to all insureds within the designated service 23 24 This subsection does not apply to an exclusive provider area. 25 benefit plan. (d) A service area, other than a statewide service area, may 26 27 include noncontiguous geographic areas but:

1

(1) may not divide a county; and

2 (2) must include at least one trauma service area in 3 <u>its entirety.</u>

4 SECTION 5. 1301.0053, Insurance Code, is amended by 5 amending Subsections (a) and (b) and adding Subsections (d) and (e) 6 to read as follows:

(a) If an out-of-network provider provides emergency care, 7 as defined by Section 1301.155 or post-emergency stabilization care 8 9 to an enrollee in an exclusive provider benefit plan, the issuer of 10 the plan shall reimburse the out-of-network provider at the usual 11 and customary rate or at a rate agreed to by the issuer and the out-of-network provider for the provision of the services and any 12 13 supply related to those services. The insurers shall make a payment required by this subsection directly to the provider not later 14 15 than, as applicable:

16 (1) the 30th day after the date the insurer receives an 17 electronic clean claim as defined by Section 1301.101 for those 18 services that includes all information necessary for the insurer to 19 pay the claim; or

(2) the 45th day after the date the insurer receives a
nonelectronic clean claim as defined by Section 1301.101 for those
services that includes all information necessary for the insurer to
pay the claim;

(b) For emergency care <u>or post-emergency stabilization care</u> subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured

1 does not have financial responsibility for, an amount greater than
2 an applicable copayment, coinsurance, and deductible under the
3 insured's exclusive provider benefit plan that:

4 (1) is based on:
5 (A) the amount initially determined payable by
6 the insurer; or

7 (B) if applicable, a modified amount as
8 determined under the insured's internal appeal process; and

9 (2) is not based on any additional amount determined 10 to be owed to the provider under Chapter 1467.

11 (d) Post-emergency stabilization care that is subject to 12 this section and a supply related to that care are subject to 13 Chapter 1467 in the same manner as if they were emergency care, as 14 defined by Section 1301.155.

15 (e) This section does not apply to claims for post-emergency 16 stabilization care if each of the conditions described under 42 USC 17 §300gg-111(a)(3)(C)(ii)(II) are met.

SECTION 6. Section 1301.0055, Insurance Code, is amended to read as follows:

20 Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. <u>(a)</u> The 21 commissioner shall by rule adopt network adequacy standards that:

(1) require an insurer offering a preferred provider
benefit plan to monitor compliance with network adequacy standards,
including provisions of this chapter relating to network adequacy,
on an ongoing basis, reporting any material deviation from network
adequacy standards to the department within 30 days and promptly
taking any correction action required to ensure the network is

1 compliant; [adapted to local markets in which the insurer offering
2 a preferred provider benefit plan operates];

3 (2) ensure availability of, and accessibility to, a
4 full range of contracted physicians and health care providers to
5 provide <u>current and projected utilization</u> of health care services
6 for <u>adult and minor insureds</u>; [and]

7 [on good cause shown,] may allow a waiver for a (3) departure from [local market] network adequacy standards for a 8 9 period not to exceed one year if the commissioner determines after receiving testimony at a public hearing under Section 1301.00565 10 that good cause is shown and posts on the department's Internet 11 website the name of the preferred provider benefit plan, the 12 13 insurer offering the plan, each affected county, and the specific 14 network adequacy standards waived;

15 <u>(4) require disclosure by the insurer of the</u> 16 <u>information described by Subdivision (3) in all promotion and</u> 17 <u>advertisement of the preferred provider benefit plan for which a</u> 18 <u>waiver is allowed under that subdivision; and</u>

19 (5) limit a waiver from being issued to a preferred 20 provider benefit plan:

(A) more than twice consecutively for the same network adequacy standard in the same county unless the insurer demonstrates, in addition to the good cause described in Subdivision (4), multiple good faith attempts to bring the plan into compliance with the network adequacy standard during each of the prior consecutive waiver periods; or

27 (B) more than a total of four times within a

1	21-year period for each county in a service area for issues that may
2	be remedied through good faith efforts [and the affected local
3	<pre>market].</pre>
4	(b) The standards described by Subsection (a)(2) must
5	include factors regarding time, distance and appointment
6	availability. The factors must:
7	(1) require that all insureds are able to receive an
8	appointment with a preferred provider within the maximum travel
9	times and distances established under Sections 1301.00553 and
10	<u>1301.00554;</u>
11	(2) require that at all insureds are able to receive an
12	appointment with a preferred provider within the maximum
13	appointment wait times established under Section 1301.0055;
14	(3) require a preferred provider benefit plan to
15	ensure sufficient choice, access, and quality of physicians and
16	health care providers, in number, size, and geographic
17	distribution, to be capable of providing the health care services
18	covered by the plan from preferred providers to all insureds within
19	the insurer's designated service area, taking into account the
20	insureds' characteristics, medical conditions, and health care
21	needs, including:
22	(A) the current utilization of covered health
23	care services within the counties of the service area; and
24	(B) an actuarial projection of utilization of
25	covered health care services, physicians, and health care providers
26	needed within the counties of the service area to meet the needs of
27	the number of projected insureds.

1 (4) require a sufficient number of preferred providers of emergency medicine, anesthesiology, pathology, radiology, 2 neonatology, surgery, hospitalist, intensivist and diagnostic 3 services, including radiology and laboratory services at each 4 preferred hospital, ambulatory surgical center or freestanding 5 emergency medical care facility with credentials for these 6 7 specialties to ensure all insureds are able to receive covered 8 benefits at that preferred location; (5) require that all insureds have the ability to 9 access a preferred institutional provider listed in Section 10 1301.00553 within the maximum travel times and distances for the 11 corresponding county classification; 12 13 (6) require that insureds have the option of facilities, if available, of pediatric, for-profit, nonprofit, and 14 tax-supported institutions, with special consideration 15 to contracting with teaching hospitals that provide indigent care or 16 17 care for uninsured individual as a significant percentage of their overall patient load; 18 (7) require that there is an adequate number of 19 20 preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's 21 designated service area to make any necessary hospital admissions; 22 (8) provide for necessary hospital services by 23 requiring contracting with general, pediatric, specialty, and 24 psychiatric hospitals on a preferred benefit basis within the 25

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26 <u>insurer's designated service area, as applicable;</u>

(9) ensure that emergency care, as defined by Section

S.B. No. 1765 1301.155, is available and accessible 24 hours a day, seven days a 1 week, by preferred providers; 2 3 (10) ensure that covered urgent care is available and accessible from preferred providers within the insurer's 4 designated service area within 24 hours for medical and behavioral 5 6 health conditions; 7 (11) <u>require</u> an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a 8 9 week, within the insurer's designated service area; and (12) require sufficient numbers and classes of 10 11 preferred providers to ensure choice, access, and quality of care across the insurer's designated service area. 12 SECTION 7. Subchapter A, Chapter 1301, Insurance Code, is 13 amended by adding Sections 1301.00553, 1301.00554, and 1301.00555 14 15 to read as follows: 16 Sec. 1301.00553. MAXIMUM TRAVEL TIME AND DISTANCE STANDARDS BY PREFERRED PROVIDER TYPE. (a) For purposes of this section, each 17 county in this state is classified as a large metro, metro, micro, 18 or rural county, or a county with extreme access considerations as 19 determined by the federal Centers for Medicare and Medicaid 20 Services by population and density thresholds as of March 1, 2023. 21 (b) Maximum travel time in minutes and maximum distance in 22 miles for preferred provider benefit plans by preferred provider 23 type for each large metro county are: 24 25 (1) For physicians: (A) <u>Designated by physician specialty.</u> 26 The 27 preferred provider benefit plan's network must comply with the time

1	and distance standards for the following ph	ysician sp	ecialties:
2		Time	Distance
3	Allergy and Immunology	30	<u>15</u>
4	Anesthesiology	20	10
5	Cardiology	20	10
6	Cardiothoracic Surgery	30	<u>15</u>
7	Dermatology	20	10
8	Emergency Medicine	20	10
9	Endocrinology	30	15
10	Ear, Nose, and Throat/Otolaryngology	30	15
11	Gastroenterology	20	10
12	General Surgery	20	10
13	Gynecology and Obstetrics	10	5
14	Infectious Diseases	30	15
15	Nephrology	<u>30</u>	15
16	Neurology	20	10
17	Neurosurgery	30	15
18	Oncology: Medical, Surgical	20	10
19	Oncology: Radiation	30	15
20	Ophthalmology	20	10
21	Orthopedic Surgery	20	10
22	Physical Medicine and Rehabilitation	<u>30</u>	15
23	Plastic Surgery	30	15
24	Primary Care: Adults	10	<u>5</u>
25	Primary Care: Pediatric	10	5
26	Psychiatry	20	10
27	Pulmonology	20	10

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1	Rheumatology	3	<u>0 1</u>	5
2	Urology		0 1	_
3	Vascular Surgery	3	0 1	5
4	(2) For he	alth care providers:		
5	<u>(</u> A)	Designated by the kin	d of prac	titioner or
6	institutional provider	furnishing the health	care servi	ce.
7		(i) The preferred pr	ovider bei	nefit plan's
8	network must comply	with the time and di	.stance st	andards for
9	practitioners license	d to provide health c	are servi	ces in this
10	state, in the following	g disciplines:		
11			Time	<u>Distance</u>
12		<u>Chiropractic</u>	<u>30</u>	<u>15</u>
13		Occupational Therapy	20	<u>10</u>
14		Physical Therapy	20	<u>10</u>
15		<u>Podiatry</u>	20	10
16		Speech Therapy	20	10
17		(ii) The preferred pr	ovider be	nefit plan's
18	network must comply w	ith the time and dista	nce standa	ards for the
19	following kinds of inst	titutional providers:		
20			Time	Distance
21	Acute In	npatient Hospitals (Eme	ergency	
22	Service	s Available 24/7)	20	<u>10</u>
23	Cardiac	Catheterization Servi	<u>ces</u> <u>30</u>	<u>15</u>
24	Cardiac	Surgery Program	<u>30</u>	<u>15</u>
25	<u>Critica</u>	l Care Services: Intens	sive	
26	Care Un	its	20	<u>10</u>
27	Diagnos	tic Radiology (Freesta	nding;	

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1	Hospital Outpatient; Ambulatory		
2	Health Facilities with Diagnostic		
3	Radiology)	20	10
4	Inpatient or Residential Behaviora	al	
5	Health Facility Services	<u>30</u>	<u>15</u>
6	Mammography	20	10
7	Outpatient Infusion/Chemotherapy	20	10
8	Skilled Nursing Facilities	<u>20</u>	10
9	Surgical Services (Outpatient or		
10	Ambulatory Surgical Center)	20	10
11	(3) For other settings:		
12	(A) The preferred provider	benef	it plan's
13	network must comply with the time and distance	standa	rds for the
1 /	following settings:		
14	Torrowing Settings.		
14	<u>rorrowing sectings.</u>	Time	Distance
	Outpatient Clinical Behavioral Health	<u>Time</u>	<u>Distance</u>
15		<u>Time</u>	<u>Distance</u> <u>5</u>
15 16	Outpatient Clinical Behavioral Health		
15 16 17	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	<u>10</u> 20	<u>5</u> <u>10</u>
15 16 17 18	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care	<u>10</u> 20 aximum	<u>5</u> <u>10</u> distance in
15 16 17 18 19	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care (c) Maximum travel time in minutes and ma	<u>10</u> 20 aximum	<u>5</u> <u>10</u> distance in
15 16 17 18 19 20	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care (c) Maximum travel time in minutes and ma miles for preferred provider benefit plans by p	<u>10</u> 20 aximum	<u>5</u> <u>10</u> distance in
15 16 17 18 19 20 21	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care (c) Maximum travel time in minutes and ma miles for preferred provider benefit plans by p type for each metro county are:	<u>10</u> 20 aximum preferre	<u>5</u> <u>10</u> distance in ed provider
15 16 17 18 19 20 21 22	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care (c) Maximum travel time in minutes and ma miles for preferred provider benefit plans by p type for each metro county are: (1) For physicians:	<u>10</u> 20 aximum oreferre specia	<u>5</u> <u>10</u> distance in ed provider .lty. The
15 16 17 18 19 20 21 22 23	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care (c) Maximum travel time in minutes and maximiles for preferred provider benefit plans by p type for each metro county are: (1) For physicians: (A) Designated by physician	<u>10</u> <u>20</u> aximum oreferre specia mply wi	<u>5</u> <u>10</u> distance in ed provider lty. The th the time
15 16 17 18 19 20 21 22 23 24	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care (c) Maximum travel time in minutes and maximiles for preferred provider benefit plans by p type for each metro county are: (1) For physicians: (A) Designated by physician preferred provider benefit plan's network must count of the following physician	<u>10</u> <u>20</u> aximum oreferre specia mply wi n speci	<u>5</u> <u>10</u> distance in ed provider lty. The th the time
15 16 17 18 19 20 21 22 23 24 25	Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) Urgent Care (c) Maximum travel time in minutes and maximiles for preferred provider benefit plans by p type for each metro county are: (1) For physicians: (A) Designated by physician preferred provider benefit plan's network must count of the following physician	<u>10</u> <u>20</u> aximum oreferre specia mply wi n speci	5 10 distance in ed provider lty. The th the time alties:

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1	Anesthesiology	30	20
2	<u>Cardiology</u>	30	20
3	Cardiothoracic Surgery	60	40
4	Dermatology	45	30
5	Emergency Medicine	45	30
6	Endocrinology	60	40
7	Ear, Nose, and Throat/Otolaryngology	<u>45</u>	30
8	<u>Gastroenterology</u>	<u>45</u>	30
9	<u>General Surgery</u>	<u>30</u>	20
10	Gynecology and Obstetrics	15	10
11	Infectious Diseases	60	40
12	Nephrology	<u>45</u>	30
13	<u>Neurology</u>	<u>45</u>	30
14	Neurosurgery	60	40
15	Oncology: Medical, Surgical	<u>45</u>	30
16	Oncology: Radiation	60	40
17	Ophthalmology	<u>30</u>	20
18	Orthopedic Surgery	30	20
19	Physical Medicine and Rehabilitation	<u>45</u>	30
20	Plastic Surgery	60	40
21	Primary Care: Adults	15	10
22	Primary Care: Pediatric	15	10
23	<u>Psychiatry</u>	<u>45</u>	30
24	Pulmonology	<u>45</u>	30
25	Rheumatology	<u>60</u>	40
26	Urology	45	30
27	Vascular Surgery	60	40

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1	(2) For health care providers:		
2	(A) Designated by the kind of	prac	titioner or
3	institutional provider furnishing the health care	servi	ce.
4	(i) The preferred provide	er ben	efit plan's
5	network must comply with the time and distan	ce sta	andards for
6	practitioners licensed to provide health care	servi	ces in this
7	state, in the following disciplines:		
8		Time	<u>Distance</u>
9	Chiropractic	45	<u>30</u>
10	Occupational Therapy	45	30
11	Physical Therapy	45	30
12	Podiatry	45	30
13	Speech Therapy	45	30
	(ii) The preferred provid	-	
14	(ii) The preferred provid	er ber	nefit plan's
14 15	network must comply with the time and distance		
15	network must comply with the time and distance		
15 16	network must comply with the time and distance	standa	rds for the
15 16 17	network must comply with the time and distance a following kinds of institutional providers:	standa <u>Time</u>	rds for the
15 16 17 18	network must comply with the time and distance a following kinds of institutional providers: <u>Acute Inpatient Hospitals</u>	standa <u>Time</u>	nds for the Distance
15 16 17 18 19	network must comply with the time and distance a following kinds of institutional providers: <u>Acute Inpatient Hospitals</u> (Emergency Services Available 24/7	<u>standa</u> <u>Time</u>) <u>45</u>	nds for the Distance <u>30</u>
15 16 17 18 19 20	network must comply with the time and distance a following kinds of institutional providers: <u>Acute Inpatient Hospitals</u> (Emergency Services Available 24/7 Cardiac Catheterization Services	<u>Time</u>) <u>45</u> <u>60</u>	<u>nds for the</u> <u>Distance</u> <u>30</u> <u>40</u>
15 16 17 18 19 20 21	network must comply with the time and distance a following kinds of institutional providers: <u>Acute Inpatient Hospitals</u> (Emergency Services Available 24/7 Cardiac Catheterization Services Cardiac Surgery Program	<u>Time</u>) <u>45</u> <u>60</u>	<u>nds for the</u> <u>Distance</u> <u>30</u> <u>40</u>
15 16 17 18 19 20 21 22	network must comply with the time and distance a following kinds of institutional providers: <u>Acute Inpatient Hospitals</u> (Emergency Services Available 24/7 Cardiac Catheterization Services Cardiac Surgery Program Critical Care Services: Intensive	<u>Time</u> <u>) 45</u> <u>60</u> <u>60</u> <u>45</u>	<u>Distance</u> <u>30</u> <u>40</u> <u>40</u>
15 16 17 18 19 20 21 22 23	network must comply with the time and distance a following kinds of institutional providers: Acute Inpatient Hospitals (Emergency Services Available 24/7 Cardiac Catheterization Services Cardiac Surgery Program Critical Care Services: Intensive Care Units	<u>Time</u> <u>) 45</u> <u>60</u> <u>60</u> <u>45</u>	<u>Distance</u> <u>30</u> <u>40</u> <u>40</u>
15 16 17 18 19 20 21 22 23 24	network must comply with the time and distance a following kinds of institutional providers: Acute Inpatient Hospitals (Emergency Services Available 24/7 Cardiac Catheterization Services Cardiac Surgery Program Critical Care Services: Intensive Care Units Diagnostic Radiology (Freestanding	<u>Time</u> <u>) 45</u> <u>60</u> <u>60</u> <u>45</u>	<u>Distance</u> <u>30</u> <u>40</u> <u>40</u>

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1	Inpatient or Residential		
2	Behavioral Health Facility Service	s 70	45
3	Mammography	<u>45</u>	<u>30</u>
4	Outpatient Infusion/Chemotherapy	<u>45</u>	<u>30</u>
5	Skilled Nursing Facilities	45	30
6	Surgical Services (Outpatient or		
7	Ambulatory Surgical Center)	45	30
8	(3) For other settings:		
9	(A) The preferred provider	benef	it plan's
10	network must comply with the time and distance	standar	ds for the
11	following settings:		
12		Time	Distance
13	Outpatient Clinical Behavioral Health		
14	(Licensed, Accredited, or Certified)	15	10
15	Urgent Care	45	30
16	(d) Maximum travel time in minutes and ma	ximum d	listance in
17	miles for preferred provider benefit plans by p	referre	ed provider
18	type for each micro county are:		
19	(1) For physicians:		
20	(A) Designated by physician	specia	lty. The
21	preferred provider benefit plan's network must com	mply wi	th the time
22	and distance standards for the following physician	n specia	alties:
23	2	Time	<u>Distance</u>
24	Allergy and Immunology	80	<u>60</u>
25	Anesthesiology	50	<u>35</u>
26	Cardiology	50	<u>35</u>
27	Cardiothoracic Surgery	100	75

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1	Dermatology	<u>60</u>	45
2	Emergency Medicine	80	60
3	Endocrinology	100	75
4	Ear, Nose, and Throat/Otolaryngology	80	60
5	Gastroenterology	80	60
6	General Surgery	50	35
7	Gynecology and Obstetrics	30	20
8	Infectious Diseases	100	75
9	Nephrology	80	60
10	Neurology	60	45
11	Neurosurgery	100	75
12	Oncology: Medical, Surgical	60	45
13	Oncology: Radiation	100	75
14	Ophthalmology	50	<u>35</u>
15	Orthopedic Surgery	50	<u>35</u>
16	Physical Medicine and Rehabilitation	80	<u>60</u>
17	Plastic Surgery	100	75
18	Primary Care: Adults	30	20
19	Primary Care: Pediatric	30	20
20	Psychiatry	60	45
21	Pulmonology	60	45
22	Rheumatology	100	75
23	Urology	60	45
24	Vascular Surgery	100	75
25	(2) For health care providers:		
26	(A) Designated by the kind of	E practition	ner or
27	institutional provider furnishing the health care	service.	

1	(i) The preferred prove	lder bene	fit plan's
2	network must comply with the time and dist	ance star	ndards for
3	practitioners licensed to provide health car	e service	es in this
4	state, in the following disciplines:		
5		Time	Distance
6	Chiropractic	80	<u>60</u>
7	Occupational Therapy	80	60
8	Physical Therapy	<u>80</u>	60
9	<u>Podiatry</u>	<u>60</u>	45
10	Speech Therapy	80	60
11	(ii) The preferred prov	ider bene	fit plan's
12	network must comply with the time and distance	e standar	ds for the
13	following kinds of institutional providers:		
14		Time	<u>Distance</u>
15	Acute Inpatient Hospitals		
16	(Emergency Services Available 24	<u>4/7) 80</u>	60
17	Cardiac Catheterization Services	<u>160</u>	120
18	Cardiac Surgery Program	160	120
19	Critical Care Services: Intensiv	e	
20	Care Units	160	120
21	Diagnostic Radiology (Freestandi	<u>ng;</u>	
22	Hospital Outpatient; Ambulatory		
23	Health Facilities with Diagnosti	C	
24	<u>Radiology)</u>	80	60
25	Inpatient or Residential		
26	Behavioral Health Facility Servi	<u>ces 100</u>	75
27	Mammography	80	60

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1	Outpatient Infusion/Chemotherapy	80	<u>60</u>
2	Skilled Nursing Facilities	80	60
3	Surgical Services (Outpatient or		
4	Ambulatory Surgical Center)	80	60
5	(3) For other care and settings:		
6	(A) The preferred provider	benefi	t plan's
7	network must comply with the time and distance	standard	s for the
8	following care and settings:		
9		Time I	Distance
10	Outpatient Clinical Behavioral Health		
11	(Texas Licensed, Accredited, or		
12	<u>Certified)</u>	30	20
13	<u>Urgent Care</u>	80	60
14	(e) Maximum travel time in minutes and ma	aximum di	stance in
14 15	(e) Maximum travel time in minutes and ma miles for preferred provider benefit plans by p		
15	miles for preferred provider benefit plans by p		
15 16	miles for preferred provider benefit plans by p type for each rural county are:	preferred	provider
15 16 17	<pre>miles for preferred provider benefit plans by p type for each rural county are: (1) For physicians:</pre>	oreferred specialt	provider zy. The
15 16 17 18	<pre>miles for preferred provider benefit plans by p type for each rural county are:</pre>	oreferred specialt omply with	provider cy. The h the time
15 16 17 18 19	<pre>miles for preferred provider benefit plans by p type for each rural county are:</pre>	oreferred specialt omply with	provider cy. The h the time
15 16 17 18 19 20	<pre>miles for preferred provider benefit plans by p type for each rural county are:</pre>	oreferred specialt omply with n special	provider cy. The h the time ties:
15 16 17 18 19 20 21	<pre>miles for preferred provider benefit plans by p type for each rural county are:</pre>	oreferred specialt omply with n special <u>Time</u>	provider ty. The the time ties: Distance
15 16 17 18 19 20 21 22	<pre>miles for preferred provider benefit plans by p type for each rural county are:</pre>	oreferred specialt omply with n special <u>Time</u> <u>90</u>	provider ty. The the time ties: Distance <u>75</u>
15 16 17 18 19 20 21 22 23	<pre>miles for preferred provider benefit plans by p type for each rural county are:</pre>	oreferred specialt mply with n special <u>Time</u> <u>90</u> <u>75</u>	provider ty. The the time ties: Distance <u>75</u> <u>60</u>
15 16 17 18 19 20 21 22 23 24	<pre>miles for preferred provider benefit plans by p type for each rural county are:</pre>	oreferred specialt omply with <u>n special</u> <u>Time</u> <u>90</u> <u>75</u> <u>75</u>	provider ty. The the time ties: Distance <u>75</u> <u>60</u> <u>60</u>

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1	Endocrinology	110	90
2	Ear, Nose, and Throat/Otolaryngology	90	75
3	Gastroenterology	75	60
4	General Surgery	75	60
5	Gynecology and Obstetrics	40	30
6	Infectious Diseases	110	90
7	Nephrology	90	75
8	Neurology	75	<u>60</u>
9	Neurosurgery	110	90
10	Oncology: Medical, Surgical	75	60
11	Oncology: Radiation	110	90
12	Ophthalmology	75	60
13	Orthopedic Surgery	75	60
14	Physical Medicine and Rehabilitation	90	75
15	Plastic Surgery	110	90
16	Primary Care: Adults	40	30
17	Primary Care: Pediatric	40	30
18	Psychiatry	75	60
19	Pulmonology	75	60
20	Rheumatology	110	90
21	Urology	75	60
22	Vascular Surgery	110	90
23	(2) For health care providers:		
24	(A) Designated by the kind of p	ractitio	ner or
25	institutional provider furnishing the health care se	rvice.	
26	(i) The preferred provider	benefit	plan's
27	network must comply with the time and distance	standar	ds for

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1	practitioners licensed to provide health care	servic	es in this
2	state, in the following disciplines:		
3		Time	Distance
4	<u>Chiropractic</u>	90	75
5	Occupational Therapy	75	60
6	Physical Therapy	75	60
7	<u>Podiatry</u>	75	60
8	Speech Therapy	<u>75</u>	60
9	(ii) The preferred provid	ler bene	efit plan's
10	network must comply with the time and distance	standar	ds for the
11	following kinds of institutional providers:		
12		Time	<u>Distance</u>
13	Acute Inpatient Hospitals		
14	(Emergency Services Available 24/	<u>7) 75</u>	60
15	Cardiac Catheterization Services	145	120
16	Cardiac Surgery Program	145	120
17	Critical Care Services: Intensive		
18	Care Units	145	120
19	Diagnostic Radiology (Freestandin	g;	
20	Hospital Outpatient; Ambulatory		
21	Health Facilities with Diagnostic		
22	Radiology)	75	60
23	Inpatient or Residential		
24	Behavioral Health Facility Service	<u>es 90</u>	75
25	Mammography	<u>75</u>	60
26	Outpatient Infusion/Chemotherapy	75	60
27	Skilled Nursing Facilities	75	60

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1	Surgical Services (Outpatient or		
2	Ambulatory Surgical Center)	75	60
3	(3) For other settings:		
4	(A) The preferred provider	benefi	t plan's
5	network must comply with the time and distance s	standard	s for the
6	following settings:		
7	-	<u> Time</u> I	Distance
8	Outpatient Clinical Behavioral Health		
9	(Licensed, Accredited, or Certified)	40	30
10	Urgent Care	75	60
11	(f) Maximum travel time in minutes and max	kimum di	<u>stance in</u>
12	miles for preferred provider benefit plans by pr	eferred	provider
13	type for each county with extreme access consideration	tions ar	e:
14	(1) For physicians:		
15	(A) Designated by physician	specialt	zy. The
16	preferred provider benefit plan's network must com	ply with	n the time
17	and distance standards for the following physician	special	ties:
18		Time	Distance
19	Allergy and Immunology	125	110
20	Anesthesiology	95	85
21	Cardiology	95	85
22	Cardiothoracic Surgery	145	130
23	Dermatology	110	100
24	Emergency Medicine	110	100
25	Endocrinology	145	130
26	Ear, Nose, and Throat/Otolaryngology	y <u>125</u>	110
27	Gastroenterology	110	100

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1	General Surgery	95	85
2	Gynecology and Obstetrics	70	60
3	Infectious Diseases	145	130
4	Nephrology	125	110
5	Neurology	110	100
6	Neurosurgery	145	130
7	Oncology: Medical, Surgical	110	100
8	Oncology: Radiation	145	130
9	Ophthalmology	<u>95</u>	85
10	Orthopedic Surgery	95	85
11	Physical Medicine and Rehabilitati	on <u>125</u>	110
12	Plastic Surgery	145	130
13	Primary Care: Adults	70	60
14	Primary Care: Pediatric	70	60
15	Psychiatry	110	100
16	Pulmonology	110	100
17	Rheumatology	145	130
18	Urology	110	100
19	Vascular Surgery	145	130
20	(2) For health care providers:		
21	(A) Designated by the kind o	<u>f pract</u>	itioner or
22	institutional provider furnishing the health care	<u>e servic</u>	<u>e.</u>
23	(i) The preferred provid	ler bene	efit plan's
24	network must comply with the time and distan	nce sta	andards for
25	practitioners licensed to provide health care	servic	es in this
26	state, in the following disciplines:		
27		Time	Distance

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1	Chiropractic	125	110
2	Occupational Therapy	110	100
3	Physical Therapy	110	100
4	Podiatry	110	100
5	Speech Therapy	110	100
6	(ii) The preferred provider	bene	fit plan's
7	network must comply with the time and distance st	andard	ls for the
8	following kinds of institutional providers:		
9	<u>T</u>	ime	Distance
10	Acute Inpatient Hospitals		
11	(Emergency Services Available 24/7)	110	100
12	Cardiac Catheterization Services	155	140
13	Cardiac Surgery Program	155	140
14	Critical Care Services: Intensive		
15	<u>Care Units</u>	155	140
16	Diagnostic Radiology (Freestanding;		
17	Hospital Outpatient; Ambulatory		
18	Health Facilities with Diagnostic		
19	<u>Radiology)</u>	110	100
20	Inpatient or Residential Behavioral		
21	Health Facility Services	155	140
22	Mammography	110	100
23	Outpatient Infusion/Chemotherapy	110	100
24	Skilled Nursing Facilities	95	85
25	Surgical Services (Outpatient or		
26	Ambulatory Surgical Center)	110	100
27	(3) For other settings:		

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1	(A) The preferred provider benefit plan's
2	network must comply with the time and distance standards for the
3	following settings:
4	<u>Time</u> <u>Distance</u>
5	Outpatient Clinical Behavioral Health
6	(Licensed, Accredited, or Certified) 70 60
7	<u>Urgent Care</u> <u>110</u> <u>100</u>
8	Sec. 1301.00554. OTHER MAXIMUM DISTANCE STANDARD
9	REQUIREMENTS. (a) For any physician specialty not specifically
10	listed in Section 1301.00553, the maximum distance, in any county
11	classification, is 75 miles.
12	(b) When necessary due to utilization or supply patterns,
13	the commissioner may by rule decrease the base maximum time and
14	distance standards listed in this Section or Section 1301.00553 for
15	specific counties.
16	Sec. 1301.00555. MAXIMUM APPOINTMENT WAIT TIME STANDARDS.
17	An insurer must ensure that:
18	(1) routine care is available and accessible from
19	preferred providers:
20	(A) within three weeks for medical conditions;
21	and
22	(B) within two weeks for behavioral health
23	conditions; and
24	(2) preventive health care services are available and
25	accessible from preferred providers:
26	(A) within two months for a child, or earlier if
27	necessary for compliance with recommendations for specific

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preventive health care services; and

2 (B) within three months for an adult. 3 SECTION 8. Section 1301.0056, Insurance Code, is amended by 4 amending Subsection (a) and adding Subsections (a-1) and (e) to

5 read as follows:

6 (a) The commissioner shall by rule adopt a process for the 7 commissioner to examine a preferred provider benefit plan before an insurer offers for delivery the plan to insureds to determine 8 9 whether the plan meets the quality of care and network adequacy standards of this chapter. An insurer may not offer [used by] a 10 11 preferred provider benefit plan before [or an exclusive provider benefit plan offered by] the commissioner determines that the 12 13 network meets the quality of care and network adequacy standards of [insurer under] this chapter. 14

15 (a-1) An insurer is subject to a qualifying examination of 16 the insurer's preferred provider benefit plans [and exclusive provider benefit plans] and subsequent quality of care and network 17 adequacy examinations by the commissioner at least once every three 18 years, in connection with a public hearing under Section 1301.00565 19 20 concerning a material deviation from network adequacy standards by a previously authorized plan or a request for a waiver of a network 21 adequacy standard, and whenever the commissioner considers an 22 examination necessary. Documentation provided to the commissioner 23 24 during an examination conducted under this section is confidential 25 and is not subject to disclosure as public information under Chapter 552, Government Code. 26

27 (e) Rules adopted under this section must require insurers

1 to provide access to or submit data necessary for the commissioner 2 to evaluate and make a determination of compliance with quality of 3 care and network adequacy standards. The rules must require 4 insurers to submit data that includes: 5 (1) a searchable and sortable database of network physicians and health care providers by national provider 6 7 identifier, county, physician specialty, hospital privileges and 8 credentials, and kind of health care provider or licensure type, as 9 applicable; 10 (2) actuarial data of current and projected number of 11 insureds by county; and (3) actuarial data of current and projected 12 13 utilization of each preferred provider type listed in Sections 1301.00553 and 1301.00554(a) by county; and 14 15 (4) any other data or information considered necessary by the commissioner to make a determination to authorize the use of 16 the preferred provider benefit plan in the most efficient and 17 effective manner possible. 18 SECTION 9. Subchapter A, Chapter 1301, Insurance Code, is 19 20 amended by adding Section 1301.00565 to read as follows: 21 Sec. 1301.00565. PUBLIC HEARING ON NETWORK ADEQUACY STANDARDS WAIVERS. (a) On the earlier of a request from an insurer 22 to receive a waiver from any network adequacy standard or receipt of 23 notice under Section 1301.0055 of a material deviation from the 24 network adequacy standards of this chapter, the commissioner shall 25 26 set a public hearing for a determination of whether there is good 27 cause for a waiver.

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(b) The commissioner shall notify affected physicians and 1 2 health care providers that may be the subject of a discussion of 3 good faith efforts on behalf of the insurer to meet network adequacy 4 standards and provide the physicians and health care providers with an opportunity to submit evidence, including written testimony, and 5 to attend the public hearing and offer testimony either in person or 6 7 virtually. A physician, including a physician group referenced in 8 the insurer's waiver request or notice of material deviation, may 9 not be identified by name at the hearing unless the physician consents to be identified in advance of the hearing. 10

11 (c) At the hearing, the commissioner shall consider all 12 written and oral testimony and evidence submitted by the insurer 13 and the public pertinent to the requested waiver, including:

14 <u>(1) the total number of physicians or health care</u> 15 providers in each preferred provider type listed in Section 16 <u>1301.00553 within the county and service area being submitted for</u> 17 <u>the waiver and whether the insurer made a good faith effort to</u> 18 <u>contract with those required preferred provider types to meet</u> 19 <u>network adequacy standards of this chapter;</u>

20 (2) the total number of facilities, and availability 21 of pediatric, for-profit, nonprofit, tax-supported, and teaching 22 facilities, within the county and service area being submitted for 23 a waiver and whether the insurer made a good faith effort to 24 contract with these facilities and facility-based physicians and 25 health care providers to meet network adequacy standards of this 26 chapter;

27

(3) population, density, and geographical information

1	to determine the possibility and travel time and distance
2	requirements within the county and service area being submitted for
3	a waiver; and
4	(4) availability of services, population, and density
5	within a county and service area being submitted for a waiver.
6	(d) The commissioner may not consider a prohibition on
7	balance billing in determining whether to grant a waiver from
8	network adequacy standards.
9	(e) The commissioner may not grant a waiver without a public
10	hearing.
11	(f) Except as provided by this subsection, any evidence
12	submitted to the commissioner as evidence for the public hearing
13	that is proprietary in nature is confidential and not subject to
14	disclosure as public information under Chapter 552, Government
15	Code. Information related to provider directories, credentials,
16	and privileges, estimates of patient populations, and actuarial
17	estimates of needed providers to meet the estimated patient
18	population is not protected under this subsection.
19	(g) A policyholder is entitled to seek judicial review of
20	the commissioner's decision to grant a waiver under this section in
21	Travis County district court. Review by the district court under
22	this subsection is de novo.
23	SECTION 10. Section 1301.009(b), Insurance Code, is amended
24	to read as follows:
25	(b) The report shall:
26	(1) be verified by at least two principal officers;
27	(2) be in a form prescribed by the commissioner; and

(3) include: 1 2 (A) a financial statement of the insurer, including its balance sheet and receipts and disbursements for the 3 4 preceding calendar year, certified by an independent public accountant; 5 6 (B) the number of individuals enrolled during the 7 preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that 8 9 year; and a statement of: 10 (C) 11 (i) an evaluation of enrollee satisfaction; 12 (ii) an evaluation of quality of care; 13 (iii) coverage areas; 14 (iv) accreditation status; 15 (v) premium costs; 16 (vi) plan costs; 17 (vii) premium increases; 18 (viii) the range of benefits provided; (ix) copayments and deductibles; 19 20 (x) the accuracy and speed of claims 21 payment by the insurer for the plan; 22 (xi) the credentials of physicians who are preferred providers; 23 24 (xii) the number of preferred providers; 25 [and] 26 (xiii) any waiver requests made and waivers 27 of network adequacy standards granted under Section 1301.00565; and

S.B. No. 1765 1 (xiv) any material deviation from network 2 adequacy standards reported to the department under Section 3 1301.0055; and (xv) any corrective actions, sanctions or 4 penalties assessed against the insurer by the department for 5 deficiencies related to the preferred provider benefit plan. 6 7 SECTION 11. Subchapter B, Chapter 1301, Insurance Code is 8 amended by adding Section 1301.0642 to read as follows: 9 Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN CHANGE PROHIBITED. (a) In this section, "adverse material change" 10 11 means a change to a preferred provider contract that would decrease the preferred provider's payment or compensation; change the 12 13 preferred provider's tier to a less preferred tier; or change the administrative procedures in a way that may reasonably be expected 14 to significantly increase the provider's administrative expenses. 15 Adverse material change does not include: 16 17 (1) a decrease in payment or compensation resulting soley from a change in a published fee schedule upon which the 18 payment or compensation is based and the date of applicability is 19 20 clearly identified in the contract; 21 (2) a decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date 22 23 of applicability of the decrease is clearly identified in the 24 contract; 25 (3) An administrative change that may significantly increase the preferred provider's administrative expense, the 26 27 specific applicability of which is clearly identified in the

1	contract; or
2	(4) A change that is required by the operation of state
3	or federal law.
4	(b) An adverse material change to a preferred provider
5	contract may only be made during the term of the preferred provider
6	contract with the mutual agreement of the parties. A provision in a
7	preferred provider contract that allows the insurer to unilaterally
8	make an adverse material change during the term of the contract is
9	void and unenforceable.
10	(c) Any adverse material change to the preferred provider
11	contract may not go into effect until 120 days after physician or
12	health care provider affirmatively agrees to the adverse material
13	change in writing.
14	(d) A proposed amendment by an insurer seeking an adverse
15	material change to a preferred provider contract must include a
16	notice that clearly and conspicuously identifies such amendment as
17	proposing an adverse material change to the contract. The notice
18	must also clearly and conspicuously state that a physician or
	health care provider may choose not to agree to the amendment and
20	that such a decision not to agree to the amendment may not affect
21	the terms of the physician or health care provider's existing
22	contract with the insurer or the preferred provider's participation
23	in other health plans or products.
24	(e) A physician or health care provider's failure to agree
25	to an adverse material change to a preferred provider contract
26	shall not affect:
27	(1) the terms of the physician or health care

1 provider's existing contract or other contracts with the insurer; 2 or 3 (2) the preferred provider's participation in other 4 health care products or plans.

5 (f) An insurer's failure to include the notice described by 6 Subsection (d) with the proposed amendment shall make an otherwise 7 agreed-to adverse material change void and unenforceable.

8 SECTION 12. The changes in law made by this Act apply only 9 to an insurance policy that is delivered, issued, for delivery, or 10 renewed on or after January 1, 2024. A policy delivered, issued for 11 delivery, or renewed before January 1, 2024, is governed by the law 12 as it existed immediately before the effective date of this Act, and 13 the law is continued in effect for that purpose.

14 SECTION 13. This Act takes effect September 1, 2023.