

By: Smithee

H.B. No. 3270

Substitute the following for H.B. No. 3270:

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C.S.H.B. No. 3270

A BILL TO BE ENTITLED

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AN ACT

relating to preferred provider and exclusive provider network regulations; providing administrative sanctions and penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1301, Insurance Code, is amended by adding Subchapters F, G, and H to read as follows:

SUBCHAPTER F. NETWORK ADEQUACY STANDARDS

Sec. 1301.251. NETWORK ADEQUACY REQUIREMENTS. A preferred provider benefit plan must include a health care service delivery network that complies with this chapter and local market access adequacy requirements as established by the commissioner by rule, including requirements within the insurer's designated service area relating to:

(1) the sufficiency of:

(A) the number, size, and geographic distribution of networks in relation to:

(i) the number of insureds;

(ii) the insureds' relevant characteristics and medical and health care needs; and

(iii) the current and projected utilization of covered health care services;

(B) the number and classes of preferred providers to ensure choice, access, and quality of care; and

(C) the number of preferred provider physicians

1 with admitting privileges at one or more preferred provider  
2 hospitals located within the insurer's designated service area; and

3 (2) the availability and accessibility of:

4 (A) preferred providers at all times;

5 (B) necessary general, specialty, and  
6 psychiatric hospital services;

7 (C) physical and occupational therapy services  
8 and chiropractic services;

9 (D) emergency care at all times;

10 (E) urgent care for medical and behavioral health  
11 conditions; and

12 (F) routine care and preventive care on a timely  
13 basis as determined by the commissioner by rule.

14 Sec. 1301.252. SERVICE AREAS. A preferred provider benefit  
15 plan may have one or more contiguous or noncontiguous service areas  
16 provided that a service area that is not statewide must comply with  
17 geographic parameters established by the commissioner by rule.

18 Sec. 1301.253. MONITORING AND CORRECTIVE ACTION. An  
19 insurer shall monitor on an ongoing basis, and take corrective  
20 action to maintain compliance with, the network requirements  
21 described by Sections 1301.251 and 1301.252.

22 Sec. 1301.254. REQUEST FOR WAIVER OF NETWORK ADEQUACY  
23 STANDARDS. (a) On an insurer's showing of good cause as described  
24 by this section, the commissioner may waive one or more adequacy  
25 standards for the insurer's network imposed under this subchapter  
26 or adopted by the commissioner by rule.

27 (b) The commissioner may find good cause to grant the waiver

1 if the insurer demonstrates as described by this section that  
2 physicians or health care providers necessary for an adequate local  
3 market access network are not available for contract or have  
4 refused to contract with the insurer on reasonable terms or any  
5 terms.

6 (c) If physicians or health care providers necessary for an  
7 adequate local market access network are available within the  
8 relevant service area for a covered service for which the insurer  
9 requests a waiver, the insurer's request for waiver must include:

10 (1) a list of the physicians or providers within the  
11 relevant service area that the insurer attempted to contract with,  
12 identified by name and specialty or facility type;

13 (2) a description of the manner in which the insurer  
14 last contacted each physician or provider and the date of the  
15 contact;

16 (3) a description of each reason each physician or  
17 provider gave for refusing to contract with the insurer;

18 (4) an estimate of total claims cost savings in a year  
19 the insurer anticipates will result from using a local market  
20 access plan instead of contracting with physicians or providers  
21 located within the service area, and the impact of the savings on  
22 premiums;

23 (5) a description of the steps the insurer will take to  
24 improve the network to avoid future requests to renew the waiver;  
25 and

26 (6) any other information required by the commissioner  
27 by rule or requested by the commissioner.

1       (d) The insurer's request for a waiver must state whether  
2 any physician or health care provider is available within the  
3 service area for the covered service or services for which the  
4 insurer requests the waiver.

5       (e) Not later than the 30th day after the date an insurer  
6 files a request for a waiver, a physician or health care provider  
7 may file a response to the request in the manner prescribed by the  
8 commissioner by rule.

9       Sec. 1301.255. GRANTING REQUEST FOR WAIVER OF NETWORK  
10 ADEQUACY STANDARDS. If the commissioner grants a waiver requested  
11 under Section 1301.254, the department shall post on the  
12 department's Internet website information relevant to the grant of  
13 a waiver, including:

14               (1) the name of the preferred provider benefit plan  
15 for which the request is granted;

16               (2) the insurer offering the plan; and

17               (3) the affected service area.

18       Sec. 1301.256. RENEWAL OF WAIVER. (a) An insurer may apply  
19 annually for renewal of a waiver that has been granted under Section  
20 1301.254.

21       (b) Application for renewal of a waiver must be filed in a  
22 manner prescribed by the commissioner by rule not less than the 30th  
23 day before the anniversary of the date the commissioner granted the  
24 waiver.

25       Sec. 1301.257. EXPIRATION OF WAIVER. A waiver of network  
26 adequacy standards expires on the anniversary of the date the  
27 commissioner granted the waiver if:

1           (1) an insurer fails to timely request a renewal under  
2 Section 1301.256; or

3           (2) the department denies the insurer's request for  
4 renewal.

5           Sec. 1301.258. LOCAL MARKET ACCESS PLAN REQUIRED. (a) Not  
6 later than the 30th day after the date an insurer's network fails to  
7 comply with the network adequacy requirements under this subchapter  
8 for a specific service area, the insurer must:

9           (1) establish a local market access plan as described  
10 by Section 1301.259; and

11           (2) request a waiver of network adequacy standards  
12 under Section 1301.254 seeking approval of the local market access  
13 plan.

14           (b) An insurer must file a local market access plan with the  
15 request for a waiver under Section 1301.254.

16           (c) The local market access plan must be provided to the  
17 department on request.

18           Sec. 1301.259. LOCAL MARKET ACCESS PLAN CONTENTS. A local  
19 market access plan required under Section 1301.258 must specify for  
20 each service area that does not meet the network adequacy  
21 requirements:

22           (1) the geographic area within the service area in  
23 which a sufficient number of preferred providers, identified by  
24 class of provider, are not available as required by network  
25 adequacy standards;

26           (2) a map, with key and scale, that identifies the  
27 geographic areas within the service area in which the health care

1 services, physicians, or health care providers are not available;

2 (3) the reasons that the preferred provider network  
3 does not meet the network adequacy standards;

4 (4) procedures that the insurer will implement to  
5 assist insureds in obtaining medically necessary services if a  
6 preferred provider is not reasonably available, including  
7 procedures to coordinate care to avoid balance billing; and

8 (5) the manner in which nonpreferred provider benefit  
9 claims will be handled when a preferred or otherwise contracted  
10 provider is not available, including procedures for compliance with  
11 requirements for claims payments.

12 Sec. 1301.260. LOCAL MARKET ACCESS PLAN PROCEDURES. (a) An  
13 insurer must establish and implement procedures for use in each  
14 service area for which a local market access plan is submitted,  
15 including procedures to:

16 (1) identify requests for preauthorization of  
17 services for insureds that are likely to require the provision of  
18 services by physicians or health care providers that do not have a  
19 contract with the insurer;

20 (2) furnish to insureds, before a health care service  
21 is provided, an estimate of the amount the insurer will pay the  
22 physician or health care provider;

23 (3) except in the case of an exclusive provider  
24 benefit plan, notify insureds that they may be liable for any  
25 amounts charged by the physician or provider that are not paid in  
26 full by the insurer;

27 (4) identify claims filed by nonpreferred providers in

1 instances in which a preferred provider was not reasonably  
2 available to the insured; and

3 (5) make initial and, if required, subsequent payment  
4 of the claims in the manner required by this subchapter.

5 (b) A local market access plan may include a process for  
6 negotiating with a nonpreferred provider before the provider  
7 provides a health care service.

8 Sec. 1301.261. LOCAL MARKET ACCESS PLAN ANNUAL FILINGS. An  
9 insurer must submit a local market access plan established under  
10 Section 1301.258 as a part of the annual report on network adequacy  
11 required under Section 1301.263.

12 Sec. 1301.262. PAYMENT OF CERTAIN BASIC BENEFIT CLAIMS;  
13 DISCLOSURES. (a) Except as provided by Subsection (f), an insurer  
14 shall pay claims in compliance with this section if a preferred  
15 provider is not reasonably available to an insured and services are  
16 provided by a nonpreferred provider, including if:

17 (1) emergency care is required;

18 (2) a preferred provider is not reasonably available  
19 within the relevant service area; or

20 (3) a nonpreferred provider's service is preapproved  
21 or preauthorized based on the unavailability of a preferred  
22 provider in the relevant service area.

23 (b) If services are provided to an insured by a nonpreferred  
24 provider because a preferred provider is not reasonably available  
25 to the insured, the insurer shall:

26 (1) pay not less than the usual or customary charge for  
27 the service, less any patient coinsurance, copayment, or deductible

1 responsibility under the preferred provider benefit plan;

2 (2) pay the claim at the preferred benefit coinsurance  
3 level; and

4 (3) in addition to any amounts that would have been  
5 credited had the provider been a preferred provider, credit any  
6 out-of-pocket amounts shown by the insured to have been actually  
7 paid to the nonpreferred provider for covered services in excess of  
8 the allowed amount toward the insured's deductible and annual  
9 out-of-pocket maximum applicable to preferred provider services.

10 (c) An insurer must calculate the reimbursement of a  
11 nonpreferred provider for a covered service using an appropriate  
12 methodology that:

13 (1) if based on usual, reasonable, or customary  
14 charges, is based on generally accepted industry standards and  
15 practices for determining the customary billed charge for a service  
16 and that fairly and accurately reflect market rates, including  
17 geographic differences in costs;

18 (2) if based on claims data, is based on sufficient  
19 data to constitute a representative and statistically valid sample;

20 (3) is updated at least annually;

21 (4) does not use data that is more than three years  
22 old; and

23 (5) is consistent with nationally recognized and  
24 generally accepted bundling edits and logic.

25 (d) An insurer shall pay all covered basic benefits for  
26 services obtained from physicians or health care providers at a  
27 level not less than the preferred provider benefit plan's basic



1 benefit level of coverage, regardless of whether the service is  
2 provided within the designated service area for the plan. The  
3 insurer may not deny a claim because the services were provided by  
4 physicians or health care providers outside the designated service  
5 area for the plan.

6 (e) If a service is provided to an insured by a nonpreferred  
7 facility-based physician and the difference between the allowed  
8 amount and the billed charge is at least \$1,000, the insurer must  
9 include a notice on the explanation of benefits that the insured may  
10 have the right to request mediation of the claim of an uncontracted  
11 facility-based provider under Chapter 1467 and may obtain  
12 information at the department's Internet website.

13 (f) This section does not apply to an exclusive provider  
14 benefit plan.

15 Sec. 1301.263. NETWORK ADEQUACY ANNUAL REPORT. (a) Before  
16 marketing a preferred provider benefit plan in a new service area  
17 and not less frequently than annually on a date prescribed by the  
18 commissioner by rule, an insurer shall file a network adequacy  
19 report as described by Subsection (b) with the department.

20 (b) The network adequacy report must specify:

21 (1) the trade name of each preferred provider benefit  
22 plan in which insureds participate;

23 (2) the applicable service area of each plan;

24 (3) whether the preferred provider service delivery  
25 network supporting each plan is adequate under applicable network  
26 adequacy standards; and

27 (4) as required by the commissioner by rule, the

1 number of:

2 (A) claims for nonpreferred provider benefits,  
3 excluding claims paid at the preferred benefit coinsurance level;

4 (B) claims for nonpreferred provider benefits  
5 that were paid at the preferred benefit coinsurance level;

6 (C) complaints by nonpreferred providers;

7 (D) complaints by insureds relating to the amount  
8 of the insurer's payment for basic benefits or balance billing;

9 (E) complaints by insureds relating to the  
10 availability of preferred providers; and

11 (F) complaints by insureds relating to the  
12 accuracy of preferred provider listings.

13 (c) The annual report required under this section must be  
14 submitted as required by the commissioner by rule.

15 Sec. 1301.264. ENFORCEMENT; SANCTIONS. (a) The  
16 commissioner may impose sanctions under Chapter 82 or issue a cease  
17 and desist order under Chapter 83 if the commissioner determines,  
18 after notice and opportunity for hearing, that the insurer's  
19 network and any local market access plan supporting the network are  
20 inadequate to ensure the availability and accessibility of:

21 (1) preferred provider benefits;

22 (2) all medical and health care services and items  
23 covered under a preferred provider benefit plan; or

24 (3) adequate personnel, specialty care, and  
25 facilities.

26 (b) In exercising the authority under Subsection (a), the  
27 commissioner may order an insurer to:

1           (1) reduce a service area of a preferred provider  
2 benefit plan;

3           (2) stop marketing a preferred provider benefit plan  
4 in all or part of the state; or

5           (3) withdraw from the preferred provider benefit plan  
6 market.

7           (c) This section does not limit the authority of the  
8 commissioner to order any other appropriate corrective action,  
9 sanction, or penalty.

10                   SUBCHAPTER G. DISCLOSURES TO INSURED

11           Sec. 1301.301. MANDATORY DISCLOSURES. (a) An application  
12 for a health insurance policy that provides preferred provider  
13 benefits and an endorsement, amendment, or rider to the policy must  
14 be written in a readable and understandable format adopted by the  
15 commissioner by rule.

16           (b) An insurer shall, on request, provide to a current or  
17 prospective insured an accurate written description of the policy  
18 terms that allows the insured to make comparisons and informed  
19 decisions about selecting a health care plan. The written  
20 description must be in a readable and understandable format adopted  
21 by the commissioner by rule and must include a clear, complete, and  
22 accurate description that:

23           (1) discloses the name of the entity providing the  
24 coverage;

25           (2) discloses that the entity providing the coverage  
26 is an insurance company;

27           (3) provides a toll-free telephone number, unless the

1 company is exempted by statute or rule from having a toll-free  
2 telephone number, and a mailing address to enable a current or  
3 prospective insured to obtain additional information;

4 (4) explains the coverage is for, as applicable:

5 (A) preferred provider benefits; or

6 (B) exclusive provider benefits that only  
7 provide benefits from preferred providers, except as otherwise  
8 provided in the policy;

9 (5) explains the distinction between preferred and  
10 nonpreferred providers;

11 (6) identifies all covered services and benefits,  
12 including benefits that provide payment for:

13 (A) the services of a preferred provider and a  
14 nonpreferred provider;

15 (B) prescription drug coverage for generic and  
16 name brand drugs;

17 (C) emergency care services and benefits and  
18 information on access to after-hours care; and

19 (D) out-of-area services and benefits;

20 (7) explains the insured's financial responsibility  
21 for payment for any premiums and for deductibles, copayments,  
22 coinsurance, or other out-of-pocket expenses for noncovered or  
23 nonpreferred services;

24 (8) discloses any limitations and exclusions,  
25 including the existence of any drug formulary limitations and any  
26 limitations regarding preexisting conditions;

27 (9) discloses any prior authorization requirements,

1 including preauthorization review, concurrent review, post-service  
2 review, and postpayment review, and any penalties or reductions in  
3 benefits resulting from the failure to obtain required  
4 authorizations;

5 (10) explains provisions for continuity of treatment  
6 in the event of termination of a preferred provider's participation  
7 in the plan;

8 (11) provides a summary of complaint resolution  
9 procedures, if any;

10 (12) discloses that the insurer is prohibited from  
11 retaliating against the insured because the insured or another  
12 person has filed a complaint on behalf of the insured, or against a  
13 physician or health care provider who, on behalf of the insured, has  
14 reasonably filed a complaint against the insurer or appealed a  
15 decision of the insurer;

16 (13) in a format required or permitted by the  
17 commissioner by rule, provides a current list of preferred  
18 providers and complete descriptions of the provider networks,  
19 including names and locations of physicians and health care  
20 providers, and a disclosure of which preferred providers will not  
21 accept new patients;

22 (14) shows the service area or areas; and

23 (15) advises that information is updated at least  
24 annually regarding whether any waivers or local access plans  
25 approved by the commissioner apply to the plan.

26 (c) A copy of the written description of policy terms  
27 required by Subsection (b) must be filed with the department:

1           (1) on the date of the initial filing of the preferred  
2 provider benefit plan; and

3           (2) not later than the 60th day after the date of a  
4 material change to a policy term.

5           Sec. 1301.302. PROMOTIONAL MATERIAL. (a) A preferred  
6 provider benefit plan and all promotional, solicitation, and  
7 advertising material related to the plan must clearly describe the  
8 distinction between preferred and nonpreferred providers. An  
9 illustration of preferred provider benefits must be in proximity to  
10 an equally prominent description of basic benefits.

11           (b) An insurer that maintains an Internet website providing  
12 information about the insurer or the health insurance policies  
13 offered by the insurer for use by current or prospective insureds is  
14 required to provide:

15                   (1) an Internet-based provider listing;

16                   (2) an Internet-based listing of the state regions,  
17 counties, or postal code areas within the insurer's service area or  
18 areas;

19                   (3) an Internet-based listing of the information  
20 required by Section 1301.301; and

21                   (4) a statement of whether the network meets or does  
22 not meet the network adequacy requirements under Subchapter F and  
23 as prescribed by the commissioner by rule.

24           Sec. 1301.303. PREFERRED PROVIDER AND EXCLUSIVE PROVIDER  
25 NOTICES. (a) An insurer shall provide a notice in all health  
26 insurance policies that provide preferred provider benefits and  
27 outlines of coverage in at least 12-point font that must read

1 substantially similar to the following:

2 You have the right to an adequate network of preferred  
3 providers (also known as "network providers").

4 If you believe that the network is inadequate, you may file a  
5 complaint with the Texas Department of Insurance.

6 If you obtain out-of-network services because a preferred  
7 provider was not reasonably available, you may be entitled to have  
8 the claim paid at the in-network rate and your out-of-pocket  
9 expenses counted toward your in-network deductible and  
10 out-of-pocket maximum.

11 You have the right to obtain advance estimates of the amounts  
12 that:

13 (1) a provider may bill for projected services, from  
14 your out-of-network provider; and

15 (2) the insurer may pay for the projected services,  
16 from your insurer.

17 You may obtain a current directory of preferred providers at  
18 the following website: (insurer's Internet website address or  
19 marked inapplicable if the insurer does not maintain an Internet  
20 website) or by calling (insurer's telephone number) for assistance  
21 in finding available preferred providers. If the directory is  
22 materially inaccurate, you may be entitled to have an  
23 out-of-network claim paid at the in-network level of benefits.

24 If you are treated by a provider or hospital that is not a  
25 preferred provider, you may be billed for anything not paid by the  
26 insurer.

27 If the amount you owe to an out-of-network hospital-based

1 radiologist, anesthesiologist, pathologist, emergency department  
2 physician, or neonatologist is greater than \$1,000 (not including  
3 your copayment, coinsurance, and deductible responsibilities) for  
4 services received in a network hospital, you may be entitled to have  
5 the parties participate in a teleconference and, if the result is  
6 not to your satisfaction, in a mandatory mediation at no cost to  
7 you. You can learn more about mediation at the Texas Department of  
8 Insurance Internet website.

9 (b) An insurer shall provide a notice in all health  
10 insurance policies that provide exclusive provider benefits and  
11 outlines of the coverage in at least 12-point font that must read  
12 substantially similar to the following:

13 An exclusive provider benefit plan does not provide benefits  
14 for services you receive from out-of-network providers, with  
15 specific exceptions as described in your policy and below.

16 You have the right to an adequate network of preferred  
17 providers (also known as "network providers").

18 If you believe that the network is inadequate, you may file a  
19 complaint with the Texas Department of Insurance.

20 If your insurer approves a referral for out-of-network  
21 services because a preferred provider is not available, or if you  
22 have received out-of-network emergency care, your insurer must, in  
23 most cases, resolve the nonpreferred provider's bill so that you  
24 only have to pay any applicable coinsurance, copay, and deductible  
25 amounts.

26 You may obtain a current directory of preferred providers at  
27 the following website: (insurer's Internet website address or



1 marked inapplicable if the insurer does not maintain an Internet  
2 website) or by calling (insurer's telephone number) for assistance  
3 in finding available preferred providers. If the directory is  
4 materially inaccurate, you may be entitled to have an  
5 out-of-network claim paid at the in-network level of benefits.

6 Sec. 1301.304. ACCESS TO INFORMATION. Not less than  
7 annually an insurer shall provide notice to all insureds describing  
8 the manner by which an insured may:

9 (1) on a cost-free basis access a current list of all  
10 preferred providers, including a nonelectronic copy of the list;  
11 and

12 (2) obtain by telephone at a specified telephone  
13 number during regular business hours assistance to identify  
14 available preferred providers.

15 Sec. 1301.305. PROVIDER LISTING UPDATES. (a) An insurer  
16 shall update all electronic or nonelectronic listings of preferred  
17 providers made available to insureds not less than quarterly.

18 (b) If an insurer does not maintain a preferred provider  
19 listing, electronically or otherwise, that an insured may access to  
20 identify current preferred providers, the insurer shall distribute  
21 a current preferred provider listing to all insureds not less than  
22 annually by mail or other method as agreed by the insured.

23 Sec. 1301.306. HOSPITAL DISCLOSURES. Preferred provider  
24 information and listings must include a method by which an insured  
25 may identify hospitals that have contractually agreed to:

26 (1) exercise good faith efforts to accommodate a  
27 request from an insured to use a preferred provider; and

1           (2) provide in a timely manner as prescribed by the  
2 commissioner by rule information sufficient to enable the insured  
3 to determine whether an assigned facility-based physician or  
4 physician group is a preferred provider.

5           Sec. 1301.307. PROVIDER DISCLOSURES. Information about a  
6 preferred provider must:

7           (1) disclose whether the provider is accepting new  
8 patients;

9           (2) provide a method by which an insured may notify the  
10 insurer of inaccurate information in the listing, including  
11 information related to:

12                   (A) the provider's contract status; and

13                   (B) whether the provider is accepting new  
14 patients;

15           (3) identify preferred provider facility-based  
16 physicians able to provide services at a preferred provider  
17 facility;

18           (4) specifically identify those facilities at which  
19 the insurer has no contracts with a class of facility-based  
20 providers; and

21           (5) be dated and provided in not less than 10-point  
22 font.

23           Sec. 1301.308. LOCAL MARKET ACCESS PLANS. An insurer  
24 shall, if applicable, on issuance of a policy or not less than 30  
25 days before the date a policy is renewed, provide notice that the  
26 preferred provider benefit plan relies on a local market access  
27 plan as specified by the commissioner by rule. The contents of the

1 notice shall be determined by the commissioner by rule.

2 Sec. 1301.309. REIMBURSEMENT RATES FOR NONPREFERRED  
3 PROVIDERS. An insurer shall disclose in each insurance policy and  
4 outline of coverage information relating to the reimbursement of  
5 basic benefit services, including how reimbursements of  
6 nonpreferred providers are determined and except in an exclusive  
7 provider benefit plan:

8 (1) if an insurer reimburses nonpreferred providers  
9 based directly or indirectly on usual, customary, or reasonable  
10 charges, the source of the data, how the data is used in determining  
11 reimbursements, and the existence of any reduction to a  
12 reimbursement to nonpreferred providers; and

13 (2) if an insurer bases reimbursement of nonpreferred  
14 providers on an amount other than the total billed charges:

15 (A) whether the reimbursement of claims for  
16 nonpreferred providers is less than the billed charge for the  
17 service;

18 (B) whether the insured may be liable to the  
19 nonpreferred provider for any amounts not paid by the insurer;

20 (C) a description of the methodology by which the  
21 reimbursement amount for nonpreferred providers is calculated; and

22 (D) a method for insureds to obtain a real-time  
23 estimate of the amount of reimbursement that the insurer will pay to  
24 a nonpreferred provider for a particular service.

25 Sec. 1301.310. FALSE OR MISLEADING INFORMATION PROHIBITED.

26 An insurer may not cause or permit the use or distribution of  
27 information related to a preferred provider benefit plan that is

1 untrue or misleading.

2 Sec. 1301.311. PROVIDER LISTING BINDING IN CERTAIN CASES.

3 An insurer shall pay a claim for services provided by a nonpreferred  
4 provider at the applicable preferred benefit coinsurance  
5 percentage if the insured demonstrates that:

6 (1) the insured reasonably relied on a statement that  
7 a physician or provider was a preferred provider as specified in:

8 (A) a provider listing; or

9 (B) provider information; and

10 (2) the statement was obtained from the insurer, the  
11 insurer's Internet website, or the Internet website of a third  
12 party designated by the insurer to provide the listing for use by  
13 the insureds not more than 30 days before the date of service.

14 SUBCHAPTER H. CONSUMER PROTECTIONS FOR EXCLUSIVE PROVIDER BENEFIT  
15 PLANS

16 Sec. 1301.351. EXCLUSIVE PROVIDER BENEFIT PLAN  
17 REQUIREMENTS. This subchapter applies only to exclusive provider  
18 benefit plans.

19 Sec. 1301.352. NETWORK APPROVAL REQUIRED. An insurer may  
20 not offer, deliver, or issue for delivery an exclusive provider  
21 benefit plan in this state unless the commissioner has:

22 (1) completed a qualifying examination of the plan to  
23 determine compliance with this chapter; and

24 (2) approved the insurer's exclusive provider network  
25 in the relevant service area.

26 Sec. 1301.353. NETWORK APPROVAL: APPLICATION. An  
27 applicant for approval of an exclusive provider network must submit

1 to the department a complete application disclosing the following  
2 information:

3 (1) a statement that the filing is:

4 (A) an application for approval; or

5 (B) a modification to an approved application;

6 (2) organizational information for the applicant,  
7 including:

8 (A) the full name of the applicant;

9 (B) the applicant's license or certificate  
10 number issued by the department;

11 (C) the applicant's home office address; and

12 (D) the applicant's telephone number;

13 (3) the name and telephone number of a contact person  
14 who will facilitate requests relating to the application from the  
15 department;

16 (4) an attestation signed by the applicant's corporate  
17 president or secretary or the president's or secretary's authorized  
18 representative that:

19 (A) the person has read the application, is  
20 familiar with its contents, and the information submitted in the  
21 application, including the attachments, is true and complete; and

22 (B) the network, including any requested or  
23 granted waiver and any access plan if applicable, is adequate for  
24 the services to be provided under the exclusive provider benefit  
25 plan;

26 (5) a description and a map of the service area, with  
27 key and scale, identifying the area to be served within the

1 parameters established by the commissioner by rule;

2 (6) a list of all plan documents and each plan document  
3 pending the department's approval or review, including each  
4 associated form number or filing identification number;

5 (7) each form of physician and health care provider  
6 contracts to demonstrate inclusion of provisions required by the  
7 commissioner by rule or a sworn statement by the attestator that the  
8 physician and health care provider contracts comply with the  
9 requirements of this chapter;

10 (8) a description of the quality improvement program  
11 and work plan that must include a process for medical peer review  
12 and that explains arrangements to ensure confidentiality of medical  
13 records shared among preferred providers;

14 (9) network configuration information, including:

15 (A) a map for each specialty demonstrating the  
16 location and distribution of the physician and health care provider  
17 network within the proposed service area as prescribed by the  
18 commissioner by rule; and

19 (B) a list of each of the following:

20 (i) each physician and individual health  
21 care practitioner who is a preferred provider, including license  
22 type and specialization and an indication of whether the provider  
23 is accepting new patients; and

24 (ii) each institutional provider that is a  
25 preferred provider;

26 (10) documentation demonstrating that:

27 (A) the exclusive provider benefit plan

1 documents and procedures comply with Section 1301.363;

2 (B) without regard to whether the physician or  
3 health care provider has a contractual or other arrangement to  
4 provide items or services to insureds, the plan contains the  
5 provisions and procedures that comply with Section 1301.363; and

6 (C) the insurer maintains a complaint system that  
7 provides reasonable procedures to resolve a written complaint  
8 initiated by a complainant; and

9 (11) the physical address of the location of all books  
10 and records described by Section 1301.354.

11 Sec. 1301.354. NETWORK APPROVAL: QUALIFYING EXAMINATIONS.

12 An applicant shall make available for examination at the physical  
13 address designated by the insurer under Section 1301.353(11) the  
14 policy and certificate of insurance and documents relating to:

15 (1) quality improvement, including a program  
16 description and work plan required by Section 1301.359;

17 (2) utilization management, including a program  
18 description, policies and procedures, criteria used to determine  
19 medical necessity, and examples of adverse determination letters,  
20 adverse determination logs, and independent review organization  
21 logs;

22 (3) network configuration, including information  
23 demonstrating the adequacy of the exclusive provider network  
24 described by Section 1301.353(9) and all executed physician and  
25 provider contracts applicable to the network;

26 (4) credentialing;

27 (5) marketing of the exclusive provider benefit plan,

1 including all written materials to be presented to prospective  
2 insureds that discuss the exclusive provider network available to  
3 insureds under the plan and how preferred and nonpreferred  
4 physicians or health care providers are to be paid under the plan;  
5 and

6 (6) complaints made, including a complaint log  
7 categorized and completed as prescribed by the commissioner by  
8 rule.

9 Sec. 1301.355. NETWORK MODIFICATIONS. (a) An insurer must  
10 file with the department an application for approval to implement a  
11 change to an exclusive provider network configuration that affects  
12 the adequacy of the network, expands or reduces an existing service  
13 area, or adds a new service area.

14 (b) If a document submitted under Section 1301.353(5), (7),  
15 or (9) is replaced or materially changed, an insurer must submit a  
16 replacement or amended document and identify the change before the  
17 change is implemented.

18 (c) Before the department grants approval of an application  
19 for expansion or reduction of a service area, the insurer must be in  
20 compliance with the requirements of Section 1301.359 through  
21 1301.361 in the existing service areas and in the proposed service  
22 areas.

23 (d) Except as provided by Subsection (b), an insurer must  
24 file with the department any change to information filed under  
25 Subsection (a) not later than the 30th day after the date the change  
26 is implemented.

27 Sec. 1301.356. NETWORK APPROVAL: REVISED APPLICATIONS. If



1 the application for approval under Section 1301.353 or network  
2 modification under Section 1301.355 is revised or supplemented  
3 during the review process, the applicant must submit to the  
4 department a transmittal letter filing the entire revised or  
5 supplemented page and describing the revision or supplement.

6 Sec. 1301.357. EXAMINATIONS. (a) The commissioner shall  
7 conduct an examination relating to an exclusive provider benefit  
8 plan not less than once every five years.

9 (b) On-site financial, market conduct, complaint, or  
10 quality of care examinations are conducted under Chapter 401 or 751  
11 and rules adopted by the commissioner.

12 (c) An insurer shall make the books and records relating to  
13 the insurer's operations available to the department to facilitate  
14 an examination.

15 (d) On request of the commissioner, an insurer must provide  
16 a copy of any contract, agreement, or other arrangement between the  
17 insurer and a physician or health care provider. Documentation  
18 provided to the commissioner under this subsection is confidential  
19 as described by Section 1301.0056.

20 (e) The commissioner may examine and use the records of an  
21 insurer, including records of a quality of care program or medical  
22 peer review committee as defined by Section 151.002, Occupations  
23 Code, as necessary to implement this subchapter, including  
24 commencement and prosecution of an enforcement action under  
25 Subtitle B, Title 2, or rules adopted by the commissioner.  
26 Information obtained under this subsection is confidential as  
27 described by Section 1301.0056.

1       (f) An insurer shall make available for examination at the  
2 physical address designated under Section 1301.353(11)  
3 documentation relating to:

4           (1) quality improvement, including program  
5 descriptions, work plans, program evaluations, and committee and  
6 subcommittee meeting minutes;

7           (2) utilization management, including program  
8 descriptions, policies and procedures, criteria used to determine  
9 medical necessity, and examples of adverse determination letters,  
10 adverse determination logs, including all levels of appeal, and  
11 utilization management files;

12           (3) complaints made, including complaint files, a  
13 complaint log categorized and completed as prescribed by rules  
14 adopted by the commissioner and documentation and details of  
15 actions taken;

16           (4) the satisfaction of insureds, physicians, and  
17 health care providers, including satisfaction surveys, insured  
18 disenrollment logs, and termination logs;

19           (5) network configuration, including information  
20 required by Section 1301.353(9);

21           (6) credentialing, including credentialing files; and

22           (7) any reports submitted by the insurer to any  
23 federal or state governmental entity.

24       Sec. 1301.358. QUALITY IMPROVEMENT PROGRAMS REQUIRED. An  
25 insurer shall develop and maintain a quality improvement program  
26 designed to objectively and systematically monitor and evaluate the  
27 quality and appropriateness of health care services provided under

1 a benefit plan and to pursue opportunities for improvement. The  
2 program must be ongoing and comprehensive, addressing the quality  
3 of clinical care and health care services. The insurer must  
4 dedicate adequate resources, including personnel and information  
5 systems, to the program.

6 Sec. 1301.359. QUALITY IMPROVEMENT PROGRAMS: CONTENTS OF  
7 PROGRAM. The program established under Section 1301.358 must  
8 include:

9 (1) a written description of the program's  
10 organizational structure, functional responsibilities, and meeting  
11 frequency;

12 (2) an annual work plan designed to reflect the type of  
13 services and the population served by the benefit plan in terms of  
14 age groups, disease categories, and special risk status, including:

15 (A) objective and measurable goals, planned  
16 activities to accomplish the goals, time frames for implementation,  
17 designation of responsible individuals, and evaluation  
18 methodology; and

19 (B) measures to address each program area,  
20 including:

21 (i) network adequacy, availability and  
22 accessibility of care, and assessment of open and closed physician  
23 and individual provider panels;

24 (ii) continuity of medical and health care  
25 and related services;

26 (iii) the conduct of clinical studies;

27 (iv) the adoption and updating of clinical

1 practice guidelines or clinical care standards, including  
2 guidelines and standards for preventive health care services, that  
3 are communicated to and approved by participating physicians and  
4 individual providers;

5 (v) insured, physician, and individual  
6 health care provider satisfaction;

7 (vi) the complaint process, including  
8 complaint data, and identification and removal of barriers that may  
9 impede insureds, physicians, and health care providers from  
10 effectively making complaints against the insurer;

11 (vii) preventive health care, including  
12 health promotion and outreach activities;

13 (viii) claims payment processes;

14 (ix) contract monitoring, including  
15 oversight and compliance with filing requirements;

16 (x) utilization review processes;

17 (xi) credentialing;

18 (xii) insured services; and

19 (xiii) pharmacy services, including drug  
20 utilization;

21 (3) an annual written report addressing completed  
22 activities, trending of clinical and service goals, analysis of  
23 program performance, and conclusions;

24 (4) a process for selection and retention of  
25 contracted preferred providers that complies with rules  
26 established by the commissioner; and

27 (5) a peer review procedure for physicians and

1 individual providers, as required in Chapters 151 through 164,  
2 Occupations Code, that designates a credentialing committee to  
3 administer the review and make recommendations regarding  
4 credentialing decisions.

5 Sec. 1301.360. QUALITY IMPROVEMENT PROGRAMS: DUTIES OF  
6 GOVERNING BODIES. (a) The insurer's governing body shall appoint a  
7 quality improvement committee that:

8 (1) includes practicing physicians and individual  
9 providers; and

10 (2) may include one or more insureds from the  
11 exclusive provider benefit plan's service area.

12 (b) An employee of the insurer may not serve as a committee  
13 member.

14 (c) The governing body is responsible for the program. The  
15 quality improvement program and the annual work plan may not be  
16 implemented without the approval of the governing body.

17 (d) The governing body must meet not less frequently than  
18 annually to receive and review reports of the committee or its  
19 subcommittees and take action when appropriate.

20 (e) The governing body must review the annual written report  
21 on the quality improvement program.

22 Sec. 1301.361. QUALITY IMPROVEMENT PROGRAMS: DUTIES OF  
23 COMMITTEES; SUBCOMMITTEES. (a) The quality improvement committee  
24 established under Section 1301.360 shall evaluate the overall  
25 effectiveness of the quality improvement program.

26 (b) The committee may delegate duties to subcommittees  
27 subject to the committee's oversight. A subcommittee may include

1 practicing physicians, individual health care providers, and  
2 insureds from the service area.

3 (c) The subcommittees shall:

4 (1) collaborate and coordinate efforts to improve the  
5 quality, availability, and accessibility of health care services;

6 (2) meet regularly; and

7 (3) report the findings of each meeting, including any  
8 recommendations, in writing to the quality improvement committee.

9 (d) The quality improvement committee shall use  
10 multidisciplinary teams as necessary to accomplish quality  
11 improvement program goals.

12 Sec. 1301.362. QUALITY IMPROVEMENT PROGRAMS:  
13 PRESUMPTIONS. (a) Except as provided by Subsection (b), in a  
14 review of an insurer's quality improvement program, the department  
15 shall presume the program complies with statutory and regulatory  
16 requirements if the insurer received nonconditional accreditation  
17 or certification in connection with quality improvement by:

18 (1) the National Committee for Quality Assurance;

19 (2) the Joint Commission;

20 (3) the Utilization Review Accreditation Commission;

21 or

22 (4) the Accreditation Association for Ambulatory  
23 Health Care.

24 (b) If the department determines that an accreditation or  
25 certification program does not adequately address a material  
26 statutory or regulatory requirement of this state, the department  
27 may not presume compliance.

1       Sec. 1301.363. OUT-OF-NETWORK CLAIMS: PAYMENT. (a) An  
2 insurer shall fully reimburse a nonpreferred provider at the usual  
3 and customary rate or at a rate agreed to by the nonpreferred  
4 provider for services provided before the date the insured can  
5 reasonably be transferred to a preferred provider if an insured  
6 cannot reasonably reach a preferred provider for:

7           (1) a medical screening examination or other  
8 evaluation required by state or federal law and necessary to  
9 determine whether a medical emergency condition exists to be  
10 provided in a hospital emergency facility, a freestanding emergency  
11 medical care facility, or a comparable emergency facility; and

12           (2) necessary emergency care services, including the  
13 treatment and stabilization of an emergency medical condition  
14 provided in a hospital emergency facility, a freestanding emergency  
15 medical care facility, or a comparable emergency facility.

16       (b) If medically necessary covered services other than  
17 emergency care are not available through a preferred provider, on  
18 the request of a preferred provider, the insurer:

19           (1) must approve a referral to a nonpreferred provider  
20 in a timely manner appropriate to the delivery of the services and  
21 the condition of the patient, but not later than five business days  
22 after the date the insurer receives documentation relating to the  
23 referral; and

24           (2) may not deny a referral until a health care  
25 provider with expertise in the same specialty as or a specialty  
26 similar to the type of health care provider to whom a referral is  
27 requested has reviewed the referral.

1       (c) An insurer may facilitate an insured's selection of a  
2 nonpreferred provider if medically necessary covered services,  
3 excluding emergency care, are not available through a preferred  
4 provider and an insured has received a referral from a preferred  
5 provider.

6       (d) If an insurer facilitates an insured's selection as  
7 described by Subsection (c), the insurer must offer an insured a  
8 list of not less than three nonpreferred providers with expertise  
9 in the necessary specialty who are reasonably available considering  
10 the medical condition and location of the insured.

11       (e) An insurer reimbursing a nonpreferred provider under  
12 Subsection (a), (b), or (d) must:

13               (1) ensure that the insured is held harmless for any  
14 amounts in excess of the copayment and deductible amount and  
15 coinsurance percentage that the insured would have paid had the  
16 insured received services from a preferred provider; and

17               (2) issue payment to the nonpreferred provider at the  
18 usual and customary rate or at a rate agreed to by the nonpreferred  
19 provider.

20       (f) An insurer must provide with the payment an explanation  
21 of benefits to the insured and request that the insured notify the  
22 insurer if the nonpreferred provider bills the insured for amounts  
23 in excess of the amount paid by the insurer.

24       (g) An insurer must pay any amounts that the nonpreferred  
25 provider bills the insured in excess of the amount paid by the  
26 insurer in a manner consistent with Subsection (e).

27       (h) If the insured selects a nonpreferred provider that is



1 not included in the list provided under Subsection (d) by the  
2 insurer, notwithstanding Section 1301.262(f), the insurer must pay  
3 the claim in accordance with Section 1301.262.

4 Sec. 1301.364. OUT-OF-NETWORK CLAIMS: MEDIATION. (a) An  
5 insurer may require that an insured request mediation under Chapter  
6 1467 or under provisions adopted by the commissioner by rule. The  
7 insurer must notify the insured when mediation is available and  
8 inform the insured of how to request mediation. The insurer may  
9 not:

10 (1) except as provided by Subsection (b), penalize the  
11 insured for failing to request mediation; or

12 (2) require the insured to participate in the  
13 mediation.

14 (b) Notwithstanding Subsection (a)(1), an insurer that  
15 requests that the insured initiate mediation is not responsible for  
16 any balance bill the insured receives from the nonpreferred  
17 provider until the insured requests mediation.

18 (c) Eligibility for mediation under this section is based on  
19 the entire unpaid amount of the nonpreferred provider bills, less  
20 any applicable copayment, deductible, and coinsurance.

21 (d) The insurer's payment must be based on the amount due  
22 resulting from the mediation process.

23 Sec. 1301.365. OUT-OF-NETWORK CLAIMS: PAYMENT  
24 METHODOLOGIES. Any methodology used by an insurer to calculate  
25 reimbursement of nonpreferred providers for services that are  
26 covered under an exclusive provider benefit plan must be:

27 (1) based on:

1           (A) generally accepted industry standards and  
2 practices for determining the usual, reasonable, or customary fee  
3 for a service to ensure market rates, including geographic  
4 differences in costs, are fairly and accurately reflected; or

5           (B) claims data that is:

6                   (i) sufficient to constitute a  
7 representative and statistically valid sample;

8                   (ii) updated not less than annually; and

9                   (iii) not more than three years old; and

10           (2) consistent with nationally recognized and  
11 generally accepted bundling edits and logic.

12           SECTION 2. Section 1301.005(b), Insurance Code, is amended  
13 to read as follows:

14           (b) Subject to Sections 1301.262, 1301.309, and 1301.363,  
15 if [~~if~~] services are not available through a preferred provider  
16 within a designated service area under a preferred provider benefit  
17 plan or an exclusive provider benefit plan, an insurer shall  
18 reimburse a physician or health care provider who is not a preferred  
19 provider at the same percentage level of reimbursement as a  
20 preferred provider would have been reimbursed had the insured been  
21 treated by a preferred provider.

22           SECTION 3. Section 1301.0051(a), Insurance Code, is amended  
23 to read as follows:

24           (a) An insurer that offers an exclusive provider benefit  
25 plan shall establish procedures in compliance with Section 1301.358  
26 to ensure that health care services are provided to insureds under  
27 reasonable standards of quality of care that are consistent with

1 prevailing professionally recognized standards of care or  
2 practice. The procedures must include:

3 (1) mechanisms to ensure availability, accessibility,  
4 quality, and continuity of care;

5 (2) subject to Section 1301.059, a continuing quality  
6 improvement program to monitor and evaluate services provided under  
7 the plan, including primary and specialist physician services and  
8 ancillary and preventive health care services, provided in  
9 institutional or noninstitutional settings;

10 (3) a method of recording formal proceedings of  
11 quality improvement program activities and maintaining quality  
12 improvement program documentation in a confidential manner;

13 (4) subject to Section 1301.059, a physician review  
14 panel to assist the insurer in reviewing medical guidelines or  
15 criteria;

16 (5) a patient record system that facilitates  
17 documentation and retrieval of clinical information for the  
18 insurer's evaluation of continuity and coordination of services and  
19 assessment of the quality of services provided to insureds under  
20 the plan;

21 (6) a mechanism for making available to the  
22 commissioner the clinical records of insureds for examination and  
23 review by the commissioner on request of the commissioner; and

24 (7) a specific procedure for the periodic reporting of  
25 quality improvement program activities to:

26 (A) the governing body and appropriate staff of  
27 the insurer; and

1 (B) physicians and health care providers that  
2 provide health care services under the plan.

3 SECTION 4. Sections 1301.0052, Insurance Code, is amended  
4 to read as follows:

5 Sec. 1301.0052. EXCLUSIVE PROVIDER BENEFIT PLANS:  
6 REFERRALS FOR MEDICALLY NECESSARY SERVICES. (a) If a covered  
7 service is medically necessary and is not available through a  
8 preferred provider, the issuer of an exclusive provider benefit  
9 plan, on the request of a preferred provider, shall subject to  
10 Subchapter H:

11 (1) approve the referral of an insured to a  
12 nonpreferred provider within a reasonable period; and

13 (2) fully reimburse the nonpreferred provider at the  
14 usual and customary rate or at a rate agreed to by the issuer and the  
15 nonpreferred provider.

16 (b) Subject to Section 1301.363, an [An] exclusive provider  
17 benefit plan must provide for a review by a health care provider  
18 with expertise in the same specialty as or a specialty similar to  
19 the type of health care provider to whom a referral is requested  
20 under Subsection (a) before the issuer of the plan may deny the  
21 referral.

22 SECTION 5. Section 1301.0053, Insurance Code, is amended to  
23 read as follows:

24 Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS:  
25 EMERGENCY CARE. If a nonpreferred provider provides emergency care  
26 as defined by Section 1301.155 to an enrollee in an exclusive  
27 provider benefit plan, the issuer of the plan shall, subject to

1 Section 1301.363(a), reimburse the nonpreferred provider at the  
2 usual and customary rate or at a rate agreed to by the issuer and the  
3 nonpreferred provider for the provision of the services.

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

6 Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. The  
7 commissioner shall by rule adopt network adequacy standards in  
8 compliance with Subchapters F, G, and H and that:

9 (1) are adapted to local markets in which an insurer  
10 offering a preferred provider benefit plan operates;

11 (2) ensure availability of, and accessibility to, a  
12 full range of contracted physicians and health care providers to  
13 provide health care services to insureds; and

14 (3) on good cause shown, may allow departure from  
15 local market network adequacy standards if the commissioner posts  
16 on the department's Internet website the name of the preferred  
17 provider plan, the insurer offering the plan, and the affected  
18 local market.

19 SECTION 7. Section 1301.006(a), Insurance Code, is amended  
20 to read as follows:

21 (a) Subject to Subchapter F, an [An] insurer that markets a  
22 preferred provider benefit plan shall contract with physicians and  
23 health care providers to ensure that all medical and health care  
24 services and items contained in the package of benefits for which  
25 coverage is provided, including treatment of illnesses and  
26 injuries, will be provided under the health insurance policy in a  
27 manner ensuring availability of and accessibility to adequate

1 personnel, specialty care, and facilities.

2 SECTION 8. Section 1301.009(a), Insurance Code, is amended  
3 to read as follows:

4 (a) In addition to the reports required under Section  
5 1301.263, not ~~[Not]~~ later than March 1 of each year, an insurer  
6 shall file with the commissioner a report relating to the preferred  
7 provider benefit plan offered under this chapter and covering the  
8 preceding calendar year.

9 SECTION 9. Section 1301.056(a), Insurance Code, is amended  
10 to read as follows:

11 (a) Subject to Subchapters F, G, and H, an ~~[An]~~ insurer or  
12 third-party administrator may not reimburse a physician or other  
13 practitioner, institutional provider, or organization of  
14 physicians and health care providers on a discounted fee basis for  
15 covered services that are provided to an insured unless:

16 (1) the insurer or third-party administrator has  
17 contracted with either:

18 (A) the physician or other practitioner,  
19 institutional provider, or organization of physicians and health  
20 care providers; or

21 (B) a preferred provider organization that has a  
22 network of preferred providers and that has contracted with the  
23 physician or other practitioner, institutional provider, or  
24 organization of physicians and health care providers;

25 (2) the physician or other practitioner,  
26 institutional provider, or organization of physicians and health  
27 care providers has agreed to the contract and has agreed to provide

1 health care services under the terms of the contract; and

2 (3) the insurer or third-party administrator has  
3 agreed to provide coverage for those health care services under the  
4 health insurance policy.

5 SECTION 10. Section 1301.059(b), Insurance Code, is amended  
6 to read as follows:

7 (b) Except as provided in Subchapter H, an ~~An~~ insurer may  
8 not engage in quality assessment except through a panel of at least  
9 three physicians selected by the insurer from among a list of  
10 physicians contracting with the insurer. The physicians  
11 contracting with the insurer in the applicable service area shall  
12 provide the list of physicians to the insurer.

13 SECTION 11. This Act applies only to an insurance policy  
14 that is delivered, issued for delivery, or renewed on or after  
15 January 1, 2014. A policy delivered, issued for delivery, or  
16 renewed before January 1, 2014, is governed by the law as it existed  
17 immediately before the effective date of this Act, and that law is  
18 continued in effect for that purpose.

19 SECTION 12. This Act takes effect September 1, 2013.