By: Smithee H.B. No. 3270

A BILL TO BE ENTITLED

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

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

(2) the availability and accessibility of:

(A) preferred providers at all times;

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

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

(D) emergency care at all times;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the insurer offering the plan; and

(3) the affected service area.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) identify claims filed by nonpreferred providers in

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

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

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

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

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

(1) emergency care is required;

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

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

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

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

responsibility under the preferred provider benefit plan;

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

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

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

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

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

(3) is updated at least annually;

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

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

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

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

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

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

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

(b) The network adequacy report must specify:

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

(2) the applicable service area of each plan;

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

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

number of:

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

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

(C) complaints by nonpreferred providers;

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

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

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

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

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

(1) preferred provider benefits;

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

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

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

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

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

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

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

SUBCHAPTER G. DISCLOSURES TO INSUREDS

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

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

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

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

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

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

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

(A) preferred provider benefits; or

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

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

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

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

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

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

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

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

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

(9) discloses any prior authorization requirements,

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

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

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

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

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

(14) shows the service area or areas; and

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

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

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

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

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

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

(1) an Internet-based provider listing;

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

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

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

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

substantially similar to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) the provider's contract status; and

(B) whether the provider is accepting new patients;

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

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

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

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

notice shall be determined by the commissioner by rule.

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

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

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

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

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

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

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

Sec. 1301.310. FALSE OR MISLEADING INFORMATION PROHIBITED. An insurer may not cause or permit the use or distribution of information related to a preferred provider benefit plan that is

untrue or misleading.

Sec. 1301.311. PROVIDER LISTING BINDING IN CERTAIN CASES. An insurer shall pay a claim for services provided by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that:

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

(A) a provider listing; or

(B) provider information; and

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

SUBCHAPTER H. CONSUMER PROTECTIONS FOR EXCLUSIVE PROVIDER BENEFIT PLANS

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

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

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

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

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

to the department a complete application disclosing the following information:

(1) a statement that the filing is:

(A) an application for approval; or

(B) a modification to an approved application;

(2) organizational information for the applicant, including:

(A) the full name of the applicant;

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

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

(D) the applicant's telephone number;

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

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

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

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

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

parameters established by the commissioner by rule;

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

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

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

(9) network configuration information, including:

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

(B) a list of each of the following:

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

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

(10) documentation demonstrating that:

(A) the exclusive provider benefit plan

documents and procedures comply with Section 1301.363;

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

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

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

Sec. 1301.354. NETWORK APPROVAL: QUALIFYING EXAMINATIONS. An applicant shall make available for examination at the physical address designated by the insurer under Section 1301.353(11) the policy and certificate of insurance and documents relating to:

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

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

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

(4) credentialing;

(5) marketing of the exclusive provider benefit plan,

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

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

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

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

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

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

Sec. 1301.356. NETWORK APPROVAL: REVISED APPLICATIONS. If

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

Sec. 1307.357. EXAMINATIONS. (a) The commissioner shall conduct an examination relating to an exclusive provider benefit plan not less than once every five years.

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

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

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

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

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

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

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

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

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

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

(6) credentialing, including credentialing files; and

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

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

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

Sec. 1301.359. QUALITY IMPROVEMENT PROGRAMS: CONTENTS OF PROGRAM. (a) The program established under Section 1301.358 must include:

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

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

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

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

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

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

(iii) the conduct of clinical studies;

(iv) the adoption and updating of clinical

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

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

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

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

(viii) claims payment processes;

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

(x) utilization review processes;

(xi) credentialing;

(xii) insured services; and

(xiii) pharmacy services, including drug utilization;

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

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

(5) a peer review procedure for physicians and

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

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

(1) includes practicing physicians and individual providers; and

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

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

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

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

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

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

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

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

(c) The subcommittees shall:

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

(2) meet regularly; and

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

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

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

(1) the National Committee for Quality Assurance;

(2) the Joint Commission;

(3) the Utilization Review Accreditation Commission; or

(4) the Accreditation Association for Ambulatory Health Care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) based on:

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

(B) claims data that is:

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

(ii) updated not less than annually; and

(iii) not more than three years old; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

personnel, specialty care, and facilities.

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

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

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

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

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

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

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

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

health care services under the terms of the contract; and

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

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

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

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

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