BILL ANALYSIS

Senate Research Center

H.B. 3359
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Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Texas Department of Insurance (TDI) has testified in the House Insurance Committee that 90 percent of health insurance plans offered in Texas have been granted access waivers because their health plan networks do not meet the standards in the Texas Administrative Code. TDI has limited ability in statute to deny a waiver request, and these requests and decisions are not transparent to those purchasing or enrolled in the plans. H.B. 3359 seeks to codify measurable network adequacy standards for preferred provider benefit plans and require carriers to meet these standards prior to offering the networks. The bill also increases the transparency of the waiver process by requiring public hearings for waiver requests and limits the number of waivers allowed to be issued by TDI and the reasons for issuing them.

H.B. 3359 amends current law relating to network adequacy standards and other requirements for preferred provider benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority previously granted to the commissioner of Insurance is modified in SECTION 5 (Section 1301.0055, Insurance Code), SECTION 6 (Section 1301.00554, Insurance Code) and SECTION 7 (Section 1301.0056, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1301.001, Insurance Code, by adding Subdivision (6-a), to define "post-emergency stabilization care."

SECTION 2. Amends the heading to Section 1301.005, Insurance Code, to read as follows:

> Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS; SERVICE AREA LIMITATIONS.

SECTION 3. Amends Section 1301.005, Insurance Code, by amending Subsection (a) and adding Subsection (d), as follows:

> (a) Requires an insurer offering a preferred provider benefit plan to ensure that both preferred provider benefits and basic level benefits, including benefits for emergency care, as defined by Section 1301.155 (Emergency Care), and post-emergency stabilization care, are reasonably available to all insureds within a designated service area.
>
> (d) Authorizes a service area, other than a statewide service area, to include noncontiguous geographic areas but prohibits a service area from dividing a county.

SECTION 4. Amends Section 1301.0053, Insurance Code, by amending Subsections (a) and (b) and adding Subsections (d) and (e), as follows:

> (a) Requires the issuer of the exclusive provider benefits plan, if an out-of-network provider provides emergency care as defined by a certain section or post-emergency stabilization care to an enrollee in an exclusive provider benefit plan, to reimburse the

out-of-network provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network provider for the provision of the services and any supply related to those services.

(b) Makes a conforming change to this subsection.

(d) Provides that post-emergency stabilization care that is subject to Section 1301.0053 (Exclusive Provider Benefit Plans: Emergency Care) and a supply related to that care are subject to Chapter 1467 (Out-of-Network Claim Dispute Resolution) in the same manner as if the care and supply are emergency care, as defined by Section 1301.155.

(e) Provides that this section does not apply to claims for post-emergency stabilization care if all of the conditions described by 42 U.S.C. Section 300gg-111(a)(3)(C)(ii)(II) are met.

SECTION 5. Amends Section 1301.0055, Insurance Code, as follows:

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. (a) Requires the commissioner of insurance (commissioner) to adopt by rule network adequacy standards that:

(1) require an insurer offering a preferred provider benefit plan to:

(A) monitor compliance with network adequacy standards, including provisions of Chapter 1301 (Preferred Provider Benefit Plans) relating to network adequacy, on an ongoing basis, reporting any material deviation from network adequacy standards to the Texas Department of Insurance (TDI) within 30 days of the date the material deviation occurred; and

(B) promptly take any corrective action required to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred unless:

(i) there are no uncontracted licensed physicians or health care providers in the affected county; or

(ii) the insurer requests a waiver under this subsection. Deletes existing text requiring the commissioner to by rule adopt standards that 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 current and projected utilization of health care services for adult and minor insureds;

(3) is authorized to allow a waiver for a departure from network adequacy standards for a period not to exceed one year if the commissioner determines after receiving public testimony at a public hearing under Section 1301.00565 that good cause is shown and posts on TDI's Internet website the name of the preferred provider benefit plan, the insurer offering the plan, each affected county, the specific network adequacy standards waived, and the insurer's access plan;

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

(5) except as provided by Subdivision (6), limit a waiver from being issued to a preferred provider benefit plan:

(A) more than twice consecutively for the same network adequacy standard in the same county unless the insurer demonstrates, in addition to the good cause described by Subdivision (3), multiple good faith attempts to bring the plan into compliance with the network adequacy standard during each of the prior consecutive waiver periods; or

(B) more than a total of four times within a 21-year period for each county in a service area for issues that may be remedied through good faith efforts; and

(6) authorize the commissioner to issue a waiver that would otherwise be unavailable under Subdivision (5) if the waiver request demonstrates, and TDI confirms annually, that there are no uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area.

(b) Requires that the standards described by Subsection (a)(2) include factors regarding time, distance, and appointment availability. Requires that the factors:

(1) require that all insureds are able to receive an appointment with a preferred provider within the maximum travel times and distances established under Sections 1301.00553 and 1301.00554;

(2) require that all insureds are able to receive an appointment with a preferred provider within the maximum appointment wait times established under Section 1301.00555;

(3) require a preferred provider benefit plan to ensure sufficient choice, access, and quality of physicians and health care providers, in number, size, and geographic distribution, to be capable of providing the health care services covered by the plan from preferred providers to all insureds within the insurer's designated service area, taking into account the insureds' characteristics, medical conditions, and health care needs, including:

(A) the current utilization of covered health care services within the counties of the service area; and

(B) an actuarial projection of utilization of covered health care services, physicians, and health care providers needed within the counties of the service area to meet the needs of the number of projected insureds;

(4) require a sufficient number of preferred providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, oncology, including medical, surgical, and radiation oncology, surgery, and hospitalist, intensivist, and diagnostic services, including radiology and laboratory services, at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility that credentials the particular specialty to ensure all insureds are able to receive covered benefits, including access to clinical trials covered by the health benefit plan, at that preferred location;

(5) require that all insureds have the ability to access a preferred institutional provider listed in Section 1301.00553 within the maximum

travel times and distances established under Section 1301.00553 for the corresponding county classification;

(6) require that insureds have the option of facilities, if available, of pediatric, for-profit, nonprofit, and tax-supported institutions, with special consideration to contracting with:

(A) teaching hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load; and

(B) teaching facilities that specialize in providing care for rare and complex medical conditions and conducting clinical trials;

(7) require that there is an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;

(8) provide for necessary hospital services by requiring contracting with general, pediatric, specialty, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;

(9) ensure that emergency care, as defined by Section 1301.155, is available and accessible 24 hours a day, seven days a week, by preferred providers;

(10) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;

(11) require an adequate number of preferred providers to be available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area; and

(12) require sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area.

SECTION 6. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Sections 1301.00553, 1301.00554, and 1301.00555, as follows:

Sec. 1301.00553. MAXIMUM TRAVEL TIME AND DISTANCE STANDARDS BY PREFERRED PROVIDER TYPE. (a) Defines "maximum distance."

(b) Classifies each county in this state, for purposes of this section, as a large metro, metro, micro, or rural county, or a county with extreme access considerations as determined by the federal Centers for Medicare and Medicaid Services by population and density thresholds as of March 1, 2023.

(c) Sets forth maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each large metro county for certain physicians, as designated by physician specialty. Sets forth physician specialties, institutional providers, and required travel time and maximum distance in miles.

(d) Sets forth maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each metro county for certain physicians, as designated by physician specialty. Sets forth physician

specialties, institutional providers, and required travel time and maximum distance in miles.

(e) Sets forth maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each micro county for certain physicians, as designated by physician specialty. Sets forth physician specialties, institutional providers, and required travel time and maximum distance in miles.

(f) Sets forth maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each rural county for certain physicians, as designated by physician specialty for each rural county. Sets forth physician specialties, institutional providers, and required travel time and maximum distance in miles.

(g) Sets forth maximum travel time and maximum distance in miles for preferred provider benefit plans by preferred provider type for each county with extreme access considerations for certain physicians, as designated by physician specialty for each county with extreme access considerations. Sets forth physician specialties, institutional providers, and required travel time and maximum distance in miles.

Sec. 1301.00554. OTHER MAXIMUM DISTANCE STANDARD REQUIREMENTS; COMMISSIONER AUTHORITY. (a) Defines "maximum distance."

(b) Provides that the maximum distance, in any county classification, for a physician specialty not specifically listed in Section 1301.00553, is 75 miles.

(c) Authorizes the commissioner, when necessary due to utilization or supply patterns, by rule to decrease the base maximum travel time and distance standards listed in this section or Section 1301.00553 for specific counties.

Sec. 1301.00555. MAXIMUM APPOINTMENT WAIT TIME STANDARDS. Requires an insurer to ensure that:

(1) routine care is available and accessible from preferred providers:

(A) within three weeks for medical conditions; and

(B) within two weeks for behavioral health conditions; and

(2) preventive health care services are available and accessible from preferred providers:

(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive health care services; and

(B) within three months for an adult.

SECTION 7. Amends Section 1301.0056, Insurance Code, by amending Subsection (a) and adding Subsections (a-1) and (e), as follows:

(a) Requires the commissioner by rule to adopt a process for the commissioner to examine a preferred provider benefit plan before an insurer offers the plan for delivery to insureds to determine whether the plan meets the quality of care and network adequacy standards of this chapter. Prohibits an insurer from offering a preferred provider benefit plan or an exclusive provider benefit plan before the commissioner determines that the network meets the quality of care and network adequacy standards of this chapter or the insurer receives a waiver under Section 1301.0055. Makes nonsubstantive changes.

(a-1) Provides that an insurer is subject to a qualifying examination of the insurer's preferred provider benefit plans and subsequent quality of care and network adequacy examinations by the commissioner at least once every three years, in connection with a public hearing under Section 1301.00565 concerning a material deviation from network adequacy standards by a previously authorized plan or a request for a waiver of a network adequacy standard, and whenever the commissioner considers an examination necessary.

(e) Requires that the rules adopted under this section require insurers to provide access to or submit data or information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards. Provides that the rules are required for insurers to provide access to or submit data or information that includes:

(1) a searchable and sortable database of network physicians and health care providers by national provider identifier, county, physician specialty, hospital privileges and credentials, and type of health care provider or licensure, as applicable;

(2) actuarial data of current and projected number of insureds by county;

(3) actuarial data of current and projected utilization of each preferred provider type listed in Section 1301.00553 and described by Section 1301.00554 by county; and

(4) any other data or information considered necessary by the commissioner to make a determination to authorize the use of the preferred provider benefit plan in the most efficient and effective manner possible.

SECTION 8. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Sections 1301.00565 and 1301.00566, as follows:

Sec. 1301.00565. PUBLIC HEARING ON NETWORK ADEQUACY STANDARDS WAIVERS. (a) Defines "good faith effort."

(b) Requires the commissioner to set a public hearing for a determination of whether there is good cause for a waiver when an insurer:

(1) requests a waiver that does not satisfy Section 1301.0055(a)(6);

(2) requests a waiver that the commissioner does not deny; and

(3) does not complete corrective action for a material deviation reported under Section 1301.0055.

(c) Requires the commissioner to notify affected physicians and health care providers that are authorized to be the subject of a discussion of good faith efforts on behalf of the insurer to meet network adequacy standards and provide the physicians and health care providers with an opportunity to submit evidence, including written testimony, and to attend the public hearing and offer testimony either in person or virtually. Prohibits an out-of-network physician or hospital, including a physician group or health care system referenced in the insurer's waiver request or notice of material deviation, from being identified by name at the hearing unless the physician or hospital consents to the identification in advance of the hearing.

(d) Requires the commissioner, at the hearing, to consider all written and oral testimony and evidence submitted by the insurer and the public pertinent to the requested waiver, including:

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

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

(3) population, density, and geographical information to determine the possibility of meeting travel time and distance requirements within the county and service area being submitted for a waiver; and

(4) availability of services, population, and density within the county and service area being submitted for the waiver.

(e) Prohibits the commissioner from considering a prohibition on balance billing in determining whether to grant a waiver from network adequacy standards.

(f) Prohibits the commissioner from granting a waiver without a public hearing.

(g) Provides that any evidence submitted to the commissioner as evidence for the public hearing that is proprietary in nature, except as provided by this subsection, is confidential and not subject to disclosure as public information under Chapter 552 (Public Information), Government Code. Provides that information related to provider directories, credentials, and privileges, estimates of patient populations, and actuarial estimates of needed providers to meet the estimated patient population is not protected under this subsection.

(h) Entitles a policyholder to seek judicial review of the commissioner's decision to grant a waiver under this section in a Travis County district court. Provides that the review by the district court under this subsection is de novo.

Sec. 1301.00566. EFFECT OF NETWORK ADEQUACY STANDARDS WAIVER ON BALANCE BILLING PROHIBITIONS. Authorizes an insurer, after a network adequacy standards waiver is granted by the commissioner, to refer to the provisions prohibiting balance billing under certain sections as applicable, in an access plan submitted to the TDI for the sole purpose of explaining how the insurer will coordinate care to limit the likelihood of a balance bill for services subject to those provisions and not to justify a departure from network adequacy standards.

SECTION 9. Amends Section 1301.009(b), Insurance Code, to require that the report include a statement of any waiver requests made and waivers of network adequacy standards granted under Section 1301.00565; any material deviation from network adequacy standards reported to TDI under Section 1301.0055; and any corrective actions, sanctions, or penalties assessed against the insurer by TDI for deficiencies related to the preferred provider benefit plan.

SECTION 10. Amends Subchapter B, Chapter 1301, Insurance Code, by adding Section 1301.0642, as follows:

Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN ADVERSE MATERIAL CHANGES PROHIBITED. (a) Defines "adverse material change."

(b) Authorizes an adverse material change to a preferred provider contract to only be made during the term of the preferred provider contract with the mutual agreement of the parties. Provides that a provision in a preferred provider contract

that allows the insurer to unilaterally make an adverse material change during the term of the contract is void and unenforceable.

(c) Prohibits any adverse material change to the preferred provider contract from going into effect until the 120th day after the date the preferred provider affirmatively agrees to the adverse material change in writing.

(d) Requires that a proposed amendment by an insurer seeking an adverse material change to a preferred provider contract include notice that clearly and conspicuously states that a preferred provider is authorized to choose to not agree to the amendment and that the decision to not agree to the amendment is prohibited from affecting:

(1) the terms of the provider's existing contract with the insurer; or

(2) the provider's participation in other health plans or products.

(e) Provides that a preferred provider's failure to agree to an adverse material change to a preferred provider contract does not affect:

(1) the terms of the provider's existing contract with the insurer; or

(2) the provider's participation in other health care products or plans.

(f) Provides that an insurer's failure to include the notice described by Subsection (d) with the proposed amendment makes an otherwise agreed-to adverse material change void and unenforceable.

SECTION 11. (a) Makes application of the changes in law made by this Act prospective to January 1, 2024.

(b) Makes application of Section 1301.009(b), Insurance Code, as amended by this Act, prospective to October 1, 2024.

(c) Makes application of Section 1301.0642, Insurance Code, as added by this Act, prospective.

SECTION 12. Effective date: September 1, 2023.