BILL ANALYSIS

C.S.H.B. 3359
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

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. C.S.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 which are allowed to be issued by TDI and the reasons for issuing them.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTIONS 5, 6, and 7 of this bill.

ANALYSIS

Network Adequacy Standards for Preferred Provider Benefit Plans

Adoption of Standards; Waivers

C.S.H.B. 3359 amends the Insurance Code to revise provisions relating to network adequacy standards for preferred provider benefit plans, which are adopted by commissioner of insurance rule, and waivers of those standards. Specifically, the bill revises the requirements for the standards adopted by commissioner rule as follows:

- removes the provision providing for the adoption of standards that are adapted to local markets in which an insurer offering a preferred provider benefit plan operates;
- adds provisions requiring the adoption of standards that require an insurer offering a preferred provider benefit plan to do the following:
    - monitor compliance with network adequacy standards, including statutes relating to network adequacy, on an ongoing basis, reporting any material deviation from the standards to the Texas Department of Insurance (TDI) within 30 days of the date the material deviation occurred; and
    - 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 there are no licensed physicians or health care providers in the affected county;

- replaces the requirement that the adopted standards ensure availability of, and accessibility to, a full range of contracted physicians to provide health care services to insureds with a requirement that the adopted standards 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;
- replaces the authorization for the adopted standards to allow departure from local market network adequacy standards on good cause shown if the commissioner posts on the TDI website the name of the preferred provider plan, the insurer offering the plan, and the affected local market with an authorization for the adopted standards 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, as required under the bill's provisions and later described, that good cause is shown; and
    - posts on the TDI 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;
- requires the adopted standards to require disclosure by the insurer of the information posted on the TDI website in all promotion and advertisement of the preferred provider benefit plan for which a waiver is allowed;
- requires the adopted standards to limit a waiver from being issued to a preferred provider benefit plan for a specified number of occurrences as follows:
    - 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 the bill, multiple good faith attempts to bring the plan into compliance with the network adequacy standard during each of the prior consecutive waiver periods; or
    - 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
- authorizes the commissioner to issue a waiver that would otherwise be unavailable because of such limitations if the waiver request demonstrates, and TDI confirms annually, that there are no physicians or health care providers in the area to meet the specific standard for a county in a service area.

Factors Regarding Time, Distance, and Appointment Availability

C.S.H.B. 3359 establishes that the network adequacy standards that ensure availability of, and accessibility to, a full range of contracted physicians and providers must include factors regarding time, distance, and appointment availability. The factors, as follows, must:

- require that all insureds are able to receive an appointment with a preferred provider within the maximum travel times and distances established under the bill's provisions;
- require that at all insureds are able to receive an appointment with a preferred provider within the maximum appointment wait times established under the bill's provisions;
- 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:
    - the current utilization of covered health care services within the counties of the service area; and
    - 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;
- 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;

- require that all insureds have the ability to access an applicable preferred institutional provider within the maximum travel times and distances established under the bill's provisions for the corresponding county classification;
- 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 teaching hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load and with teaching facilities that specialize in providing care for rare and complex medical conditions and conducting clinical trials;
- 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;
- 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;
- ensure that emergency care is available and accessible 24 hours a day, seven days a week, by preferred providers;
- 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;
- 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
- require sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area.

Maximum Travel Time, Distance, and Wait Time Standards

C.S.H.B. 3359 prescribes the specific maximum travel time and maximum distance standards for preferred provider benefit plans by preferred provider type. The bill sets out such times and distances for specific physician specialties, health care provider disciplines, and institutional provider types and for outpatient clinical behavioral health and urgent care settings. The times and distances are also based on whether the county is classified as a large metro, metro, micro, or rural county or as 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. Moreover, the maximum distance standard for a physician specialty not specifically listed among the specialties set out in the bill is 75 miles. The bill authorizes the commissioner, when necessary due to utilization or supply patterns, to decrease by rule the base maximum travel time and distance standards prescribed under the bill's provisions for specific counties. The bill defines "maximum distance" for purposes of these provisions as the miles calculated to drive by automobile within a service area without using tolled roadways or waterway passages to a particular type of preferred provider.

With respect to maximum appointment wait time standards, C.S.H.B. 3359 requires an insurer to ensure that:

- routine care is available and accessible from preferred providers within three weeks for medical conditions and within two weeks for behavioral health conditions; and
- preventive health care services are available and accessible from preferred providers within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive health care services, and within three months for an adult.

Examinations of Compliance With Quality of Care and Network Adequacy Standards

C.S.H.B. 3359 changes the process by which the commissioner determines whether a preferred provider plan meets quality of care and adequacy of network standards. Accordingly, the bill does the following:

- removes the statutory requirement for the commissioner to examine an insurer to determine the quality and adequacy of a network used by a preferred provider benefit plan offered by the insurer and requires the commissioner instead to adopt a process by rule under which the commissioner examines a preferred provider benefit plan, before an insurer offers the plan for delivery to insureds, in order to determine whether the plan meets quality of care and network adequacy standards;
- prohibits an insurer from offering a preferred provider benefit plan before the commissioner determines that the network meets those standards;
- specifies that the qualifying examination of the insurer's preferred provider benefit plans and subsequent examinations conducted by the commissioner at least once every three years are in connection with a public hearing, as required under the bill's provisions and later described, 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
- requires rules adopted under the bill's provisions concerning the commissioner's examination of a preferred provider benefit plan to 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, including the following:
    - 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;
    - by county, actuarial data of current and projected number of insureds;
    - by county, actuarial data of current and projected utilization of each preferred provider type subject to the bill's maximum travel time and distance standards; and
    - 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.

The bill removes references to exclusive provider benefit plans from the examination provisions, but these plans are subject to provisions governing preferred provider benefit plans unless a provision specifies otherwise.

Public Hearing on Network Adequacy Standards Waiver

C.S.H.B. 3359 establishes a public hearing process for a determination of whether there is good cause for a waiver from network adequacy standards and prohibits the commissioner from granting a waiver without such a public hearing. The bill, as follows:

- requires the commissioner to set a hearing for such a determination when an insurer requests a waiver that does not demonstrate that there are no physicians or health care providers in the area to meet the specific standard for a county in a service area, requests a waiver that the commissioner does not deny, and does not complete corrective action for a material deviation from network adequacy standards;
- requires the commissioner to notify affected physicians and health care providers that may be the subject of a discussion of good faith efforts on behalf of the insurer to meet the 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 the identification of an out-of-network physician or hospital by name at the hearing, including a physician group or health care system referenced in the insurer's

waiver request or notice of material deviation, unless the physician or hospital consents to the identification in advance of the hearing;

- requires the commissioner to consider all written and oral testimony and evidence submitted by the insurer and the public pertinent to the requested waiver;
- makes any evidence submitted to the commissioner for the public hearing that is proprietary in nature confidential and not subject to disclosure under state public information law but specifies 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 provision;
- prohibits the commissioner from considering a prohibition on balance billing in determining whether to grant a waiver from network adequacy standards;
- entitles a policyholder to seek judicial review of the commissioner's decision to grant a waiver in a Travis County district court and specifies that such a review by the district court is de novo; and
- specifies that the testimony and evidence that the commissioner must consider includes the following:
    - the total number of physicians or health care providers in each preferred provider type, as listed in the bill, 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;
    - 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;
    - 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
    - availability of services, population, and density within the county and service area being submitted for the waiver.

The bill defines "good faith effort," for purposes of these hearing provisions, to mean honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patients' access to in-network care.

Effect of Waiver on Balance Billing Prohibitions

C.S.H.B. 3359 authorizes an insurer, after a network adequacy standards waiver is granted, to refer to certain statutory provisions prohibiting balance billing in an access plan submitted to 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.

Annual Report

C.S.H.B. 3359 requires the annual report that an insurer offering a preferred provider benefit plan must file with the commissioner relating to the plan to include a statement of the following:

- any waiver requests made and waivers of network adequacy standards granted under the bill's provisions;
- any material deviation from network adequacy standards reported to TDI; and
- any corrective actions, sanctions, or penalties assessed against the insurer by TDI for deficiencies related to the preferred provider benefit plan.

This requirement applies only to a report filed on or after October 1, 2024.

Adverse Material Change to a Contract

C.S.H.B. 3359 sets out provisions regarding adverse material changes to a preferred provider contract. The bill establishes that an adverse material change to a preferred provider contract

may only be made during the term of the contract with the mutual agreement of the parties and that a provision in the contract that allows the insurer to unilaterally make an adverse material change during the term of the contract is void and unenforceable. Moreover, the bill does the following:

- prohibits any adverse material change to the contract from going into effect until the 120th day after the date the preferred provider affirmatively agrees to the change in writing;
- requires a proposed amendment by an insurer seeking an adverse material change to a preferred provider contract to include notice that clearly and conspicuously states that a preferred provider may choose to not agree to the amendment and that the decision to not agree to the amendment may not affect the terms of the provider's existing contract with the insurer or the provider's participation in other health plans or products;
- prohibits a preferred provider's failure to agree to the adverse material change to the contract from affecting the terms of the provider's existing contract with the insurer or the provider's participation in other health care products or plans; and
- specifies that an insurer's failure to include the notice with the proposed amendment makes an otherwise agreed-to adverse material change void and unenforceable.

The bill's provisions relating to an adverse material change to a preferred provider contract apply only to a contract entered into on or after the bill's effective date.

C.S.H.B. 3359 defines "adverse material change" for purposes of these provisions to mean a change to a preferred provider contract that would do the following:

- decrease the preferred provider's payment or compensation;
- change the provider's tier to a less preferred tier; or
- change the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses.

The bill specifies that an adverse material change does not include the following:

- a decrease in payment or compensation resulting solely from a change in a published governmental fee schedule on which the payment or compensation is based if the applicability of the schedule is clearly identified in the contract;
- a decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;
- an administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;
- a change that is required by federal or state law;
- a termination for cause; or
- a termination without cause at the end of the contract's term.

Service Area

C.S.H.B. 3359 establishes that a service area for a preferred provider benefit plan, other than a statewide service area, may include noncontiguous geographic areas but may not divide a county.

Emergency and Post-Emergency Stabilization Care

Available Benefits

C.S.H.B. 3359 includes benefits for emergency care and post-emergency stabilization care among the preferred provider benefits and basic level benefits that an insurer must ensure are reasonably available to all insureds within a designated service area.

Reimbursement Rates; Claim Dispute Resolution

C.S.H.B. 3359 expands the scope of provisions that require an issuer of an exclusive provider benefit plan to reimburse an out-of-network provider that provides emergency care to an enrollee 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 the services, set a deadline for the insurer to make the payment, and provide certain restrictions on the amount the out-of-network provider may bill the insured to include post-emergency stabilization care provided by an out-of-network provider under the plan. The bill subjects such post-emergency stabilization care and a supply related to that care to statutory provisions relating to out-of-network claim dispute resolution in the same manner as if the care and supply are emergency care. These provisions do not apply to claims for post-emergency stabilization care if specified conditions of federal law relating to the prevention of surprise medical bills are met.

Definition

C.S.H.B. 3359 defines "post-emergency stabilization care" for purposes of these provisions as health care services that are furnished by an out-of-network provider, including an out-of-network hospital, freestanding emergency medical care facility, or comparable emergency facility, regardless of the department of the facility in which the services are furnished, after an insured is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency care is furnished

Applicability

C.S.H.B. 3359 applies only to an insurance policy that is delivered, issued for delivery, or renewed on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 3359 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute omits the following provisions relating to cost-sharing that appeared in the introduced:

- a requirement for an insurer to credit a cost-sharing payment paid on behalf of an insured for services furnished by an out-of-network provider to any out-of-pocket maximum that applies to the insured;
- a requirement for the cost-sharing payment to be applied to the out-of-pocket maximum in the same manner as if it were made with respect to services furnished by a preferred provider;
- a prohibition against an insurer having separate out-of-pocket maximums for in-network and out-of-network services; and
- a requirement for the commissioner of insurance by rule to set a reasonable cap on an out-of-pocket maximum.

The substitute omits a requirement from the introduced for a service area to include at least one trauma service area in its entirety.

The substitute includes the following provisions absent from the introduced:

- a deadline for an insurer to take corrective action required to ensure that the preferred provider network is compliant with network adequacy standards, which does not apply if there are no licensed physicians or health care providers in the affected county;
- an authorization for the commissioner to issue a waiver of network adequacy standards that would otherwise be unavailable because of limitations on the number of waivers that may be granted if the waiver request demonstrates, and TDI confirms annually, that there are no physicians or health care providers in the area to meet the specific standard for a county in a service area;
- a requirement to post on the TDI website the access plan of an insurer that is granted a waiver;
- provisions defining "maximum distance" for purposes of the prescribed distance standards and "good faith effort" for purposes of the waiver hearing procedures; and
- an authorization for an insurer, after a waiver has been granted, to refer to certain statutory provisions prohibiting balance billing in the access plan the insurer submitted to TDI for the sole purpose of explaining how the insurer will coordinate care to limit the likelihood of a balance bill for a service subject to those provisions and not to justify a departure from network adequacy standards.

The introduced required a sufficient number of certain types of specialists 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 at that preferred location. The substitute retains this requirement but adds providers of oncology, including medical, surgical, and radiation oncology, to the list of specialists and changes the criteria on which sufficiency is based to ensuring all insureds are able to receive covered benefits, including access to clinical trials covered by the health benefit plan, at the preferred location.

The introduced required that insureds have the option of facilities, if available, of pediatric, for-profit, nonprofit, and tax-supported institutions, with special consideration to contracting with teaching hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load. The substitute retains this requirement but also includes among the facilities given special consideration teaching facilities that specialize in providing care for rare and complex medical conditions and conducting clinical trials.

While both the introduced and substitute prescribe maximum travel time and distance standards for specific physician specialties, the substitute omits anesthesiology from the listed specialties. The substitute also corrects an error in one of the time and distance entries for gastroenterology.

The introduced required rules concerning the commissioner's examination of a preferred provider benefit plan to require insurers to provide access to or submit data necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards. The substitute clarifies that this requirement also applies to information other than data. Moreover, while the introduced set out specified data and information that the rules must require insurers to submit, the substitute provides that the rules must require insurers to provide access to or submit that specified data and information.

Whereas the introduced required the commissioner to set a public hearing for determination of whether there is good cause for a network adequacy standards waiver on the earlier of a request from an insurer to receive a waiver or receipt of notice of a material deviation from the standards, the substitute requires the commissioner to set such a hearing when an insurer:

- requests a waiver that does not demonstrate that there are no physicians or health care providers in the area to meet the specific standard for a county in a service area;
- requests a waiver the commissioner does not deny; and
- does not complete corrective action for a material deviation from the standards.

The substitute replaces the introduced version's prohibition against identifying a physician by name at the hearing without advance consent with a prohibition against identifying an out-of-network physician or hospital by name at the hearing without advance consent. The substitute clarifies that the prohibition applies to a health care system referenced in the waiver request or notice of material deviation.

The substitute revises the definition of "adverse material change" included in the introduced by excluding from that term a termination for cause or a termination without cause at the end of a contract's term and by specifying that the exclusion of a decrease in payment or compensation resulting solely from a change in a published fee schedule applies only with respect to a governmental fee schedule.

The substitute omits a requirement present in the introduced for the notice an insurer includes with a proposed amendment seeking an adverse material change to a preferred provider contract to clearly and conspicuously identify such an amendment as proposing an adverse material change to the contract.

The substitute includes provisions absent from the introduced that make the bill's changes to the content of the annual report filed with commissioner by an insurer regarding a preferred provider benefit plan applicable only to a report submitted on or after October 1, 2024, and that make the bill's provisions relating to adverse material changes to a preferred provider contract applicable only to a contract entered into on or after the bill's effective date.