By: Bonnen H.B. No. 3359

A BILL TO BE ENTITLED

AN ACT

relating to network adequacy standards and other requirements for preferred provider benefit plans.

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

SECTION 1. Section 1301.001, Insurance Code, is amended by adding Subdivision (6-a) to read as follows:

(6-a) "Post-emergency stabilization care" means 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, as defined by Section 1301.155, is furnished.

SECTION 2. The heading to Section 1301.005, Insurance Code, is amended to read as follows:

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

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

(a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level

benefits, including benefits for emergency care, as defined by Section 1301.155, and post-emergency stabilization care, are reasonably available to all insureds within a designated service area. This subsection does not apply to an exclusive provider benefit plan.

(d) A service area, other than a statewide service area, may include noncontiguous geographic areas but may not divide a county.

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

(a) If an out-of-network provider provides emergency care as defined by Section 1301.155 or post-emergency stabilization care to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall 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. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

(b) For emergency care or post-emergency stabilization care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's exclusive provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

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

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

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

(e) 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. Section 1301.0055, Insurance Code, is amended to read as follows:

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. (a) The commissioner shall by rule adopt 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 this chapter relating to network adequacy, on an ongoing basis, reporting any material deviation from network adequacy standards to the department 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 [~~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 [~~to~~] insureds; [~~and~~]

(3) [~~on good cause shown,~~] may allow a waiver for a departure from [~~local market~~] 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 the department'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 the department 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 [~~and the affected local market~~].

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

(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. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Sections 1301.00553, 1301.00554, and 1301.00555 to read as follows:

Sec. 1301.00553. MAXIMUM TRAVEL TIME AND DISTANCE STANDARDS BY PREFERRED PROVIDER TYPE. (a) In this section, "maximum distance" means the miles calculated to drive by automobile within a service area to a particular type of preferred provider.

(b) For purposes of this section, each county in this state is classified 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) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each large metro county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	30	15

Cardiology	20	10
Cardiothoracic Surgery	30	15
Dermatology	20	10
Emergency Medicine	20	10
Endocrinology	30	15
Ear, Nose, and Throat/Otolaryngology	30	15
Gastroenterology	20	10
General Surgery	20	10
Gynecology and Obstetrics	10	5
Infectious Diseases	30	15
Nephrology	30	15
Neurology	20	10
Neurosurgery	30	15
Oncology: Medical, Surgical	20	10
Oncology: Radiation	30	15
Ophthalmology	20	10
Orthopedic Surgery	20	10
Physical Medicine and Rehabilitation	30	15
Plastic Surgery	30	15
Primary Care: Adults	10	5
Primary Care: Pediatric	10	5
Psychiatry	20	10
Pulmonology	20	10
Rheumatology	30	15
Urology	20	10
Vascular Surgery	30	15

(2) for health care practitioners in the following

disciplines:

	Time	Distance
Chiropractic	30	15
Occupational Therapy	20	10
Physical Therapy	20	10
Podiatry	20	10
Speech Therapy	20	10

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	20	10
Cardiac Catheterization Services	30	15
Cardiac Surgery Program	30	15
Critical Care Services: Intensive Care Units	20	10
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	20	10
Inpatient or Residential Behavioral Health Facility Services	30	15
Mammography	20	10
Outpatient Infusion/Chemotherapy	20	10
Skilled Nursing Facilities	20	10
Surgical Services (Outpatient or Ambulatory Surgical Center)	20	10

(4) for the following settings:

	Time	Distance

Outpatient Clinical Behavioral Health		
(Licensed, Accredited, or Certified)	10	5
Urgent Care	20	10

(d) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each metro county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	45	30
Cardiology	30	20
Cardiothoracic Surgery	60	40
Dermatology	45	30
Emergency Medicine	45	30
Endocrinology	60	40
Ear, Nose, and Throat/Otolaryngology	45	30
Gastroenterology	45	30
General Surgery	30	20
Gynecology and Obstetrics	15	10
Infectious Diseases	60	40
Nephrology	45	30
Neurology	45	30
Neurosurgery	60	40
Oncology: Medical, Surgical	45	30
Oncology: Radiation	60	40
Ophthalmology	30	20
Orthopedic Surgery	30	20

Physical Medicine and Rehabilitation	45	30
Plastic Surgery	60	40
Primary Care: Adults	15	10
Primary Care: Pediatric	15	10
Psychiatry	45	30
Pulmonology	45	30
Rheumatology	60	40
Urology	45	30
Vascular Surgery	60	40

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	45	30
Occupational Therapy	45	30
Physical Therapy	45	30
Podiatry	45	30
Speech Therapy	45	30

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	45	30
Cardiac Catheterization Services	60	40
Cardiac Surgery Program	60	40
Critical Care Services: Intensive Care Units	45	30

Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	45	30
Inpatient or Residential Behavioral Health Facility Services	70	45
Mammography	45	30
Outpatient Infusion/Chemotherapy	45	30
Skilled Nursing Facilities	45	30
Surgical Services (Outpatient or Ambulatory Surgical Center)	45	30

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	15	10
Urgent Care	45	30

(e) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each micro county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	80	60
Cardiology	50	35
Cardiothoracic Surgery	100	75
Dermatology	60	45
Emergency Medicine	80	60
Endocrinology	100	75

Ear, Nose, and Throat/Otolaryngology	80	60
Gastroenterology	60	45
General Surgery	50	35
Gynecology and Obstetrics	30	20
Infectious Diseases	100	75
Nephrology	80	60
Neurology	60	45
Neurosurgery	100	75
Oncology: Medical, Surgical	60	45
Oncology: Radiation	100	75
Ophthalmology	50	35
Orthopedic Surgery	50	35
Physical Medicine and Rehabilitation	80	60
Plastic Surgery	100	75
Primary Care: Adults	30	20
Primary Care: Pediatric	30	20
Psychiatry	60	45
Pulmonology	60	45
Rheumatology	100	75
Urology	60	45
Vascular Surgery	100	75

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	80	60
Occupational Therapy	80	60
Physical Therapy	80	60

Podiatry	60	45
Speech Therapy	80	60

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	80	60
Cardiac Catheterization Services	160	120
Cardiac Surgery Program	160	120
Critical Care Services: Intensive Care Units	160	120
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	80	60
Inpatient or Residential Behavioral Health Facility Services	100	75
Mammography	80	60
Outpatient Infusion/Chemotherapy	80	60
Skilled Nursing Facilities	80	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	80	60

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	30	20
Urgent Care	80	60

(f) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider

type for each rural county are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	90	75
Cardiology	75	60
Cardiothoracic Surgery	110	90
Dermatology	75	60
Emergency Medicine	75	60
Endocrinology	110	90
Ear, Nose, and Throat/Otolaryngology	90	75
Gastroenterology	75	60
General Surgery	75	60
Gynecology and Obstetrics	40	30
Infectious Diseases	110	90
Nephrology	90	75
Neurology	75	60
Neurosurgery	110	90
Oncology: Medical, Surgical	75	60
Oncology: Radiation	110	90
Ophthalmology	75	60
Orthopedic Surgery	75	60
Physical Medicine and Rehabilitation	90	75
Plastic Surgery	110	90
Primary Care: Adults	40	30
Primary Care: Pediatric	40	30
Psychiatry	75	60

Pulmonology	75	60
Rheumatology	110	90
Urology	75	60
Vascular Surgery	110	90

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	90	75
Occupational Therapy	75	60
Physical Therapy	75	60
Podiatry	75	60
Speech Therapy	75	60

(3) for the following types of institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	75	60
Cardiac Catheterization Services	145	120
Cardiac Surgery Program	145	120
Critical Care Services: Intensive Care Units	145	120
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	75	60
Inpatient or Residential Behavioral Health Facility Services	90	75
Mammography	75	60
Outpatient Infusion/Chemotherapy	75	60

Skilled Nursing Facilities	75	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	75	60

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	40	30
Urgent Care	75	60

(g) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each county with extreme access considerations are:

(1) for the following physicians, as designated by physician specialty:

	Time	Distance
Allergy and Immunology	125	110
Cardiology	95	85
Cardiothoracic Surgery	145	130
Dermatology	110	100
Emergency Medicine	110	100
Endocrinology	145	130
Ear, Nose, and Throat/Otolaryngology	125	110
Gastroenterology	110	100
General Surgery	95	85
Gynecology and Obstetrics	70	60
Infectious Diseases	145	130
Nephrology	125	110
Neurology	110	100

Neurosurgery	145	130
Oncology: Medical, Surgical	110	100
Oncology: Radiation	145	130
Ophthalmology	95	85
Orthopedic Surgery	95	85
Physical Medicine and Rehabilitation	125	110
Plastic Surgery	145	130
Primary Care: Adults	70	60
Primary Care: Pediatric	70	60
Psychiatry	110	100
Pulmonology	110	100
Rheumatology	145	130
Urology	110	100
Vascular Surgery	145	130

(2) for health care practitioners in the following disciplines:

	Time	Distance
Chiropractic	125	110
Occupational Therapy	110	100
Physical Therapy	110	100
Podiatry	110	100
Speech Therapy	110	100

(3) for the following institutional providers:

	Time	Distance
Acute Inpatient Hospitals (Emergency Services Available 24/7)	110	100
Cardiac Catheterization Services	155	140

Cardiac Surgery Program	155	140
Critical Care Services: Intensive Care Units	155	140
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	110	100
Inpatient or Residential Behavioral Health Facility Services	155	140
Mammography	110	100
Outpatient Infusion/Chemotherapy	110	100
Skilled Nursing Facilities	95	85
Surgical Services (Outpatient or Ambulatory Surgical Center)	110	100

(4) for the following settings:

	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	70	60
Urgent Care	110	100

Sec. 1301.00554. OTHER MAXIMUM DISTANCE STANDARD REQUIREMENTS; COMMISSIONER AUTHORITY. (a) In this section, "maximum distance" has the meaning assigned by Section 1301.00553.

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

(c) When necessary due to utilization or supply patterns, the commissioner by rule may 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. An insurer must 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. Section 1301.0056, Insurance Code, is amended by amending Subsection (a) and adding Subsections (a-1) and (e) to read as follows:

(a) The commissioner shall by rule 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. An insurer may not offer [~~of a network used by~~] a preferred provider benefit plan or an exclusive provider benefit plan before [~~offered by~~] the commissioner determines that the network meets the quality of care and network adequacy standards of [~~insurer under~~] this chapter or the insurer receives a waiver under Section 1301.0055.

(a-1) An insurer is subject to a qualifying examination of the insurer's preferred provider benefit plans [~~and exclusive 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. Documentation provided to the commissioner during an examination conducted under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(e) Rules adopted under this section must 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. The rules must require 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. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Sections 1301.00565 and 1301.00566 to read as follows:

Sec. 1301.00565. PUBLIC HEARING ON NETWORK ADEQUACY STANDARDS WAIVERS. (a) In this section, "good faith effort" means honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patients' access to in-network care.

(b) The commissioner shall 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) The commissioner shall 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 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. 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, may not be identified by name at the hearing unless the physician or hospital consents to the identification in advance of the hearing.

(d) At the hearing, the commissioner shall 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) The commissioner may not consider a prohibition on balance billing in determining whether to grant a waiver from network adequacy standards.

(f) The commissioner may not grant a waiver without a public hearing.

(g) Except as provided by this subsection, any evidence submitted to the commissioner as evidence for the public hearing that is proprietary in nature is confidential and not subject to disclosure as public information under Chapter 552, Government Code. 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) A policyholder is entitled to seek judicial review of the commissioner's decision to grant a waiver under this section in a Travis County district court. Review by the district court under this subsection is de novo.

Sec. 1301.00566. EFFECT OF NETWORK ADEQUACY STANDARDS WAIVER ON BALANCE BILLING PROHIBITIONS. After a network adequacy standards waiver is granted by the commissioner, an insurer may refer to the provisions prohibiting balance billing under Sections 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable, in an access plan submitted to the department 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. Section 1301.009(b), Insurance Code, is amended to read as follows:

(b) The report shall:

(1) be verified by at least two principal officers;

(2) be in a form prescribed by the commissioner; and

(3) include:

(A) a financial statement of the insurer, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year; and

(C) a statement of:

(i) an evaluation of enrollee satisfaction;

(ii) an evaluation of quality of care;

(iii) coverage areas;

(iv) accreditation status;

(v) premium costs;

(vi) plan costs;

(vii) premium increases;

(viii) the range of benefits provided;

(ix) copayments and deductibles;

(x) the accuracy and speed of claims payment by the insurer for the plan;

(xi) the credentials of physicians who are preferred providers; [~~and~~]

(xii) the number of preferred providers;

(xiii) any waiver requests made and waivers of network adequacy standards granted under Section 1301.00565;

(xiv) any material deviation from network adequacy standards reported to the department under Section 1301.0055; and

(xv) any corrective actions, sanctions, or penalties assessed against the insurer by the department for deficiencies related to the preferred provider benefit plan.

SECTION 10. Subchapter B, Chapter 1301, Insurance Code, is amended by adding Section 1301.0642 to read as follows:

Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN ADVERSE MATERIAL CHANGES PROHIBITED. (a) In this section, "adverse material change" means a change to a preferred provider contract that would 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 or decrease the provider's payment or compensation. The term does not include:

(1) 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;

(2) 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;

(3) an administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

(4) a change that is required by federal or state law;

(5) a termination for cause; or

(6) a termination without cause at the end of the term of the contract.

(b) An adverse material change to a preferred provider contract may only be made during the term of the preferred provider contract with the mutual agreement of the parties. 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) Any adverse material change to the preferred provider contract may not go into effect until the 120th day after the date the preferred provider affirmatively agrees to the adverse material change in writing.

(d) A proposed amendment by an insurer seeking an adverse material change to a preferred provider contract must 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:

(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) 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) 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) The changes in law made by this Act apply only to an insurance policy that is delivered, issued for delivery, or renewed on or after January 1, 2024. A policy delivered, issued for delivery, or renewed before January 1, 2024, 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.

(b) Section 1301.009(b), Insurance Code, as amended by this Act, applies only to a report submitted on or after October 1, 2024. A report submitted before October 1, 2024, is governed by the law in effect on the date the report was submitted, and that law is continued in effect for that purpose.

(c) Section 1301.0642, Insurance Code, as added by this Act, applies only to a contract entered into, amended, or renewed on or after the effective date of this Act.

SECTION 12. This Act takes effect September 1, 2023.