

By: Bonnen

H.B. No. 3359

Substitute the following for H.B. No. 3359:

By: Oliverson

C.S.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

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

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

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

11 (a) If an out-of-network provider provides emergency care
12 as defined by Section 1301.155 or post-emergency stabilization care
13 to an enrollee in an exclusive provider benefit plan, the issuer of
14 the plan shall reimburse the out-of-network provider at the usual
15 and customary rate or at a rate agreed to by the issuer and the
16 out-of-network provider for the provision of the services and any
17 supply related to those services. The insurer shall make a payment
18 required by this subsection directly to the provider not later
19 than, as applicable:

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

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

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

8 (1) is based on:

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

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

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

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

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

22 SECTION 5. Section 1301.0055, Insurance Code, is amended to
23 read as follows:

24 Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. (a) The
25 commissioner shall by rule adopt network adequacy standards that:

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

1 (A) monitor compliance with network adequacy
2 standards, including provisions of this chapter relating to network
3 adequacy, on an ongoing basis, reporting any material deviation
4 from network adequacy standards to the department within 30 days of
5 the date the material deviation occurred; and

6 (B) promptly take any corrective action required
7 to ensure that the network is compliant not later than the 90th day
8 after the date the material deviation occurred unless there are no
9 licensed physicians or health care providers in the affected county
10 [are adapted to local markets in which an insurer offering a
11 preferred provider benefit plan operates];

12 (2) ensure availability of, and accessibility to, a
13 full range of contracted physicians and health care providers to
14 provide current and projected utilization of health care services
15 for adult and minor ~~to~~ insureds; ~~and~~

16 ~~(3) [on good cause shown,]~~ may allow a waiver for a
17 departure from [local market] network adequacy standards for a
18 period not to exceed one year if the commissioner determines after
19 receiving public testimony at a public hearing under Section
20 1301.00565 that good cause is shown and posts on the department's
21 Internet website the name of the preferred provider benefit plan,
22 the insurer offering the plan, each affected county, the specific
23 network adequacy standards waived, and the insurer's access plan;

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

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

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

9 (B) more than a total of four times within a
10 21-year period for each county in a service area for issues that may
11 be remedied through good faith efforts; and

12 (6) authorize the commissioner to issue a waiver that
13 would otherwise be unavailable under Subdivision (5) if the waiver
14 request demonstrates, and the department confirms annually, that
15 there are no physicians or health care providers in the area to meet
16 the specific standard for a county in a service area [~~and the~~
17 affected local market].

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

21 (1) require that all insureds are able to receive an
22 appointment with a preferred provider within the maximum travel
23 times and distances established under Sections 1301.00553 and
24 1301.00554;

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

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

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

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

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

25 (5) require that all insureds have the ability to
26 access a preferred institutional provider listed in Section
27 1301.00553 within the maximum travel times and distances

1 established under Section 1301.00553 for the corresponding county
2 classification;

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

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

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

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

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

21 (9) ensure that emergency care, as defined by Section
22 1301.155, is available and accessible 24 hours a day, seven days a
23 week, by preferred providers;

24 (10) ensure that covered urgent care is available and
25 accessible from preferred providers within the insurer's
26 designated service area within 24 hours for medical and behavioral
27 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 without using tolled roadways or waterway passages 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:

	<u>Time</u>	<u>Distance</u>
<u>Allergy and Immunology</u>	<u>30</u>	<u>15</u>
<u>Cardiology</u>	<u>20</u>	<u>10</u>

1	<u>Cardiothoracic Surgery</u>	<u>30</u>	<u>15</u>
2	<u>Dermatology</u>	<u>20</u>	<u>10</u>
3	<u>Emergency Medicine</u>	<u>20</u>	<u>10</u>
4	<u>Endocrinology</u>	<u>30</u>	<u>15</u>
5	<u>Ear, Nose, and Throat/Otolaryngology</u>	<u>30</u>	<u>15</u>
6	<u>Gastroenterology</u>	<u>20</u>	<u>10</u>
7	<u>General Surgery</u>	<u>20</u>	<u>10</u>
8	<u>Gynecology and Obstetrics</u>	<u>10</u>	<u>5</u>
9	<u>Infectious Diseases</u>	<u>30</u>	<u>15</u>
10	<u>Nephrology</u>	<u>30</u>	<u>15</u>
11	<u>Neurology</u>	<u>20</u>	<u>10</u>
12	<u>Neurosurgery</u>	<u>30</u>	<u>15</u>
13	<u>Oncology: Medical, Surgical</u>	<u>20</u>	<u>10</u>
14	<u>Oncology: Radiation</u>	<u>30</u>	<u>15</u>
15	<u>Ophthalmology</u>	<u>20</u>	<u>10</u>
16	<u>Orthopedic Surgery</u>	<u>20</u>	<u>10</u>
17	<u>Physical Medicine and Rehabilitation</u>	<u>30</u>	<u>15</u>
18	<u>Plastic Surgery</u>	<u>30</u>	<u>15</u>
19	<u>Primary Care: Adults</u>	<u>10</u>	<u>5</u>
20	<u>Primary Care: Pediatric</u>	<u>10</u>	<u>5</u>
21	<u>Psychiatry</u>	<u>20</u>	<u>10</u>
22	<u>Pulmonology</u>	<u>20</u>	<u>10</u>
23	<u>Rheumatology</u>	<u>30</u>	<u>15</u>
24	<u>Urology</u>	<u>20</u>	<u>10</u>
25	<u>Vascular Surgery</u>	<u>30</u>	<u>15</u>
26	<u>(2) for health care practitioners in the following</u>		
27	<u>disciplines:</u>		

1		<u>Time</u>	<u>Distance</u>
2	<u>Chiropractic</u>	<u>30</u>	<u>15</u>
3	<u>Occupational Therapy</u>	<u>20</u>	<u>10</u>
4	<u>Physical Therapy</u>	<u>20</u>	<u>10</u>
5	<u>Podiatry</u>	<u>20</u>	<u>10</u>
6	<u>Speech Therapy</u>	<u>20</u>	<u>10</u>
7	<u>(3) for the following types of institutional</u>		
8	<u>providers:</u>		
9		<u>Time</u>	<u>Distance</u>
10	<u>Acute Inpatient Hospitals (Emergency</u>		
11	<u>Services Available 24/7)</u>	<u>20</u>	<u>10</u>
12	<u>Cardiac Catheterization Services</u>	<u>30</u>	<u>15</u>
13	<u>Cardiac Surgery Program</u>	<u>30</u>	<u>15</u>
14	<u>Critical Care Services: Intensive Care Units</u>	<u>20</u>	<u>10</u>
15	<u>Diagnostic Radiology (Freestanding; Hospital</u>		
16	<u>Outpatient; Ambulatory Health Facilities</u>		
17	<u>with Diagnostic Radiology)</u>	<u>20</u>	<u>10</u>
18	<u>Inpatient or Residential Behavioral Health</u>		
19	<u>Facility Services</u>	<u>30</u>	<u>15</u>
20	<u>Mammography</u>	<u>20</u>	<u>10</u>
21	<u>Outpatient Infusion/Chemotherapy</u>	<u>20</u>	<u>10</u>
22	<u>Skilled Nursing Facilities</u>	<u>20</u>	<u>10</u>
23	<u>Surgical Services (Outpatient or Ambulatory</u>		
24	<u>Surgical Center)</u>	<u>20</u>	<u>10</u>
25	<u>(4) for the following settings:</u>		
26		<u>Time</u>	<u>Distance</u>

1 Outpatient Clinical Behavioral Health

2 (Licensed, Accredited, or Certified) 10 5

3 Urgent Care 20 10

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

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

	<u>Time</u>	<u>Distance</u>
9		
10 <u>Allergy and Immunology</u>	<u>45</u>	<u>30</u>
11 <u>Cardiology</u>	<u>30</u>	<u>20</u>
12 <u>Cardiothoracic Surgery</u>	<u>60</u>	<u>40</u>
13 <u>Dermatology</u>	<u>45</u>	<u>30</u>
14 <u>Emergency Medicine</u>	<u>45</u>	<u>30</u>
15 <u>Endocrinology</u>	<u>60</u>	<u>40</u>
16 <u>Ear, Nose, and Throat/Otolaryngology</u>	<u>45</u>	<u>30</u>
17 <u>Gastroenterology</u>	<u>45</u>	<u>30</u>
18 <u>General Surgery</u>	<u>30</u>	<u>20</u>
19 <u>Gynecology and Obstetrics</u>	<u>15</u>	<u>10</u>
20 <u>Infectious Diseases</u>	<u>60</u>	<u>40</u>
21 <u>Nephrology</u>	<u>45</u>	<u>30</u>
22 <u>Neurology</u>	<u>45</u>	<u>30</u>
23 <u>Neurosurgery</u>	<u>60</u>	<u>40</u>
24 <u>Oncology: Medical, Surgical</u>	<u>45</u>	<u>30</u>
25 <u>Oncology: Radiation</u>	<u>60</u>	<u>40</u>
26 <u>Ophthalmology</u>	<u>30</u>	<u>20</u>
27 <u>Orthopedic Surgery</u>	<u>30</u>	<u>20</u>

1	<u>Physical Medicine and Rehabilitation</u>	<u>45</u>	<u>30</u>
2	<u>Plastic Surgery</u>	<u>60</u>	<u>40</u>
3	<u>Primary Care: Adults</u>	<u>15</u>	<u>10</u>
4	<u>Primary Care: Pediatric</u>	<u>15</u>	<u>10</u>
5	<u>Psychiatry</u>	<u>45</u>	<u>30</u>
6	<u>Pulmonology</u>	<u>45</u>	<u>30</u>
7	<u>Rheumatology</u>	<u>60</u>	<u>40</u>
8	<u>Urology</u>	<u>45</u>	<u>30</u>
9	<u>Vascular Surgery</u>	<u>60</u>	<u>40</u>
10	<u>(2) for health care practitioners in the following</u>		
11	<u>disciplines:</u>		
12		<u>Time</u>	<u>Distance</u>
13	<u>Chiropractic</u>	<u>45</u>	<u>30</u>
14	<u>Occupational Therapy</u>	<u>45</u>	<u>30</u>
15	<u>Physical Therapy</u>	<u>45</u>	<u>30</u>
16	<u>Podiatry</u>	<u>45</u>	<u>30</u>
17	<u>Speech Therapy</u>	<u>45</u>	<u>30</u>
18	<u>(3) for the following types of institutional</u>		
19	<u>providers:</u>		
20		<u>Time</u>	<u>Distance</u>
21	<u>Acute Inpatient Hospitals (Emergency</u>		
22	<u>Services Available 24/7)</u>	<u>45</u>	<u>30</u>
23	<u>Cardiac Catheterization Services</u>	<u>60</u>	<u>40</u>
24	<u>Cardiac Surgery Program</u>	<u>60</u>	<u>40</u>
25	<u>Critical Care Services: Intensive Care Units</u>	<u>45</u>	<u>30</u>

1	<u>Diagnostic Radiology (Freestanding; Hospital</u>		
2	<u>Outpatient; Ambulatory Health Facilities</u>		
3	<u>with Diagnostic Radiology)</u>	<u>45</u>	<u>30</u>
4	<u>Inpatient or Residential Behavioral Health</u>		
5	<u>Facility Services</u>	<u>70</u>	<u>45</u>
6	<u>Mammography</u>	<u>45</u>	<u>30</u>
7	<u>Outpatient Infusion/Chemotherapy</u>	<u>45</u>	<u>30</u>
8	<u>Skilled Nursing Facilities</u>	<u>45</u>	<u>30</u>
9	<u>Surgical Services (Outpatient or Ambulatory</u>		
10	<u>Surgical Center)</u>	<u>45</u>	<u>30</u>

11 (4) for the following settings:

12		<u>Time</u>	<u>Distance</u>
13	<u>Outpatient Clinical Behavioral Health</u>		
14	<u>(Licensed, Accredited, or Certified)</u>	<u>15</u>	<u>10</u>
15	<u>Urgent Care</u>	<u>45</u>	<u>30</u>

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

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

21		<u>Time</u>	<u>Distance</u>
22	<u>Allergy and Immunology</u>	<u>80</u>	<u>60</u>
23	<u>Cardiology</u>	<u>50</u>	<u>35</u>
24	<u>Cardiothoracic Surgery</u>	<u>100</u>	<u>75</u>
25	<u>Dermatology</u>	<u>60</u>	<u>45</u>
26	<u>Emergency Medicine</u>	<u>80</u>	<u>60</u>
27	<u>Endocrinology</u>	<u>100</u>	<u>75</u>

1	<u>Ear, Nose, and Throat/Otolaryngology</u>	<u>80</u>	<u>60</u>
2	<u>Gastroenterology</u>	<u>60</u>	<u>45</u>
3	<u>General Surgery</u>	<u>50</u>	<u>35</u>
4	<u>Gynecology and Obstetrics</u>	<u>30</u>	<u>20</u>
5	<u>Infectious Diseases</u>	<u>100</u>	<u>75</u>
6	<u>Nephrology</u>	<u>80</u>	<u>60</u>
7	<u>Neurology</u>	<u>60</u>	<u>45</u>
8	<u>Neurosurgery</u>	<u>100</u>	<u>75</u>
9	<u>Oncology: Medical, Surgical</u>	<u>60</u>	<u>45</u>
10	<u>Oncology: Radiation</u>	<u>100</u>	<u>75</u>
11	<u>Ophthalmology</u>	<u>50</u>	<u>35</u>
12	<u>Orthopedic Surgery</u>	<u>50</u>	<u>35</u>
13	<u>Physical Medicine and Rehabilitation</u>	<u>80</u>	<u>60</u>
14	<u>Plastic Surgery</u>	<u>100</u>	<u>75</u>
15	<u>Primary Care: Adults</u>	<u>30</u>	<u>20</u>
16	<u>Primary Care: Pediatric</u>	<u>30</u>	<u>20</u>
17	<u>Psychiatry</u>	<u>60</u>	<u>45</u>
18	<u>Pulmonology</u>	<u>60</u>	<u>45</u>
19	<u>Rheumatology</u>	<u>100</u>	<u>75</u>
20	<u>Urology</u>	<u>60</u>	<u>45</u>
21	<u>Vascular Surgery</u>	<u>100</u>	<u>75</u>
22	<u>(2) for health care practitioners in the following</u>		
23	<u>disciplines:</u>		
24		<u>Time</u>	<u>Distance</u>
25	<u>Chiropractic</u>	<u>80</u>	<u>60</u>
26	<u>Occupational Therapy</u>	<u>80</u>	<u>60</u>
27	<u>Physical Therapy</u>	<u>80</u>	<u>60</u>

1	<u>Podiatry</u>	<u>60</u>	<u>45</u>
2	<u>Speech Therapy</u>	<u>80</u>	<u>60</u>
3	<u>(3) for the following types of institutional</u>		
4	<u>providers:</u>		
5		<u>Time</u>	<u>Distance</u>
6	<u>Acute Inpatient Hospitals (Emergency</u>		
7	<u>Services Available 24/7)</u>	<u>80</u>	<u>60</u>
8	<u>Cardiac Catheterization Services</u>	<u>160</u>	<u>120</u>
9	<u>Cardiac Surgery Program</u>	<u>160</u>	<u>120</u>
10	<u>Critical Care Services: Intensive Care Units</u>	<u>160</u>	<u>120</u>
11	<u>Diagnostic Radiology (Freestanding; Hospital</u>		
12	<u>Outpatient; Ambulatory Health Facilities</u>		
13	<u>with Diagnostic Radiology)</u>	<u>80</u>	<u>60</u>
14	<u>Inpatient or Residential Behavioral Health</u>		
15	<u>Facility Services</u>	<u>100</u>	<u>75</u>
16	<u>Mammography</u>	<u>80</u>	<u>60</u>
17	<u>Outpatient Infusion/Chemotherapy</u>	<u>80</u>	<u>60</u>
18	<u>Skilled Nursing Facilities</u>	<u>80</u>	<u>60</u>
19	<u>Surgical Services (Outpatient or Ambulatory</u>		
20	<u>Surgical Center)</u>	<u>80</u>	<u>60</u>
21	<u>(4) for the following settings:</u>		
22		<u>Time</u>	<u>Distance</u>
23	<u>Outpatient Clinical Behavioral Health</u>		
24	<u>(Licensed, Accredited, or Certified)</u>	<u>30</u>	<u>20</u>
25	<u>Urgent Care</u>	<u>80</u>	<u>60</u>
26	<u>(f) Maximum travel time in minutes and maximum distance in</u>		
27	<u>miles for preferred provider benefit plans by preferred provider</u>		

1 type for each rural county are:

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

	<u>Time</u>	<u>Distance</u>
4		
5 <u>Allergy and Immunology</u>	<u>90</u>	<u>75</u>
6 <u>Cardiology</u>	<u>75</u>	<u>60</u>
7 <u>Cardiothoracic Surgery</u>	<u>110</u>	<u>90</u>
8 <u>Dermatology</u>	<u>75</u>	<u>60</u>
9 <u>Emergency Medicine</u>	<u>75</u>	<u>60</u>
10 <u>Endocrinology</u>	<u>110</u>	<u>90</u>
11 <u>Ear, Nose, and Throat/Otolaryngology</u>	<u>90</u>	<u>75</u>
12 <u>Gastroenterology</u>	<u>75</u>	<u>60</u>
13 <u>General Surgery</u>	<u>75</u>	<u>60</u>
14 <u>Gynecology and Obstetrics</u>	<u>40</u>	<u>30</u>
15 <u>Infectious Diseases</u>	<u>110</u>	<u>90</u>
16 <u>Nephrology</u>	<u>90</u>	<u>75</u>
17 <u>Neurology</u>	<u>75</u>	<u>60</u>
18 <u>Neurosurgery</u>	<u>110</u>	<u>90</u>
19 <u>Oncology: Medical, Surgical</u>	<u>75</u>	<u>60</u>
20 <u>Oncology: Radiation</u>	<u>110</u>	<u>90</u>
21 <u>Ophthalmology</u>	<u>75</u>	<u>60</u>
22 <u>Orthopedic Surgery</u>	<u>75</u>	<u>60</u>
23 <u>Physical Medicine and Rehabilitation</u>	<u>90</u>	<u>75</u>
24 <u>Plastic Surgery</u>	<u>110</u>	<u>90</u>
25 <u>Primary Care: Adults</u>	<u>40</u>	<u>30</u>
26 <u>Primary Care: Pediatric</u>	<u>40</u>	<u>30</u>
27 <u>Psychiatry</u>	<u>75</u>	<u>60</u>

1	<u>Pulmonology</u>	<u>75</u>	<u>60</u>
2	<u>Rheumatology</u>	<u>110</u>	<u>90</u>
3	<u>Urology</u>	<u>75</u>	<u>60</u>
4	<u>Vascular Surgery</u>	<u>110</u>	<u>90</u>
5	<u>(2) for health care practitioners in the following</u>		
6	<u>disciplines:</u>		
7		<u>Time</u>	<u>Distance</u>
8	<u>Chiropractic</u>	<u>90</u>	<u>75</u>
9	<u>Occupational Therapy</u>	<u>75</u>	<u>60</u>
10	<u>Physical Therapy</u>	<u>75</u>	<u>60</u>
11	<u>Podiatry</u>	<u>75</u>	<u>60</u>
12	<u>Speech Therapy</u>	<u>75</u>	<u>60</u>
13	<u>(3) for the following types of institutional</u>		
14	<u>providers:</u>		
15		<u>Time</u>	<u>Distance</u>
16	<u>Acute Inpatient Hospitals (Emergency</u>		
17	<u>Services Available 24/7)</u>	<u>75</u>	<u>60</u>
18	<u>Cardiac Catheterization Services</u>	<u>145</u>	<u>120</u>
19	<u>Cardiac Surgery Program</u>	<u>145</u>	<u>120</u>
20	<u>Critical Care Services: Intensive Care Units</u>	<u>145</u>	<u>120</u>
21	<u>Diagnostic Radiology (Freestanding; Hospital</u>		
22	<u>Outpatient; Ambulatory Health Facilities</u>		
23	<u>with Diagnostic Radiology)</u>	<u>75</u>	<u>60</u>
24	<u>Inpatient or Residential Behavioral Health</u>		
25	<u>Facility Services</u>	<u>90</u>	<u>75</u>
26	<u>Mammography</u>	<u>75</u>	<u>60</u>
27	<u>Outpatient Infusion/Chemotherapy</u>	<u>75</u>	<u>60</u>

1	<u>Skilled Nursing Facilities</u>	<u>75</u>	<u>60</u>
2	<u>Surgical Services (Outpatient or Ambulatory</u>		
3	<u>Surgical Center)</u>	<u>75</u>	<u>60</u>
4	<u>(4) for the following settings:</u>		
5		<u>Time</u>	<u>Distance</u>
6	<u>Outpatient Clinical Behavioral</u>		
7	<u>Health (Licensed, Accredited, or Certified)</u>	<u>40</u>	<u>30</u>
8	<u>Urgent Care</u>	<u>75</u>	<u>60</u>
9	<u>(g) Maximum travel time in minutes and maximum distance in</u>		
10	<u>miles for preferred provider benefit plans by preferred provider</u>		
11	<u>type for each county with extreme access considerations are:</u>		
12	<u>(1) for the following physicians, as designated by</u>		
13	<u>physician specialty:</u>		
14		<u>Time</u>	<u>Distance</u>
15	<u>Allergy and Immunology</u>	<u>125</u>	<u>110</u>
16	<u>Cardiology</u>	<u>95</u>	<u>85</u>
17	<u>Cardiothoracic Surgery</u>	<u>145</u>	<u>130</u>
18	<u>Dermatology</u>	<u>110</u>	<u>100</u>
19	<u>Emergency Medicine</u>	<u>110</u>	<u>100</u>
20	<u>Endocrinology</u>	<u>145</u>	<u>130</u>
21	<u>Ear, Nose, and Throat/Otolaryngology</u>	<u>125</u>	<u>110</u>
22	<u>Gastroenterology</u>	<u>110</u>	<u>100</u>
23	<u>General Surgery</u>	<u>95</u>	<u>85</u>
24	<u>Gynecology and Obstetrics</u>	<u>70</u>	<u>60</u>
25	<u>Infectious Diseases</u>	<u>145</u>	<u>130</u>
26	<u>Nephrology</u>	<u>125</u>	<u>110</u>
27	<u>Neurology</u>	<u>110</u>	<u>100</u>

1	<u>Neurosurgery</u>	<u>145</u>	<u>130</u>
2	<u>Oncology: Medical, Surgical</u>	<u>110</u>	<u>100</u>
3	<u>Oncology: Radiation</u>	<u>145</u>	<u>130</u>
4	<u>Ophthalmology</u>	<u>95</u>	<u>85</u>
5	<u>Orthopedic Surgery</u>	<u>95</u>	<u>85</u>
6	<u>Physical Medicine and Rehabilitation</u>	<u>125</u>	<u>110</u>
7	<u>Plastic Surgery</u>	<u>145</u>	<u>130</u>
8	<u>Primary Care: Adults</u>	<u>70</u>	<u>60</u>
9	<u>Primary Care: Pediatric</u>	<u>70</u>	<u>60</u>
10	<u>Psychiatry</u>	<u>110</u>	<u>100</u>
11	<u>Pulmonology</u>	<u>110</u>	<u>100</u>
12	<u>Rheumatology</u>	<u>145</u>	<u>130</u>
13	<u>Urology</u>	<u>110</u>	<u>100</u>
14	<u>Vascular Surgery</u>	<u>145</u>	<u>130</u>
15	<u>(2) for health care practitioners in the following</u>		
16	<u>disciplines:</u>		
17		<u>Time</u>	<u>Distance</u>
18	<u>Chiropractic</u>	<u>125</u>	<u>110</u>
19	<u>Occupational Therapy</u>	<u>110</u>	<u>100</u>
20	<u>Physical Therapy</u>	<u>110</u>	<u>100</u>
21	<u>Podiatry</u>	<u>110</u>	<u>100</u>
22	<u>Speech Therapy</u>	<u>110</u>	<u>100</u>
23	<u>(3) for the following institutional providers:</u>		
24		<u>Time</u>	<u>Distance</u>
25	<u>Acute Inpatient Hospitals (Emergency</u>		
26	<u>Services Available 24/7)</u>		
26		<u>110</u>	<u>100</u>
27	<u>Cardiac Catheterization Services</u>	<u>155</u>	<u>140</u>

1	<u>Cardiac Surgery Program</u>	<u>155</u>	<u>140</u>
2	<u>Critical Care Services: Intensive Care Units</u>	<u>155</u>	<u>140</u>
3	<u>Diagnostic Radiology (Freestanding; Hospital</u>		
4	<u>Outpatient; Ambulatory Health Facilities</u>		
5	<u>with Diagnostic Radiology)</u>	<u>110</u>	<u>100</u>
6	<u>Inpatient or Residential Behavioral Health</u>		
7	<u>Facility Services</u>	<u>155</u>	<u>140</u>
8	<u>Mammography</u>	<u>110</u>	<u>100</u>
9	<u>Outpatient Infusion/Chemotherapy</u>	<u>110</u>	<u>100</u>
10	<u>Skilled Nursing Facilities</u>	<u>95</u>	<u>85</u>
11	<u>Surgical Services (Outpatient or Ambulatory</u>		
12	<u>Surgical Center)</u>	<u>110</u>	<u>100</u>

13 (4) for the following settings:

14		<u>Time</u>	<u>Distance</u>
15	<u>Outpatient Clinical Behavioral</u>		
16	<u>Health (Licensed, Accredited, or Certified)</u>	<u>70</u>	<u>60</u>
17	<u>Urgent Care</u>	<u>110</u>	<u>100</u>

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

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

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

1 Sec. 1301.00555. MAXIMUM APPOINTMENT WAIT TIME STANDARDS.

2 An insurer must ensure that:

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

5 (A) within three weeks for medical conditions;
6 and

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

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

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

14 (B) within three months for an adult.

15 SECTION 7. Section 1301.0056, Insurance Code, is amended by
16 amending Subsection (a) and adding Subsections (a-1) and (e) to
17 read as follows:

18 (a) The commissioner shall by rule adopt a process for the
19 commissioner to examine a preferred provider benefit plan before an
20 insurer offers the plan for delivery to insureds to determine
21 whether the plan meets the quality of care and network adequacy
22 standards of this chapter. An insurer may not offer ~~[of a network~~
23 ~~used by]~~ a preferred provider benefit plan before ~~[or an exclusive~~
24 ~~provider benefit plan offered by]~~ the commissioner determines that
25 the network meets the quality of care and network adequacy
26 standards of ~~[insurer under]~~ this chapter.

27 (a-1) An insurer is subject to a qualifying examination of

1 the insurer's preferred provider benefit plans [~~and exclusive~~
2 ~~provider benefit plans~~] and subsequent quality of care and network
3 adequacy examinations by the commissioner at least once every three
4 years, in connection with a public hearing under Section 1301.00565
5 concerning a material deviation from network adequacy standards by
6 a previously authorized plan or a request for a waiver of a network
7 adequacy standard, and whenever the commissioner considers an
8 examination necessary. Documentation provided to the commissioner
9 during an examination conducted under this section is confidential
10 and is not subject to disclosure as public information under
11 Chapter 552, Government Code.

12 (e) Rules adopted under this section must require insurers
13 to provide access to or submit data or information necessary for the
14 commissioner to evaluate and make a determination of compliance
15 with quality of care and network adequacy standards. The rules must
16 require insurers to provide access to or submit data or information
17 that includes:

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

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

25 (3) actuarial data of current and projected
26 utilization of each preferred provider type listed in Section
27 1301.00553 and described by Section 1301.00554 by county; and

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

5 SECTION 8. Subchapter A, Chapter 1301, Insurance Code, is
6 amended by adding Sections 1301.00565 and 1301.00566 to read as
7 follows:

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

13 (b) The commissioner shall set a public hearing for a
14 determination of whether there is good cause for a waiver when an
15 insurer:

16 (1) requests a waiver that does not satisfy Section
17 1301.0055(a)(6);

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

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

22 (c) The commissioner shall notify affected physicians and
23 health care providers that may be the subject of a discussion of
24 good faith efforts on behalf of the insurer to meet network adequacy
25 standards and provide the physicians and health care providers with
26 an opportunity to submit evidence, including written testimony, and
27 to attend the public hearing and offer testimony either in person or

1 virtually. An out-of-network physician or hospital, including a
2 physician group or health care system referenced in the insurer's
3 waiver request or notice of material deviation, may not be
4 identified by name at the hearing unless the physician or hospital
5 consents to the identification in advance of the hearing.

6 (d) At the hearing, the commissioner shall consider all
7 written and oral testimony and evidence submitted by the insurer
8 and the public pertinent to the requested waiver, including:

9 (1) the total number of physicians or health care
10 providers in each preferred provider type listed in Section
11 1301.00553 within the county and service area being submitted for
12 the waiver and whether the insurer made a good faith effort to
13 contract with those required preferred provider types to meet
14 network adequacy standards of this chapter;

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

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

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

1 (e) The commissioner may not consider a prohibition on
2 balance billing in determining whether to grant a waiver from
3 network adequacy standards.

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

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

14 (h) A policyholder is entitled to seek judicial review of
15 the commissioner's decision to grant a waiver under this section in
16 a Travis County district court. Review by the district court under
17 this subsection is de novo.

18 Sec. 1301.00566. EFFECT OF NETWORK ADEQUACY STANDARDS
19 WAIVER ON BALANCE BILLING PROHIBITIONS. After a network adequacy
20 standards waiver is granted by the commissioner, an insurer may
21 refer to the provisions prohibiting balance billing under Sections
22 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable, in an
23 access plan submitted to the department for the sole purpose of
24 explaining how the insurer will coordinate care to limit the
25 likelihood of a balance bill for services subject to those
26 provisions and not to justify a departure from network adequacy
27 standards.

1 SECTION 9. Section 1301.009(b), Insurance Code, is amended
2 to read as follows:

3 (b) The report shall:

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

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

6 (3) include:

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

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

15 (C) a statement of:

16 (i) an evaluation of enrollee satisfaction;

17 (ii) an evaluation of quality of care;

18 (iii) coverage areas;

19 (iv) accreditation status;

20 (v) premium costs;

21 (vi) plan costs;

22 (vii) premium increases;

23 (viii) the range of benefits provided;

24 (ix) copayments and deductibles;

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

27 (xi) the credentials of physicians who are

1 preferred providers; ~~and~~

2 (xii) the number of preferred providers;

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

5 (xiv) any material deviation from network
6 adequacy standards reported to the department under Section
7 1301.0055; and

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

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

13 Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN
14 ADVERSE MATERIAL CHANGES PROHIBITED. (a) In this section,
15 "adverse material change" means a change to a preferred provider
16 contract that would decrease the preferred provider's payment or
17 compensation, change the provider's tier to a less preferred tier,
18 or change the administrative procedures in a way that may
19 reasonably be expected to significantly increase the provider's
20 administrative expenses. The term does not include:

21 (1) a decrease in payment or compensation resulting
22 solely from a change in a published governmental fee schedule on
23 which the payment or compensation is based if the applicability of
24 the schedule is clearly identified in the contract;

25 (2) a decrease in payment or compensation that was
26 anticipated under the terms of the contract, if the amount and date
27 of applicability of the decrease is clearly identified in the

1 contract;

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

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

6 (5) a termination for cause; or

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

9 (b) An adverse material change to a preferred provider
10 contract may only be made during the term of the preferred provider
11 contract with the mutual agreement of the parties. A provision in a
12 preferred provider contract that allows the insurer to unilaterally
13 make an adverse material change during the term of the contract is
14 void and unenforceable.

15 (c) Any adverse material change to the preferred provider
16 contract may not go into effect until the 120th day after the date
17 the preferred provider affirmatively agrees to the adverse material
18 change in writing.

19 (d) A proposed amendment by an insurer seeking an adverse
20 material change to a preferred provider contract must include
21 notice that clearly and conspicuously states that a preferred
22 provider may choose to not agree to the amendment and that the
23 decision to not agree to the amendment may not affect:

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

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

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

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

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

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

10 SECTION 11. (a) The changes in law made by this Act apply
11 only to an insurance policy that is delivered, issued for delivery,
12 or renewed on or after January 1, 2024. A policy delivered, issued
13 for delivery, or renewed before January 1, 2024, is governed by the
14 law as it existed immediately before the effective date of this Act,
15 and that law is continued in effect for that purpose.

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

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

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