

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 hospital in which such services or supplies are furnished) after the insured is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services defined by Section 1301.155(a) are furnished.

SECTION 2. Section 1301.0046, Insurance Code, is amended to read as follows:

Sec. 1301.0046. COST-SHARING [~~COINSURANCE~~] REQUIREMENTS FOR SERVICES OF NONPREFERRED PROVIDERS. (a) The insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services.

(b) An insurer shall credit a cost-sharing payment, including any copayment, coinsurance, or deductible, paid by or on

1 behalf of an insured for services furnished by an out-of-network
2 provider to any out-of-pocket maximum that applies to the insured.
3 The cost-sharing payment must be applied to the out-of-pocket
4 maximum in the same manner as if it were made with respect to
5 services furnished by a preferred provider.

6 (c) An insurer may not have separate out-of-pocket maximums
7 for in-network and out-of-network services.

8 (d) The commissioner by rule shall set a reasonable cap on
9 an out-of-pocket maximum under this section.

10 (e) This section does not apply to an exclusive provider
11 benefit plan.

12 SECTION 3. The heading to Section 1301.005, Insurance Code,
13 is amended to read as follows:

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

16 SECTION 4. Section 1301.005, Insurance Code, is amended by
17 amending Subsections (a) and adding Subsection (d) to read as
18 follows:

19 (a) An insurer offering a preferred provider benefit plan
20 shall ensure that both preferred provider benefits and basic level
21 benefits, including benefits for emergency care, as defined by
22 Section 1301.155 and post-emergency stabilization care, are
23 reasonably available to all insureds within the designated service
24 area. This subsection does not apply to an exclusive provider
25 benefit plan.

26 (d) A service area, other than a statewide service area, may
27 include noncontiguous geographic areas but:

- 1 (1) may not divide a county; and
2 (2) must include at least one trauma service area in
3 its entirety.

4 SECTION 5. [1301.0053](#), Insurance Code, is amended by
5 amending Subsections (a) and (b) and adding Subsections (d) and (e)
6 to read as follows:

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

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

20 (2) the 45th day after the date the insurer receives a
21 nonelectronic 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;

24 (b) For emergency care or post-emergency stabilization care
25 subject to this section or a supply related to that care, an
26 out-of-network provider or a person asserting a claim as an agent or
27 assignee of the provider may not bill an insured in, and the insured

1 does not have financial responsibility for, an amount greater than
2 an applicable copayment, coinsurance, and deductible under the
3 insured's exclusive provider benefit plan that:

4 (1) is based on:

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

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

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

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

15 (e) This section does not apply to claims for post-emergency
16 stabilization care if each of the conditions described under 42 USC
17 §300gg-111(a)(3)(C)(ii)(II) are met.

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

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

22 (1) require an insurer offering a preferred provider
23 benefit plan to monitor compliance with network adequacy standards,
24 including provisions of this chapter relating to network adequacy,
25 on an ongoing basis, reporting any material deviation from network
26 adequacy standards to the department within 30 days and promptly
27 taking any correction action required to ensure the network is

1 compliant; [adapted to local markets in which the insurer offering
2 a preferred provider benefit plan operates];

3 (2) ensure availability of, and accessibility to, a
4 full range of contracted physicians and health care providers to
5 provide current and projected utilization of health care services
6 for adult and minor insureds; [and]

7 (3) [~~on good cause shown,~~] may allow a waiver for a
8 departure from [local market] network adequacy standards for a
9 period not to exceed one year if the commissioner determines after
10 receiving testimony at a public hearing under Section 1301.00565
11 that good cause is shown and posts on the department's Internet
12 website the name of the preferred provider benefit plan, the
13 insurer offering the plan, each affected county, and the specific
14 network adequacy standards waived;

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

19 (5) limit a waiver from being issued to a preferred
20 provider benefit plan:

21 (A) more than twice consecutively for the same
22 network adequacy standard in the same county unless the insurer
23 demonstrates, in addition to the good cause described in
24 Subdivision (4), multiple good faith attempts to bring the plan
25 into compliance with the network adequacy standard during each of
26 the prior consecutive waiver periods; or

27 (B) more than a total of four times within a

1 21-year period for each county in a service area for issues that may
2 be remedied through good faith efforts [~~and the affected local~~
3 ~~market~~].

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

7 (1) require that all insureds are able to receive an
8 appointment with a preferred provider within the maximum travel
9 times and distances established under Sections 1301.00553 and
10 1301.00554;

11 (2) require that at all insureds are able to receive an
12 appointment with a preferred provider within the maximum
13 appointment wait times established under Section 1301.0055;

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

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

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

1 (4) require a sufficient number of preferred providers
2 of emergency medicine, anesthesiology, pathology, radiology,
3 neonatology, surgery, hospitalist, intensivist and diagnostic
4 services, including radiology and laboratory services at each
5 preferred hospital, ambulatory surgical center or freestanding
6 emergency medical care facility with credentials for these
7 specialties to ensure all insureds are able to receive covered
8 benefits at that preferred location;

9 (5) require that all insureds have the ability to
10 access a preferred institutional provider listed in Section
11 1301.00553 within the maximum travel times and distances for the
12 corresponding county classification;

13 (6) require that insureds have the option of
14 facilities, if available, of pediatric, for-profit, nonprofit, and
15 tax-supported institutions, with special consideration to
16 contracting with teaching hospitals that provide indigent care or
17 care for uninsured individual as a significant percentage of their
18 overall patient load;

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

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

27 (9) ensure that emergency care, as defined by Section

1 1301.155, is available and accessible 24 hours a day, seven days a
2 week, by preferred providers;

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

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

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

13 SECTION 7. Subchapter A, Chapter 1301, Insurance Code, is
14 amended by adding Sections 1301.00553, 1301.00554, and 1301.00555
15 to read as follows:

16 Sec. 1301.00553. MAXIMUM TRAVEL TIME AND DISTANCE STANDARDS
17 BY PREFERRED PROVIDER TYPE. (a) For purposes of this section, each
18 county in this state is classified as a large metro, metro, micro,
19 or rural county, or a county with extreme access considerations as
20 determined by the federal Centers for Medicare and Medicaid
21 Services by population and density thresholds as of March 1, 2023.

22 (b) Maximum travel time in minutes and maximum distance in
23 miles for preferred provider benefit plans by preferred provider
24 type for each large metro county are:

25 (1) For physicians:

26 (A) Designated by physician specialty. The
27 preferred provider benefit plan's network must comply with the time

	<u>Time</u>	<u>Distance</u>
1 <u>and distance standards for the following physician specialties:</u>		
2		
3 <u>Allergy and Immunology</u>	<u>30</u>	<u>15</u>
4 <u>Anesthesiology</u>	<u>20</u>	<u>10</u>
5 <u>Cardiology</u>	<u>20</u>	<u>10</u>
6 <u>Cardiothoracic Surgery</u>	<u>30</u>	<u>15</u>
7 <u>Dermatology</u>	<u>20</u>	<u>10</u>
8 <u>Emergency Medicine</u>	<u>20</u>	<u>10</u>
9 <u>Endocrinology</u>	<u>30</u>	<u>15</u>
10 <u>Ear, Nose, and Throat/Otolaryngology</u>	<u>30</u>	<u>15</u>
11 <u>Gastroenterology</u>	<u>20</u>	<u>10</u>
12 <u>General Surgery</u>	<u>20</u>	<u>10</u>
13 <u>Gynecology and Obstetrics</u>	<u>10</u>	<u>5</u>
14 <u>Infectious Diseases</u>	<u>30</u>	<u>15</u>
15 <u>Nephrology</u>	<u>30</u>	<u>15</u>
16 <u>Neurology</u>	<u>20</u>	<u>10</u>
17 <u>Neurosurgery</u>	<u>30</u>	<u>15</u>
18 <u>Oncology: Medical, Surgical</u>	<u>20</u>	<u>10</u>
19 <u>Oncology: Radiation</u>	<u>30</u>	<u>15</u>
20 <u>Ophthalmology</u>	<u>20</u>	<u>10</u>
21 <u>Orthopedic Surgery</u>	<u>20</u>	<u>10</u>
22 <u>Physical Medicine and Rehabilitation</u>	<u>30</u>	<u>15</u>
23 <u>Plastic Surgery</u>	<u>30</u>	<u>15</u>
24 <u>Primary Care: Adults</u>	<u>10</u>	<u>5</u>
25 <u>Primary Care: Pediatric</u>	<u>10</u>	<u>5</u>
26 <u>Psychiatry</u>	<u>20</u>	<u>10</u>
27 <u>Pulmonology</u>	<u>20</u>	<u>10</u>

1	<u>Rheumatology</u>	<u>30</u>	<u>15</u>
2	<u>Urology</u>	<u>20</u>	<u>10</u>
3	<u>Vascular Surgery</u>	<u>30</u>	<u>15</u>

4 (2) For health care providers:

5 (A) Designated by the kind of practitioner or
 6 institutional provider furnishing the health care service.

7 (i) The preferred provider benefit plan's
 8 network must comply with the time and distance standards for
 9 practitioners licensed to provide health care services in this
 10 state, in the following disciplines:

	<u>Time</u>	<u>Distance</u>
11 <u>Chiropractic</u>	<u>30</u>	<u>15</u>
12 <u>Occupational Therapy</u>	<u>20</u>	<u>10</u>
13 <u>Physical Therapy</u>	<u>20</u>	<u>10</u>
14 <u>Podiatry</u>	<u>20</u>	<u>10</u>
15 <u>Speech Therapy</u>	<u>20</u>	<u>10</u>

16 (ii) The preferred provider benefit plan's
 17 network must comply with the time and distance standards for the
 18 following kinds of institutional providers:

	<u>Time</u>	<u>Distance</u>
19 <u>Acute Inpatient Hospitals (Emergency</u> 20 <u>Services Available 24/7)</u>	<u>20</u>	<u>10</u>
21 <u>Cardiac Catheterization Services</u>	<u>30</u>	<u>15</u>
22 <u>Cardiac Surgery Program</u>	<u>30</u>	<u>15</u>
23 <u>Critical Care Services: Intensive</u> 24 <u>Care Units</u>	<u>20</u>	<u>10</u>
25 <u>Diagnostic Radiology (Freestanding;</u> 26 <u></u>		

1	<u>Hospital Outpatient; Ambulatory</u>		
2	<u>Health Facilities with Diagnostic</u>		
3	<u>Radiology)</u>	<u>20</u>	<u>10</u>
4	<u>Inpatient or Residential Behavioral</u>		
5	<u>Health Facility Services</u>	<u>30</u>	<u>15</u>
6	<u>Mammography</u>	<u>20</u>	<u>10</u>
7	<u>Outpatient Infusion/Chemotherapy</u>	<u>20</u>	<u>10</u>
8	<u>Skilled Nursing Facilities</u>	<u>20</u>	<u>10</u>
9	<u>Surgical Services (Outpatient or</u>		
10	<u>Ambulatory Surgical Center)</u>	<u>20</u>	<u>10</u>

11 (3) For other settings:

12 (A) The preferred provider benefit plan's
 13 network must comply with the time and distance standards for the
 14 following settings:

	<u>Time</u>	<u>Distance</u>
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19 (c) Maximum travel time in minutes and maximum distance in
 20 miles for preferred provider benefit plans by preferred provider
 21 type for each metro county are:

22 (1) For physicians:

23 (A) Designated by physician specialty. The
 24 preferred provider benefit plan's network must comply with the time
 25 and distance standards for the following physician specialties:

	<u>Time</u>	<u>Distance</u>
26		
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1	<u>Anesthesiology</u>	<u>30</u>	<u>20</u>
2	<u>Cardiology</u>	<u>30</u>	<u>20</u>
3	<u>Cardiothoracic Surgery</u>	<u>60</u>	<u>40</u>
4	<u>Dermatology</u>	<u>45</u>	<u>30</u>
5	<u>Emergency Medicine</u>	<u>45</u>	<u>30</u>
6	<u>Endocrinology</u>	<u>60</u>	<u>40</u>
7	<u>Ear, Nose, and Throat/Otolaryngology</u>	<u>45</u>	<u>30</u>
8	<u>Gastroenterology</u>	<u>45</u>	<u>30</u>
9	<u>General Surgery</u>	<u>30</u>	<u>20</u>
10	<u>Gynecology and Obstetrics</u>	<u>15</u>	<u>10</u>
11	<u>Infectious Diseases</u>	<u>60</u>	<u>40</u>
12	<u>Nephrology</u>	<u>45</u>	<u>30</u>
13	<u>Neurology</u>	<u>45</u>	<u>30</u>
14	<u>Neurosurgery</u>	<u>60</u>	<u>40</u>
15	<u>Oncology: Medical, Surgical</u>	<u>45</u>	<u>30</u>
16	<u>Oncology: Radiation</u>	<u>60</u>	<u>40</u>
17	<u>Ophthalmology</u>	<u>30</u>	<u>20</u>
18	<u>Orthopedic Surgery</u>	<u>30</u>	<u>20</u>
19	<u>Physical Medicine and Rehabilitation</u>	<u>45</u>	<u>30</u>
20	<u>Plastic Surgery</u>	<u>60</u>	<u>40</u>
21	<u>Primary Care: Adults</u>	<u>15</u>	<u>10</u>
22	<u>Primary Care: Pediatric</u>	<u>15</u>	<u>10</u>
23	<u>Psychiatry</u>	<u>45</u>	<u>30</u>
24	<u>Pulmonology</u>	<u>45</u>	<u>30</u>
25	<u>Rheumatology</u>	<u>60</u>	<u>40</u>
26	<u>Urology</u>	<u>45</u>	<u>30</u>
27	<u>Vascular Surgery</u>	<u>60</u>	<u>40</u>

1 (2) For health care providers:

2 (A) Designated by the kind of practitioner or
 3 institutional provider furnishing the health care service.

4 (i) The preferred provider benefit plan's
 5 network must comply with the time and distance standards for
 6 practitioners licensed to provide health care services in this
 7 state, in the following disciplines:

	<u>Time</u>	<u>Distance</u>
<u>Chiropractic</u>	<u>45</u>	<u>30</u>
<u>Occupational Therapy</u>	<u>45</u>	<u>30</u>
<u>Physical Therapy</u>	<u>45</u>	<u>30</u>
<u>Podiatry</u>	<u>45</u>	<u>30</u>
<u>Speech Therapy</u>	<u>45</u>	<u>30</u>

14 (ii) The preferred provider benefit plan's
 15 network must comply with the time and distance standards for the
 16 following kinds of institutional providers:

	<u>Time</u>	<u>Distance</u>
<u>Acute Inpatient Hospitals</u>		
<u>(Emergency Services Available 24/7)</u>	<u>45</u>	<u>30</u>
<u>Cardiac Catheterization Services</u>	<u>60</u>	<u>40</u>
<u>Cardiac Surgery Program</u>	<u>60</u>	<u>40</u>
<u>Critical Care Services: Intensive</u>		
<u>Care Units</u>	<u>45</u>	<u>30</u>
<u>Diagnostic Radiology (Freestanding;</u>		
<u>Hospital Outpatient; Ambulatory</u>		
<u>Health Facilities with Diagnostic</u>		
<u>Radiology)</u>	<u>45</u>	<u>30</u>

1	<u>Inpatient or Residential</u>		
2	<u>Behavioral Health Facility Services</u>	<u>70</u>	<u>45</u>
3	<u>Mammography</u>	<u>45</u>	<u>30</u>
4	<u>Outpatient Infusion/Chemotherapy</u>	<u>45</u>	<u>30</u>
5	<u>Skilled Nursing Facilities</u>	<u>45</u>	<u>30</u>
6	<u>Surgical Services (Outpatient or</u>		
7	<u>Ambulatory Surgical Center)</u>	<u>45</u>	<u>30</u>

(3) For other settings:

(A) The preferred provider benefit plan's network must comply with the time and distance standards for the following settings:

	<u>Time</u>	<u>Distance</u>
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(d) 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 physicians:

(A) Designated by physician specialty. The preferred provider benefit plan's network must comply with the time and distance standards for the following physician specialties:

	<u>Time</u>	<u>Distance</u>
24	<u>80</u>	<u>60</u>
25	<u>50</u>	<u>35</u>
26	<u>50</u>	<u>35</u>
27	<u>100</u>	<u>75</u>

1	<u>Dermatology</u>	<u>60</u>	<u>45</u>
2	<u>Emergency Medicine</u>	<u>80</u>	<u>60</u>
3	<u>Endocrinology</u>	<u>100</u>	<u>75</u>
4	<u>Ear, Nose, and Throat/Otolaryngology</u>	<u>80</u>	<u>60</u>
5	<u>Gastroenterology</u>	<u>80</u>	<u>60</u>
6	<u>General Surgery</u>	<u>50</u>	<u>35</u>
7	<u>Gynecology and Obstetrics</u>	<u>30</u>	<u>20</u>
8	<u>Infectious Diseases</u>	<u>100</u>	<u>75</u>
9	<u>Nephrology</u>	<u>80</u>	<u>60</u>
10	<u>Neurology</u>	<u>60</u>	<u>45</u>
11	<u>Neurosurgery</u>	<u>100</u>	<u>75</u>
12	<u>Oncology: Medical, Surgical</u>	<u>60</u>	<u>45</u>
13	<u>Oncology: Radiation</u>	<u>100</u>	<u>75</u>
14	<u>Ophthalmology</u>	<u>50</u>	<u>35</u>
15	<u>Orthopedic Surgery</u>	<u>50</u>	<u>35</u>
16	<u>Physical Medicine and Rehabilitation</u>	<u>80</u>	<u>60</u>
17	<u>Plastic Surgery</u>	<u>100</u>	<u>75</u>
18	<u>Primary Care: Adults</u>	<u>30</u>	<u>20</u>
19	<u>Primary Care: Pediatric</u>	<u>30</u>	<u>20</u>
20	<u>Psychiatry</u>	<u>60</u>	<u>45</u>
21	<u>Pulmonology</u>	<u>60</u>	<u>45</u>
22	<u>Rheumatology</u>	<u>100</u>	<u>75</u>
23	<u>Urology</u>	<u>60</u>	<u>45</u>
24	<u>Vascular Surgery</u>	<u>100</u>	<u>75</u>

25 (2) For health care providers:

26 (A) Designated by the kind of practitioner or
27 institutional provider furnishing the health care service.

1 (i) The preferred provider benefit plan's
 2 network must comply with the time and distance standards for
 3 practitioners licensed to provide health care services in this
 4 state, in the following disciplines:

	<u>Time</u>	<u>Distance</u>
<u>Chiropractic</u>	<u>80</u>	<u>60</u>
<u>Occupational Therapy</u>	<u>80</u>	<u>60</u>
<u>Physical Therapy</u>	<u>80</u>	<u>60</u>
<u>Podiatry</u>	<u>60</u>	<u>45</u>
<u>Speech Therapy</u>	<u>80</u>	<u>60</u>

11 (ii) The preferred provider benefit plan's
 12 network must comply with the time and distance standards for the
 13 following kinds of institutional providers:

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

1	<u>Outpatient Infusion/Chemotherapy</u>	<u>80</u>	<u>60</u>
2	<u>Skilled Nursing Facilities</u>	<u>80</u>	<u>60</u>
3	<u>Surgical Services (Outpatient or</u>		
4	<u>Ambulatory Surgical Center)</u>	<u>80</u>	<u>60</u>

(3) For other care and settings:

(A) The preferred provider benefit plan's network must comply with the time and distance standards for the following care and settings:

	<u>Time</u>	<u>Distance</u>
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(e) 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 physicians:

(A) Designated by physician specialty. The preferred provider benefit plan's network must comply with the time and distance standards for the following physician specialties:

	<u>Time</u>	<u>Distance</u>
22	<u>90</u>	<u>75</u>
23	<u>75</u>	<u>60</u>
24	<u>75</u>	<u>60</u>
25	<u>110</u>	<u>90</u>
26	<u>75</u>	<u>60</u>
27	<u>75</u>	<u>60</u>

1	<u>Endocrinology</u>	<u>110</u>	<u>90</u>
2	<u>Ear, Nose, and Throat/Otolaryngology</u>	<u>90</u>	<u>75</u>
3	<u>Gastroenterology</u>	<u>75</u>	<u>60</u>
4	<u>General Surgery</u>	<u>75</u>	<u>60</u>
5	<u>Gynecology and Obstetrics</u>	<u>40</u>	<u>30</u>
6	<u>Infectious Diseases</u>	<u>110</u>	<u>90</u>
7	<u>Nephrology</u>	<u>90</u>	<u>75</u>
8	<u>Neurology</u>	<u>75</u>	<u>60</u>
9	<u>Neurosurgery</u>	<u>110</u>	<u>90</u>
10	<u>Oncology: Medical, Surgical</u>	<u>75</u>	<u>60</u>
11	<u>Oncology: Radiation</u>	<u>110</u>	<u>90</u>
12	<u>Ophthalmology</u>	<u>75</u>	<u>60</u>
13	<u>Orthopedic Surgery</u>	<u>75</u>	<u>60</u>
14	<u>Physical Medicine and Rehabilitation</u>	<u>90</u>	<u>75</u>
15	<u>Plastic Surgery</u>	<u>110</u>	<u>90</u>
16	<u>Primary Care: Adults</u>	<u>40</u>	<u>30</u>
17	<u>Primary Care: Pediatric</u>	<u>40</u>	<u>30</u>
18	<u>Psychiatry</u>	<u>75</u>	<u>60</u>
19	<u>Pulmonology</u>	<u>75</u>	<u>60</u>
20	<u>Rheumatology</u>	<u>110</u>	<u>90</u>
21	<u>Urology</u>	<u>75</u>	<u>60</u>
22	<u>Vascular Surgery</u>	<u>110</u>	<u>90</u>

23 (2) For health care providers:

24 (A) Designated by the kind of practitioner or
 25 institutional provider furnishing the health care service.

26 (i) The preferred provider benefit plan's
 27 network must comply with the time and distance standards for

1 practitioners licensed to provide health care services in this
 2 state, in the following disciplines:

	<u>Time</u>	<u>Distance</u>
3		
4	<u>90</u>	<u>75</u>
5	<u>75</u>	<u>60</u>
6	<u>75</u>	<u>60</u>
7	<u>75</u>	<u>60</u>
8	<u>75</u>	<u>60</u>

9 (ii) The preferred provider benefit plan's
 10 network must comply with the time and distance standards for the
 11 following kinds of institutional providers:

	<u>Time</u>	<u>Distance</u>
12		
13		
14	<u>75</u>	<u>60</u>
15	<u>145</u>	<u>120</u>
16	<u>145</u>	<u>120</u>
17		
18	<u>145</u>	<u>120</u>
19		
20		
21		
22	<u>75</u>	<u>60</u>
23		
24	<u>90</u>	<u>75</u>
25	<u>75</u>	<u>60</u>
26	<u>75</u>	<u>60</u>
27	<u>75</u>	<u>60</u>

1 Surgical Services (Outpatient or
 2 Ambulatory Surgical Center) 75 60

3 (3) For other settings:

4 (A) The preferred provider benefit plan's
 5 network must comply with the time and distance standards for the
 6 following settings:

	<u>Time</u>	<u>Distance</u>
7 <u>Outpatient Clinical Behavioral Health</u>		
8 <u>(Licensed, Accredited, or Certified)</u>	<u>40</u>	<u>30</u>
9 <u>Urgent Care</u>	<u>75</u>	<u>60</u>

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

13 (1) For physicians:

14 (A) Designated by physician specialty. The
 15 preferred provider benefit plan's network must comply with the time
 16 and distance standards for the following physician specialties:

	<u>Time</u>	<u>Distance</u>
17 <u>Allergy and Immunology</u>	<u>125</u>	<u>110</u>
18 <u>Anesthesiology</u>	<u>95</u>	<u>85</u>
19 <u>Cardiology</u>	<u>95</u>	<u>85</u>
20 <u>Cardiothoracic Surgery</u>	<u>145</u>	<u>130</u>
21 <u>Dermatology</u>	<u>110</u>	<u>100</u>
22 <u>Emergency Medicine</u>	<u>110</u>	<u>100</u>
23 <u>Endocrinology</u>	<u>145</u>	<u>130</u>
24 <u>Ear, Nose, and Throat/Otolaryngology</u>	<u>125</u>	<u>110</u>
25 <u>Gastroenterology</u>	<u>110</u>	<u>100</u>

1	<u>General Surgery</u>	<u>95</u>	<u>85</u>
2	<u>Gynecology and Obstetrics</u>	<u>70</u>	<u>60</u>
3	<u>Infectious Diseases</u>	<u>145</u>	<u>130</u>
4	<u>Nephrology</u>	<u>125</u>	<u>110</u>
5	<u>Neurology</u>	<u>110</u>	<u>100</u>
6	<u>Neurosurgery</u>	<u>145</u>	<u>130</u>
7	<u>Oncology: Medical, Surgical</u>	<u>110</u>	<u>100</u>
8	<u>Oncology: Radiation</u>	<u>145</u>	<u>130</u>
9	<u>Ophthalmology</u>	<u>95</u>	<u>85</u>
10	<u>Orthopedic Surgery</u>	<u>95</u>	<u>85</u>
11	<u>Physical Medicine and Rehabilitation</u>	<u>125</u>	<u>110</u>
12	<u>Plastic Surgery</u>	<u>145</u>	<u>130</u>
13	<u>Primary Care: Adults</u>	<u>70</u>	<u>60</u>
14	<u>Primary Care: Pediatric</u>	<u>70</u>	<u>60</u>
15	<u>Psychiatry</u>	<u>110</u>	<u>100</u>
16	<u>Pulmonology</u>	<u>110</u>	<u>100</u>
17	<u>Rheumatology</u>	<u>145</u>	<u>130</u>
18	<u>Urology</u>	<u>110</u>	<u>100</u>
19	<u>Vascular Surgery</u>	<u>145</u>	<u>130</u>

20 (2) For health care providers:

21 (A) Designated by the kind of practitioner or
 22 institutional provider furnishing the health care service.

23 (i) The preferred provider benefit plan's
 24 network must comply with the time and distance standards for
 25 practitioners licensed to provide health care services in this
 26 state, in the following disciplines:

27 Time Distance

1	<u>Chiropractic</u>	<u>125</u>	<u>110</u>
2	<u>Occupational Therapy</u>	<u>110</u>	<u>100</u>
3	<u>Physical Therapy</u>	<u>110</u>	<u>100</u>
4	<u>Podiatry</u>	<u>110</u>	<u>100</u>
5	<u>Speech Therapy</u>	<u>110</u>	<u>100</u>

6 (ii) The preferred provider benefit plan's
 7 network must comply with the time and distance standards for the
 8 following kinds of institutional providers:

		<u>Time</u>	<u>Distance</u>
9			
10	<u>Acute Inpatient Hospitals</u>		
11	<u>(Emergency Services Available 24/7)</u>	<u>110</u>	<u>100</u>
12	<u>Cardiac Catheterization Services</u>	<u>155</u>	<u>140</u>
13	<u>Cardiac Surgery Program</u>	<u>155</u>	<u>140</u>
14	<u>Critical Care Services: Intensive</u>		
15	<u>Care Units</u>	<u>155</u>	<u>140</u>
16	<u>Diagnostic Radiology (Freestanding;</u>		
17	<u>Hospital Outpatient; Ambulatory</u>		
18	<u>Health Facilities with Diagnostic</u>		
19	<u>Radiology)</u>	<u>110</u>	<u>100</u>
20	<u>Inpatient or Residential Behavioral</u>		
21	<u>Health Facility Services</u>	<u>155</u>	<u>140</u>
22	<u>Mammography</u>	<u>110</u>	<u>100</u>
23	<u>Outpatient Infusion/Chemotherapy</u>	<u>110</u>	<u>100</u>
24	<u>Skilled Nursing Facilities</u>	<u>95</u>	<u>85</u>
25	<u>Surgical Services (Outpatient or</u>		
26	<u>Ambulatory Surgical Center)</u>	<u>110</u>	<u>100</u>

27 (3) For other settings:

1 (A) The preferred provider benefit plan's
2 network must comply with the time and distance standards for the
3 following settings:

	<u>Time</u>	<u>Distance</u>
4 <u>Outpatient Clinical Behavioral Health</u>		
5 <u>(Licensed, Accredited, or Certified)</u>	<u>70</u>	<u>60</u>
6 <u>Urgent Care</u>	<u>110</u>	<u>100</u>
7 <u>Sec. 1301.00554. OTHER MAXIMUM DISTANCE STANDARD</u>		

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

11 (b) When necessary due to utilization or supply patterns,
12 the commissioner may by rule decrease the base maximum time and
13 distance standards listed in this Section or Section 1301.00553 for
14 specific counties.

15 Sec. 1301.00555. MAXIMUM APPOINTMENT WAIT TIME STANDARDS.
16 An insurer must ensure that:

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

19 (A) within three weeks for medical conditions;
20 and

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

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

25 (A) within two months for a child, or earlier if
26 necessary for compliance with recommendations for specific
27

1 preventive health care services; and

2 (B) within three months for an adult.

3 SECTION 8. Section 1301.0056, Insurance Code, is amended by
4 amending Subsection (a) and adding Subsections (a-1) and (e) to
5 read as follows:

6 (a) The commissioner shall by rule adopt a process for the
7 commissioner to examine a preferred provider benefit plan before an
8 insurer offers for delivery the plan to insureds to determine
9 whether the plan meets the quality of care and network adequacy
10 standards of this chapter. An insurer may not offer ~~used by~~ a
11 preferred provider benefit plan before ~~or an exclusive provider~~
12 ~~benefit plan offered by~~ the commissioner determines that the
13 network meets the quality of care and network adequacy standards of
14 ~~insurer under~~ this chapter.

15 (a-1) An insurer is subject to a qualifying examination of
16 the insurer's preferred provider benefit plans ~~and exclusive~~
17 ~~provider benefit plans~~ and subsequent quality of care and network
18 adequacy examinations by the commissioner at least once every three
19 years, in connection with a public hearing under Section 1301.00565
20 concerning a material deviation from network adequacy standards by
21 a previously authorized plan or a request for a waiver of a network
22 adequacy standard, and whenever the commissioner considers an
23 examination necessary. Documentation provided to the commissioner
24 during an examination conducted under this section is confidential
25 and is not subject to disclosure as public information under
26 Chapter 552, Government Code.

27 (e) Rules adopted under this section must require insurers

1 to provide access to or submit data necessary for the commissioner
2 to evaluate and make a determination of compliance with quality of
3 care and network adequacy standards. The rules must require
4 insurers to submit data that includes:

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

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

12 (3) actuarial data of current and projected
13 utilization of each preferred provider type listed in Sections
14 1301.00553 and 1301.00554(a) by county; and

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

19 SECTION 9. Subchapter A, Chapter 1301, Insurance Code, is
20 amended by adding Section 1301.00565 to read as follows:

21 Sec. 1301.00565. PUBLIC HEARING ON NETWORK ADEQUACY
22 STANDARDS WAIVERS. (a) On the earlier of a request from an insurer
23 to receive a waiver from any network adequacy standard or receipt of
24 notice under Section 1301.0055 of a material deviation from the
25 network adequacy standards of this chapter, the commissioner shall
26 set a public hearing for a determination of whether there is good
27 cause for a waiver.

1 (b) The commissioner shall notify affected physicians and
2 health care providers that may be the subject of a discussion of
3 good faith efforts on behalf of the insurer to meet network adequacy
4 standards and provide the physicians and health care providers with
5 an opportunity to submit evidence, including written testimony, and
6 to attend the public hearing and offer testimony either in person or
7 virtually. A physician, including a physician group referenced in
8 the insurer's waiver request or notice of material deviation, may
9 not be identified by name at the hearing unless the physician
10 consents to be identified in advance of the hearing.

11 (c) At the hearing, the commissioner shall consider all
12 written and oral testimony and evidence submitted by the insurer
13 and the public pertinent to the requested waiver, including:

14 (1) the total number of physicians or health care
15 providers in each preferred provider type listed in Section
16 1301.00553 within the county and service area being submitted for
17 the waiver and whether the insurer made a good faith effort to
18 contract with those required preferred provider types to meet
19 network adequacy standards of this chapter;

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

27 (3) population, density, and geographical information

1 to determine the possibility and travel time and distance
2 requirements within the county and service area being submitted for
3 a waiver; and

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

6 (d) The commissioner may not consider a prohibition on
7 balance billing in determining whether to grant a waiver from
8 network adequacy standards.

9 (e) The commissioner may not grant a waiver without a public
10 hearing.

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

19 (g) A policyholder is entitled to seek judicial review of
20 the commissioner's decision to grant a waiver under this section in
21 Travis County district court. Review by the district court under
22 this subsection is de novo.

23 SECTION 10. Section 1301.009(b), Insurance Code, is amended
24 to read as follows:

25 (b) The report shall:

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

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

1 (3) include:

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

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

10 (C) a statement of:

11 (i) an evaluation of enrollee satisfaction;

12 (ii) an evaluation of quality of care;

13 (iii) coverage areas;

14 (iv) accreditation status;

15 (v) premium costs;

16 (vi) plan costs;

17 (vii) premium increases;

18 (viii) the range of benefits provided;

19 (ix) copayments and deductibles;

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

22 (xi) the credentials of physicians who are
23 preferred providers;

24 (xii) the number of preferred providers;

25 [~~and~~]

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

1 (xiv) any material deviation from network
2 adequacy standards reported to the department under Section
3 1301.0055; and

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

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

9 Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN
10 CHANGE PROHIBITED. (a) In this section, "adverse material change"
11 means a change to a preferred provider contract that would decrease
12 the preferred provider's payment or compensation; change the
13 preferred provider's tier to a less preferred tier; or change the
14 administrative procedures in a way that may reasonably be expected
15 to significantly increase the provider's administrative expenses.
16 Adverse material change does not include:

17 (1) a decrease in payment or compensation resulting
18 solely from a change in a published fee schedule upon which the
19 payment or compensation is based and the date of applicability is
20 clearly identified in the contract;

21 (2) a decrease in payment or compensation that was
22 anticipated under the terms of the contract, if the amount and date
23 of applicability of the decrease is clearly identified in the
24 contract;

25 (3) An administrative change that may significantly
26 increase the preferred provider's administrative expense, the
27 specific applicability of which is clearly identified in the

1 contract; or

2 (4) A change that is required by the operation of state
3 or federal law.

4 (b) An adverse material change to a preferred provider
5 contract may only be made during the term of the preferred provider
6 contract with the mutual agreement of the parties. A provision in a
7 preferred provider contract that allows the insurer to unilaterally
8 make an adverse material change during the term of the contract is
9 void and unenforceable.

10 (c) Any adverse material change to the preferred provider
11 contract may not go into effect until 120 days after physician or
12 health care provider affirmatively agrees to the adverse material
13 change in writing.

14 (d) A proposed amendment by an insurer seeking an adverse
15 material change to a preferred provider contract must include a
16 notice that clearly and conspicuously identifies such amendment as
17 proposing an adverse material change to the contract. The notice
18 must also clearly and conspicuously state that a physician or
19 health care provider may choose not to agree to the amendment and
20 that such a decision not to agree to the amendment may not affect
21 the terms of the physician or health care provider's existing
22 contract with the insurer or the preferred provider's participation
23 in other health plans or products.

24 (e) A physician or health care provider's failure to agree
25 to an adverse material change to a preferred provider contract
26 shall not affect:

27 (1) the terms of the physician or health care

1 provider's existing contract or other contracts with the insurer;
2 or
3 (2) the preferred provider's participation in other
4 health care products or plans.

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

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

14 SECTION 13. This Act takes effect September 1, 2023.