By: Schwertner S.B. No. 1765

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

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

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

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

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

SECTION 3. 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 4. Section 1301.005, Insurance Code, is amended by amending Subsections (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 the 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:

(1) may not divide a county; and

(2) must include at least one trauma service area in its entirety.

SECTION 5. 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 insurers 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 insured'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 they were emergency care, as defined by Section 1301.155.

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

SECTION 6. 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 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 and promptly taking any correction action required to ensure the network is

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

(2) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide current and projected utilization of health care services for adult and minor insureds; [~~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 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, and the specific network adequacy standards waived;

(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; and

(5) 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 in Subdivision (4), 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 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 at all insureds are able to receive an appointment with a preferred provider within the maximum appointment wait times established under Section 1301.0055;

(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, surgery, hospitalist, intensivist and diagnostic services, including radiology and laboratory services at each preferred hospital, ambulatory surgical center or freestanding emergency medical care facility with credentials for these specialties to ensure all insureds are able to receive covered benefits 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 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 teaching hospitals that provide indigent care or care for uninsured individual as a significant percentage of their overall patient load;

(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 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 7. 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) 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.

(b) 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 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:

	Time	Distance
Allergy and Immunology	30	15
Anesthesiology	20	10
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 providers:

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

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

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

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

(3) For other settings:

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

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

(c) 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 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:

	Time	Distance
Allergy and Immunology	45	30

Anesthesiology	30	20
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 providers:

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

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

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

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

(3) For other settings:

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

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

(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:

	Time	Distance
Allergy and Immunology	80	60
Anesthesiology	50	35
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	80	60
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 providers:

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

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

	Time	Distance
Chiropractic	80	60
Occupational Therapy	80	60
Physical Therapy	80	60
Podiatry	60	45
Speech Therapy	80	60

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

(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:

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

(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:

	Time	Distance
Allergy and Immunology	90	75
Anesthesiology	75	60
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 providers:

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

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

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

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

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

(3) For other settings:

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

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

(f) 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 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:

	Time	Distance
Allergy and Immunology	125	110
Anesthesiology	95	85
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 providers:

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

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

	Time	Distance

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

(ii) The preferred provider benefit plan's network must comply with the time and distance standards for the following kinds of 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

(3) For other settings:

(A) The preferred provider benefit plan's network must comply with the time and distance standards 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. (a) For any physician specialty not specifically listed in Section 1301.00553, the maximum distance, in any county classification, is 75 miles.

(b) When necessary due to utilization or supply patterns, the commissioner may by rule decrease the base maximum 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 8. 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 for delivery the plan to insureds to determine whether the plan meets the quality of care and network adequacy standards of this chapter. An insurer may not offer [~~used by~~] a preferred provider benefit plan before [~~or an exclusive provider benefit plan offered by~~] the commissioner determines that the network meets the quality of care and network adequacy standards of [~~insurer under~~] this chapter.

(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 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 submit data 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 kind of health care provider or licensure type, as applicable;

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

(3) actuarial data of current and projected utilization of each preferred provider type listed in Sections 1301.00553 and 1301.00554(a) 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 9. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.00565 to read as follows:

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

(b) 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. A physician, including a physician group referenced in the insurer's waiver request or notice of material deviation, may not be identified by name at the hearing unless the physician consents to be identified in advance of the hearing.

(c) 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 and 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 a county and service area being submitted for a waiver.

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

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

(f) 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.

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

SECTION 10. 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;

(xii) the number of preferred providers; [~~and~~]

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

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

Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN CHANGE 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 preferred 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. Adverse material change does not include:

(1) a decrease in payment or compensation resulting soley from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability 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 preferred provider's administrative expense, the specific applicability of which is clearly identified in the

contract; or

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

(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 120 days after physician or health care 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 a notice that clearly and conspicuously identifies such amendment as proposing an adverse material change to the contract. The notice must also clearly and conspicuously state that a physician or health care provider may choose not to agree to the amendment and that such a decision not to agree to the amendment may not affect the terms of the physician or health care provider's existing contract with the insurer or the preferred provider's participation in other health plans or products.

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

(1) the terms of the physician or health care

provider's existing contract or other contracts with the insurer; or

(2) the preferred 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 shall make an otherwise agreed-to adverse material change void and unenforceable.

SECTION 12. 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 the law is continued in effect for that purpose.

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