# SENATE AMENDMENTS

## 2nd Printing

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A BILL TO BE ENTITLED

AN ACT

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

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

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

(6-a) "Post-emergency stabilization care" means health care services that are furnished by an out-of-network provider, including an out-of-network hospital, freestanding emergency medical care facility, or comparable emergency facility, regardless of the department of the facility in which the services are furnished, after an insured is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency care, as defined by Section 1301.155, is furnished.

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

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

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

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

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

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

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

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

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

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

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

(1) is based on:

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

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

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

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

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

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

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

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

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

(B) promptly take any corrective action required to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred unless:

(i) there are no uncontracted licensed physicians or health care providers in the affected county; or

(ii) the insurer requests a waiver under this subsection [~~are adapted to local markets in which an insurer offering a preferred provider benefit plan operates~~];

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

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

(4) require disclosure by the insurer of the information described by Subdivision (3) in all promotion and

advertisement of the preferred provider benefit plan for which a waiver is allowed under that subdivision;

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

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

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

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

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

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

(2) require that all insureds are able to receive an

appointment with a preferred provider within the maximum appointment wait times established under Section 1301.00555;

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

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

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

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

(5) require that all insureds have the ability to

access a preferred institutional provider listed in Section 1301.00553 within the maximum travel times and distances established under Section 1301.00553 for the corresponding county classification;

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

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

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

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

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

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

(10) ensure that covered urgent care is available and accessible from preferred providers within the insurer's

designated service area within 24 hours for medical and behavioral health conditions;

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

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

SECTION 6. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Sections 1301.00553, 1301.00554, and 1301.00555 to read as follows:

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

(b) For purposes of this section, each county in this state is classified as a large metro, metro, micro, or rural county, or a county with extreme access considerations as determined by the federal Centers for Medicare and Medicaid Services by population and density thresholds as of March 1, 2023.

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

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

| | Time | Distance |
|---|---|---|
| Allergy and Immunology | 30 | 15 |

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

(2) for health care practitioners in the following

disciplines:

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

(3) for the following types of institutional providers:

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

(4) for the following settings:

| | Time | Distance |
|---|---|---|

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

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

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

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

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

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

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

(3) for the following types of institutional providers:

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

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

(4) for the following settings:

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

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

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

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

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

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

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

| | | |
|---|---|---|
| Podiatry | 60 | 45 |
| Speech Therapy | 80 | 60 |

(3) for the following types of institutional providers:

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

(4) for the following settings:

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

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

type for each rural county are:

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

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

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

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

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

(3) for the following types of institutional providers:

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

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

(4) for the following settings:

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

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

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

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

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

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

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

(3) for the following institutional providers:

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

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

(4) for the following settings:

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

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

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

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

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

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

(A) within three weeks for medical conditions; and

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

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

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

(B) within three months for an adult.

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

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

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

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

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

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

(3) actuarial data of current and projected utilization of each preferred provider type listed in Section

1301.00553 and described by Section 1301.00554 by county; and

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

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

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

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

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

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

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

(c) The commissioner shall notify affected physicians and health care providers that may be the subject of a discussion of good faith efforts on behalf of the insurer to meet network adequacy standards and provide the physicians and health care providers with an opportunity to submit evidence, including written testimony, and

to attend the public hearing and offer testimony either in person or virtually. An out-of-network physician or hospital, including a physician group or health care system referenced in the insurer's waiver request or notice of material deviation, may not be identified by name at the hearing unless the physician or hospital consents to the identification in advance of the hearing.

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

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

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

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

(4) availability of services, population, and density

within the county and service area being submitted for the waiver.

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

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

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

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

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

standards.

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

(b) The report shall:

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

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

(3) include:

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

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

(C) a statement of:

(i) an evaluation of enrollee satisfaction;

(ii) an evaluation of quality of care;

(iii) coverage areas;

(iv) accreditation status;

(v) premium costs;

(vi) plan costs;

(vii) premium increases;

(viii) the range of benefits provided;

(ix) copayments and deductibles;

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

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

(xii) the number of preferred providers;

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

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

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

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

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

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

(2) a decrease in payment or compensation that was

anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;

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

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

(5) a termination for cause; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FLOOR AMENDMENT NO. 1 BY: 

Amend H.B. 3359 (senate committee printing) as follows:

(1) In SECTION 5 of the bill, immediately after added Section 1301.0055(b), Insurance Code (page 4, between lines 12 and 13), insert the following:

(c) Subsection (b)(6) does not apply to an exclusive provider benefit plan if the plan has:

(1) contracted with preferred provider hospitals in sufficient number capable of meeting the covered inpatient and outpatient health care benefits for current and actuarially projected utilization in accordance with Subsection (b)(3); or

(2) received a waiver under Subsection (a).

(2) In SECTION 10 of the bill, in added Section 1301.0642(a), Insurance Code (page 11, line 50), between "contract" and "that", insert "with a physician, health care practitioner, or organization of physicians or health care practitioners".

(3) In SECTION 10 of the bill, immediately after added Section 1301.0642(f), Insurance Code (page 12, between lines 29 and 30), insert the following:

(g) This section does not apply to a preferred provider contract:

(1) with an unspecified and indefinite duration;

(2) with no stated or automatic renewal period or event; and

(3) that may only be terminated by notice from one party to the other.

(4) In SECTION 11(a) of the bill, in the transition language (page 12, lines 32 and 33), strike "January" each time it appears and substitute "September".

(5) In SECTION 11 of the bill, in the transition language

immediately after Subsection (a) of that section (page 12, between lines 35 and 36), add the following appropriately lettered subsection and reletter subsequent subsections accordingly:

(__) Notwithstanding Subsection (a) of this section, maximum appointment wait time standards prescribed by Sections 1301.0055(b) and 1301.00555, Insurance Code, as added by this Act, apply only to an insurance policy that is delivered, issued for delivery, or renewed on or after September 1, 2025.

**LEGISLATIVE BUDGET BOARD**
**Austin, Texas**

**FISCAL NOTE, 88TH LEGISLATIVE REGULAR SESSION**

**May 24, 2023**

**TO:** Honorable Dade Phelan, Speaker of the House, House of Representatives

**FROM:** Jerry McGinty, Director, Legislative Budget Board

**IN RE: HB3359** by Bonnen (Relating to network adequacy standards and other requirements for preferred provider benefit plans.), **As Passed 2nd House**

**Estimated Two-year Net Impact to General Revenue Related Funds** for HB3359, As Passed 2nd House : an impact of $0 through the biennium ending August 31, 2025.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

**General Revenue-Related Funds, Five- Year Impact:**

| *Fiscal Year* | Probable Net Positive/(Negative) Impact to *General Revenue Related Funds* |
|---|---|
| 2024 | $0 |
| 2025 | $0 |
| 2026 | $0 |
| 2027 | $0 |
| 2028 | $0 |

**All Funds, Five-Year Impact:**

| *Fiscal Year* | Probable Revenue Gain from *Dept Ins Operating Acct* 36 | Probable (Cost) from *Dept Ins Operating Acct* 36 | *Change in Number of State Employees from FY 2023* |
|---|---|---|---|
| 2024 | $855,011 | ($855,011) | 3.5 |
| 2025 | $636,218 | ($636,218) | 1.5 |
| 2026 | $636,218 | ($636,218) | 1.5 |
| 2027 | $636,218 | ($636,218) | 1.5 |
| 2028 | $636,218 | ($636,218) | 1.5 |

**Fiscal Analysis**

This bill would amend the Insurance Code to require the Department of Insurance to participate in public hearings and expand requirements for certain health insurance plans or network types. This bill would be effective September 1, 2023.

**Methodology**

This analysis assumes the Department of Insurance (TDI) will be required to participate in public hearings regarding network adequacy for certain health insurance plans or network types and expand network adequacy requirements. Two divisions would provide the Commissioner of Insurance with ongoing support to all hearings related to network adequacy and additional support to those granted waivers through these hearings.

This analysis assumes TDI will utilize General Revenue-dedicated Texas Department of Insurance Operating Fund Account No. 036 (GR-D Fund 36) as this is the dedicated operating fund for the agency. TDI's GR-D Fund 36 utilizes a statutorily authorized self-leveling mechanism where appropriations made from GR-D Fund 36 would be considered in the annual adjustment of the maintenance tax rates. Therefore, the annual revenue for GR-D Fund 36 will equal the expenses incurred by the agency and result in a net zero change in the fund balance.

TDI would require 3.5 Full-Time Equivalents (FTE) in fiscal year 2024 at a cost of $470,538 and 1.5 FTEs in fiscal year 2025 at the cost of $133,309 for a total of $470,538 in GR-D Fund 36 in the 2024-25 biennium. Additionally, in fiscal year 2024, one-time startup costs include $14,099 for other operating and technology costs required to implement provisions of the bill.

This would include the following new positions:

In fiscal year 2024, 2.0 Attorney III ($83,298 plus $26,514 in benefits per FTE per fiscal year) would be needed to investigate, review, prepare, and participate in the public rulemaking process and public hearings related to network adequacy. In fiscal year 2025 and beyond, the agency would require 0.5 Attorney III ($41,649 plus $13,257 in benefits per fiscal year) for the same purposes listed above.

In fiscal year 2024, 1.5 Compliance Analyst II ($59,473 plus $18,930 in benefits per FTE per fiscal year) would be required to provide hearing support services for all public hearings related to network adequacy. In fiscal year 2025 and beyond, the agency would require 1.0 Compliance Analyst II ($59,473 plus $18,930 in benefits per fiscal year) for the same purposes listed above.

**Local Government Impact**

No significant fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JMc, NPe, LBl, GDZ, AAL

**LEGISLATIVE BUDGET BOARD**
**Austin, Texas**

**FISCAL NOTE, 88TH LEGISLATIVE REGULAR SESSION**

**May 16, 2023**

**TO:** Honorable Lois W. Kolkhorst, Chair, Senate Committee on Health & Human Services

**FROM:** Jerry McGinty, Director, Legislative Budget Board

**IN RE:** **HB3359** by Bonnen (Relating to network adequacy standards and other requirements for preferred provider benefit plans.), **As Engrossed**

**Estimated Two-year Net Impact to General Revenue Related Funds** for HB3359, As Engrossed : an impact of $0 through the biennium ending August 31, 2025.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

**General Revenue-Related Funds, Five- Year Impact:**

| *Fiscal Year* | Probable Net Positive/(Negative) Impact to *General Revenue Related Funds* |
|---|---|
| 2024 | $0 |
| 2025 | $0 |
| 2026 | $0 |
| 2027 | $0 |
| 2028 | $0 |

**All Funds, Five-Year Impact:**

| *Fiscal Year* | Probable Revenue Gain from *Dept Ins Operating Acct* 36 | Probable (Cost) from *Dept Ins Operating Acct* 36 | *Change in Number of State Employees from FY 2023* |
|---|---|---|---|
| 2024 | $855,011 | ($855,011) | 3.5 |
| 2025 | $636,218 | ($636,218) | 1.5 |
| 2026 | $636,218 | ($636,218) | 1.5 |
| 2027 | $636,218 | ($636,218) | 1.5 |
| 2028 | $636,218 | ($636,218) | 1.5 |

**Fiscal Analysis**

This bill would amend the Insurance Code to require the Department of Insurance to participate in public hearings and expand requirements for certain health insurance plans or network types. This bill would be effective September 1, 2023.

**Methodology**

This analysis assumes the Department of Insurance (TDI) will be required to participate in public hearings regarding network adequacy for certain health insurance plans or network types and expand network adequacy requirements. Two divisions would provide the Commissioner of Insurance with ongoing support to all hearings related to network adequacy and additional support to those granted waivers through these hearings.

This analysis assumes TDI will utilize General Revenue-dedicated Texas Department of Insurance Operating Fund Account No. 036 (GR-D Fund 36) as this is the dedicated operating fund for the agency. TDI's GR-D Fund 36 utilizes a statutorily authorized self-leveling mechanism where appropriations made from GR-D Fund 36 would be considered in the annual adjustment of the maintenance tax rates. Therefore, the annual revenue for GR-D Fund 36 will equal the expenses incurred by the agency and result in a net zero change in the fund balance.

TDI would require 3.5 Full-Time Equivalents (FTE) in fiscal year 2024 at a cost of $470,538 and 1.5 FTEs in fiscal year 2025 at the cost of $133,309 for a total of $470,538 in GR-D Fund 36 in the 2024-25 biennium. Additionally, in fiscal year 2024, one-time startup costs include $14,099 for other operating and technology costs required to implement provisions of the bill.

This would include the following new positions:

In fiscal year 2024, 2.0 Attorney III ($83,298 plus $26,514 in benefits per FTE per fiscal year) would be needed to investigate, review, prepare, and participate in the public rulemaking process and public hearings related to network adequacy. In fiscal year 2025 and beyond, the agency would require 0.5 Attorney III ($41,649 plus $13,257 in benefits per fiscal year) for the same purposes listed above.

In fiscal year 2024, 1.5 Compliance Analyst II ($59,473 plus $18,930 in benefits per FTE per fiscal year) would be required to provide hearing support services for all public hearings related to network adequacy. In fiscal year 2025 and beyond, the agency would require 1.0 Compliance Analyst II ($59,473 plus $18,930 in benefits per fiscal year) for the same purposes listed above.

**Local Government Impact**

No significant fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JMc, NPe, GDZ, LBl, AAL

**LEGISLATIVE BUDGET BOARD**
**Austin, Texas**

**FISCAL NOTE, 88TH LEGISLATIVE REGULAR SESSION**

**April 18, 2023**

**TO:** Honorable Tom Oliverson, Chair, House Committee on Insurance

**FROM:** Jerry McGinty, Director, Legislative Budget Board

**IN RE:** **HB3359** by Bonnen (relating to network adequacy standards and other requirements for preferred provider benefit plans.), **Committee Report 1st House, Substituted**

**Estimated Two-year Net Impact to General Revenue Related Funds** for HB3359, Committee Report 1st House, Substituted : an impact of $0 through the biennium ending August 31, 2025.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

**General Revenue-Related Funds, Five- Year Impact:**

| *Fiscal Year* | Probable Net Positive/(Negative) Impact to *General Revenue Related Funds* |
|---|---|
| 2024 | $0 |
| 2025 | $0 |
| 2026 | $0 |
| 2027 | $0 |
| 2028 | $0 |

**All Funds, Five-Year Impact:**

| *Fiscal Year* | Probable Revenue Gain from *Dept Ins Operating Acct* 36 | Probable (Cost) from *Dept Ins Operating Acct* 36 | *Change in Number of State Employees from FY 2023* |
|---|---|---|---|
| 2024 | $855,011 | ($855,011) | 3.5 |
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| 2026 | $636,218 | ($636,218) | 1.5 |
| 2027 | $636,218 | ($636,218) | 1.5 |
| 2028 | $636,218 | ($636,218) | 1.5 |

**Fiscal Analysis**

This bill would amend the Insurance Code to require the Department of Insurance to participate in public hearings and expand requirements for certain health insurance plans or network types. This bill would be effective September 1, 2023.

## Methodology

This analysis assumes the Department of Insurance (TDI) will be required to participate in public hearings regarding network adequacy for certain health insurance plans or network types and expand network adequacy requirements. Two divisions would provide the Commissioner of Insurance with ongoing support to all hearings related to network adequacy and additional support to those granted waivers through these hearings.

This analysis assumes TDI will utilize General Revenue-dedicated Texas Department of Insurance Operating Fund Account No. 036 (GR-D Fund 36) as this is the dedicated operating fund for the agency. TDI's GR-D Fund 36 utilizes a statutorily authorized self-leveling mechanism where appropriations made from GR-D Fund 36 would be considered in the annual adjustment of the maintenance tax rates. Therefore, the annual revenue for GR-D Fund 36 will equal the expenses incurred by the agency and result in a net zero change in the fund balance.

TDI would require 3.5 Full-Time Equivalents (FTE) in fiscal year 2024 at a cost of $470,538 and 1.5 FTEs in fiscal year 2025 at the cost of $133,309 for a total of $470,538 in GR-D Fund 36 in the 2024-25 biennium. Additionally, in fiscal year 2024, one-time startup costs include $14,099 for other operating and technology costs required to implement provisions of the bill.

This would include the following new positions:

In fiscal year 2024, 2.0 Attorney III ($83,298 plus $26,514 in benefits per FTE per fiscal year) would be needed to investigate, review, prepare, and participate in the public rulemaking process and public hearings related to network adequacy. In fiscal year 2025 and beyond, the agency would require 0.5 Attorney III ($41,649 plus $13,257 in benefits per fiscal year) for the same purposes listed above.

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## Local Government Impact

No significant fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JMc, AAL, LBl, GDZ

**LEGISLATIVE BUDGET BOARD**
**Austin, Texas**

**FISCAL NOTE, 88TH LEGISLATIVE REGULAR SESSION**

**April 3, 2023**

**TO:** Honorable Tom Oliverson, Chair, House Committee on Insurance

**FROM:** Jerry McGinty, Director, Legislative Budget Board

**IN RE:** **HB3359** by Bonnen (Relating to network adequacy standards and other requirements for preferred provider benefit plans.), **As Introduced**

**Estimated Two-year Net Impact to General Revenue Related Funds** for HB3359, As Introduced : an impact of $0 through the biennium ending August 31, 2025.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

**General Revenue-Related Funds, Five- Year Impact:**

| *Fiscal Year* | Probable Net Positive/(Negative) Impact to *General Revenue Related Funds* |
|---|---|
| 2024 | $0 |
| 2025 | $0 |
| 2026 | $0 |
| 2027 | $0 |
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**All Funds, Five-Year Impact:**

| *Fiscal Year* | Probable Revenue Gain from *Dept Ins Operating Acct* 36 | Probable (Cost) from *Dept Ins Operating Acct* 36 | *Change in Number of State Employees from FY 2023* |
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**Fiscal Analysis**

This bill would amend the Insurance Code to require the Department of Insurance to participate in public hearings and expand requirements for certain health insurance plans or network types.

## Methodology

This analysis assumes the Department of Insurance (TDI) will be required to participate in public hearings regarding network adequacy for certain health insurance plans or network types and expand network adequacy requirements. Two divisions would provide the Commissioner of Insurance with ongoing support to all hearings related to network adequacy and additional support to those granted waivers through these hearings.

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## Local Government Impact

No significant fiscal implication to units of local government is anticipated.

**Source Agencies:** 454 Department of Insurance

**LBB Staff:** JMc, AAL, GDZ, LBl