

House Bill 3359
Senate Amendments
Section-by-Section Analysis

HOUSE VERSION

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.

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SECTION 1. Same as House version.

SECTION 2. Same as House version.

SECTION 3. Same as House version.

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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:

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- (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:

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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:

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(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

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(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

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(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

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(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

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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

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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

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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:

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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.

(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). [FA1(1)]

SECTION 6. Substantially the same as Senate version.

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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:

TimeDistance

Allergy and Immunology3015

Cardiology2010

Cardiothoracic Surgery3015

Dermatology2010

Emergency Medicine2010

Endocrinology3015

Ear, Nose, and Throat/Otolaryngology3015

Gastroenterology2010

General Surgery2010

Gynecology and Obstetrics105

Infectious Diseases3015

Nephrology3015

Neurology2010

Neurosurgery3015

Oncology: Medical, Surgical2010

Oncology: Radiation3015

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Ophthalmology2010

Orthopedic Surgery2010

Physical Medicine and Rehabilitation3015

Plastic Surgery3015

Primary Care: Adults105

Primary Care: Pediatric105

Psychiatry2010

Pulmonology2010

Rheumatology3015

Urology2010

Vascular Surgery3015

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

TimeDistance

Chiropractic3015

Occupational Therapy2010

Physical Therapy2010

Podiatry2010

Speech Therapy2010

(3) for the following types of institutional providers:

TimeDistance

Acute Inpatient Hospitals (Emergency Services Available
24/7)2010

Cardiac Catheterization Services3015

Cardiac Surgery Program3015

Critical Care Services: Intensive Care Units2010

Diagnostic Radiology (Freestanding; Hospital Outpatient;
Ambulatory Health Facilities with Diagnostic
Radiology)2010

Inpatient or Residential Behavioral Health Facility
Services3015

Mammography2010

Outpatient Infusion/Chemotherapy2010

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Skilled Nursing Facilities2010

Surgical Services (Outpatient or Ambulatory Surgical Center)2010

(4) for the following settings:

TimeDistance

Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)105

Urgent Care2010

(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:

TimeDistance

Allergy and Immunology4530

Cardiology3020

Cardiothoracic Surgery6040

Dermatology4530

Emergency Medicine4530

Endocrinology6040

Ear, Nose, and Throat/Otolaryngology4530

Gastroenterology4530

General Surgery3020

Gynecology and Obstetrics1510

Infectious Diseases6040

Nephrology4530

Neurology4530

Neurosurgery6040

Oncology: Medical, Surgical4530

Oncology: Radiation6040

Ophthalmology3020

Orthopedic Surgery3020

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Physical Medicine and Rehabilitation4530

Plastic Surgery6040

Primary Care: Adults1510

Primary Care: Pediatric1510

Psychiatry4530

Pulmonology4530

Rheumatology6040

Urology4530

Vascular Surgery6040

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

TimeDistance

Chiropractic4530

Occupational Therapy4530

Physical Therapy4530

Podiatry4530

Speech Therapy4530

(3) for the following types of institutional providers:

TimeDistance

Acute Inpatient Hospitals (Emergency Services Available
24/7)4530

Cardiac Catheterization Services6040

Cardiac Surgery Program6040

Critical Care Services: Intensive Care Units4530

Diagnostic Radiology (Freestanding; Hospital Outpatient;
Ambulatory Health Facilities with Diagnostic
Radiology)4530

Inpatient or Residential Behavioral Health Facility
Services7045

Mammography4530

Outpatient Infusion/Chemotherapy4530

Skilled Nursing Facilities4530

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Surgical Services (Outpatient or Ambulatory Surgical Center)4530

(4) for the following settings:

TimeDistance

Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)1510

Urgent Care4530

(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:

TimeDistance

Allergy and Immunology8060

Cardiology5035

Cardiothoracic Surgery10075

Dermatology6045

Emergency Medicine8060

Endocrinology10075

Ear, Nose, and Throat/Otolaryngology8060

Gastroenterology6045

General Surgery5035

Gynecology and Obstetrics3020

Infectious Diseases10075

Nephrology8060

Neurology6045

Neurosurgery10075

Oncology: Medical, Surgical6045

Oncology: Radiation10075

Ophthalmology5035

Orthopedic Surgery5035

Physical Medicine and Rehabilitation8060

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CONFERENCE

Plastic Surgery10075

Primary Care: Adults3020

Primary Care: Pediatric3020

Psychiatry6045

Pulmonology6045

Rheumatology10075

Urology6045

Vascular Surgery10075

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

TimeDistance

Chiropractic8060

Occupational Therapy8060

Physical Therapy8060

Podiatry6045

Speech Therapy8060

(3) for the following types of institutional providers:

TimeDistance

Acute Inpatient Hospitals (Emergency Services Available
24/7)8060

Cardiac Catheterization Services160120

Cardiac Surgery Program160120

Critical Care Services: Intensive Care Units160120

Diagnostic Radiology (Freestanding; Hospital Outpatient;
Ambulatory Health Facilities with Diagnostic
Radiology)8060

Inpatient or Residential Behavioral Health Facility
Services10075

Mammography8060

Outpatient Infusion/Chemotherapy8060

Skilled Nursing Facilities8060

Surgical Services (Outpatient or Ambulatory Surgical
Center)8060

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(4) for the following settings:

TimeDistance

Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)3020

Urgent Care8060

(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:

TimeDistance

Allergy and Immunology9075

Cardiology7560

Cardiothoracic Surgery11090

Dermatology7560

Emergency Medicine7560

Endocrinology11090

Ear, Nose, and Throat/Otolaryngology9075

Gastroenterology7560

General Surgery7560

Gynecology and Obstetrics4030

Infectious Diseases11090

Nephrology9075

Neurology7560

Neurosurgery11090

Oncology: Medical, Surgical7560

Oncology: Radiation11090

Ophthalmology7560

Orthopedic Surgery7560

Physical Medicine and Rehabilitation9075

Plastic Surgery11090

Primary Care: Adults4030

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Primary Care: Pediatric4030

Psychiatry7560

Pulmonology7560

Rheumatology11090

Urology7560

Vascular Surgery11090

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

TimeDistance

Chiropractic9075

Occupational Therapy7560

Physical Therapy7560

Podiatry7560

Speech Therapy7560

(3) for the following types of institutional providers:

TimeDistance

Acute Inpatient Hospitals (Emergency Services Available 24/7)7560

Cardiac Catheterization Services145120

Cardiac Surgery Program145120

Critical Care Services: Intensive Care Units145120

Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)7560

Inpatient or Residential Behavioral Health Facility Services9075

Mammography7560

Outpatient Infusion/Chemotherapy7560

Skilled Nursing Facilities7560

Surgical Services (Outpatient or Ambulatory Surgical Center)7560

(4) for the following settings:

TimeDistance

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Outpatient Clinical Behavioral

Health (Licensed, Accredited, or Certified)4030

Urgent Care7560

(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:

TimeDistance

Allergy and Immunology125110

Cardiology9585

Cardiothoracic Surgery145130

Dermatology110100

Emergency Medicine110100

Endocrinology145130

Ear, Nose, and Throat/Otolaryngology125110

Gastroenterology110100

General Surgery9585

Gynecology and Obstetrics7060

Infectious Diseases145130

Nephrology125110

Neurology110100

Neurosurgery145130

Oncology: Medical, Surgical110100

Oncology: Radiation145130

Ophthalmology9585

Orthopedic Surgery9585

Physical Medicine and Rehabilitation125110

Plastic Surgery145130

Primary Care: Adults7060

Primary Care: Pediatric7060

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CONFERENCE

Psychiatry110100

Pulmonology110100

Rheumatology145130

Urology110100

Vascular Surgery145130

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

TimeDistance

Chiropractic125110

Occupational Therapy110100

Physical Therapy110100

Podiatry110100

Speech Therapy110100

(3) for the following institutional providers:

TimeDistance

Acute Inpatient Hospitals (Emergency Services Available
24/7)110100

Cardiac Catheterization Services155140

Cardiac Surgery Program155140

Critical Care Services: Intensive Care Units155140

Diagnostic Radiology (Freestanding; Hospital Outpatient;
Ambulatory Health Facilities with Diagnostic
Radiology)110100

Inpatient or Residential Behavioral Health Facility
Services155140

Mammography110100

Outpatient Infusion/Chemotherapy110100

Skilled Nursing Facilities9585

Surgical Services (Outpatient or Ambulatory Surgical
Center)110100

(4) for the following settings:

TimeDistance

Outpatient Clinical Behavioral

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Health (Licensed, Accredited, or Certified)7060

Urgent Care110100

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

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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

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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.

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(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

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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

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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;

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(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

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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 with a physician, health care practitioner, or organization of physicians or health care practitioners 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: [FA1(2)]

- (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

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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:

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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:

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- (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,

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- (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.
- (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. [FA1(3)]

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 September 1, 2024. A policy delivered, issued for delivery, or renewed before September 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. [FA1(4)]

() 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. [FA1(5)]

(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,

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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.

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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. Same as House version.

CONFERENCE