SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
Division 1. General Requirements
28 TAC §§3.3701 – 3.3710
Division 2. Exclusive Provider Benefit Plan Requirements
28 TAC §§3.3720 – 3.3725

1. INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC Chapter 3, Subchapter X, Preferred Provider Plans, §§3.3701 – 3.3710, concerning the regulation of preferred provider benefit plans, and new §§3.3720 – 3.3725, concerning the regulation of exclusive provider benefit plans. The commissioner adopts sections 3.3701 – 3.3710 and sections 3.3720 – 3.3725. Sections 3.3702 – 3.3705, 3.3707 – 3.3709, and 3.3720 – 3.3725 are adopted with changes to the proposed text published in the November 2, 2012, issue of the *Texas Register* (37 TexReg 8690). Sections 3.3701, 3.3706, and 3.3710 are adopted without changes to the proposed text.

2. REASONED JUSTIFICATION. Amendments to Subchapter X are necessary to implement HB 1772, 82nd Legislature, Regular Session (2011), and to conform existing provisions of Subchapter X with HB 1772. HB 1772 amends Insurance Code Chapter 1301 to create exclusive provider benefit plans, which, under Insurance Code §1301.001(1), are benefit plans in which an insurer excludes benefits to an insured for some or all services, other than required emergency care provided by a physician or health care provider who is not a preferred provider.

The purpose of HB 1772 is to provide health insurers offering health plan coverage in Texas additional options to offer lower cost health plans to employers and individual consumers by permitting plans with closed networks where, as with health maintenance organizations, "only services provided by network providers are covered,

with the exception of emergency services and out-of-network services provided when no network provider is available." *House Committee on Insurance, Bill Analysis, HB 1772, 82nd Legislature, Regular Session (2011).*

HB 1772 amends several sections of Insurance Code Chapter 1301, including §§1301.0041, 1301.0042, 1301.003, and 1301.005.

HB 1772 amends Insurance Code §1301.0041 and §1301.0042 to address applicability of Insurance Code Chapter 1301 and of insurance law in general to exclusive provider benefit plans. Under Insurance Code §1301.0041, an exclusive provider benefit plan is subject to Insurance Code Chapter 1301 in the same manner as a preferred provider benefit plan, unless the chapter specifies otherwise. Under Insurance Code §1301.0042, an insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan, except to the extent the commissioner determines the function is inconsistent with the function and purpose of an exclusive provider benefit plan.

HB 1772 also adds references to exclusive provider benefit plans to Insurance Code §1301.003 and §1301.005(b). The amendment to Insurance Code §1301.003 provides that an exclusive provider benefit plan that meets the requirements of Insurance Code Chapter 1301 is not unjust under Insurance Code Chapter 1701, unfair discrimination under Insurance Code Chapter 544 Subchapter A or B, or a violation of Insurance Code Chapter 1451 Subchapter B or C. The amendment to Insurance Code §1301.005(b) provides that an insurer must reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a

preferred provider and services were not available through a preferred provider within a designated service area under the exclusive provider benefit plan.

The department has taken Insurance Code §§1301.0041, 1301.0042, 1301.003, and 1301.005 into consideration in preparing the rule text adopted through this order. The department amends rule provisions that previously contemplated only preferred provider plans as necessary to make them applicable to exclusive provider benefit plans. The department also adopts new sections that are necessary to address the specific function and purpose of exclusive provider benefit plans and implement statutes that apply differently or exclusively to exclusive provider plans. These amendments are necessary to ensure that exclusive provider benefit plans meet the requirements of Insurance Code Chapter 1301, as contemplated by Insurance Code §1301.003.

HB 1772 also adds several new sections to Insurance Code Chapter 1301. These include Insurance Code §§1301.0051, 1301.0052, 1301.0053, 1301.0056, and 1301.1581. These new sections contain provisions applicable specifically to exclusive provider benefit plans. Insurance Code §1301.0051 addresses quality improvement and utilization management. Insurance Code §1301.0052 addresses referrals for medically necessary services. Insurance Code §1301.0053 addresses emergency care. Insurance Code §1301.0056 addresses examination and fees. Insurance Code §1301.1581 addresses information concerning exclusive provider benefit plans. Amendments to existing rule sections and new rule sections are necessary to implement these sections to establish processes and procedures for exclusive provider benefit plan compliance with Insurance Code Chapter 1301.

The department adopts the amended and new sections under and to implement Insurance Code §§1301.003, 1301.007, 1301.0042, and 1301.0055. Insurance Code §1301.003 permits exclusive benefit plans that meet the requirements of Insurance Code Chapter 1301. Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301. Insurance Code §1301.0042 provides that a provision of the Insurance Code or other insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan unless the provision is determined to be inconsistent with the function and purpose of an exclusive provider benefit plan. Insurance Code §1301.0042 also authorizes the commissioner to determine whether a provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

Under Insurance Code §1301.0042, the department also adopts the amended and new sections to implement statutes applicable to preferred provider benefit plans as is consistent with the function and purpose of an exclusive provider benefit plan, including Insurance Code §§1301.0055, 1701.055, 1201.006, 1201.101-1201.102, 1251.008, 1456.006, 1456.003, and 1501.010 as those sections apply to exclusive provider benefit plans.

Insurance Code §1301.0055 requires the commissioner to adopt by rule network adequacy standards adapted to local markets to ensure availability of and accessibility to a full range of contracted physicians and health care providers and, with good cause, may allow departure from local market network adequacy standards if the commissioner posts on the department's website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

Insurance Code §1701.055 permits the department to disapprove an insurance form if it violates the Insurance Code or a rule of the commissioner or any other law, contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

Insurance Code §1201.006 permits the commissioner to adopt reasonable rules as necessary to implement Insurance Code Chapter 1201. Insurance Code §1201.101 and §1201.102 permit the commissioner to adopt rules specifying the content of an individual accident and health insurance policy and to prohibit provisions in individual accident and health insurance policies that the commissioner determines to be unjust, unfair, or unfairly discriminatory.

Insurance Code §1251.008 permits the commissioner to adopt rules necessary to administer the group health insurance chapter of the Insurance Code.

Insurance Code §1456.006 permits the commissioner to adopt by rule specific requirements for the health benefit plan disclosure required under §1456.003.

Insurance Code §1501.010 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501, the Health Insurance Portability and Availability Act.

In accord with Insurance Code §1301.0042(a), a provision of this code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan unless the department determines that the provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

The department makes the following nonsubstantive changes to the proposed text as a result of comments. These changes do not affect persons not previously on notice or raise new issues.

Section 3.3702(b)(16)

The department revises the definition of "pediatric practitioner" as adopted in §3.3702(b)(16) to be "A physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults."

A commenter asks that the department revise the definition "pediatric practitioner" to reference advance practice nurses in addition to physicians. The department declines to make the requested change, because the definition only appears in §3.3707, in regard to waivers from network adequacy requirements. The provisions within the rule that relate to network requirements do not generally address specific provider types, but rather address "physicians or providers." So, for consistency with that usage, the department revises the definition "pediatric practitioner" to reference a "physician or provider."

Section 3.3703(a)(23)

The department amends the text of §3.3703(a)(23) as adopted to provide that in a contract provision under that section a referring physician or provider would need to disclose that the physician, provider, or facility to which the insured is being referred might not be a preferred provider. The department also revises the text to clarify that

the requirement that a referring physician or provider disclose an ownership interest is only applicable if the referring physician or provider actually has an ownership interest in the provider to which the insured is being referred.

Two commenters ask that the department revise §3.3703(a)(23) and offer suggested new text.

The text offered by one commenter would revise the ownership interest disclosure language in §3.3703(a)(23) to require that a referring physician or provider disclose any financial interests the physician or provider has in the physician, provider, or facility to which the insured is being referred. It would also add a requirement for physicians and providers to give annual updates of financial interests in other physicians and health care providers. It would also define the term "financial interests."

The text offered by the other commenter would create a new section that prohibits insurers from: requiring providers to disclose financial interests, requiring that providers refer patients to preferred providers, or requiring that insureds sign documents acknowledging that a provider has a financial or ownership interest in a referred physician or health care provider.

The department declines to adopt either offered version. However, in partial response to one of the comments the department agrees to make a clarifying change to the paragraph.

Section 3.3703(a)(27) and (28) and the figure in §3.3705(f)(1)

The department amends §3.3703(a)(27) and (28) to except applicability of the paragraphs to emergency care. The department also revises the figure in §3.3705(f)(1) to clarify that the right to advance estimates only applies in most cases.

Three commenters ask that the department revise these provisions to exempt applicability of the paragraphs to emergency care because it is not feasible for an emergency care provider to provide advanced notices or estimates and to prevent confusion and avoid delays for insureds in emergency care situations. The department agrees in regard to §3.3703(a)(27) and (28). However, the department makes an alternative revision to the figure in §3.3705(f)(1), incorporating language that will address emergency situations and other situations where an insured may not be able to obtain advance estimates of out-of-network provider charges or insurer payment.

Section 3.3703(a)(27)(A) and (B) and §3.3703(a)(28)(A) and (B)

The department revises §3.3703(a)(27)(A) and §3.3703(a)(28)(A) to change the phrase "to coordinate the insured's care" to "for more information." The department revises §3.3703(a)(27)(B) and §3.3703(a)(28)(B) to delete the words "so that the insurer has the opportunity to coordinate the insured's care."

Several commenters voice concerns regarding §3.3703(a)(27)(A) and (B) and §3.3703(a)(28)(A) and (B). They say that the provisions are awkwardly worded or that they imply that the department intends to limit an insured's choice of provider, interfere with medical care, or create a duty for insurers to oversee the coordination of insureds' care.

In response to the comment, the department clarifies that the purpose of the provisions relates to advance information that could help insureds and insurers avoid balance billing, and the department revises the text of the provisions.

Section 3.3703(a)(29)

The department does not adopt proposed §3.3703(a)(29).

A commenter opposes adoption of proposed §3.3703(a)(29) on the grounds that it would limit the department's authority.

The department does not agree with the commenter's assessment that proposed §3.3703(a)(29) would limit the department's authority. However, the department agrees to withdraw the proposed paragraph on the basis that the provision is not necessary, and the department can regulate insurers and carry out the department's statutory responsibilities without it.

Section 3.3704(a)(1) and (11)

The department restructures the way exclusive provider benefit plans are addressed in the fairness provisions under §3.3704(a).

A commenter raises concerns that the exclusion under §3.3704(a)(1) addressing exclusive provider benefit plans would allow exclusive provider benefit plans to require insureds to have services performed by particular hospitals, physicians, or practitioners. The commenter also says the proposed amendment to §3.3704(a)(11) is overly broad, and one could read it as exempting exclusive provider benefit plans from having to

make preferred provider benefits reasonably available to insureds within a designated service area. The commenter offers alternative text to address this concern.

The department does not agree with the comment regarding §3.3704(a)(1), but agrees to withdraw the proposed amendment to avoid confusion. The department agrees with the comment regarding §3.3704(a)(11) and adopts the alternative text the commenter suggests. This results in amendments to §3.3704(a) and in new §3.3704(b).

Section 3.3704(a)(12)

The department adds the word "reasonably" to §3.3704(a)(12).

A commenter asks that the department revise §3.3704(a)(12) by adding the word "reasonably."

The department agrees to the addition.

Section 3.3704(d)

The department revises §3.3704(d) as adopted to state that an insurer is prohibited from engaging in retaliatory action against an insured because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer.

A commenter asks the department to clarify in proposed §3.3704(c), which is adopted as §3.3704(d), that the prohibition under the subsection includes instances when the insured or a person acting on behalf of the insured files a complaint "with the department or the insurer."

The department agrees to add the clarification requested by the commenter.

Section 3.3705(b)(1)

The department revises proposed §3.3705(b)(1) to insert the phrase "and written description or as otherwise required by law" at the end of the paragraph.

A commenter recommends that the department modify the proposed language of §3.3705(b)(1) to ensure that the subsection would require an insurer to provide to consumers adequate information regarding their exclusive provider benefit plan coverage in its written description. The commenter suggests language to accomplish this.

The department agrees to the revision.

Section 3.3705(b)(14)

The department withdraws the proposed deletion of text in §3.3705(b)(14) and relocates the new text proposed for §3.3705(b)(14) to new §3.3705(b)(15).

A commenter supports retaining the text proposed for deletion in §3.3705(b)(14). The commenter points out that the demographic information disclosed under the paragraph could prevent unanticipated balance billing by informing consumers of the composition of insurers' networks, enabling consumers to assess the potential for balance billing.

The department agrees with the comment and withdraws the proposed deletion of text in §3.3705(b)(14). This necessitates redesignating the proposed amended text as a new paragraph.

Section 3.3705(f)(1) and (2)

The department revises the language of the figures in §3.3705(f)(1) and (2) to more closely track the statutory language.

Two commenters comment on the figures in §3.3705(f)(1) and (2). One commenter says that the language in the figure in §3.3705(f)(1) is confusing and asks the department to not adopt the figure. A second commenter suggests the department revise the language in the figures in §3.3705(f)(1) and (2) and suggests language to use.

The department uses part of the second commenter's suggested language in the figure in §3.3705(f)(1) and completely incorporates the second commenter's suggested language for the figure in §3.3705(f)(2).

Section 3.3705(l)(2) and (3)

The department withdraws its proposed deletion of §3.3705(l)(2) and (3). The department also revises §3.3705(l) to reference "the requirements in paragraphs (1) – (9)."

A commenter supports retaining the text proposed for deletion in §3.3705(l)(2) and (3), pointing out that deletion of the provisions would undermine the collective impact of the transparency provisions of §3.3705(l).

The department agrees with the comment and withdraws the proposed deletion of text in §3.3705(l)(2) and (3). For consistency with this change, the department also revises §3.3705(l) to reference "the requirements in paragraphs (1) – (9)."

Section 3.3705(m)

The department revises §3.3705(m) to require two additional pieces of information in an insurer's annual policyholder notice concerning use of a local market access plan, information on how any local market access plan or plans the insurer uses may be obtained or viewed, and a link to the department's website where the department posts information relevant to the grant of waivers.

A commenter suggests that the insurer's annual policyholder notice be improved to give insureds access to all relevant information on the waiver and local market access plan in one place. The commenter suggests that the notice should point insureds to two other important pieces of information: (1) how they can obtain or view the full local market access plan and (2) a link to TDI's web page on waivers that have been granted.

The department agrees with the commenter and incorporates the revision into the adoption order.

Section 3.3705(n)

The department withdraws its proposed deletion of §3.3705(n).

A commenter opposes the proposed deletion of §3.3705(n). The commenter says §3.3705(n) would aid consumers in decision making and reduce incidents of unanticipated balance billing. The commenter disputes arguments that disclosures under §3.3705(n) could be misleading in instances where decreases in the availability of network providers is temporary, noting that there is a low risk of insureds getting

misleading information because the information required under the section is posted in online directories and can easily be updated. The commenter also points out that the requirement for updated provider listings under §3.3705(i) and (j) and the detrimental reliance provisions under §3.3705(k) would not provide sufficient consumer protection to outweigh the detriment caused by the loss of §3.3705(n).

In response to the comments, the department agrees to withdraw its proposed deletion of §3.3705(n).

Section 3.3705(p) and (q) and the text that was located in §3.3707(f)

The department withdraws its proposed deletion of §3.3705(p) and (q) and the text that was located in §3.3707(f), which is redesignated §3.3707(n) in the adopted text. The department revises the text of §3.3705(p) to only require plan designations on the outline of coverage and the cover page of any provider listing describing the network.

A commenter opposes the proposed deletion of §3.3705(p) and (q). The commenter says removal of these provisions would deprive insureds of the ability to investigate their insurance options. The commenter says that removal of the provisions would open the possibility for insurers to use unjust and deceptive forms. The commenter also says the requirement for updated provider listings under §3.3705(i) and (j) and the detrimental reliance provisions under §3.3705(k) would not provide sufficient consumer protection to outweigh the detriment caused by the loss of §3.3705(p) and (q). In addition, the commenter requests that the department retain the text that was located in §3.3707(f). This text references the requirements of §3.3705 (p) and (q), and

the commenter says it is also important for insureds to understand limitations of their network.

The department withdraws its proposed deletion of §3.3705(p) and (q) and the text that was located in §3.3707(f), but revises the text of §3.3705(p).

Section 3.3707(i)

The department revises §3.3707(i) to include a time frame for a waiver request if the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704.

A commenter requests that the department build reasonable time frames for payers to identify and address network gaps into §3.3707(i).

The department agrees with the commenter and revises §3.3707(i) to include time frames for payers to identify and address network gaps. As adopted, §3.3707(i) allows an insurer 90 days from the date a network becomes inadequate to file for a waiver. This gives insurers time to contract with providers to fix a network inadequacy and permits the consolidation and presentation of multiple waiver requests at the same time.

Section 3.3707(i)(1)

The department removes the requirement in §3.3707(i)(1) that an insurer's local market access plan must be made available to the department on request.

A commenter points out that provisions require insurers to file their local market access plans with the department and asks why, in light of those provisions, it is necessary to include the requirement in §3.3707(i)(1).

The department agrees that the requirement in §3.3707(i)(1) that an insurer's local market access plan must be made available to the department on request is redundant and does not include it in the adopted rule text.

Section 3.3708(b)(3)

The department removes the phrase "in excess of the allowed amount" from the text proposed for §3.3708(b) and inserts the words "charges for covered services that were above and beyond."

A commenter references the department's intent that under §3.3708(b), an insurer must credit the full amount paid by an insured to the insured's deductible and annual out-of-pocket maximum applicable to in-network services when the insured receives services from a nonpreferred provider and the insured pays a balance bill. The commenter says the department's description of the credit an insurer must give an insured is open to several interpretations and could result in different administration by different insurers. The commenter supports maintaining §3.3708(b) as it existed prior to the proposal, asserting that the previous text would better protect insureds who do not voluntarily choose to obtain services from nonpreferred providers by giving the insureds credit for their actual out-of-pocket expenses in the same manner they would receive credit if they had received services from a contracted preferred provider.

The department declines to withdraw the proposed amendment, and instead revises §3.3708(b) to clarify the ambiguity the commenter identifies.

Section 3.3724(d)

The department revises §3.3724(d) to provide that the nonconditional accreditation an insurer receives be "certification specific and germane to the insurer's quality improvement program."

A commenter recommends that the department modify §3.3724(d) to emphasize accreditations or certifications specifically tailored to the insurer's quality improvement program.

The department agrees with the commenter and revises §3.3724(d) using the commenter's suggested text.

The department makes the following non-substantive changes to the proposed rule text in addition to the changes made as a result of comments. These changes do not affect persons not previously on notice or raise new issues.

Necessary redesignation of provisions

The department redesignates subsections, paragraphs, and citations to subsections and paragraphs where necessary to conform with the changes the department made in response to comments.

Definition of "health care provider or provider" in §3.3702(10)

As proposed, the definition of "health care provider or provider" in §3.3702(b)(10) references the definition of the term as defined by Insurance Code §1301.001(1). However, "health care provider or provider" is actually defined in Insurance Code §1301.001(1-a). The department revises §3.3702(b)(10) as adopted to include the correct citation.

Email addresses

In November 2012, all contact emails for department program areas changed from "[program area]@tdi.state.tx.us" to "[program area]@tdi.texas.gov." In accord with this change, all department program area email addresses in this adoption order have been updated to reflect the new domain.

Also, in conjunction with the domain name change, the Managed Care Quality Assurance (MCQA) office updated its email address. The MCQA was previously called the Health and Workers' Compensation Network Certification and Quality Assurance (HWCN) office. The HWCN office used the email address "hwcn@tdi.state.tx.us." The MCQA office continued to use this email address after its name change, until after the finalization of the domain name change. With the finalization of the domain name change, the MCQA office updated its email address to reflect its name. Accordingly, all references to hwcn@tdi.state.tx.us in the rule text are changed to mcqa@tdi.texas.gov.

Revisions for consistency with department style

The department has initiated a comprehensive overhaul of its writing style guidelines to ensure consistency, clarity, and conciseness in department rules. The

department has made non substantive revisions to the adopted rule text to implement these changes, as follows.

The department makes the following changes to improve conciseness:

The department removes the words "that are" from the definition of "exclusive provider network" in §3.3702(b)(7). The department also removes the words "that are" from §3.3703(a)(8) and (11).

The department removes word "the" from in front of the words "termination of the contract" in §3.3703(a)(26). In addition the department removes the word "the" from in front of the words "Insurance Code" and "Health and Safety Code" in each instance where it appears in a citation to a specific part of those codes. The department only makes these revisions in provisions that were not labeled "no change" in the proposal.

The department changes the word "upon" to "on" in §3.3705(k) and (p), and §3.3725(e).

The department changes "such that" to "so" in the words "at the facility such that the" in §3.3705(n)(2)(A).

The department deletes the word "to" from the words "and to update its" in §3.3705(n)(5).

The department deletes the word "that" from the words "at the same time that" in §3.3707(d).

The department deletes the words "set forth" from the words "the standards set forth in" in §3.3709(b)(3).

The department deletes the word "a" from the words "as a part of the annual report," in §3.3709(c).

The department changes the word "accordance" to "accord" in §§3.3722(d)(7), 3.3723(f)(3), 3.3725(c)(3)(B).

The department makes the following changes to avoid use of passive voice:

The department revises the words "the information must identify how the local market access plan may be obtained or viewed" to "the information must identify how to obtain or view the local market access plan," in §3.3705(b)(15)(C).

The department revises the words "information concerning how a nonelectric copy of the listing may be obtained" to "information concerning how to obtain a nonelectric copy of the listing" in §3.3705(h).

The department revises the sentence "The insurer must ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months," to "The insurer must ensure that it updates all electronic or nonelectronic listings of preferred providers made available to insureds at least every three months," in §3.3705(h).

The department changes the words "information on how any local market access plan or plans the insurer uses may be obtained or viewed" to "information on how to obtain or view any local market access plan or plans the insurer uses" in §3.3705(m)(2).

The department changes the words "is required to" to "must" in §3.3705(n)(3), (n)(5), and (q); and §3.3708(e).

The department changes the words "is also required to" to "must also, "request for waiver" to "waiver request," and "the request is filed with," to "the insurer files the request" in §3.3707(d).

The department changes the words "must be in compliance with" to "must comply with" in §3.3722(e)(3).

The department changes the words "reports submitted by the insurer," to "reports the insurer submits" in §3.3723(f)(7).

The department makes the following changes for consistency with current department rule drafting style:

The department makes the word "Department" lowercase in §3.3705(n)(2)(B) and (4)(C).

The department adds a comma following the word "reasonable" in §3.3706(a) and to the dollar amount "$1000" in §3.3708(e).

The department changes the words "such response" to "the response" in two places and the word "shall" to "must" in one place in §3.3707(e).

3. HOW THE SECTIONS WILL FUNCTION. As adopted, Subchapter X relates to Preferred and Exclusive Provider Plans. The subchapter is separated into two divisions.

Division 1, relating to General Requirements, addresses general requirements applicable to both preferred provider benefit plans and exclusive provider benefit plans, unless otherwise indicated. Division 1 includes §§3.3701 – 3.3711.

Sections 3.3701 – 3.3711 address regulation of both preferred provider benefit plans and exclusive provider benefit plans. The sections specify minimum requirements for the content of a waiver request and strengthen review processes for local market access plans.

Section 3.3701 provides effective dates for the rules and also addresses applicability of other rules in Title 28 to exclusive provider benefit plans. The provisions in this section provide notice to insurers of the applicability and effective dates of the regulations under the subchapter and clarify certain limitations on the scope of the amended subchapter. Under Section 3.3701, the subchapter applies to any preferred or exclusive provider benefit plan that is offered, delivered, or issued for delivery on or after 150 days from the effective date of the rules. However, the subchapter does not apply to an exclusive provider benefit plan regulated under 28 TAC Chapter 3, Subchapter KK (relating to Exclusive Provider Benefit Plan) written by an insurer under a contract with the Texas Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program, Medicaid, or with the Statewide Rural Health Care System.

Section 3.3702 incorporates definitions for terms defined in Insurance Code Chapter 1301 and includes necessary definitions for terms used in the subchapter. The purpose of §3.3702 is to ensure consistent terminology throughout Subchapter X. As adopted, §3.3702 includes the following new defined terms: "adverse determination," "allowed amount," "complainant," "complaint," "exclusive provider network," "in-network," and "out-of-network." The adoption also amends the definitions of "pediatric practitioner" and "urgent care."

Section 3.3703 addresses current standards and requirements for contracting, enforcement of contracting standards and rights, and delegation of contracting to exclusive provider benefit plans, exclusive provider organizations, and health care collaboratives.

This adoption amends §3.3703(a)(23) to clarify the contract provision that addresses disclosure by a referring physician or provider regarding the preferred provider status of the physician, provider, or facility to which the insured is being referred and, if applicable, ownership interest in the provider that a patient is being referred to. Under the provision, all referring providers must disclose to insureds that the provider the insured is being referred to might not be a preferred provider. Also, providers referring to facilities they have an ownership interest in must disclose this.

Amended §3.3703(a)(27) and (28) establish contracting requirements that provide for notice to insurers and insureds in specific instances where a recommended or scheduled surgery may result in care being provided to an insured by an out-of-network provider.

Section 3.3704 addresses freedom of choice and availability of preferred providers. As amended, §3.3704 includes provisions addressing exemptions from the general requirements to the extent necessary to conform to the statutorily permitted structure of exclusive provider benefit plans.

Amended §3.3704(b), which is added in response to a comment, clarifies that an exclusive provider benefit plan is not considered unjust under Insurance Code §§1701.002 – 1701.005, 1701.051-1701.060, 1701.101 – 1701.103, and 1701.151; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or §§544.051 – 544.054; or to violate Insurance Code §§1451.101 – 1451.127 if it complies with the requirements of §3.3704(a)(1) – (10) and (12). For purposes of §3.3704(a)(11), an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

Amended §3.3704(d) includes a clarification that an insurer is prohibited from engaging in retaliatory action against an insured because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider. The clarification also provides that an insurer is prohibited from engaging in retaliatory action against an insured because the insured or a person acting on behalf of the insured has appealed a decision of the insurer.

Section 3.3705 addresses insurer communications with and disclosures to insureds. As amended, §3.3705 includes clarifications and exemptions necessary to conform to the statutorily permitted structure of exclusive provider benefit plans.

Amended §3.3705 retains provisions in Subsections (b)(14), (l)(2) and (3), (n), (p), and (q) that the department had proposed to delete, including: requirements for annually updated network demographics for each service area, additional listing-specific disclosure requirements, information required in an annual policyholder notice concerning use of a local market access plan, disclosure of substantial decrease in the availability of certain preferred providers, plan designations, and loss of status as an approved hospital care network.

Section 3.3705(b)(14) addresses required information regarding network demographics related to the number of insureds in a service area, the number of specified provider types, and the number of preferred provider hospitals in a service area or region.

New §3.3705(b)(15) addresses required information regarding whether any waivers or local market access plans approved pursuant to §3.3707 apply to the plan.

Amended §3.3705(f) also addresses reliance by an insured on provider listings in certain cases, and includes language for a notice of rights under a network plan applicable to a preferred provider benefit plan and a notice of rights under a network plan applicable to an exclusive provider benefit plan.

Section 3.3706 addresses designation as a preferred provider, decision to withhold designation, termination of a preferred provider, and review of the process. As adopted, §3.3706 contains minor clarifications and revisions for consistency with department rule drafting style.

Section 3.3707 addresses waivers due to failure to contract in local markets.

Section 3.3707(b) specifies minimum required elements in a request for a waiver from network adequacy requirements, and §3.3707(c) requires that an insurer file a local market access plan at the same time the insurer submits a request for waiver. The commissioner will take the local market access plan into consideration in deciding whether to grant or deny a waiver request.

As adopted, §3.3707(d) – (f) address copies of waiver requests insurers send to providers and department posting of information relevant to the grant of a waiver, and adopted §3.3707(g) provides the processes for an insurer to apply to renew a waiver.

Section 3.3707(h) addresses expiration of a waiver.

Section 3.3707(i) provides the time frame for establishment of a local market access plan and the filing of a waiver request if the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704.

Section 3.3707(j) – (m) incorporate provisions related to local market access plans.

Section 3.3707(n) retains text previously included in §3.3707(f) regarding insurer compliance with §3.3705(p) concerning designation as having a "Limited Hospital Care Network" when the department grants the insurer a waiver concerning network adequacy requirements for hospital-based services.

Section 3.3708 addresses payment of certain basic benefit claims and related disclosures. Amendments the department adopts in §3.3708 address payment of claims when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, add clarification to the section, and address inapplicability of the section to exclusive provider plans.

Amendments to §3.3708(b) provide that when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, the insurer must pay the claim based on usual or customary charges. This requirement is based on and clarifies the provisions of Insurance Code §1301.005(b) and §1301.155(b), which require that claims in these circumstances be paid at the same level of reimbursement as for a preferred provider. It also is based on the requirement of Insurance Code §1301.005(a) that an insurer make out-of-network (basic level) benefits "reasonably available" to all insureds.

Amendments to §3.3708(b) also clarify that, when an insured receives services from a nonpreferred provider because no preferred provider is reasonably available and the insured actually pays a balance bill to the nonpreferred provider, the insurer must credit the full amount paid by the insured for charges for covered services that were

above and beyond the allowed amount to the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

New §3.3708(e) requires an insurer to provide notice on explanations of benefits that an insured may have the right to request mediation under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP, when services are rendered to the insured by a nonpreferred provider.

Section 3.3709 addresses the annual network adequacy report. Amendments to the section removed provisions addressing local market access plans that are relocated to adopted §3.3707.

Section 3.3710 addresses failure to provide an adequate network. Amendments to §3.3710 address applicability to exclusive provider networks and update statutory citations.

New Division 2, relating to Exclusive Provider Benefit Plan Requirements, addresses requirements that are applicable only to exclusive provider benefit plans. It consists of new §§3.3720 – 3.3725.

New §3.3720 addresses applicability of Division 2. As previously noted, the division is only applicable to exclusive provider benefit plans.

New §3.3721 provides that an insurer may not offer, deliver, or issue for delivery an exclusive provider benefit plan prior to obtaining commissioner approval of the insurer's exclusive provider network for each service area where the plan will be offered. This requirement is necessary to ensure that an insurer has met network adequacy requirements prior to offering, delivering, or issuing for delivery an exclusive provider benefit plan in accord with Insurance Code §1301.0056(a), which provides that

an insurer is subject to a qualifying examination of the insurer's exclusive provider benefit plan.

New §3.3722 sets forth filing requirements and specifies the content of the initial application for approval of an exclusive provider benefit plan. These requirements and procedures are necessary to ensure compliance with network adequacy requirements.

New §3.3722(a) requires an insurer seeking to offer an exclusive provider benefit plan to file an application for approval with the department. It also provides the web address for a form that an insurer may use to prepare the application.

New §3.3722(b) sets forth general filing requirements, including legibility requirements and copy requirements for the original application packet and for any revisions or supplements to the application packet.

New §3.3722(c) includes 12 elements that must be included with an application for certificate of compliance. These elements are: (i) a statement regarding whether the filing is for an original or modified certificate of compliance; (ii) the name and contact information for the insurer; (iii) the name and contact information of an individual point of contact regarding the application; (iv) an attestation regarding the accuracy and completeness of the application and stating that the network is adequate for the services to be provided under the exclusive provider benefit plan; (v) a description and map of the service area; (vi) a list of all plan documents and each document's associated form filing ID number or form number; (vii) the forms for physician and provider contracts or an attestation that the contracts comply with the requirements of Insurance Code Chapter 1301 and 28 TAC Chapter 3, Subchapter X; (viii) a description of the quality improvement program; (ix) network configuration

information; (x) documentation that demonstrates the insurer's intent to provide emergency care services; (xi) documentation that the insurer maintains a reasonable complaint system; and (xii) notification of the physical address of all books and records required under subsection (d) of the section.

New §3.3722(d) includes requirements that apply during a qualifying examination. These requirements are: insurers must make available for review by the department documents relating to quality improvement; utilization management; network configuration, including executed contracts; credentialing files; written materials for prospective insureds that contain information about the network and how preferred and nonpreferred providers will be reimbursed under the plan; the policy and certificate of insurance; and the complaint log.

New §3.3722(e) addresses approval and notification requirements for any changes implemented by an insurer after the department has granted approval of a certificate of compliance. New §3.3722(e)(1) requires an insurer to file an application for approval with the department prior to making changes to network configuration that impact the adequacy of the network, expand or reduce an existing service area, or add a new service area. New §3.3722(e)(2) requires an insurer to file with the department changes in maps of service areas, forms of contracts, or network configuration information. New §3.3722(e)(3) provides that, before the department grants approval of a service area expansion or reduction application, an insurer must comply with the requirements of §3.3724 in existing and proposed service areas. New §3.3722(e)(4) requires that an insurer file with the department any information other than the information described in §3.3722(e)(2) that amends, supplements, or replaces the items

required under subsection §3.3722(c) no later than 30 days after the implementation of any change.

New §3.3723 provides standards and requirements for examinations relating to exclusive provider benefit plans conducted by the department. These requirements are necessary to ensure continued compliance with network adequacy standards.

New §3.3723(a) states that the commissioner may conduct an examination as often as the commissioner considers necessary, and it specifies that an examination be conducted at least once every five years.

New §3.3723(b) requires financial, market conduct, complaint, or quality of care exams to be conducted under Insurance Code Chapter 401, Subchapter B, relating to the examination of carriers; Insurance Code Chapter 751, relating to market conduct surveillance; and 28 TAC §7.83, relating to appeal of examination reports.

New §3.3723(c) requires an insurer to make books and records relating to its operations available to the department to facilitate an examination.

New §3.3723(d) requires an insurer to provide to the commissioner on request a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider.

New §3.3723(e) allows the commissioner to examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, for examination and enforcement purposes.

New §3.3723(f) requires the insurer to make available for review by the department documents relating to quality improvement, utilization management,

complaints, satisfaction surveys, network configuration information, credentialing files, and reports.

New §3.3724 establishes minimum standards and requirements for a quality improvement program for commercial exclusive provider benefit plans in accord with Insurance Code §1301.0051. The section is necessary to ensure availability, accessibility, quality, and continuity of care for insureds.

New §3.3724(a) requires an insurer to develop and maintain an ongoing quality improvement program designed to evaluate the quality and appropriateness of care and services. It also requires an insurer to pursue opportunities for improvement. New §3.3724(a)(1) – (5) prescribes minimum standards for the quality improvement program and provides that the program must include specified standards. The standards are that the insurer: (i) include a written description of the quality improvement program that outlines program organizational structure, functional responsibilities, and meeting frequency; (ii) include an annual quality improvement work plan that includes program areas as specified in the section and that is designed to reflect the type of services and the population served by the exclusive provider benefit plan in terms of age groups, disease categories, and special risk status; (iii) include an annual written report on the quality improvement program; (iv) implement a documented process for selection and retention of contracted preferred providers that complies with the credentialing requirements set forth in §3.3706(c); and (v) provide for a peer review procedure for physicians and individual providers.

New §3.3724(b) requires the insurer's governing body to appoint a quality improvement committee, approve the quality improvement program, approve an annual

quality improvement plan, meet at least once a year to review reports of the quality improvement committee, and review the annual written report on the quality improvement program.

New §3.3724(c) requires the quality improvement committee to evaluate the overall effectiveness of the quality improvement program and sets forth delegation, collaboration, and multidisciplinary team requirements.

New §3.3724(d) provides that when reviewing an insurer's quality improvement program, the department will presume that the insurer is in compliance with statutory and regulatory requirements regarding the insurer's quality improvement program if the insurer has received nonconditional accreditation or certification specific and germane to the insurer's quality improvement program by the National Committee for Quality Assurance, the Joint Commission, URAC, or the Accreditation Association for Ambulatory Health Care. However, new §3.3724(d) also provides that if the department determines that an accreditation or certification program does not adequately address a material Texas statutory or regulatory requirement, the department will not presume the insurer to be in compliance with that requirement.

New §3.3725 provides minimum standards for emergency care services and services provided out-of-network when no preferred provider is available, claim payments, reimbursement rates, and reimbursement methodologies. New §3.3725 ensures an adequate process for insureds to obtain out-of-network services when necessary and ensures an adequate claims payment and reimbursement process.

New §3.3725(a) requires an insurer to fully reimburse a nonpreferred provider for emergency care services specified in the subsection at the usual and customary rate or

at a rate agreed to by the insurer and the nonpreferred provider for emergency care services when an insured cannot reasonably reach a preferred provider, until the insured can reasonably be expected to transfer to a preferred provider.

New §3.3725(b) requires an insurer to, upon request of a preferred provider, timely approve a referral to a nonpreferred provider for medically necessary covered services when the services are not available through a preferred provider. It also requires an insurer to provide a review by a health care provider with similar expertise as the provider to whom a referral is requested prior to denying a requested referral.

The language of §3.3725 differs from §3.3708, the section that addresses similar requirements applicable to preferred provider benefit plans, in that the department has not incorporated requirements in §3.3708(b) relating to payments of out-of-network providers when no preferred provider is reasonably available. The department determined that the language in §3.3708(b) is unnecessary given the statutory requirements in Insurance Code §§1301.0052, 1301.0053, and 1301.155. Insurance Code §1301.0052 requires an issuer of preferred provider plan to fully reimburse a nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for covered medically necessary services not available through a preferred provider. Insurance Code §1301.0053 requires an issuer of an exclusive provider plan to reimburse a nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of emergency care services. Insurance Code §1301.155 requires an insurer of an exclusive provider plan to provide reimbursement for specified emergency care

services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider.

New §3.3725(c) addresses insurer facilitation of an insured's selection of a nonpreferred provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider. Section 3.3725(c) provides that if an insurer chooses to facilitate an insured's selection of a nonpreferred provider under the subsection, the insurer must offer an insured a list of at least three nonpreferred providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the insured. If the insured selects a nonpreferred provider from the list provided by the insurer, §3.3725(d) – (f) are applicable. If the insured selects a nonpreferred provider that is not included in the list provided by the insurer, then §3.3725(d) – (f) are not applicable and, notwithstanding §3.3708(f), the insurer must pay the claim in accord with §3.3708.

New §3.3725(d) provides that an insurer reimbursing a nonpreferred provider under §3.3725(a), (b), or (c)(2) must ensure that the insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider.

New §3.3725(e) sets the process for an insurer to follow when determining that a claim from a nonpreferred provider under subsection (a), (b), or (c)(2) is payable. It specifies that the insurer issue payment to the nonpreferred provider at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider. The insurer must also provide an explanation of benefits to the insured along with a request that the insured notify the insurer if the nonpreferred provider bills the insured for

amounts beyond the amount paid by the insurer. The section requires that the insurer resolve any amounts that the nonpreferred provider bills the insured beyond the amount paid by the insurer in a manner consistent with §3.3725(d).

New §3.3725(e) also permits the insurer to require in its policy or certificate issued to an insured that, if a claim is eligible for mediation under Insurance Code Chapter 1467 and 28 TAC Chapter 21, Subchapter PP (relating to Out-of-Network Claim Dispute Resolution), the insured must request mediation, but the rule prohibits the insurer requiring the insured to participate in a mediation. The section requires that the insurer notify the insured when mediation is available, specifies what amount should be taken into consideration in determining when mediation is available, and provides that the insurer may not require that the insured participate in mediation or penalize the insured for failing to request mediation. The provision also provides that the insurer is not responsible for any balance bill after the insurer requests that the insured initiate mediation and until mediation is requested.

New §3.3725(f) provides methodology for insurer calculation of reimbursements.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General

Comment: A commenter believes that consumers should have strong from balance bills. The commenter says that exclusive provider benefit plans, which are new to Texas, must have sufficient consumer protections, including protections from balance billing, clear consumer disclosures, and adequate networks.

Agency response: The department agrees with the comment. The adopted rules will provide safeguards to an insured being charged for receiving services from a nonpreferred provider because no preferred provider was reasonably available to the insured. The adopted rules provide insureds some certainty in their insurance coverage and their financial security in regard to exclusive provider benefit plans, the rules establish sufficient consumer protections, including clear consumer disclosures and regulations that will result in adequate networks.

Comment: A commenter emphasizes the commenter's support for the department's clarifications and amendments included in the rule proposal and the department's deletion of some of the numerous disclosure requirements in the rules. The commenter says that despite some concerns it has with the rules, they are a vast improvement over the previously adopted rules in terms of administrative obligations.

Agency response: The department appreciates the supportive comment. However, the department notes that it has withdrawn the proposed deletion of some of the disclosures required by the rules, based on other comments.

Comment: A commenter is disappointed with the proposed rules, describing them as following a misguided path that undercuts the previously adopted regulatory framework. The commenter says the rules will cause irreparable harm for consumers by reducing the value of products they have purchased and increasing their out-of-pocket expenses, and by allowing unjust and deceptive policies into the market.

The commenter says the department could easily avoid this harm if it would proceed with a more robust and consumer protective stance by retaining and implementing previously adopted rules. The commenter says that the proposed rules disregard objections of consumer advocates and include objectionable provisions from a withdrawn proposal, with yet more insurer-friendly provisions added. The commenter is disappointed its comments on the previous withdrawn proposal were not heeded.

The commenter says that to ensure HB 2256 and HB 1772 are properly adhered to and that Texas consumers receive value for their insurance premiums, the department should: (1) jettison the rule proposal in its entirety; (2) implement the preferred provider benefit plan rules the department adopted May 19, 2011; and (3) restart the rule development process for exclusive provider benefit plan rules, going back to the draft rules posted on the department's website on September 8, 2011.

Agency response: The department disagrees with the comment and declines to the suggested changes. The department considered all comments received on the proposal published on November 2, 2012, and the proposal withdrawn effective November 2, 2012.

The department does not agree that the adopted rules undercut the previously adopted framework. In the rule proposal, the department proposed deletion of some insurer disclosure requirements. However, based on other comments, the department has withdrawn its proposed deletion of the disclosure requirements in §3.3705(b)(14),which the department retains in new §3.3705(b)(15), and §3.3705(n). The department also retains a modified version of §3.3705(p) and (q), which were initially adopted May 19, 2011.

Further, in the adopted rules, the department integrates requirements that will result in stronger insurer networks of providers and services. For example, the department's amendments to §3.3707 implement a rigorous process requiring that insurers obtain waivers from the department for continued use of local market access plans and specify required elements that must be included in an insurer's request for waiver.

The department does not agree that the rule proposal should be jettisoned in its entirety. The adopted rules are not satisfactory to all parties commenting. However, in these rules the department strikes a balance between opposed sides. Given the nature of the health insurance market, it is unlikely the department could propose rules that satisfy all stakeholders. If the department were to start over on a completely new rule proposal, the end result would still be a controversial adoption order with many opposing comments.

The department does not agree that it should merely implement the preferred provider benefit plan rules the department adopted May 19, 2011. The legislature has given the department the task of integrating exclusive provider benefit plans into the Texas market. Because of the related nature of preferred and exclusive provider benefit plans, that integration necessitates changes to the rules adopted May 19, 2011.

As previously noted, the department has withdrawn the proposed deletion of several provisions from the rules adopted effective May 19, 2011, based on stakeholder comments. Because those provisions will remain in the rules, some of the provisions regarding consumer protections that the commenter requested will be implemented.

The department does not agree that it should restart the rule development process based on the draft rules posted on the department's website September 8, 2011. Many parties have provided valuable effort and input into developing the rules beyond the September 8, 2011, draft. These contributions have resulted in improved regulations.

In addition, going back to the September 8, 2011, draft would not reduce the contentiousness of this rulemaking process. The department has undertaken the task of balancing opposed positions, and starting over where the rules were in September 2011 would not generate agreement among the stakeholders or negate the difficulty of the task.

Comment: A commenter says that the proposed rules miss the mark regarding consumer protection because they relieve health plans from the basic responsibility of providing robust networks. The commenter supports rules previously adopted in December of 2011, and the commenter is confused by the removal of disclosure provisions on the basis that they are not helpful to insureds.

The commenter feels that removal of disclosure provisions lessens the up-front proactive oversight of insurers' networks, and points out that previously the department said these disclosures were necessary. The commenter says that the department must regulate its licensees and certificate holders prior to any consumer harm arising, and that disclosures to consumers regarding the true character of a network and failure of a network to comply with regulatory standards is vital.

The commenter says that the proposed rules remove up-front accountability and place the burden of proof on insureds or address issues on the back end, such as through mediation. The commenter says that it is not necessary to choose between protections or delete disclosures in favor of mediation. The commenter suggests that the changes will benefit insurers who want to rush products to market.

Agency response: The department disagrees that the proposed rules miss the mark in regard to consumer protection by relieving health plans from the basic responsibility of providing robust networks. The adopted rules aim at ensuring that an insurer's network is adequate for the services to be provided.

The department agrees it should adopt certain disclosure provisions. As the department discusses in connection with comments on the specific provisions, the department withdraws the proposed deletion of the disclosure provisions in §3.3705(b)(14) and (n) and retains a modified version of (p) and (q).

Comment: A commenter says that despite the department's acknowledgment that those commenting on the department's previous, withdrawn rule proposal were concerned that the withdrawn proposal relaxed requirements for insurers and diluted insurer reporting provisions, the content of the proposal published on November 2, 2012, does little or nothing to address those concerns.

The commenter says that the only significant changes in the new proposal are an attempt to provide a rational and defensible justification for amendments to the rules adopted May 19, 2011, and introduce new insurer-friendly provisions. It is wasteful and devoid of any rational or legitimate justification to amend previously adopted rules that

were the result of years of work, deemed necessary by the department, and were never permitted to be implemented.

The commenter says the department fails in its legal responsibility to demonstrate in a clear and logical fashion that adoption of the proposed sections is a reasonable means to a legitimate objective. There is nothing reasonable about dilution of network adequacy requirements under a guise of alignment of statutes, or anything legitimate about pursuing insurer-friendly objectives when the department has acknowledged the necessary and proper nature of the previously adopted rules.

The commenter asserts that the purpose of the rule proposal is to provide insurers with the opportunity to dismantle previously adopted rules at the expense of Texas consumers, and the fact that comments on the withdrawn rule proposal incorporated in the new proposal were primarily those of insurers supports this view. The department's general statements regarding the need for the proposal published on November 2, 2012, were unsupported conclusory statements lacking the substance necessary to explain the department's deference to the insurance industry's recommendations or meet the department's ultimate statutory burden to provide a reasoned justification for the proposal.

Agency response: The department disagrees with the comment and declines to make a change based on it.

After reviewing comments on the prior proposed rules, the department determined that it was necessary to make substantive revisions to the proposed rules to address network adequacy concerns and consumer protection from balance billing.

Specifically, to address concerns regarding network adequacy, the department revised its proposal for §3.3707 to require that a waiver must be granted for an insurer to continue to use a network access plan. The proposed revisions to §3.3707 also make the waiver process more rigorous by requiring additional detailed information to justify the need for a waiver to use an access plan.

No insurer requested that the department require an insurer with an inadequate network to obtain a waiver from the department for continued use of a local market access plan. No insurer asked the department to impose additional requirements for the granting of a waiver.

In addition, the department proposed additions to the contracting requirements under §3.3703(a) to require notice to insurers and insureds regarding surgery referrals, to warn insureds about the possibility of a balance bill, and to enable an insurer to negotiate a rate with the referred provider to prevent a balance bill.

These changes impose new requirements on insurers not included in the withdrawn proposal, and would likely have been impermissible substantive changes if not introduced in a new proposal. However, the department believes the changes will lead to stronger networks, reduced reliance by insurers on access plans, and reduced instances of balance billing.

The department appreciated the comments it received on the withdrawn proposal, and used them in preparing the new proposal. The department did not rely on the comments from any one commenter or any one group of stakeholders. As an example of changes made based on comments on the proposal withdrawn effective November 2, 2012, the proposal published on November 2, 2012, §3.3725 incorporates

changes to clarify that an insurer may not require that an insured participate in a mediation requested under Insurance Code Chapter 1467 and 28 TAC Chapter 21, Subchapter PP, or penalize an insured for failing to request a mediation.

Comment: A commenter says that the department's statement regarding the necessity of conforming amendments to the proposed rules is not supported by the facts or the underlying law. The preamble of the proposal relies on references to alignment to justify reaching into previously adopted preferred provider benefit plan rules to promulgate exclusive provider benefit plan rules. The department has previously used the alignment rationale, but the commenter has repeatedly challenged this justification and continues to disagree with the idea that the current proposal is necessary to align or confirm existing rule provisions.

The commenter says these arguments demonstrate that the proposal fails to constitute a reasonable means to amend or implement the preferred and exclusive provider benefit plan network adequacy requirements under HB 2256 and HB 1772.

The commenter raises four points against the department's justification for the rule proposal based on alignment of preferred and exclusive provider benefit plan rules.

First, the commenter says it is unnecessary to adopt rules addressing both preferred and exclusive provider benefit plans, because the department could achieve alignment through separate, stand-alone rules.

The commenter says alignment of the exclusive provider benefit plan rules was already happening before the department suspended implementation of its previously adopted preferred provider benefit plan rules and began proposing new rules. In 2011,

the department made a working draft of exclusive provider benefit plan rules available that created a separate, stand-alone subchapter. That draft aligned exclusive and preferred provider benefit plans by largely tracking many of the provisions applicable to preferred provider benefit plans, with modifications to address incompatibilities.

The commenter says the posting of the initial draft made it clear the department initially intended independent rules. This shows it is unnecessary to adopt rules that address both preferred and exclusive provider benefit plans, and the commenter questions why the department would change this approach. The commenter suggests that the department decided to combine the rules at the insistence of the insurance industry.

Second, the commenter says aligning the preferred and exclusive provider benefit plan rules does not result in administrative simplification. Instead, the result is administrative complication.

The commenter says the proposed rules make it difficult to determine the applicability of specific provisions. As an example, the commenter points to §3.3701(f) and §3.3703(a)(1). Section 3.3701(f) says, "A provision of this title applicable to a preferred provider benefit plan is applicable to an exclusive provider benefit plan unless specified otherwise."

The commenter says the intent of §3.3701(f) must be to make every part of Division 1 that says "preferred provider benefit plan" read as if it also says "exclusive provider benefit plan." However, the term "exclusive provider benefit plan" appears in §3.3703(a)(1) in the line "A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers,

preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs."

The commenter says that, given §3.3701(f), use of the term "exclusive provider network" in §3.3703(a)(1) is redundant, makes one question whether the rest of §3.3703 is applicable to exclusive provider benefit plans, and is a misstep that casts doubt on the applicability of other sections to exclusive provider benefit plans. The commenter does not understand why the department would inject such a level of uncertainty and confusion into its rules.

The commenter also asks why the department was willing to create a separate division to address requirements solely applicable to exclusive provider benefit plans, yet not put all exclusive provider benefit plan requirements in a single division. As proposed, the rules will require people to flip between two divisions to determine all requirements for exclusive provider benefit plans. The commenter suggests the department may have decided to take this approach based on comments an insurance industry representative organization submitted in response to the department's request for comments on its informal working draft rules.

The commenter says that even if the department did consider comments from the insurance industry in organizing the preferred and exclusive provider benefit plan rules, it was not necessary. The structure of the rules does not relieve the insurance industry of its administrative or compliance burden. However, a proposal with aligned rules does give the insurance industry a chance to attack network adequacy standards

for both preferred and exclusive provider benefit plan at the same time. If the department did not intend this, it should withdraw the proposed rules.

Third, the commenter says the rule proposal makes substantive amendments that are not merely conforming, as stated in the proposal preamble.

The commenter says the proposal makes numerous substantive changes to the preferred provider benefit plan rules that weaken them and are unnecessary and contrary to statements the department made when originally adopting them. The changes will also benefit insurers to the detriment of consumers by forcing consumers to seek care out-of-network and pay out-of-pocket for care.

The commenter says that substantive changes include deletion of insurer disclosure requirements in §3.3705(b)(14), (n), (p), and (q).

The commenter says the rule proposal could not actually be intended for alignment, because strong network requirements are necessary to protect consumers in exclusive provider benefit plans. If alignment were necessary, the result would be increased, not decreased network adequacy requirements.

Fourth, the commenter says that the proposed rule takes an opposite approach to the statutory mandate. The commenter would not be opposed to alignment if the department did it in a manner consistent with law, but true alignment would result in few if any changes to the preferred provider benefit plan rules. The commenter points out that under Insurance Code Chapter 1301, exclusive provider benefit plans must comply with laws applicable to preferred provider benefit plans. The proposed rules take an opposite approach, by dragging preferred provider benefit plan rules down to accommodate exclusive provider benefit plans.

The commenter urges the department to instead bring exclusive provider benefit plans up to existing preferred provider benefit plan standards. This would ensure that exclusive provider benefit plans offer some value to consumers and also reduce the potential of preferred provider benefit plans becoming a type of "junk policy."

Agency response: The department disagrees with the comment and declines to make a change based on it. However, the department notes that in response to other comments it has withdrawn the proposed amendments to §3.3705(b)(14) and (n) and retained a modified version of (p) and (q), which contain the insurer disclosure requirements referenced by the commenter.

Alignment of the preferred and exclusive provider benefit plan rules is necessary. Just as the legislature made exclusive provider benefit plans a subset of preferred provider benefit plan products by addressing them in Insurance Code Chapter 1301, the chapter that addresses preferred provider benefit plans, and making them subject to preferred provider benefit plan statutory requirements, the department has incorporated exclusive provider benefit plans into the preferred provider benefit plan rules with specific exceptions.

To accommodate exclusive provider benefit plans into 28 TAC Chapter 3, a number of changes to the preferred provider rule are necessary. As addressed separately in this preamble, the department has reassessed the changes made in the rule proposal and has determined that some proposed changes are not necessary at this time.

In regard to the first point, the department agrees that alternatives exist to implement the statutes addressing preferred and exclusive provider plans, but it does

not agree that it is bound to any one approach taken in an informal draft proposal. The department frequently uses informal draft rule text as a tool to explore regulatory options and involve stakeholders in rule development. Informal draft rules are clearly identified as subject to review and revision, and use of informal drafts does not restrict the ability of the department to fully develop regulations.

Factors the commenter cites regarding the initial informal draft illustrate the usefulness of the informal rule draft process. These factors demonstrate the appropriateness of integrating the rules applicable to preferred and exclusive provider benefit plans. The commenter notes that the informal rules for exclusive provider benefit plans largely tracked the preferred provider benefit plan rules. The department contends that this argument supports combining the rules. Rather than repeating nearly identical provisions in separate sections, the department made those provisions applicable to both preferred and exclusive provider benefit plans.

It is also appropriate that the rules addressing preferred and exclusive provider benefit plans be combined, because they are established by the same statutes, Insurance Code Chapter 1301. Under Insurance Code §1301.0042(a), a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan, except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan. Because the laws are equally applicable to both preferred and exclusive provider benefit plans, it is appropriate that the department's regulations address them together, unless there is a specific need to address them separately.

In regard to the commenter's second point, the department does not agree that aligning rules for preferred and exclusive provider benefit plans results in administrative complication. As noted by the commenter in support of the commenter's first argument, many rule provisions are equally applicable to both preferred and exclusive provider benefit plans.

The department does not agree that §3.3701(f) demonstrates an example of administrative complication. Section 3.3701(f) does not specifically address how a person should read Division 1; it implements Insurance Code §1301.0042(a) by equating the term "exclusive provider plan" with "preferred provider plan" wherever that term appears in Title 28 of the Texas Administrative Code. This does not mean that the phrase "exclusive provider benefit plan" cannot be used separately in Title 28.

The department does not agree that the need to "flip between" two divisions within a chapter creates a burden. A thorough implementation of the exclusive and preferred provider statutes necessitates more than one section. Regardless of whether the sections are in a single division or divided between two divisions, a person must go between them to see the complete regulation.

In regard to the commenter's third point, the department notes that substantive changes within a rule proposal do not prevent adoption of the rule. A primary purpose of publishing a rule proposal is to notify interested parties of substantive changes an agency proposes to make to a rule. The bar against substantive changes arises when the agency prepares its adoption order. If an agency adopts rule text that is substantively changed from text the agency proposed, an interested party might not have sufficient notice as required by Government Code §2001.023 and §2001.024. The

department withdrew its initial proposal and filed a proposal published on November 2, 2012, to comply with the notice requirements of these sections.

For these rules, the department filed all rule text with the Secretary of State and included all elements of a rule proposal, as required by Government Code §2001.024. The department filed notice of its proposed rule text twice, because the department decided to make changes to the text included in the first rule proposal and wanted to ensure that all interested parties had sufficient notice of the changes.

The department also notes that it has withdrawn the proposed amendments to all the specific subsections cited by the commenter, in response to other comments from the commenter.

In regard to the commenter's fourth point, the department does not agree that the rules take an opposite approach to the statutory mandate. In support of its argument, the commenter says that the proposed rules drag requirements for preferred providers down to accommodate exclusive providers. However, these rules impose stricter network adequacy requirements on both preferred and exclusive provider benefit plans.

Under the previous rules, access plans were not so closely tied to the waiver process. Under the adopted rules, insurers under all plans must obtain a waiver in order to continue to market their products in areas with inadequate networks. The new rules also establishes detailed requirements for waiver requests.

Section 3.3707(a) and (i) address situations where an insurer's network fails to meet network adequacy requirements. Under these provisions, an insurer must obtain a waiver from the department to use a local market access plan.

Section 3.3707(a) now also specifies the minimum contents of an insurer's waiver request. Under that section, if an insurer wants to include in its network an area where providers or physicians are available but the insurer has failed to contract with them, the insurer must provide specific information about the insurer's attempts to contract with providers, the insurer's cost savings from not contracting, and steps the insurer will take to improve the insurer's network to avoid the need for future waivers.

The department believes these new requirements will improve network adequacy and benefit consumers in both preferred and exclusive provider benefit plans.

Comment: A commenter references the department's explanation for proposing amendments to the rule text a second time, rather than just adopting the rule text based on the department's initial proposal. The commenter says the department's statements are not supported by the changes to text made in the proposal published on November 2, 2012.

The commenter says the changes to text in the November 2, 2012, rule proposal do not require insurers to have complete networks and does not limit insurer reliance on alternatives to complete networks which provide only limited protections from balance billing. The text of the proposal published on November 2, 2012, only contains a few "insurer-friendly" changes from the text the department initially proposed. The commenter asserts that the changes actually weaken previously adopted network adequacy requirements.

To support this point, the commenter references a proposed clarification the department added to the contracting requirements in §3.3707(a)(29). The commenter

also notes that the department simultaneously struck "a 'catch-all' provision previously adopted to aid in the regulation of insurers with regard to local market access plans."

The commenter then provides a bullet list of issues that demonstrate how the department has an apparent lack of intent to require insurers to provide complete networks to insureds. The list includes the following issues: permitting insurers to use indirect contracts with physicians to establish secret preferred provider organizations consumers cannot use to plan care; not establishing exclusive provider benefit plan certification requirements, as was contemplated at one point in an informal draft rule; removing important marketing incentives by deleting consumer disclosures; weakening department oversight by removing notifications plan insurers must provide to the department regarding reduction of network providers; and reducing the burden on insurers seeking waivers from network adequacy requirements by making it difficult for doctors to refute insurer assertions.

The commenter says these issues make it clear the department did not propose new rule text on November 2, 2012, to require insurers to have more complete networks.

The commenter says the department should adopt a regulatory framework that requires insurers to create and maintain complete networks, requires insurers to be transparent with consumers regarding the relative strength or weakness of their networks, and provides reasonable remedies if consumers are victims of an insurer's failure to provide an adequate network or updated information on its network.

The commenter says the department has failed to build this necessary framework, and that in fact it has deleted requirements that would support the

framework, including disclosure of a substantial decrease in facility-based providers, disclosure of Approved Hospital Care Network status, and disclosure of loss of Approved Hospital Care Network status. The commenter then focuses on the detrimental reliance provision of §3.3705(k) to protect consumers from harm in the absence of these provisions, asserting that §3.3705(k) is only a limited protection from balance billing, that the department apparently over-estimates how many consumers will take advantage of the provision, and that the detrimental reliance provision alone is insufficient for consumer protection.

The commenter also says that the rules in the proposal published on November 2, 2012, reflect a department desire to push insureds into mediation of balance bills. However, adopting a preference of mediation over consumer disclosure provisions creates a false dichotomy. Providing up-front notice and maintaining mediation as a back-end measure for reducing impact would create the most comprehensive framework for consumer protection.

The commenter says the push to back-end remedies in the November 2, 2012, proposal text is clearly inconsistent with the department's statement that the rules are intended to limit insurers' reliance on alternatives to complete networks that provide only limited protections from balance billing.

Agency response: The department disagrees with the comment and declines to make a change based on it. However, the department has withdrawn the proposed deletion of requirements related to disclosure of substantial decrease in facility-based providers, disclosure of Approved Hospital Care Network status, and disclosure of loss of Approved Hospital Care Network status.

The department re-proposed the rule text because of substantive changes proposed for §§3.3703, 3.3707, and 3.3709.

The additional changes the department proposed for §3.3707 and §3.3709 in the proposal published November 2, 2012, will limit insurers' reliance on alternatives to complete networks by imposing restrictions on the waiver and local market access plan process.

Under the initial rule proposal, the department did not specify what information an insurer would need to provide to the department to show good cause for the department to grant a waiver from network adequacy requirements. In addition, the initial rule proposal did not require that an insurer secure the grant of a waiver for an insurer's continued use of a local market access plan.

Under the proposal published on November 2, 2012, the waiver and local market access plan processes are integrated in §3.3707. If an insurer's network does not comply with the network adequacy requirements of §3.3704, the insurer must have a waiver to avoid a violation of the department's rules. This requirement also applies in regard to local market access plans. If an insurer wants to continue to use a local market access plan to address an inadequate network, the insurer must file with the department a request for a waiver to use the plan.

To show good cause for a waiver, an insurer must provide specific information to the department. If the waiver is for an area where providers or physicians are available, an insurer seeking a waiver must describe attempts to contract with providers or physicians, cost savings from not contracting, and steps the insurer will take to improve

the insurer's network to avoid the need for future waivers. The department will take this information into consideration in determining if good cause exists for the waiver.

The additional changes the department proposed for §3.3703 on November 2, 2012, would establish contracting provisions that require provider notice to insurers and insureds in specific instances where a recommended or scheduled surgery may result in an insured receiving care from an out-of-network provider. The purpose of this change was to add an up-front notice to insureds and insurers regarding the possibility of out-of-network care and resulting balance bills.

In addition to the substantive changes in §§3.3703, 3.3707, and 3.3709, the department makes nonsubstantive revisions to the text the department included in the November 2, 2012, rule proposal. These changes clarify points in the initial proposal text and implemented revisions based on comments the department received on the initial text.

The change to §3.3703(a)(29) was one of these clarifications. In the initial proposal, the department proposed new §3.3707(a)(29), which provided: "This subsection does not prohibit other contractual provisions allowed by law." In the proposal published on November 2, 2012, the word "allowed" is changed to "not prohibited." The change was a nonsubstantive change, made to clarify that the provision did not create a prohibition where prohibitions were not otherwise created under law. The department has removed this paragraph in response to another comment.

The "catch-all" the commenter notes was a provision stating, "The department may request additional information necessary to assess the local market access plan."

The department believes a requirement for insurers to provide specific information, as set out in the proposed rule, will better aid the department in reviewing network adequacy than a general statement that the department may request additional information.

The issues in the commenter's list are not things the department added or revised in the proposal published November 2, 2012.

The department's proposed deletion of §3.3705(b)(14), (n), (p), and (q) was included in the initial proposal, not added in the November 2, 2012, rule proposal. As such, these do not support an assertion that the changes in the department's text weaken network adequacy requirements. The department has also withdrawn the proposed deletion of §3.3705(b)(14), (n), (p), and (q) in response to other comments by the commenter.

All other issues the commenter includes in the list, as well as the commenter's concerns regarding §3.3705(b)(14), (n), (p), and (q) and the commenter's opposition to the department's reliance on §3.3705(k), are repeated and addressed in more detail elsewhere in this preamble in response to additional comments from the commenter on specific sections of the rule proposal.

Comment: A commenter addresses the difference between health maintenance organizations, preferred provider benefit plans, and exclusive provider benefit plans regarding payments. The commenter says that statutorily, health maintenance organizations must hold an enrollee harmless, while under a preferred provider benefit plan an insured may have different required coinsurance amounts based on whether the

insured goes to an in-network or out-of-network provider. However, the commenter says, an insured covered under an exclusive provider plan should have only one level of coinsurance, which only applies if the insured goes to an in-network provider. The commenter says the department needs to clarify this concept in the rule.

Agency response: The department agrees that exclusive provider befit plan products generally only have one level of coinsurance. The department construes the coinsurance applicable to in-network providers as equating to the preferred level of benefits in a preferred provider benefit plan product.

Comment: A commenter applauds the department for its work on the proposed rules. The commenter says the rules will provide substantial benefit to patients, ensuring they receive the adequate networks they deserve. The commenter notes that the proposed additional requirements for waivers strengthen the rules' requirements that insurers provide adequate networks.

The commenter also references the provisions in §3.3708(B) and §3.3725 that address insurer reimbursement for services provided by a nonpreferred provider when a provider is not available in the insured's preferred or exclusive provider benefit plan's network. The commenter says that these provisions will provide valuable stimulus for plans to negotiate the contracts that create network adequacy and effectively address the issue of balance billing. The commenter says the provisions will also reverse a current incentive some plans have to refuse to negotiate with emergency providers.

Agency response: The department appreciates the supportive comment.

Comment: A commenter says the department has underestimated the cost of some of the requirements, because insurers will need to revise and re-file virtually all forms. The commenter says the estimate of two to 10 hours of administrative time is insufficient and the proposal does not address filing fees. The commenter believes that to assemble an exclusive provider benefit plan application, an insurer will require additional attorney and administrative staff time, for a total of at least 40-50 hours.

Agency response: The department disagrees with the comment and declines to make a change based on it.

The department does not agree that insurers will need to revise and re-file virtually all forms.

An insurer offering an exclusive provider benefit plan may satisfy most of the portions of the rule which require revisions to policy forms through the filing of a single document with the department in the nature of an endorsement containing the newly required elements.

Regarding additional expenses of the rule, the department believes that it has accounted for the expenses associated with the rule proposal.

The department based the cost note it included in the rule proposal on input received following a request for comments posted on the department's website. The department received general input on the cost of compliance, but did not receive specific cost estimates.

The department worked with the information available to identify categories of labor and cost of printing, copying, and mailing reasonably necessary to implement the proposed rules. The department also estimated hours of labor necessary to implement

provisions, where possible, and acknowledged instances where expenses would vary from insurer to insurer.

The department also received one comment in response to the withdrawn proposal that addressed potential costs, and the department included this information in the cost note.

The department acknowledged that the commenter suggested the proposed rules could subject an insurer to filing fees, but that the commenter did not list specific forms and was unable to provide a cost estimate. The department also noted that the commenter suggested assembly of an exclusive provider benefit plan could total 40 to 50 hours.

In addition, because exclusive provider benefit plans are new products in Texas, costs for compliance with the rules will be a part of the overall cost of plan development, which is a result of the statute permitting insurers to establish exclusive provider benefit plans.

Comment: A commenter says that, because insureds covered by exclusive provider benefit plans cannot go out of network, network adequacy standards for exclusive provider benefit plans should be more stringent, and balance billing provisions should be more robust than they are for preferred provider benefit plans.

Agency response: The department disagrees with the comment and declines to make a change.

The network adequacy standards the department has adopted are largely the same for all network-based products, including health maintenance organizations and

preferred and exclusive provider benefit plans. This permits administrative efficiencies for insurers and the department in reviewing networks that health benefit plan issuers will use with different products.

The department intends to strictly review all waiver requests insurers file for preferred and exclusive provider benefit plan networks. In regard to exclusive provider benefit plans, the rule provides additional protection for insureds receiving out-of-network care where no network provider is available.

Section 3.3725 requires that an insurer protect insureds from balance billing in situations addressed by the section. Thus, insureds will only be required to pay their coinsurance and co-payment in most situations addressed by §3.3725. This additional requirement for insurers offering exclusive provider benefit plans, which is similar to protections afforded enrollees in health maintenance organizations, provides sufficient protection for consumers while encouraging insurers to continually enhance network adequacy.

Section 3.3701

Comment: A commenter supports the proposed effective date. The commenter appreciates the department's willingness to provide sufficient time to implement the new requirements.

Agency response: The department appreciates the supportive comment.

Section 3.3702

Comment: A commenter recommends that the department modify the definition for "complaint" to allow for oral complaints and to address issues beyond coverage concerns. The commenter suggests revising the definition by including the words "oral or" beside every reference to "written complaint" in the definition and by expanding the definition to include communication to the insurer, not solicited by the insurer, concerning "the business practices of such insurer in this state."

The commenter also suggests a revision to proposed §3.3704(c), which is adopted as §3.3704(d), to add to the protection against retaliation by an insurer against an insured for making a complaint. The commenter suggests the department revise the section to state that the prohibition includes instances when the insured or a person acting on behalf of the insured files a complaint "with the department or the insurer."

Agency response: The department agrees in part and disagrees in part with the comment.

The department agrees the rule should clarify that insurers may not retaliate for complaints made to the department or the insurer. The department has revised §3.3704(d) as adopted to include the recommended change.

However, the department does not agree that the definition of "complaint" should include oral complaints, and the department declines to revise the definition of "complaint" as the commenter requests. Confirming accurate documentation of the specific content of an oral complaint is difficult, so the department would have limited ability to take action against an insurer based on an allegation of retaliation relating to an oral complaint.

Section 3.3702(b)(5) appropriately utilizes the definition of complaint found in §21.2502, a longstanding definition that both industry and the department are familiar with. The department has traditionally construed the language in §21.2502 "concerning coverage offered or issued" by an insurer to broadly apply to the insurance business practices of the insurer regulated by the department and not to be limited solely to coverage issues.

Comment: A commenter opposes the definition of "exclusive provider network" included in §3.3702(b)(7).

The commenter says that including a reference to indirect contracts in the definition greatly expands the number of contracts the department can consider in evaluating an insurer's network, which in turn reduces the insurer's burden to proactively and transparently maintain an adequate network. This is a departure from the direct contractual framework that should form the basis of the department's evaluation of networks and undermines transparency in insurer contracting. The commenter urges the department to consider the potential negative impact of including indirect contracts and asks that the department strike the word "indirectly" from the definition.

The commenter says that transparency is necessary so that consumers can make informed decisions, the department can oversee insurer compliance with rules, and providers can understand their contractual obligations.

The commenter says it cannot discern the rationale for broadening the definition and lessening insurer's network adequacy requirements and asks what consumer

benefits result from an expansive definition for "exclusive provider network," or what is contemplated by the inclusion of indirect contracts.

The commenter says that even if the purpose of the department in including "indirectly contracted" language is to acknowledge an insurer's ability to enter into contracts with preferred provider organizations under Insurance Code §1301.061, the language is excessively broad. The definition in the rule would allow any contractual relationship, no matter how remote or tenuous, to suffice in order to fulfill network adequacy requirements.

The commenter adds that even if the department intends to reference contracts under Insurance Code §1301.061, inclusion of those contracts would frustrate the purpose of promoting transparency for consumers. Contracts under Insurance Code §1301.061 have caused much confusion, and the department's "blessing" of them in the context of exclusive provider benefit plans will only add to that confusion. Allowing use of indirect contracts under exclusive provider benefit plans might confuse consumers by making it difficult for them to assess which providers are in or out of network. The commenter also says that networks established under Insurance Code §1301.061 are typically designed for the sole benefit of the insurers, not consumers.

The commenter also opposes the definition for "exclusive provider network" because it is not clear whether contracts insurers enter into under Insurance Code §1301.061 will be subject to meaningful oversight by the department.

The commenter says it is not clear how the definition for "exclusive provider network" will work with the definition for "preferred provider," because the definition for

"preferred provider" only references providers who contract with insurers and does not address indirect contracts.

The commenter asks whether an insurer would be required to list all the indirectly contracted physicians in their provider listings. Insurers have not done so in the past, and this might be a regulatory loophole by which insurers could meet network adequacy standards while not providing complete provider listings to insureds.

In regard to this concern about a loophole, the commenter asks the following questions:

1) How does the consumer make informed decisions and plan to see an "indirectly contracted" physician, and thus utilize that plan benefit, if the indirectly contracted physician is not listed on the insurer's provider listing?

2) How does network composition like this, which is lacking in transparency, benefit the consumer (especially if contractual provisions creating out-of-network liability currently exist in many wrap network contracts)?

3) How does the preferred provider physician (a physician with a standard, direct contract) know whether he or she is making a referral to an exclusive provider network physician if only an "indirect contract" exists?

4) Will the department review and substantiate all of the "indirect contracts" when performing its analysis of the exclusive provider network's compliance with network adequacy standards?

5) How will the department evaluate and subsequently regulate compliance by the insurers who have these indirect arrangements?

6) How will the department ensure the value of the exclusive provider benefit plan product that is offered to consumers?

The commenter says that the broad inclusion of "indirect contracts" in the definition of "exclusive provider networks" would officially sanction rental networks that lease a provider's contracted rate. There is no clear regulatory mechanism to track or register those who lease a provider's rates or the contracts that allow the leasing of rates. It is unclear how the department would take those contracts into consideration when determining whether an exclusive provider benefit plan meets network adequacy requirements, substantiating the existence of the contracts, or otherwise applying the requirements in this proposal to the entities that lease a provider's contract rates.

The commenter concludes by asking that the department adopt a new section that would establish a registration process for preferred provider organizations. The commenter provides the following text for the proposed section:

Sec. 3.XXXX Registration required. (a) Unless the person holds a certificate of authority issued by the department to engage in the business of insurance in this state or operate a health maintenance organization under Insurance Code Chapter 843, a person must register with the department not later than the 30th day after the date on which the person begins acting as a preferred provider organization as described by Insurance Code §1301.061 for an exclusive provider benefit plan.

(b) Notwithstanding Subsection (a), a preferred provider organization that holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization shall

notify the commissioner that it is acting as a preferred provider organization on behalf of an exclusive provider benefit plan.

(c) A notification under Subsection (b) must be accompanied by a list of the insurer's or health maintenance organization's affiliates. The insurer or health maintenance organization shall update the list with the commissioner on an annual basis. A list of affiliates provided to the commissioner under this section is public information and is not exempt from disclosure under Government Code Chapter 552.

(d) Under subsection (a), a registration is required to include a list of all affiliates of the preferred provider organization. The list of affiliates provided to the commissioner under this section is public information and is not exempt from disclosure under Government Code Chapter 552.

Agency response: In regard to the commenter's concern that indirectly contracted physicians will not be included in the insurer's provider listing, the department notes that insurers must make provider directories available to consumers. This will enable consumers to see what providers are available, and a change in the description of contracts will not enhance this information. The department will not consider providers to be reasonably available to an insured if they are not listed in the directory.

Insurers must also show the department that the networks they rely on are sufficient to meet network adequacy requirements under §3.3704. If the insurer's contracts with providers the insurer relies on to show compliance are too remote or tenuous, the department will not find the network to be adequate. Finally, it is not the department's role to limit the terms an insurer and provider can agree to, except to the

extent required by the Insurance Code or necessary for the protection of consumers and consistent with the Insurance Code.

The department has previously taken administrative actions when an insurer was unable to demonstrate that a provider had consented by contract or chain of contracts to permit discounts taken by the insurer. The department will continue to enforce this principle.

Use of indirectly contracted preferred provider organization networks has generally been more beneficial to insurers in the past in the context of a preferred provider benefit plan product, where the insurer is responsible for payment of out-of-network claims. In an exclusive provider benefit plan, the insurer will normally not be responsible for paying out-of-network claims, so there is less of a need to access additional networks. The department has not strictly required insurers to provide complete directories of all contracted providers or enforced strict network adequacy standards. Going forward, insurers will have a much greater incentive to provide complete directories, as the department will be reviewing these issues more closely.

To address the three things the commenter cannot discern, the department notes the following:

The department has not broadened the definition of "exclusive provider network." Insurance Code §1301.056 addresses insurer contracts with organizations that have networks of contracted physicians and other practitioners, and Insurance Code §1301.061 addresses insurer contracts with preferred provider organizations. The definition of "exclusive provider network" contemplates applicability of these statutes. In addition, the definition does not lessen an insurer's network adequacy requirement.

The sufficiency of a network does not hinge on whether an insurer has directly contracted with each provider in the network or whether the insurer has contracted with an organization that has taken on the task of directly contracting with providers. Instead, it depends on making providers reasonably accessible to insureds.

The benefit that consumers can obtain from an insurer that has contracted with an organization contracted with a network of providers is access to a broader array of providers than otherwise would be available. If the provider is identified as a preferred provider, then the insured will be protected against balance billing. Even if the provider is not identified as a preferred provider, the insured will still benefit by only having to pay the coinsurance amount of a reduced charge with a preferred provider benefit plan, or a discounted amount with an exclusive provider benefit plan.

By addressing both direct and indirect contracts, the department contemplates that insurers are aware of and will follow Insurance Code §1301.056 when assembling their networks.

The department does not agree that the definition of "exclusive provider network" opens the door for insurers to enter into remote or tenuous contracts for purpose of meeting network adequacy requirements.

First, the section is under, and must be read in conjunction with, the law. Insurers must follow Insurance Code §1301.056 and §1301.061 in their dealings with providers and with preferred provider organizations. A creative reading of a definition in a rule would not excuse that statutory requirement.

Second, under the adopted rules the department will review an insurer's network for consistency with the network adequacy requirements adopted in §3.3704. Review

will occur on a case-by-case basis, but if an insurer's network is composed of remote and tenuous connections with providers, it will likely not be found adequate.

The department does not agree that exclusive provider benefit plans should be prohibited from using networks that include providers indirectly contracted with under Insurance Code §1301.061. These networks will not lead to consumer confusion or harm. Section 3.3705(b) requires insurers to provide provider listings to insureds, and §3.3705(k) protects insureds from harm if they rely on these listings.

The department does not anticipate applying these rules to exercise direct oversight of contracts insurers enter into with providers or preferred provider organizations under Insurance Code §1301.061. When the department reviews insurers' networks for adequacy, it will rely on the information available to it. The department's duty to review network adequacy does not create a role for the department to act as a referee for contracting between insurers and preferred provider organizations or providers, except to the extent necessary to ensure that insurers comply with applicable statutes and regulations.

The definition of "exclusive provider network" does not conflict with the definition of "preferred provider." The definition for "preferred provider" does not specifically address either direct or indirect contracts, and the relationship between an insurer and a preferred provider could arise through either type of contract. The department does not agree that the definition of "exclusive provider network" could create a regulatory loophole in which insurers could show compliance with network adequacy standards, yet not disclose all contracted providers to insureds. In reviewing network adequacy, the department will look at the network of providers the insurer relies on to meet

network adequacy requirements. If no providers are listed, the network would likely not be found adequate. It is also not clear why an insurer would want to hide contracted providers from insureds. If insureds are forced to go out of network because no providers are identified in the provider listings, the costs to the insurer are likely to be higher, especially under the payment requirements of the adopted rule.

In regard to the questions the commenter raises about the loophole the commenter perceives, the department makes the following replies:

1) If an insurer does not list indirectly contracted providers in the insurer's provider listings, then the department would not consider those providers a part of that network. The department would determine the adequacy of the network based on the providers the insurer identifies as a part of the network, and it is these listed providers that a consumer would choose from.

2) An insurer could not satisfy network adequacy with a network lacking in transparency. If the insurer refuses to identify the providers that make up the network, the department would not find the network adequate.

3) A preferred provider can determine whether another provider is a preferred provider by viewing the network's directory. Regardless of how the insurer and provider choose to contract, if the provider is a preferred provider, the provider should be listed in the network's directory.

4) The department will not review every indirect contract between an insurer and the providers that make up the insurer's network through an indirect contract. The department accepts information it receives from an insurer at face value. If the department learns or determines that an insurer has provided false information to

support the adequacy of a network, the department will take all appropriate action under department regulations and the Insurance Code.

5) The department will not regulate insurers differently based on how they form their networks. All insurers must comply with the Insurance Code and the department's regulations, regardless of whether they contract directly with providers or form networks based on contracts with preferred provider organizations.

6) The department does not determine the value of a preferred provider benefit plan. It determines the adequacy of the network the insurer uses for the preferred provider benefit plan and oversees the compliance of the insurer under the Insurance Code and department regulations.

In regard to the commenter's concerns about leasing of providers' rates, the department notes that it does not base its review of network adequacy on the contracts an insurer has, it bases the review on the network the insurer provides. If an insufficient number of providers are included in the network, the department will likely find the network inadequate. So it will not be necessary, as an initial matter, for the department to review an insurer's contracts with those who lease providers' rates, substantiate the existence of the contracts, or otherwise apply the requirements of these rules to the contracts or the entities that lease providers' rates.

The department declines to adopt the proposed section establishing a registration process for preferred provider organizations. The proposed section would constitute a substantive change necessitating re-proposal of these rules. The proposed section also goes beyond the applicability of these rules, as the department does not intend to apply them to regulate preferred provider organizations. Finally, the proposed

section is potentially inconsistent with law, as it attempts to interpret applicability of Government Code Chapter 552 to a broad category of information.

Comment: A commenter asks that the department revise the definition of "pediatric practitioner" to reference advance practice nurses in addition to physicians. In support of this recommendation, the commenter notes that advanced practice nurses are referenced in §1301.052 and included in the definition of "practitioner" in Insurance Code §1451.001.

Agency response: The department agrees with the comment, but declines to make the specific change requested. Instead, the department makes a similar change to the change the commenter requests.

The definition "pediatric practitioner" only appears in §3.3707, in regard to waivers from network adequacy requirements. The provisions within the rule that relate to network requirements do not generally address specific provider types, but rather address "physicians or providers." For consistency with that usage, the department has revised the definition of "pediatric practitioner" to be "[a] physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults."

Section 3.3703

Comment: A commenter asks that the department clarify that §3.3703(a)(20) applies to preferred providers and that the obligation to provide detailed reimbursement information under this provision does not equate to claim-specific information.

Agency response: The department disagrees with the comment and declines to provide the requested clarification.

Section 3.3703(a)(20) clearly applies only to contracted providers, so no clarification is necessary.

Regarding application of the section to claim-specific information, the rule requires sufficient information to be provided to allow a provider to determine the amount of payment that will be made for services to be rendered. In most cases this will not require the provision of claim-specific information, but the department declines to state that this will never be the case.

Section 3.3703(a)(23) and (a)(24)

Comment: A commenter observes that the department proposed no revision to §3.3703(a)(23). The commenter asks that the department amend this provision to expressly allow a contract between an insurer and provider to require disclosure of financial interests, rather than just ownership interests, when the provider makes a referral.

The commenter requests that the text be revised to say the following:

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain provisions requiring a referring physician or provider, or a designee;
(A) to disclose to the insured, if applicable:
(i) that the physician, provider, or facility to which the insured is being referred is not a preferred provider; and
(ii) that the referring physician or provider has a financial interest in the physician, provider, or facility to which the insured is being referred.
(B) to disclose to the insurer, if applicable:
(i) on an annual basis the financial interests the preferred provider has in other physicians and health care providers. The contract also may contain

provisions requiring disclosure of changes that have occurred from a previous disclosure. Such additional disclosures should be reasonable in time and allow at least 60 days notice after a material change in the financial interests of a preferred provider.

(C) For purposes of paragraph (23) of this subsection, the term "financial interests" may be defined by the contract provided that the definition requested by an insurer is reasonably consistent with the definition of "financial interests" in §180.24(a)(2) of this title or analogous federal regulations defining what constitutes the "financial interests" of health care providers in other health care providers.

Agency response: The department disagrees with the comment and declines to make the proposed change. The change requested by the commenter would address a new notice requirement that might be required by contract and would create a new definition for use in the provision. The department believes this would constitute a substantive change necessitating a new rule proposal.

The department notes that the provision is optional and insurers and providers are entitled to enter into contractual arrangements that are not otherwise prohibited by law, so an insurer could negotiate a contract provision as contemplated by the commenter without it being referenced in rule.

Comment: A commenter opposes modifications to §3.3703(a)(23) suggested by a commenter during the public hearing on the proposed rules. The commenter's opposition to the suggested modifications is based on the commenter's continued opposition to the use of out-of-network referral and ownership interest forms.

The commenter discusses the history of these forms and the instances when the commenter has seen insurers require these forms. The commenter says these forms discourage a physician from discussing and recommending treatment options and

services that are out-of-network. The commenter is concerned that if the department incorporates the suggested revisions into the rule, insurers will use them as a pretext to intimidate and terminate network physicians. The commenter says insurers have already brought lawsuits against doctors and surgery centers owned by doctors in several states based on this issue.

As an alternative to the modifications to §3.3703(a)(23) and (a)(24) suggested by a commenter during the public hearing on the proposed rules, the commenter suggests the department adopt a new section prohibiting insurers from requiring that providers disclose ownership interests in facilities to which they refer insureds. The commenter provides the following text for this section:

> Section 3.37XX. Interference in recommended treatment prohibited. (a) An insurer may not require, through contract or otherwise, a preferred provider to complete or retain a document substantiating the disclosure of financial or ownership interests or the insured's acknowledgment of such disclosure.
>
> (b) An insurer may not require, through contract or otherwise, a preferred provider to recommend treatment to be provided by alternate preferred provider.
>
> (c) Pursuant to Insurance Code §1301.151, an insurer may not require, directly or indirectly, through contract or otherwise, an insured to sign or otherwise execute a document acknowledging financial or ownership disclosures or consenting to referrals to certain physicians or health care providers. As used in this subsection, "acknowledging financial or ownership disclosures" includes affirmations that the insured understands and acknowledges the limitations of the benefits provided when receiving care from nonpreferred providers.

Agency response: The department agrees in part and disagrees in part with the comment and has made a change to the rule text. The department declines to adopt the new section suggested by this commenter. However, the department adopts minor clarifying amendments to §3.3703(a)(23).

The department amends the text as adopted to provide that in a contract provision under §3.3703(a)(23) a referring physician or provider needs to disclose that

the physician, provider, or facility to which the insured is being referred might not be a preferred provider.

The department also revises the text to clarify that the requirement that a referring physician or provider disclose an ownership interest is only applicable if the physician or provider actually has an ownership interest in the provider that the insured is being referred to.

In providing this clarification, the department notes that the rule provision is optional and subject to the agreement of the insurer and the preferred provider.

The department declines to adopt the suggested new section because it would impose new requirements on insurers not addressed in the rule proposal. This would constitute a substantive change necessitating a new proposal before adoption. Further, in the absence of clear statutory guidance on the issue, it is the department's position that insurers and providers are free to agree to any contractual arrangements and requirements that are not prohibited by statute or regulation.

Section 3.3703(a)(27) and Figure 3.3705(f)(1)

Comment: A commenter observes that the notification requirements of §3.3703(a)(27) and the figure in §3.3705(f)(1) do not include exceptions for emergency providers. The commenter assumes the department intended to include an exception, because it is not feasible for an emergency care provider to provide advanced notices or estimates. Without clarification one might read these provisions as applicable to emergency care providers. The commenter asks the department to add the words "except in cases of emergency care" to the provisions.

A second commenter also requests clarification of §3.3703(a)(27) and Figure: 28 TAC §3.3705(f)(1). The commenter asks that the department add exceptions for emergency care services to prevent confusion and avoid delays for patients in emergency care situations. A third commenter raises this point in regard to both §3.3703(27) and §3.3703(28).

Agency response: The department agrees that notice requirements are not applicable in cases of emergency and has adopted revised text to clarify this.

The department has used the first commenter's requested change for §3.3703(a)(27) in part, but has also included a reference to Insurance Code §1301.155. The department adopts an equivalent change in §3.3703(a)(28).

In regard to the figure in §3.3705(f)(1), the department declines to add a specific reference to emergency services. Instead, the department revises the text to note that an insured has "the right, in most cases, to obtain estimates in advance from out-of-network providers of what they will charge for their services; and from your insurer of what it will pay for the services."

This amendment will address emergency situations, but it will also address other situations where an insured may not able to obtain advance estimates of out-of-network provider charges or insurer payment.

Section 3.3703(a)(27) and (28)

Comment: A commenter asks that the department not adopt proposed §3.3703(a)(27) and (28). The commenter disagrees with the policy that insurers should have the opportunity to coordinate an insured's care. The commenter suspects the provisions

were proposed so that insurers would have notice and time to coax patients into a facility the insurer prefers and says the provisions are contrary to a patient's freedom of choice and infringe on the professional judgment of physicians.

The commenter says that the notices required under §3.3703(a)(27) and (28) are broader than disclosures under other laws and that the department would be over reaching if it adopted them. The commenter says the provisions reflect a department philosophy to deflect insurer responsibility and put burdens on patients and physicians.

A second commenter says that §3.3703(a)(27) and (28) are awkwardly worded and appear to create a duty that an insurer coordinate an insured's care. A third commenter also raises this point, saying that proposed §3.3703(a)(27) and (28) may create new duties that may or may not exist in a policy and are not derived from specific statutes, because insurers marketing preferred provider benefit plans are not required to coordinate an insured's care.

The second commenter says that while some insurers are involved in coordination of care in some complex cases, not every insurance policy requires coordination of care and not every case needs coordination. The commenter says that the amendments to §3.3703(a)(27) and (28) may not be necessary, because a large number of insurance contracts require pre-authorization for surgical procedures.

A fourth commenter generally supports the addition of §3.3703(a)(27) and (28) and says they will help consumers be more aware of the possibility of balance billing and help them avoid it. The commenter understands what is meant by the word "coordinate," but recommends changing the language to more accurately reflect that it refers to the ability of the insured to contact the insurer for any help the insurer can

provide in preventing an unexpected balance bill, such as giving information on expected out-of-pocket costs and the availability of network providers.

A fifth commenter says that proposed §3.3703(a)(27) and (28) unnecessarily increase administrative costs by mandating re-contracting. The commenter says that because the department can only address a provider's disclosure through the provider contract, the department has no authority to enforce the providers' obligations to consumers.

Agency response: The department disagrees with the first, second, fourth, and fifth commenters, but makes a clarifying change. The department agrees with the third commenter, and uses the third commenter's suggestion in clarifying the provisions.

In regard to the first commenter, the department notes that it was not the department's intent to imply that an insurer could limit an insured's choice of provider or interfere with medical care. Nor, in regard to the issue raised by the second commenter, did the department intend to create a duty for insurers to coordinate care in instances where it does not otherwise exist.

To address these concerns, the department has deleted the phrase "to coordinate the insured's care" from §3.3703(a)(27)(A) and §3.3703(a)(28)(A) and replaced it with the phrase "for more information."

The department has also deleted the phrase "so that the insurer has the opportunity to coordinate the insured's care" from §3.3703(a)(27)(B) and §3.3703(a)(28)(B).

In light of complaints the department has received regarding balance billing, the department believes it imperative that both insureds and insurers have more

opportunities to know in advance what potential costs may arise from a surgery to reduce the likelihood of being surprised by a balance bill.

The department declines to make a change in regard to the issue raised by the third commenter. The department notes that a number of other new requirements are imposed on provider contracts through the rule, reducing the cost of this particular requirement.

As discussed in the rule proposal preamble, the department has considered the cost of this requirement against the benefits to consumers. This requirement is necessary to provide consumers the opportunity to obtain in-network care and to give an insurer the opportunity to prevent insureds from being surprised by balance billing by out-of-network providers, especially at in-network facilities.

Insurers offering preferred provider benefit plans have an obligation under Insurance Code §1301.005 to ensure that preferred provider benefits are reasonably available to all insureds. The adopted subsections insure that insureds have the opportunity to obtain care from in-network providers when possible.

The required notice to the insurer regarding surgery is necessary to permit the insurer to comply with the requirement of Insurance Code §1301.005 that the insurer reimburse out-of-network physicians at the in-network coinsurance percentage when contracted physicians are not available. It is also necessary to enable an insurer to comply with the requirements of §§1301.005, 1301.0055, and 1301.006, to make contracted providers reasonably available and accessible to all insureds.

Regarding authority to enforce provider obligations to consumers, the department notes that §3.3703 contains multiple requirements for contracts between insurers and

providers. The department has authority to review insurers' contracts with providers to confirm that provisions required by statute or rule are included.

The department does not regulate a provider who enters into a contract with an insurer. However, if a provider violates the terms of a contract with an insurer, the provider is subject to termination of the contract. The department is able to take action against an insurer that does not enforce the contractual provisions required by the rule.

Comment: A commenter recommends strengthening the notice provided from a facility to an insured under §3.3703(a)(28)(A) by also requiring that contracts direct facilities to notify insureds of the contact information for the specific person or office within the facility who can provide information on expected charges and potentially help schedule care so that it is performed by network providers.

Agency response: The department disagrees with the comment and declines to make the requested change.

The department must balance the administrative costs of requiring facilities, entities not directly regulated by the department, to continually update specific contact information against the additional benefit to the consumer. The department believes that consumers already have sufficient access to facility billing and scheduling personnel so as to render provision of specific individual contact information unnecessary.

Section 3.3703(a)(29)

Comment: A commenter opposes proposed §3.3703(a)(29). The commenter says that the provision would impair the department's authority to regulate the marketplace conduct of insurers and undercut the department's regulatory enforcement authority. The commenter says the section would so hinder the department's enforcement of contract prohibitions that it would eviscerate patient rights under Insurance Code Subchapter D, Chapter 1301.

Agency response: The department agrees in part and disagrees in part.

The department does not agree with the commenter's reason for deleting the provision, because the department is generally only authorized to prohibit actions which are prohibited by statute or regulation. It is also the department's position that insurers and providers are entitled to negotiate for any contractual provisions they choose, unless prohibited by law.

The department agrees that the language is unnecessary in order for the department to regulate insurers and carry out the department's statutory responsibilities. Accordingly, the department withdraws proposed §3.3703(a)(29).

Comment: A commenter supports proposed §3.3703(a)(29).

Agency response: The department appreciates the supportive comment but, based on other comments, has declined to adopt §3.3703(a)(29).

Section 3.3704(a)(1) and (11)

Comment: A commenter opposes the exception for exclusive provider benefit plans addressed in §3.3704(a)(1) and asks that the department strike it in its entirety.

The commenter says that the provision would allow exclusive provider benefit plans to require insureds to have services performed by particular hospitals, physicians, or practitioners. The provision would prevent the department from finding an insurer unjust or in violation of the Insurance Code, even if the insurer's exclusive provider benefit plan only has one hospital or one physician of a certain specialty.

The commenter says that, coupled with other provisions in the rule concerning mediation, §3.3704(a)(1) would let an insurer force an insured to participate in mediation for emergency services any time the one hospital in the insurer's network was on diversion status. The commenter adds that even in nonpreferred provider situations an insurer cannot dictate a particular hospital, physician, or practitioner under the proposed rules and says that this shows §3.3704(a)(1) is unnecessary and unsupported.

The commenter also addresses §3.3704(a)(11), saying it appears the department proposed the amendment to §3.3704(a)(11) to reflect the closed nature of exclusive provider benefit plans. However, the commenter says the proposed amendment is overly broad and one could read it as exempting exclusive provider benefit plans from having to make preferred provider benefits reasonably available to insureds within a designated service area.

As an alternative to the proposed amendment, the commenter suggests the department adopt a new §3.3704(b) that reads as follows:

> (b) Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code §§1701.002 – 1701.005, 1701.051-1701.060, 1701.101 – 1701.103, and 1701.151; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or

§§544.051 – 544.054, or to violate Insurance Code §§1451.101 – 1451.127, provided that:

(1) the exclusive provider benefit plan complies with subsection (a)(1) – (10) and (12) of this section, and;

(2) for the purposes of subsection (a)(11) of this section, an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

Agency response: The department agrees in part and disagrees in part with the comment. The department has made the suggested changes.

In regard to the comment concerning §3.3704(a)(1), the department agrees that an exclusive provider plan is not permitted to require that a service be rendered by a particular physician or provider. However, the department does not agree that the proposed language would permit insurers to require that insureds receive services from particular providers. The department agrees to withdraw the proposed additional new text for 3.3704(a)(1) to avoid confusion on this point.

The department notes that it could approve an exclusive provider benefit plan that contains limited numbers of providers, so long as the network meets the network adequacy requirements contained in §3.3704.

The department agrees with the commenter regarding §3.3704(a)(11) and agrees to make the change the commenter suggests. The department has redesignated the remaining subsections as appropriate to reflect addition of this new subsection (b).

Section 3.3704(a)(12)

Comment: A commenter recommends the department revise §3.3704(a)(12) by adding the word "reasonably" as follows: "if medically necessary covered services are not reasonably available through preferred physicians or providers..."

Agency response: The department agrees with the comment and has adopted the requested change.

Section 3.3705(b)

Comment: A commenter appreciates the department's decision to not propose an amendment to add the words "as applicable" to §3.3705(b). The department had included this proposed amendment in the withdrawn June 29, 2012, rule proposal.

Agency response: The department appreciates the supportive comment.

Section 3.3705(b)(1)

Comment: A commenter recommends that the department modify the proposed language for §3.3705(b)(1) to ensure that the subsection requires an insurer to provide to consumers in its written description adequate information regarding their exclusive provider benefit plan coverage. The commenter suggests the department revise the paragraph to include the words "and written description and/or required by law" as follows:

"(1) A statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services from

preferred providers, except as otherwise noted in the contract and written description and/or required by law..."

Agency response: The department agrees it is important to provide consumers accurate information about their coverage. The department also agrees with the general content of the recommended language.

The department has modified the suggested language to provide additional clarification by replacing the words "and/or" with "or as otherwise."

Section 3.3705(b)(14)

Comment: A commenter notes that the department proposes to delete §3.3705(b)(14), which requires insurers to disclose network demographic information to current or prospective insureds and group contract holders in the written description of the terms and conditions of the policy.

The commenter references portions of the May 19, 2011, adoption order preamble where the department states reasons for adoption of §3.3705(b)(14).

The commenter says that there is a clear need for insurers to disclose network demographic information. The best way to prevent unanticipated balance billing is for the department to require that health plans inform consumers regarding the composition of their networks. This will enable consumers to assess the potential for balance billing and to choose, as they see fit, plans that offer more robust networks.

The commenter does not think §3.3705(b)(14) will result in increased premiums because compliance should be limited to minimal printing costs, which insurers could easily absorb. The benefits to consumers, in the form of more complete networks, more

predictable out-of-pocket expenses, increased network transparency, and more informed decision making, clearly outweigh any negligible increases in expense to insurers. The commenter also contests arguments that the requirements of §3.3705(b)(14) could result in consumers getting misleading information.

The commenter points out that the provision's requirement for an annual update of information is a minimum standard and that insurers will be motivated to provide it more often for competitive advantages and marketing purposes. The commenter says that only insurers with weak networks would want to avoid disclosing network information. The commenter also notes that insurers are required to provide a notice to insureds of substantial decreases in network strength under §3.7505(n). The commenter also points out that under §3.3705(q) as adopted May 19, 2011, a plan designated as an "Approved Hospital Care Network" loses this status and must provide notice to the department and insureds if it becomes noncompliant with the network adequacy requirements for hospitals and fails to correct this within 30 days.

The commenter says that the department's proposed amendments to §3.3705(b)(14) to insert reporting requirements related to an insurer's waivers and local market access plans are not a sufficient replacement for the provisions being removed.

The commenter summarizes the comment by saying that the department's proposed revision of §3.3705(b)(14) fails to promote plan transparency regarding the adequacy of networks, enable informed consumer decision-making, incentivize plans to contract with an adequate network of physicians and to hold plans publically accountable for their network composition, align with the department's own previous position on this issue, or conform to the department's charge under HB 2256.

The commenter urges the department to retain the language adopted May 19, 2011, and reject the proposed new language.

Agency response: The department agrees that the language in proposed §3.3705(b)(14) should be retained. As adopted, the department removes the proposed amendments to §3.3705(b)(14) and withdraws the proposed text deletions. The department has placed the new text it had proposed for §3.3705(b)(14) into a new §3.3705(b)(15).

Section 3.3705(f)(1) and (f)(2)

Comment: A commenter says that the proposed rule appears to change the notice required under the figure in §3.3705(f)(1). The commenter says that instead of notifying insureds that payment of claims for out-of-network providers will be at the "network coinsurance rate," the proposed change deletes the word "coinsurance" and adds the word "deductible."

The commenter says this amendment may be confusing if the department does not change the additional requirements relating to payment using a "usual and customary" standard. The commenter says one could tie the reference to "rate" to a usual and customary rate as opposed to the different levels of coinsurance.

The commenter says the provision also seems contrary to language in Insurance Code Chapter 1305 regulating preferred provider benefit plan contracts. Specifically, Insurance Code §1301.0046 refers to "coinsurance" differences, not rates, and Insurance Code §1301.005(b) requires reimbursement of out-of-network services at the same "percentage level of reimbursement."

The commenter says the differences in most contracts involving preferred provider services and nonpreferred provider services is expressed as a percentage difference or "coinsurance" and are not necessarily expressed as a rate.

The commenter suggests that the department not adopt the figure.

A second commenter also addresses the figure in §3.3705(f)(1), as well as the figure in §3.3705(f)(2). The commenter suggests revising the sentence following the second bullet under the words "You have the right to an adequate network of preferred providers (also known as 'network providers')" in the figure in §3.3705(f)(1) and the last sentence of the last bullet in the figure in §3.3705(f)(2) to say "If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits."

Agency response: The department agrees in part and disagrees in part.

The department agrees that the language as proposed could be construed as ambiguous, but prefers to revise the figure, rather than not adopt it as requested by the first commenter, since it provides important information to insureds.

To clarify the possible ambiguity in the figure in §3.3705(f)(1), the department has revised the language to more closely track the statute. The department used part of the second commenter's suggested text to do this, revising the third sentence of the notice to state, "If you relied on materially inaccurate directory information you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement..."

The department has incorporated the second commenter's suggested change into the figure in §3.3705(f)(2).

Section 3.3705(f)(2)

Comment: A commenter says the proposed figure in §3.3705(f)(2) seems to suggest that if an insurer approves a nonpreferred provider, the insurer must resolve the nonpreferred provider's bill so that an insured only has to pay applicable coinsurance, co-pay, and deductibles. The commenter says this duty does not exist in statute and conflicts with statutory provisions that discuss what must be done.

First, the commenter says, Insurance Code §1301.005(b) does not require an insurer to resolve a nonpreferred provider's bill. Instead, it only requires an insurer to use certain reimbursement levels. An insurer does not have a contract with a nonpreferred provider and has no legal right to require that a nonpreferred provider charge a specific rate.

The commenter says an insured may have a right to reimbursement and may assign that right to a provider to collect benefits, but the issue of whether an insured may have to pay additional amounts is not within the control of the insurer.

Second, the commenter says the notice conflicts with Insurance Code §1301.0053. This section requires than an insurer reimburse emergency care at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider. The proposed notice confuses these two standards and suggests that the standard for emergency care may also apply to other non-emergency care situations.

The commenter says the figure ignores the fact that an insurer contracts with preferred providers, but not nonpreferred providers. A nonpreferred provider could bill a patient the difference between the reimbursement and whatever "full charge" the

nonpreferred provider charges, and the insurer has no control on what the nonpreferred provider will agree to charge or accept.

Agency response: The department disagrees with the comment and declines to make a change.

Prior to the bill's passage, the 82nd Legislature amended the text of HB 1772 during the legislative session to include language regarding insurer payment of claims when no preferred provider was available, and provided for payment of claims in cases of emergency that tracks the health maintenance organization statutory language. At the time HB 1772 passed, the legislature was aware that the department has construed the health maintenance organization language to require health maintenance organizations to hold enrollees harmless in these situations. See *Biennial Report of the Texas Department of Insurance to the 80th Texas Legislature* at pages 10-12, tdi.texas.gov/reports/documents/finalbie07.pdf.

As the House Research Organization's report on HB 1772 (82nd Legislature, 2011) notes, the bill was amended to require that insurers offering preferred provider benefit plans "fully reimburse" out-of-network providers in both of these situations. See *House Research Organization Bill Analysis for HB 1772* which can be found on the House Research Organization's website at hro.house.state.tx.us/pdf/ba82r/hb1772.pdf#navpanes=0.

The consumer notice in §3.3705(f)(2) accurately reflects the requirement of the rule, informing consumers that insurers have additional payment responsibilities in circumstances of inadequate networks or emergencies.

Comment: A commenter says that insurers would like the option to offer products that continue to provide coverage for some, but not all, out-of-network services. The commenter uses transplants as an example, saying that this could be a service conducive to a closed network benefit, limited to recognized centers of excellence, while other services are available from both in and out-of-network providers.

The commenter says that HB 1772 allows for this interpretation of the term exclusive provider benefit plan, in that it says an "exclusive provider benefit plan" is a benefit plan in which an insurer excludes benefits to an insured for "some or all services" provided by a physician or health care provider who is not a preferred provider.

The commenter recommends the department revise the first bullet of the notice required by §3.3705(f)(2) to include optional text an insurer can choose from to describe the format of the insurer's exclusive provider benefit plan.

The commenter suggests the following text:

An exclusive provider benefit plan described in your policy:
[Option 1] provides no benefits for services you receive from out-of-network physicians and providers other than emergency care services.
[Option 2] provides no benefits for one or more specific types of services you receive from out-of-network physicians and providers, other than emergency care services.
[Option 3] provides no benefits for services you receive from one or more physicians and providers, other than emergency care services.
[Option 4] other than emergency care services it provides:
- no benefits for one or more specific types of services you receive from out-of-network physicians and providers, and,
- no benefits for services you receive from one or more specific physicians and providers.

Agency response: The department disagrees and declines to make a change.

The department's review of Insurance Code Chapter 1301 does not reveal an intent by the legislature to permit hybrid preferred and exclusive provider benefit plans or any indication of how such plans would be regulated. To the contrary, Insurance Code §1301.0045(b) specifically states that, except for two limited exceptions, the chapter "may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured." If hybrid plans were intended, the legislature would not have both broadly and specifically granted them exemption from many preferred provider plan requirements in the chapter relating to out-of-network services and payments.

Insurance Code §1301.0046 imposes a maximum coinsurance applicable to the payment of nonpreferred providers to 50 percent of the total covered amount, but exempts exclusive provider benefit plans from this requirement. If hybrid exclusive provider plans with out-of-network benefits were intended to be permitted, the legislature would not have granted exclusive provider benefit plans a blanket exemption from this requirement. Similarly, Insurance Code §1301.005 requires preferred provider plans to make out-of-network benefits reasonably available, but the legislature granted exclusive provider plans a blanket exemption from this requirement.

Permitting hybrid plans would allow an insurer with a single exclusive provider benefit plan element to claim an exemption from paying out-of-network providers at least 50 percent of the covered amount and from having to make out-of-network benefits reasonably available for all the other preferred provider plan elements of the product. Also, in Insurance Code §1301.1581, the legislature required that exclusive provider benefit plans note that they are such on their identification cards, again with no

reference of what should be required in the case of a hybrid plan. Given that such hybrid plans could have few or many out-of-network benefits, such a blanket requirement could be misleading to providers and insureds.

Finally, in Insurance Code §1301.0052 and §1301.0053 the legislature specified payment protections for insureds under exclusive provider benefit plans in certain circumstances separate from the requirements imposed on preferred provider benefit plans but did not specify what requirements would apply in those circumstances in the context of a hybrid product. Viewed as a whole, it is clear that the legislature did not contemplate imposing any requirements of the chapter on hybrid plans.

As the sole basis for the construction that the definition of "exclusive provider benefit plan," the commenter asserts that Insurance Code §1301.001(1) references a "plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services required under §1301.155, provided by a physician or health care provider who is not a preferred provider" and that the reference to the possibility of excluding coverage of "some" rather than all out of network services indicates an intent to permit hybrid plans. The department notes that the definition in the final enrolled bill was unchanged from the initial filing of the bill. From the initial filing of the bill, the definition referenced out of network emergency services. During the legislative development of the statutes, the legislature added §1301.0052 and §1301.0053 to specify out of network payment requirements for both emergency and inadequate network situations.

The department's position is that the reference to "some" out of network services referenced inadequate network situations in which exclusive provider benefit plans, like

health maintenance organizations, would be required to cover services when there are no network providers available.

Because hybrid plans would require harmonizing the preferred and exclusive provider benefit plan regulations in regard to a single product, substantial additions to the current rule would be required. Because stakeholders have not been put on sufficient notice to permit comments on the advisability of hybrid plans or the regulations that should apply to them, the department does not believe it is appropriate to insert such regulations at this time.

Finally, the department believes that there are sufficient public policy reasons to reject hybrid products pursuant to its rulemaking authority under Insurance Code Chapter 1701 and that authorization should be left until sufficient regulations can be developed or the legislature addresses the issue. Given that hybrid products could contain a single preferred provider element or a single exclusive provider element only, or they could contain mixes of the elements in confusing ways, the department believes that such products would be sufficiently confusing to consumers to be unjust, encourage misrepresentation, or be deceptive under Insurance Code §1701.055 and the commissioner's other rulemaking authorities. The department is concerned, for instance, that an insurer could pick and choose which services to make exclusive or preferred depending on the types of providers that the insurer could negotiate favorable contracts with or depending on which provider types would result in lower claims costs for the insurer. Insureds could be required to consult their plan documents for each service to determine whether it was an exclusive or preferred provider benefit.

Section 3.3705(l)(2) and (3)

Comment: A commenter opposes the department's proposed deletion of §3.3705(l)(2) and (3).

The commenter notes that §3.3705(l)(2) requires an insurer to include in its provider listing information regarding a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The insurer must make this information available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

The commenter says that §3.3705(l)(3) provides insurers with direction for implementing §3.3705(l)(2) by specifying the claims that an insurer should consider in determining the percentages under §3.3705(l)(2).

The commenter supports its opposition to the department's proposed deletion of §3.3705(l)(2) and (3) by referencing statements the department made in support of adoption of the provisions in its May 19, 2011, adoption order. The commenter says that the department's proposed deletion of §3.3705(l)(2) and (3) undermines the collective impact of the transparency provisions of §3.3705(l).

The commenter concludes by urging the department to not adopt its proposed deletion of §3.3705(l)(2) and (3).

Agency response: The department agrees with the comment and withdraws its proposed deletion of §3.3705(l)(2) and (3). As proposed, §3.3705(l) only referenced "the requirements in paragraphs (1) – (7)." For consistency with the withdrawn deletion

of §3.3705(l)(2) and (3), the department revises §3.3705(l) to reference "the requirements in paragraphs (1) – (9)."

Section 3.3705(m)

Comment: A commenter supports the annual policyholder notice required by §3.3705(m), but recommends that the notice be improved to give consumers access to all relevant information on the waiver and local market access plan in one place.

The commenter says that, in addition to providing a link to the online listing of regions, counties, or ZIP codes where the network is inadequate, the notice should point consumers to two other important pieces of information: (1) how they can obtain or view the full local market access plan, and (2) a link to the department's web page on waivers that have been granted.

The commenter suggests revising §3.3705(m) to include paragraphs that list the items an insurer must include in the annual policyholder's notice and suggests adding "information on how the local market access plan may be obtained or viewed" as paragraph (2) and "a link to the department's website with information relevant to the grant of waivers established under §3.3707(f)" as paragraph (3).

The commenter suggests including in §3.3705(m) a link to the department's website that lists information relevant to waivers under §3.3707(f).

The commenter also says the notice required by §3.3705(m) should identify how one may obtain an insurer's local market access plan. The commenter says that while the notice as proposed provides a link to a listing of geographic areas where a network is inadequate, the local market access plan would provide additional valuable

information to consumers. The commenter observes that insureds will get information on how to view the local market access plan in the policy terms and conditions under §3.3705(b)(14)(C), but says that including the information in the annual notice that is specific to the access plan will help insureds get all of the relevant information on the access plan in one place.

Agency response: The department agrees with the comment in part and disagrees in part. The department has made a revision to the adopted rule text in response to the comment.

Adopted §3.3705(b)(15) requires that insurers include in its consumer disclosure information regarding whether a waiver or access plan applies to the insurer's product and how the access plan may be obtained or viewed. The rule already incorporates the commenter's suggestion to some extent.

However, the department agrees that, just as consumers may want information about the access plan utilized by an insurer, they may also want information on waivers from network adequacy requirements the department has granted the insurer. The department has adopted an amendment to require that insurers include in their annual notice information on how an insured can obtain or view any local market access plans the insurers use and a link to the department's website that relates to the grant of waivers under §3.3707(f). The department's web address for this information currently is: tdi.texas.gov/wc/wcnet/documents/RuleEPOWaiverRe.docx.

The department declines to include a specific web address within the rule text, because any future change to the website address would necessitate an amendment to the rule.

In addition, the amendment requires that insurers provide in their annual policyholder notice a link to the department's website that lists information relevant to waivers established under §3.3707(f). This information will be more accessible to insureds than the rule text, and it will suffice to provide notice of where insureds can obtain information regarding the insurer's waivers.

Section 3.3705(n)

Comment: A commenter opposes the department's proposed deletion of the text in §3.3705(n) adopted May 19, 2011. The commenter says §3.3705(n) should be retained because it would aid consumers in decision making and reduce incidents of unanticipated balance billing.

The commenter references portions of the May 19, 2011, adoption order preamble where the department states reasons for adoption of §3.3705(n).

The commenter disputes arguments that disclosures under §3.3705(n) might be misleading in instances where decreases in the availability of network providers are temporary due to contract negotiations. There is a low risk of insureds getting misleading information, because the information required under the section is posted in online directories and can easily be updated.

The commenter says that a short-term failure to meet network requirements is no less of a true failure and that even an insurer's temporary non-compliance with network adequacy requirements directly impacts consumer financial responsibilities.

The commenter also points out that §3.3705(n) does not impact short-term contract terminations because it allows for a two-day implementation period. If a

contract ceases for only two days or less, an insurer would not need to take action under §3.3705(n). Further, the rule allows an insurer to remove a notice that is posted if adequate providers become available, six months after the insurer posts notice, or the date on which the insurer notifies the department by email that a provider contract termination does not result in non-compliance with adequacy standards.

The commenter says that insureds are not sufficiently protected by the requirement that an insurer provide updated provider listings under §3.3705(i) and (j), and the detrimental reliance provisions under §3.3705(k), to justify deletion of §3.3705(n). The commenter observes that §3.3705 only requires that listings be updated at least every three months, while §3.3705(k) is only a back-end measure and places the burden on an insured to show detrimental reliance on inaccurate listings.

The commenter asks that the department retain the text of §3.3705(n) that the department adopted May 19, 2011.

Agency response: The department agrees to withdraw its proposed deletion of the text in §3.3705(n) that the department adopted May 19, 2011.

Comment: A commenter observes that proposed §3.3705(n), which is adopted as §3.3705(o), requires an insurer to include in all policies, certificates, and outlines of coverage required disclosures regarding reimbursement for out-of-network services. The commenter asks that the department allow insurers the option to provide the notice separately to avoid the administrative costs associated with filing amendments to approved policy and certificate forms.

The commenter also notes that Insurance Code Chapter 1456 contains specific disclosure obligations related solely to facility-based providers, but that §3.3705(n)(3)(D) implies that the obligation to provide an estimate for facility-based provider services applies to all out-of-network providers. The commenter requests clarification.

Finally, the commenter asks that the department recognize the fiscal implication of requiring insurers with preferred provider benefit plans to revise and file all of their contract forms to comply with the new disclosure requirements.

Agency response: The department disagrees with the comment and declines to adopt the change requested by the commenter.

Because the disclosure required by proposed §3.3705(n), adopted §3.3705(o), concerns insurer claims payment under the policy, the department believes that an insurer must incorporate the required disclosures into the policy so that it will clearly be binding on the insurer.

The department notes that the rules require a number of changes to policy forms, but that an insurer may consolidate all changes into a single filing with the department. Insurers may file a unified endorsement containing all necessary new language and then utilize that endorsement with all appropriate products.

The department agrees the rule applies the required estimate to all nonpreferred provider services in cases where the insurer bases its reimbursement of nonpreferred providers on any amount other than full billed charges. If an insurer determines out-of-network reimbursements by applying a percentage stated in the policy to the billed charge, the disclosures would not be required. However, in all other cases, this additional protection for consumers is necessary so that consumers will be able to

know, prior to services being rendered, what the insurer will pay for an out-of-network service.

The department would consider failure of an insurer to specify what the policy will pay under these circumstances, without also providing an alternative method of determining what the payment will be in the manner prescribed by the rule, to be unjust under Insurance Code §1701.055. Further, the department would consider a preferred provider benefit plan that does not permit ready access to estimates of what out-of-network providers will be paid to not be making those covered benefits reasonably available under Insurance Code §1301.005(a).

Section 3.3705(p) and (q) and the text that was located in §3.3707(f)

Comment: A commenter opposes the department's proposed deletion of §3.3705(p) and (q), which provide for insurer designation of networks as "approved care hospital care networks" or "limited care hospital care networks," based on whether the insurer's network met network adequacy requirements for hospitals.

The commenter says insurers may want §3.3705(p) and (q) removed to avoid public accountability regarding plan compliance failures and plan responsibility for unanticipated balance bills. However, the commenter says, removal of these provisions works to the detriment of insureds by depriving them of the ability to investigate their options.

The commenter says that providing an easily understandable designation for insureds promotes transparency and aids in decision-making. The commenter adds that §3.3705(p) and (q) aid meaningful department oversight of an insurer's network

adequacy compliance. However, the commenter says, removal of these provisions would permit insurers to move forward with forms that are unjust, deceptive, and encourage misrepresentation.

Finally, the commenter says that insureds are not sufficiently protected by the requirement that an insurer provide updated provider listings under §3.3705(i) and (j), and the detrimental reliance provisions under §3.3705(k), to justify deletion of §3.3705(p) and (q). The commenter observes that §3.3705 only requires that provider listings be updated at least every three months, while §3.3705(k) is only a back-end measure and places the burden on an insured to show detrimental reliance on inaccurate listings.

The commenter asks that the department retain §3.3705(p) and (q).

In conjunction with this request, the commenter asks that the department retain the following text in §3.3707, which the department proposed to delete from §3.3707(f):

> An insurer that is granted a waiver under this section concerning network adequacy requirements for hospital-based services is required to comply with §3.3705(p) of this subchapter (relating to Nature of Communications with Insureds, Readability, Mandatory Disclosure Requirements and Plan Designations). The insurer is required to designate such plan as a "Limited Hospital Care Network."

In support of the request, the commenter references portions of the May 19, 2011, adoption order preamble where the department states reasons for adoption of the text.

Agency response: In regard to the proposed deletion of §3.3705(p) and (q) the department agrees in part and disagrees in part with the commenter. The department

withdraws its proposed repeal of §3.3705(p) and (q). However, it revises the text of §3.3705(p) as described in this response.

The department agrees that plan designations are important consumer protections, but this information is subject to frequent change, while policy documents are only issued on an annual basis.

On balance, the department has determined that this information is not necessary on the policy or certificates, which are issued after the insurance has been purchased. The information should be maintained on the outline of coverage and the cover page of any provider listing describing the network, which are used much more often by consumers seeking to understand their coverage and are much more easily updated by insurers. The rule text has been amended accordingly.

In regard to the text that the department proposed to delete from §3.3707(f), the department agrees with the comment and withdraws the proposed deletion of the text addressed by the comment. Because of new subsections included in §3.3707, the department has redesignated the subsection that contains the text addressed by the comment.

Section 3.3707

Comment: A commenter offers general support for the provisions addressing waiver of network adequacy requirements, which are adopted in §3.3707. The commenter says these requirements will benefit consumers by helping to ensure that networks are adequate up front.

The commenter says that the additions under §3.3707(b)(1)(A) – (E) are reasonable and appropriate requirements for an insurer seeking a waiver from network adequacy requirements, and they must be adopted to ensure a meaningful review of waiver requests.

The commenter supports the addition of §3.3707(c), which requires an insurer to file its local market access plan at the same time it makes a waiver request. The commenter says that ensuring that insurers have compliant local market access plans that are sufficient to help insureds access care in an inadequate network is an appropriate prerequisite for marketing a plan under a waiver. The commenter also supports §3.3707(g)(2) and (i), which require an insurer to submit a local market access plan at the same time it submits a waiver request at renewal or the network falls out of compliance with network adequacy standards.

The commenter also supports §3.3707(j) and (k), which outline minimum standards for local market access plans and related procedures. The commenter believes these provisions should be maintained to protect consumers.

Agency response: The department appreciates the supportive comment.

Comment: A commenter says that §3.3707 addresses a waiver process for an insurer to offer preferred and exclusive provider benefit plans in service areas where the insurer's network does not fully comply with the network adequacy requirements.

The commenter observes that the section requires specific information regarding contracting efforts and expected costs in a waiver filing for each county in which the insurer has a mileage gap for a specialty, if there is one or more licensed provider of

that specialty available. The commenter says this provision will add significant administrative obligations for insurers in the event a specific provider type is unwilling to contract in a particular service area or when there is no provider of that type located in the area.

The commenter is also concerned with this significant expansion of regulatory involvement in the provider negotiation and contracting process.

The commenter points out that with §3.3707 the department is creating greater obligations for preferred and exclusive provider benefit plans than the department currently applies to health maintenance organizations.

A second commenter also says that the waiver provisions of §3.3707 put preferred and exclusive provider benefit plans at a disadvantage compared to health maintenance organizations. The second commenter says that it appears the department has taken ideas from Insurance Code Chapters 843 and 1305 and grafted them in to Insurance Code Chapter 1301. The commenter asks the department to reconsider the burden this creates.

Agency response: The department does not agree that the amendments to §3.3707 are a significant expansion of regulatory involvement in the provider negotiation and contracting process.

Through Insurance Code §§1301.005, 1301.0055, and 1301.006, the legislature has required that insurers offering preferred provider benefit plans maintain adequate networks of contracted providers. The failure of an insurer to offer an adequate network constitutes a violation of these Insurance Code provisions, and it is an administrative violation under the preferred provider benefit plan rules.

To the extent that there is an inadequacy in the network, the waiver and access plan are necessary so that the department can ensure that any deviation from the network adequacy standards are for good cause as required under Insurance Code §1301.0055(3). In addition, §3.3707 implements the requirement in Insurance Code §1301.006 for an insurer marketing a preferred provider benefit plan to contract with physicians and providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided are provided in a manner ensuring the availability of accessibility to adequate personnel, specialty care, and facilities. The application for waiver and access plan are necessary to enable the department to monitor and ensure compliance with this requirement.

The department created the waiver process in §3.3707 to give insurers a way to offer preferred and exclusive provider benefit plans to insureds who live in areas where there are insufficient numbers of providers to contract with, without violating network adequacy requirements. As adopted, the section permits insurers an opportunity to obtain a waiver of network adequacy requirements, as contemplated by §1301.0055 of the Insurance Code.

Though the department has not previously focused on preferred provider benefit plan network adequacy, the legislature's recent directives are clear. Insurers seeking to market network-based products in particular service areas must have adequate networks in those areas; otherwise they must either cease marketing or obtain waivers from network adequacy requirements.

The department agrees that insurers seeking to continue offering network products in geographic areas where they have inadequate networks will face increased

administrative costs – due to filing waiver requests – over the current market, which previously has been virtually unregulated. However, these added costs can be mitigated by other potentially cost-saving factors in the rule. The department notes that in response to another comment it has clarified the time frame that applies for an insurer to address termination of provider contracts. As adopted, §3.3707(i) allows an insurer 90 days from the date a network becomes inadequate to file for a waiver. This will give insurers time to contract with new providers to fix a network inadequacy and will also permit the consolidation and presentation of multiple waiver requests at the same time.

In addition, the regulatory burden is less in areas where providers of a particular type of health care are not available to negotiate and contract with. For these areas an insurer would not need to describe its attempts to contract with providers of the particular health care type. The insurer would also not need to describe savings the insurer would realize by not contracting. The insurer would only need to notify the department that a provider is not available to contract with. If no providers become available in the area, renewal requests would only need to verify that fact.

In areas where providers are available to contract, the department believes it is reasonable for an insurer in its waiver request to demonstrate that it has tried to contract with the providers and to explain why these attempts have failed.

Section 3.3707 does not add to the negotiating or contracting process that occurs between insurers and providers. Instead, it provides the opportunity for insurers to offer preferred or exclusive provider benefit plans in areas of the state where insurers are otherwise unable to contract with all the necessary providers to build a network.

The information required by §3.3707 directly relates to an insurer's attempts to negotiate with providers. It also directly relates to savings the insurer will realize if the department grants a waiver from network requirements. This gives the insurer an opportunity to show the department good cause for it to grant a waiver as required under Insurance Code §1301.0055(3).

In response to the commenters' concern that §3.3707 creates a greater obligation for preferred and exclusive provider benefit plans than the department currently applies to health maintenance organizations, the department may consider examining the requirements applicable to health maintenance organizations in the future. However, this examination is beyond the scope of these rules and is not addressed here.

In addition, health maintenance organizations are generally regulated more closely by the department. For example, health maintenance organizations are examined by the department every three years for various issues, including network adequacy. Preferred and exclusive provider benefit plans are not subject to the same level of oversight. Additionally, the legislature has not included the same language regarding good cause to deviate from network adequacy requirements in the statutes regarding health maintenance organizations as it has in the preferred and exclusive provider statutes. It follows from these differences that the regulations applicable to health maintenance organizations and exclusive provider benefit plans would not be identical.

Comment: A commenter says it is imperative that exclusive provider benefit plans be robust enough to provide all covered services within a reasonable time and distance from insureds, because they provide no out-of-network benefits. The commenter has previously advocated that exclusive provider benefit plans not be granted waivers under §3.3707 and recommends that the section be revised to allow waivers for exclusive provider benefit plans but hold them to a higher standard than applies to preferred provider benefit plans.

Agency response: The department disagrees with the comment and declines to make a change.

The network adequacy standards adopted by the department are largely the same for all network-based products, including health maintenance organizations and preferred and exclusive provider benefit plans. This permits administrative efficiencies for insurers and the department in reviewing networks health benefit plan issuers use in different products.

The department intends to strictly review all waiver requests for preferred and exclusive provider benefit plan networks. However, in the context of an exclusive provider benefit plan, the rule provides additional protection for insureds receiving out-of-network care where no network provider is available.

Section 3.3725 requires that an insurer protect insureds from balance billing in the situations addressed by the section. In most cases, insureds will only need to pay their coinsurance and co-payment amounts.

This additional requirement on insurers offering exclusive provider benefit plans, which is similar to protections afforded enrollees in health maintenance organizations,

provides sufficient protection for consumers while encouraging insurers to continually enhance network adequacy.

Section 3.3707(a)

Comment: A commenter opposes the department's proposed amendment to §3.3707(a), which the commenter says would legitimize and permit inadequate networks where an insurer's business plan calls for expansion. The commenter says that an insurer must be able to demonstrate that it has an adequate network before marketing or offering a product, to avoid misleading or deceiving consumers.

The commenter urges the department to not adopt the amendment to §3.3707(a).

The commenter says that if the department does move forward with the amendment, it should require that an insurer give prominent notice to consumers that the product does not fully comply with regulations. The commenter says that as part of this notice to consumers, the department should retain the limited hospital care network designation provisions in §3.3705.

Agency response: The department disagrees with the comment and declines to follow the suggestion to not adopt the amendment.

The amendment to §3.3707(a) does not create a new ability for insurers to expand into service areas even though they have inadequate networks. The amendment clarifies the existing provision which, prior to the proposed amendment, already allowed insurers to apply for waivers from network adequacy requirements, as required by Insurance Code §1301.0055.

Some counties in Texas do not have health care providers for certain specialties. For these counties, the issue is not a matter of insurers not wanting to come to a fair agreement with providers for that specialty, but rather that no provider is available for the insurer to attempt to contract with at all. In such instances, the network adequacy requirements of §3.3704 would prevent the county from being included in a network. This would do harm to consumers in that county, because it would limit their access to insurance. It is necessary that insurers wishing to establish networks that include those counties have the ability to apply for a waiver from network requirements under §3.3704.

Under §3.3707(a), an insurer must file a request for waiver where necessary to avoid a violation of the network adequacy requirements of §3.3704 in a county that it wishes to include in a service area, and under §3.3707(c), the insurer must file a local market access plan with the department to be taken into consideration in determining whether to grant the waiver request. If the waiver request is not granted, inclusion of the county in the service area would be a violation of §3.3704. Thus, the local market access plan for the county would not be used.

Under §3.3707(i), if the status of a network used by a health benefit plan changes so that the health benefit plan no longer complies with §3.3704, the insurer must establish a local market access plan and apply for a waiver under §3.3707(a) for department approval to continue to use it.

The department would take action an insurer that operates out of compliance with the department's regulations. In addition, in response to another comment, the

department has withdrawn the proposed removal of provisions that allow for designating networks as "limited hospital care networks."

Section 3.3707(d)

Comment: A commenter opposes the provision in §3.3707(d) that allows an insurer to redact information from the waiver request copy the insurer provides to a provider or physician where sharing the information with the provider or physician would violate state or federal law. The commenter says this provision gives an insurer unilateral authority to decide what information can be legally disclosed.

The commenter says this would allow an insurer to shield information that could be disclosed to a physician that the physician might need to refute assertions the insurer makes about the physician's reasonableness in refusing to contract with the insurer.

The commenter says the provision in §3.3707(d) would severely impair a physician's ability to draft a proper and fully-informed response to an insurer's request for waiver, would silence opposition to the insurer's waiver, and would lead to department grants of more waivers than are appropriate.

The commenter says the department previously said a physician's input is necessary for consideration of a waiver, but that adoption of §3.3707(d) is a retraction of that statement. Section 3.3707(d) would create a one-sided waiver process and act as a loophole in the compliance framework.

The commenter says waiver requests will not generally contain information that could implicate state or federal laws, so the need for a redaction provision is unclear.

The commenter asks that the department strike the redaction provision from §3.3707(d).

As an alternative to striking the redaction language, the commenter says that the department should revise §3.3707(d) to allow the department to determine whether an insurer can legally disclose information in a waiver request. If an insurer specifically asserts that information cannot be disclosed, the department should request that the Antitrust Division of the Office of the Attorney General review it. The commenter adds that, in instances where an insurer says information cannot be legally disclosed, the department should require the insurer to cite the specific federal or state laws that prevent disclosure.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3707(d) does include provisions to act as a check on an insurer's redaction of information. It does not give an insurer unilateral authority to determine what waiver request information a provider or physician can receive.

Section 3.3707(d) requires an insurer to give the department a copy of the redacted version of the insurer's waiver request. The department will have the ability to review redactions, and take action against an insurer that inappropriately redacts information under §3.3707(d).

Because the department will have both the full and redacted versions of the insurer's waiver request, any person will be able to make an open records request for the records. The department will follow legal procedures for responding to open records requests. It will provide all the information it can under the Texas Public Information

Act, Government Code Chapter 552. Where a possible exception exists, the department will refer the request to the Office of the Attorney General. If, as the commenter says, waiver requests will generally not contain protected information, then it is possible the redaction provision in §3.3707(d) will not be used by insurers. However, the department believes that the provision is necessary because of the detailed information about attempts to contract that an insurer must include in a waiver request.

Under the Texas Public Information Act, some information that the department requires in waiver requests may fall under an exception to disclosure requirements. If this is the case for information included in a wavier request, the department would not be able to disclose it. However, the intent of the exceptions in Government Code Chapter 552 would be thwarted if a department rule required an insurer to directly disclose information covered by those exceptions to other parties. A disclosure requirement could also have a stifling effect if the department required an insurer to disclose all information in a waiver request to a provider because insurers might not include relevant or necessary information that should be protected under law. This could result in denial of an otherwise valid waiver and reduced availability of health insurance to consumers in areas where a waiver is necessary due to the lack of providers willing to contract with insurers.

The department does not agree that additional revisions are necessary to enable department verification that information is exempt from disclosure. Further, the department does not agree that the rule should require insurers to specifically cite federal or state laws that prohibit disclosure.

Section 3.3707(f)

Comment: A commenter supports the language in §3.3707(f), which says the department will post "information relevant to the grant of a waiver" and specific pieces of information on the department's website. The commenter asks that the department specify in the rule the reason or reasons the department found good cause to grant the wavier and any relevant supporting materials, and information on how a person may obtain or view the local market access plan.

Agency response: The department appreciates the comment in support of §3.3707(f), but declines to make the requested change. The department does not agree that the subsection must list additional information that will be posted on the department's website. The department declines to make the requested change.

The use of the word "including" indicates that under the provision the department may post additional relevant information on the department's website. Additional relevant information could include the information requested by the commenter.

Section 3.3707(g)

Comment: A commenter notes that the commenter supported the provision in §3.3707(g) of the withdrawn proposal that would have prevented exclusive provider benefit plans from applying for a waiver from network adequacy requirements. The commenter observes that the exclusion was not included in the current rules.

The commenter understands that there are regions in the state where certain provider types are not present and says that the department should only grant a waiver

to an exclusive provider benefit plan in instances under §3.3707(a)(1) where no provider is available to contract.

The commenter says that the rule appropriately holds an insured harmless if the insured is covered by an exclusive provider benefit plan and gets out-of-network care when no preferred provider is reasonably available. The commenter says this should provide good motivation for insurers to have adequate networks.

Agency response: The department disagrees with the comment and declines to make the requested change.

The network adequacy standards the department adopts are largely the same for all network-based products, including health maintenance organizations and preferred and exclusive provider benefit plans. This permits administrative efficiencies for insurers and the department in reviewing networks that health benefit plan issuers will use with different products.

The department intends to strictly review all waiver requests for preferred and exclusive provider benefit plan networks. Additionally, in regard to exclusive provider benefit plans, the rule provides additional protection for insureds receiving out-of-network care where no network provider is available. Section 3.3725 requires that an insurer protect insureds from balance billing in situations addressed by the section. Thus, insureds will, in most situations addressed by §3.3725, only be required to pay their coinsurance and co-payment.

This additional requirement for insurers offering exclusive provider benefit plans, which is similar to protections afforded enrollees in health maintenance organizations, provides sufficient protection for consumers while encouraging insurers to continually

enhance network adequacy. The department does not believe it is necessary to exclude the possibility of waivers for an insurer offering an exclusive provider benefit plan, if the insurer is unable to contract for an adequate network.

The department does not believe that the ability of an exclusive provider benefit plan to market in a service area should be contingent on the reasonableness of the contracting positions of necessary providers. The department will review the access plan submitted by the insurer to determine whether insureds will be adequately protected if a waiver is granted.

Section 3.3707(g) and (h)

Comment: A commenter objects to the proposed amendments in §3.3707(g) and (h). The commenter agrees with the department's goal of providing clear application and renewal deadlines, but does not support the amendments the department makes to achieve this.

In regard to §3.3707(g), the commenter objects to the deletion of the requirement that an insurer file its annual waiver renewal application at the same time that it files its annual network adequacy report. The commenter says that it is imperative that an insurer file waiver renewal applications in conjunction with annual network adequacy reports so that the department has up-to-date information about the network composition and a clear picture of its current status.

Because of this, the commenter opposes the language stating that "application for renewal of a waiver must be filed in the manner described in subsection (b) of this section at least 30 days prior to the anniversary of the department's grant of waiver."

The commenter asks that the department decline to adopt this language and instead maintain the language requiring filing in conjunction with the annual network adequacy report.

In regard to §3.3707(g)(3), the commenter is opposed to the language that states "a waiver granted by the department will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver or the department denies the application for renewal."

The commenter says this provision will allow waivers to continue indefinitely if the department fails to act on or deny applications for renewal. The commenter says a framework that allows perpetual waivers does not comply with Insurance Code §1301.0055, which says the department can only allow an insurer to depart from local market network adequacy standards on a showing of good cause.

To address the commenter's concerns, the commenter suggests the department adopt the following text in §3.3707(g) and (h), in place of the proposed text:

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually at the same time the insurer files the annual network adequacy report required under §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan).
(h) A waiver will expire:
(1) one year after the date the department granted it if an insurer fails to timely request a renewal under subsection (e);
(2) upon the department's denial of the insurer's timely filed request for renewal; or
(3) automatically 90 days after a timely filed request for renewal if the department fails to affirmatively grant or deny the renewal prior to the expiration of 90 days.

Agency response: The department disagrees with the comment and declines to make the change.

The department does not agree that it is necessary for insurers to file waiver renewal applications with annual network adequacy reports because the network adequacy reports will only contain general information by region. The limited information in the annual report is useful for the department to determine where problems might exist in the insurer's network, but it will generally not be relevant to the determination of whether the department should grant a waiver.

Even to the extent annual report information is relevant to the waiver decision, the department does not believe that its decision would be materially affected by having the information at the time of the waiver request rather than having information no more than a year old. If the department does need specific, up-to-date information to evaluate a waiver request, the department has the authority to request it from the insurer.

The department must balance its need for concurrent waiver renewal requests and annual network adequacy reports against stakeholders' need for timely responses from the department to waiver requests. Given the possibility that insurers may file numerous waiver requests with the department, it would be difficult for the department to resolve all waiver requests from insurers in a timely manner if they were all received at the same time April 1, when annual reports are due.

Regarding the comment on the provision in §3.3707(g)(3), which states that a waiver will remain in effect until no timely renewal is filed or the department denies the renewal, the department notes that it intends to actively assess waiver renewal applications.

Because it is impossible to tell how many renewal applications will come in each month and how many staff will be available to review the applications, it is not possible to provide a deadline for review by the department. Accordingly, while the department reviews the waiver renewal application, the rule permits insurers to rely on previously granted waivers until the department reviews and acts on the waiver renewal application. If the department determines that it should deny a waiver renewal request after reviewing it, the department will issue a denial. This includes situations where changes in circumstances occur so that the waiver is no longer warranted.

Section 3.3707(i)

Comment: A commenter says that §3.3707(i) will create a "file and use" system for local market access plans. The commenter says that the section requires insurers to establish a local market access plan if the status of the insurer's network no longer complies with network adequacy requirements. The commenter says that the section also specifies details about the plan and requires that the insurer submit the plan as part of the report on network adequacy. The commenter says the department does not express intent to approve a local market access plan before an insurer can use it.

The commenter says that there is no indication that the department takes any interest in ensuring that a local market plan will protect insureds and that the department appears satisfied to rely on the honorable intentions of insurers. The commenter urges the department to approve local market access plans prior to their use.

Agency response: The department disagrees with the comment and declines to make a change based on the comment. While the time frame established in the adopted section permits an insurer to use a local market access plan temporarily before department approval, it does require that the insurer apply for and receive a waiver to continue to use the plan beyond the short period permitted by rule. This is a heightened requirement over the rules adopted May 19, 2011, which did not require a waiver to use a local market access plan and did not address department approval of local market access plans.

Section 3.3707(i) requires an insurer to apply for a waiver for department approval to use a local market access plan. The section addresses situations where an insurer currently has an approved network for a service area, but the status of the network has changed so that it no longer complies with the network adequacy requirements of §3.3704. When this happens, 3.3707(i) requires the insurer to do two things: 1) establish a local market access plan, and 2) apply for a waiver under subsection (a) of the section requesting that the department approve use of the plan.

In response to another comment, the department revises the text of §3.3707(i) to clarify the time frame for an insurer to address termination of provider contracts. As adopted, §3.3707(i) allows an insurer 30 days from the date of termination of the contract to initiate an internal access plan; and it allows 90 days to either rectify the network inadequacy by contracting with new providers, reduce the service area, or apply to the department for a waiver of network adequacy requirements due to inability to contract with providers.

Before approving a waiver, the department will determine that the insurer has arranged through its access plan adequate alternatives for insureds dealing with network inadequacies. Given the structure of the rule, no separate formal approval of the access plan is necessary.

Consistent with Insurance Code §1301.0055(3), the commissioner will only grant a waiver for continued use of a local market access plan if good cause exists for the waiver. If an insurer attempts to use a local market access plan without a waiver, the insurer would be violating the network adequacy requirements of §3.3704.

Comment: A commenter observes that §3.3707(i) requires insurers to submit a local market access plan within 30 days of identifying a network access gap. The commenter asks what happens if two network access gaps are identified within a 30-day period, and whether a consolidated access plan should be filed to address them.

The commenter recommends that the department move away from continuous monitoring and reporting, and instead move to periodic monitoring and reporting.

The commenter also suggests that the department build in reasonable time frames for payers to identify and address network gaps.

Agency response: The department agrees in part and disagrees in part with the comment. The department has revised the section as adopted to permit an insurer additional time to file a waiver request.

An insurer that does not comply with the network adequacy requirements of §3.3704 commits an administrative violation and is subject to administrative action by the department.

As proposed, §3.3707(i) gave insurers 30 days to institute a local market access plan for adversely impacted insureds. An insurer must quickly establish an access plan when the insurer's network becomes inadequate, to avoid harm to consumers who purchased the product based on its provider network at the time of purchase. The proposed section also specified that an insurer must apply for a waiver under subsection (a) of the section requesting that the department approve use of the local market access plan. However, it did not address the time frame for requesting the waiver. The department agrees to revise §3.3707(i) to clarify this time frame.

As adopted, §3.3707(i) allows an insurer 30 days from the date of termination of the contract to initiate an internal access plan and 90 days to either rectify the network inadequacy by contracting with new providers, reducing the service area, or applying to the department for a waiver of network adequacy requirements due to the inability to contract.

This clarification of the time frames in the rule adequately balances the needs of consumers for adequate networks against the administrative burdens of insurers offering network products. Allowing 90 days gives insurers a window to negotiate with providers and either remedy the violation or develop support for the waiver request. It also sets a limit on how long an insurer can rely on an incomplete provider network without clear department approval of a waiver from the network adequacy requirements.

Insurers may file waiver requests and access plans addressing multiple network issues.

Section 3.3707(i)(1)

Comment: A commenter is confused by the language in §3.3707(i)(1), which requires an insurer to make its local market access plan available to the department upon request. The commenter says that several provisions in §3.3707 instruct an insurer on how to file a waiver request. The commenter says this requires that insurers file a local market access plan with a waiver request.

Agency response: The department acknowledges that the requirement that insurers make their local market access plans available to the department upon request is duplicative and unnecessary, because insurers must submit their local market access plan with a waiver request. The department has not included this requirement in §3.3707(i)(1) as adopted.

Section 3.3707(k)(1)

Comment: A commenter says that §3.3707(k)(1) requires an insurer to identify requests for preauthorization of services for insureds that are "likely to" require services by non-contracted providers and furnish a pre-service estimate of the amount the insurer will pay the physician or provider.

The commenter says the requirement to provide an estimate is not warranted, because the preauthorization process generally does not require the provider to supply the detailed level and amount of information necessary to provide a cost estimate. The commenter says this requirement would be more appropriate for rules under Insurance Code Chapter 1456, which addresses obligations to provide cost estimates to insureds, but that current law does not provide authority for these requirements.

Agency response: The department disagrees with the comment and declines to make a change based on it.

The department notes that the requirement in adopted §3.3707(k)(1) is limited to the narrow circumstance where no network provider is available, and that Insurance Code §1301.005 requires that insurers make preferred providers reasonably available. The department believes that where an insurer does not make preferred providers available in a service area, additional consumer protections are necessary.

Because preferred providers may not balance bill a consumer, estimates of what an insurer will pay are not as useful to patients. However, when the inadequacy of a network requires an insured to use a non-network provider, it is important that the insured be aware of how much the insurer will pay for the proposed procedures.

The department notes that the preauthorization process is administered by the insurer, who may request additional information necessary to provide a good-faith estimate. Insurance Code Chapter 1456 addresses different issues than §3.3709, and it is limited to facility-based physicians even if no access plan applies and there is no network inadequacy. The requirement in the rule that an insurer must establish and implement documented procedures to provide cost estimates applies in all inadequate network situations as a consequence of the network. Compliance with the rule will generally constitute compliance with the estimate requirements found in Insurance Code Chapter 1456.

Section 3.3708(b)

Comment: A commenter references the department's intent that under §3.3708(b), when an insured receives services from a nonpreferred provider and the insured pays a balance bill, the insurer must credit the full amount paid by the insured to the insured's deductible and annual out-of-pocket maximum applicable to in-network services. The commenter says that, as amended, §3.3708(b) does not achieve this.

The commenter says the department's description of the credit an insurer must give an insured is open to several interpretations and could result in different administration by different insurers.

The commenter supports maintaining §3.3708(b) as it existed prior to the proposal, asserting that the previous text would better protect insureds who do not voluntarily choose to obtain services from nonpreferred providers by giving the insureds credit for their actual out-of-pocket expenses in the same manner they would receive a credit if they had received services from a contracted preferred provider.

Agency response: The department agrees in part with the comment. The department declines to withdraw the proposed amendment to §3.3708(b). Instead, the department revises the text of §3.3708(b) to clarify the ambiguity the commenter identifies.

As adopted, the department removes the phrase "in excess of the allowed amount" from the text proposed for §3.3708(b) and inserts the words "charges for covered services that were above and beyond." Under this language an insurer must credit the full amount paid by an insured to the insureds deductible and out-of-pocket maximums.

Section 3.3708(b) and 3.37025(d) – (e)

Comment: A commenter commends the department's proposal of §3.3708(b) and §3.3725(d) – (e). The commenter says the legislature intended to address the problem of inadequate networks with HB 2256 and HB 1772, and that §3.3708(b) and §3.3725(d) – (e) accomplish this intent.

Agency response: The department appreciates the supportive comment.

Section 3.3708(b)(1)

Comment: A commenter says that §3.3708(b)(1) creates a new obligation for insurers to pay some out-of-network charges at "usual billed charges." The commenter says this provision was a surprise and that the department proposed it without sufficient stakeholder involvement or consideration on the cost impact to Texas consumers and employers.

Agency response: The department does not agree with the comment and declines to make a change based on it.

The rule does not require payment of any claims at "usual billed charges," though §3.3708(b) does require that an insurer pay a claim based on a minimum of usual or customary charges when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured. The department does not agree that insufficient stakeholder involvement or cost consideration has been considered regarding the proposed rule. The department has been involved in discussions of out-of-network payment rates since the enactment of SB 1731, 80th Legislature, Regular Session, 2007. Further, the department conducted

a second proposal period for these rules to ensure stakeholders had notice and opportunity to comment on all aspects of the final proposed and adopted versions.

Comment: A commenter provides a detailed actuarial analysis addressing the potential cost impact of §3.3708(b)(1).

The commenter says the analysis finds that the proposal would increase total health care costs between .28 percent and .91 percent if networks remain the same and up to 2.6 percent if all hospital-based providers terminated their contracts to maximize revenue. According to the analysis, this projected cost is higher than the cost of most Texas-mandated benefits and could result in increased premium costs for insureds ranging from $20 to $500 per year.

The commenter suggests that the department decline to adopt the proposed provision, add a requirement for insureds to notify insurers if they are balance billed, and defer the issue of reimbursement for out-of-network services to the Texas Legislature.

Agency response: The department does not agree with the comment and declines to make the requested change.

The actuarial analysis provided by the commenter relies on assumptions the department does not believe to be the case, and it does not recognize a number of factors that the department considers relevant.

Though the actuarial analysis recognizes that the rule only requires insurers to pay at the usual and customary rate when there are no available network providers and in cases of emergency, the analysis estimates the cost of the rule based on the

assumption that "all out-of-network hospital-based physicians would be paid at usual and customary fee levels." This assumption ignores the fact that, in preferred provider benefit plans, consumers may voluntarily seek out-of-network care, which would not be paid at the usual and customary rate under the rule.

The report also does not take in to account the measures that health maintenance organizations have taken to address similar issues. In particular, health maintenance organizations must pay emergency and inadequate network claims at the full billed charge or an agreed rate. Some health maintenance organizations have taken this into account by operating service areas only where they can provide an adequate network. Health maintenance organizations report that a higher percentage of their claims from facility-based physicians are in-network, as compared to preferred provider benefit plans. See tdi.texas.gov/reports/life/documents/hlthnetwork409b.doc. This indicates that health maintenance organizations have been successful in contracting with out-of-network physicians.

The department reviewed rates that health maintenance organizations and preferred provider benefit plans have filed with the department, and health maintenance organization rates are generally equivalent to or lower than preferred provider benefit plan rates. It does not appear that similar requirements have substantially impacted health maintenance organization rates.

The commenter's actuarial report also does not take into account other aspects of the rule that may have an impact. The adopted rule will require that insurers and insureds receive notice when the insured is being referred out of network.

Insureds will also be given much more information about their networks on which to base their decisions of where to seek care, they will be able to determine the hospitals that are more likely to provide assistance with finding in-network care, and they will better be able to avoid or negotiate out-of-network care. They will be motivated to seek in-network care because they will be responsible for their coinsurance portion of the usual and customary amount.

Additionally, the rule imposes network adequacy requirements that will result in much more robust networks and greatly reduced incidences of out-of-network services being rendered. The rule also creates a process where an insurer may submit information to the department showing that a provider's contract negotiating position is unreasonable. This may impact negotiations and lead to contracts with more providers.

For all these reasons, the department believes that the actuarial report overestimates the impact on premium of the rule. The department has weighed the potential costs against the statutory requirements and the potential harm to consumers and has concluded that the provision should be retained.

Comment: A commenter observes that §3.3708(b) provides mitigation of balance billing for insureds forced to seek emergency care from nonpreferred providers because of inadequate preferred provider plan networks.

The commenter says the "usual or customary" language in §3.3708(b)(1) provides valuable clarification to ensure that plans cannot circumvent the requirements of Insurance Code §1301.155 by providing unreasonably low reimbursements. Without the clarifications of §3.3708(b), the protections to insureds under Insurance Code

§1301.155 would be rendered null, and insureds would suffer hardships from balance bills resulting from unreasonably low reimbursements.

Agency response: The department appreciates the supportive comment.

Comment: A commenter observes that §3.3708(b)(1) requires an insurer to pay a claim based on usual and customary charges when an insured receives services from a non-network provider because no preferred provider is reasonably available. The commenter says the preamble to the rule proposal indicates a new "billed charges" usual and customary standard above and beyond an allowable that refers to Medicare or some other schedule for out-of-network charges.

The commenter says the proposal preamble indicates this provision is included as a clarification of legislative intent. The commenter says that the legislature has specifically considered and rejected attempts to define the payments required for non-network providers and so the department has no authority to impose this requirement in the guise of a clarification.

The commenter also says that while the department characterizes some insurers' payments as arbitrary, it fails to address the fact that providers are free to charge arbitrary amounts.

A second commenter says the department has strayed from the statutes in proposing a requirement that insurers pay some claims by nonpreferred providers at the usual and customary charge and that §3.3708(b)(1) directly conflicts with Insurance Code Chapter 1301. The first commenter agrees with the second commenter, and a third commenter asserts a similar point, saying that this is not a clarification of the

current requirement to pay claims at the preferred provider rate, but rather a new requirement not supported by current law.

The second commenter says the only reference to a "usual and customary" rate is in Insurance Code §1301.053, but that section only applies to emergency care in an exclusive provider benefit plan and does not otherwise apply to other situations involving non-network services.

The second commenter says that if a plan is not an exclusive provider benefit plan, other statutory provisions apply. Insurance Code §1301.005(b) applies to non-network providers and refers to reimbursement levels, not the "usual and customary" rate. Insurance Code §1301.155 applies to emergency care, requiring reimbursement at the preferred level of benefits until an insured can be expected to transfer to a preferred provider.

The second commenter also says that by using the phrase "usual and customary rate" the department has ignored the statutory provisions in numerous parts of Insurance Code Chapter 1301 that provide for payment of a nonpreferred provider at a preferred level if care is not reasonably available from a preferred provider. A preferred level is much different than the term "rate" or the phrase "usual and customary." The concept of payment at a usual and customary rate is nowhere in Insurance Code Chapter 1301, and the legislature has refused to give the department the authority to require payment at the usual and customary rate.

The second commenter says the provision could result in numerous unintended consequences, such as making it more difficult for insurers to contract with hospital-

based physicians or inciting preferred providers to cancel or not renew contracts in order to collect undiscounted fees.

A fourth commenter is opposed to the proposed rules because they will increase the costs of health policies for employers and employees.

The fourth commenter says that by requiring reimbursement of some out-of-network services at a usual and customary standard, the department is setting rates and requiring insurers to pay billed charges. The third commenter agrees, saying that it appears the department equates usual or customary charges as the average billed charges for a particular service area.

The fourth commenter does not believe the department has authority to set rates and says that even if the department does have this authority, the rules do not exercise it in a lawful manner. The commenter says that §3.3708(b)(1) will allow providers to set rates for out-of-network services and that this constitutes an unlawful delegation of authority to private parties.

A fifth commenter adds that the rules go beyond what the legislature or the Governor's Office has considered. The commenter says the rules should be withdrawn because they create two new out-of-network mandates which would be problematic for businesses and employers that provide employee health coverage.

First, the fifth commenter says the rules do not define the term "usual and customary charges" but that the department's comments in the proposal describe it as being the usual billed charge in a particular area. The fifth commenter opposes forcing insurers to pay billed charges, which are unilaterally set by health care providers and are often unsubstantiated and irrelevant. The commenter says that medical providers

commonly bill patients at rates higher than what they actually owe and then use this amount for negotiation, never intending that it be fully paid.

The fifth commenter also says that if the department uses its regulatory authority to force insurers to pay 100 percent of usual and customary charges, providers will raise their billed charges, fewer providers will make agreements with insurers, and the negotiated rates providers reach with insurers will be higher. Insurers forced to pay unsubstantiated billed charges will pass inflated expenses on to employers.

Second, the fifth commenter says that the proposed rules require an insurer to apply the amount paid to the in-network deductible and out-of-pocket maximum, if an insured pays billed charges and provides proof of payment to the insurer. This additional mandate undermines an insurer's ability to underwrite policies and creates uncertainty, which leads to higher prices for insurance policies. The ability of insurers to contract on behalf of employers is the main reason employers are able to offer affordable coverage. The fifth commenter asks what will incentivize providers to join networks if the department adopts the proposed rules and insurers are no longer able to negotiate contracts.

The fifth commenter asserts that the department attempts both rate setting and unlawful delegation of state authority in the proposed rules. Requiring insurers to pay usual and customary charges for out-of-network services in emergency situations or when no network provider is available is rate setting. It is also a delegation of authority, because the department describes "usual and customary" as usual billed charges, which permits providers to set their rates at any amount and determine the fees they will collect from insurers.

The fifth commenter concludes by saying that if the department adopts the proposed rules, employers and their employees will ultimately pay the price for them through higher health care premiums and co-pays, and reduced wages or benefits.

Agency response: The department disagrees with the comments and declines to make a change because the proposed language is necessary to reduce incidences of balance billing in cases where consumers have no choice regarding out-of-network care. The department contends that the rule conforms to statutory requirements applicable to preferred provider benefit plans.

The department bases the requirement that an insurer pay a claim based on usual and customary charges when an insured receives services from a non-network provider because no preferred provider is reasonably available on its interpretation of Insurance Code §1301.005(b) and §1301.155(b).

Insurance Code §1301.155(b) requires that an insurer reimburse emergency care services at the preferred level of benefits, if an insured cannot reasonably reach a preferred provider, until the insured can reasonably be expected to transfer to a preferred provider.

HB 1772 provides additional guidance by adding Insurance Code §1301.0053 in the context of exclusive provider benefit plans. It clarifies that an insurer must reimburse emergency care under Insurance Code §1301.155 at the usual and customary rate or a rate agreed to by the insurer and the nonpreferred provider. Because Insurance Code §1301.155 is ambiguous in defining what constitutes the "usual and customary rate," it is necessary for the department to do so by rule in order

to provide for uniform application of the chapter and uniform access to benefits under the chapter by insureds.

Although the focus of HB 1772 was the addition of new exclusive provider benefit plans to the network-based insurance products an insurer may offer in Texas, the clarification of an insurer's duty under Insurance Code §1301.155 accomplished through the addition of Section 1301.0053 is equally necessary for preferred provider benefit plans. Insureds under these plans are likewise faced with reimbursement of emergency care services for which reasonable access is an issue.

Under Insurance Code §1301.005(b), if services are not available through a preferred provider within a designated service area under an exclusive or preferred provider benefit plan, the insurer must reimburse a nonpreferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed for the services.

Again, HB 1772 provides guidance in the context of exclusive provider benefit plans by requiring the insurer to fully reimburse the nonpreferred provider for medically necessary services not available through a preferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider. While this additional guidance is in the context of a bill focused on exclusive provider benefit plans, the clarification of an insurer's duty under Insurance Code §1301.005 accomplished through the addition of Insurance Code §1301.0052 is equally necessary for preferred provider benefit plans. Insureds under these plans are likewise faced with reimbursement of services for which reasonable access is an issue under circumstances beyond the insured's control.

The department also bases this provision on the requirement of Insurance Code §1301.005(a), which requires that an insurer make out-of-network benefits "reasonably available" to all insureds. The department has received complaints that some insurers pay these claims at rates that are a fraction of usual and customary rates. Support for this position is found in the department's survey of insurers that was part the department's 2009 published report called *Report Of the Health Network Adequacy Advisory Committee, Senate Bill 1731, Section 11 Eightieth Legislature, Regular Session, 2007.* This report is available on the department's website at tdi.texas.gov/reports/life/documents/hlthnetwork09.doc. Table 4 on page 24 of the report illustrates the average allowed amounts for non-network providers by five insurers. Using radiology billings as an example, one insurer paid non-network providers an average of 95 percent of their billed charges. Another insurer paid 38.7 percent, leaving insureds responsible for both their share of the 38.7 percent under the insureds' plans and 100 percent of the remaining 61.3 percent. In cases of large bills, such low reimbursements could result in an insured with major medical coverage being responsible for paying the bulk of the billed charge, an amount that in some cases could make the out-of-network benefits effectively unavailable.

The rule clarifies the legislature's intent in requiring payment of these particular claims at the preferred level by specifying that the calculation must be based, at a minimum, on the usual and customary rate for such services, rather than any lower amount chosen by an insurer. By requiring payment at the usual and customary rate in situations where an insured has no choice in whether to see an out-of-network provider, either due to an emergency or the insurer's failure to provide an adequate network, the

statute and this clarifying rule give the insured some certainty in the insured's insurance coverage and financial security. Consistent with the nature of insurance, the insurer bears the risk of balance billing instead of the insured.

By setting a benchmark of usual and customary, the rule ensures that consumers can make more informed decisions when choosing their health plan coverage with some confidence of consistency on this potentially enormous financial issue, and it allows them to better understand the financial consequences of their health care decisions. Insurers are still able to set the coinsurance percentage to be applied to the usual and customary charge.

Recognizing the potential impact on premiums, the department has determined that the use of "usual and customary" will not be required when an insured voluntarily chooses to seek out-of-network care. Instead, insurers must only utilize this benchmark in cases where the insured has no choice in receiving out-of-network care, in cases of emergency, and in cases where the insurer has no available contracted providers in the network. Due to the increased requirements for network adequacy in the rule, the department expects that the three situations previously described will occur far less frequently than in the past, significantly reducing the occasions when an insurer must utilize usual and customary as the baseline. Because these situations will be relatively rare, the department believes that insurers will be able to actuarially anticipate the financial impact of insureds seeking credit toward deductible and out-of-pocket maximum for amounts actually paid for out-of-network health care services and those credits actually impacting whether the deductible and out of pocket maximums are met.

The department notes that it has required health maintenance organizations to insulate enrollees from balance billing in these limited situations, yet health maintenance organization premiums are generally comparable to or lower than preferred provider benefit plan premiums in the Texas market. Health maintenance organizations have also been able to maintain adequate networks despite this comparable requirement.

Insurers are not required to market a network product in areas where they do not contract with adequate numbers of providers. Their choice to do so should not result in their insureds being subject unexpected and substantial balance billing.

When an insurer includes regions in the insurer's service areas where the insurer does not have an adequate network, the rule provides some ability to mitigate out-of-network costs. Specifically, §3.3703(a)(27) and §3.3703(a)(28) require that physicians and facilities provide the insurer with notice of upcoming surgeries. Insurers with inadequate network coverage at the facility where surgery is scheduled will be able to minimize the likelihood of balance billing by working with non-network providers in advance of the surgery, and communicating with the insured to explain any potential out-of-pocket costs.

Neither the rule nor the rule preamble specify what would constitute a usual and customary charge, nor do they attempt to establish a new standard for usual and customary above and beyond an allowable amount in Medicare or some other schedule for out-of-network charges.

Stakeholders across the board accuse each other of arbitrary billing and payment practices. The department does not have authority to regulate the amounts that

providers bill for services, so it cannot address arbitrary provider charges by rule. However, the department has previously raised this issue with the legislature. See page 36 of the department's *Biennial Report to the 83rd Legislature*, which can be found on the department's website at tdi.texas.gov/reports/documents/finalbie13.pdf.

The rule does not require that insurers pay providers' "billed charges." Instead, the insurer may determine, subject to the requirements of the rule, what the usual and customary charge for the service is in the geographic area.

Comment: A commenter says that the rules will benefit consumers by greatly reducing incidents of balance billing and by reducing the amounts of balance bills. The commenter says this will be due in part to the addition of §3.3708(b)(1), which requires that preferred provider benefit plans pay claims at the usual or customary charge when no preferred provider is reasonably available. The commenter says that, short of a legislative solution that ends balance billing, the department's approach to minimize balance billing appears to be as protective of consumers as possible.

The commenter addresses concerns of other commenters who say that paying usual and customary rates will reduce the motivation for providers to contract, resulting in increased premiums. The commenter says that the concerns may be overblown, because the rules only address instances where an insured involuntarily receives out-of-network care.

The commenter says that the department needs to maintain a strong standard for the "floor" for payments an insurer pays to out-of-network providers when no preferred provider is available, to encourage insurers to maintain adequate networks and reduce

balance bills for consumers. The commenter also says that increased premiums are not as big a concern as getting value for premiums paid, and that a slight increase in premiums is worth it if it means reduced balanced billing.

The commenter says nonpreferred providers do not need to receive full billed charges to be considered paid in full, because balance bills are not always completely collected. So setting the floor at billed charges would result in payment higher than is needed to reduce balance billing. The commenter says that usual and customary provides the best protection against balance billing, which is a meaningful benefit in exchange for any premium increase.

The commenter does not think usual and customary will cause providers to leave networks, because insurer and provider motivation to contract is influenced by many factors. The commenter suggests that the department actively monitor balance billing complaints, requests for mediation, and information submitted through network adequacy waiver requests to identify any trends of providers moving in or out of networks.

Agency response: The department agrees with the comment that it is necessary to set a floor for payments to out-of-network providers in certain circumstances, but that potential negative consequences exist for any floor that is picked, including the potential for higher premiums and higher incidences of balance billing.

The department believes that the proper course is to err on the side of protecting consumers from unexpected balance bills when they have no choice of the provider, while giving consumers and insurers as much opportunity as possible to reduce the

frequency of unintentional use of out-of-network providers and the opportunity to negotiate out-of-network charges in advance.

Accordingly, the department makes no change at this time. However, as recommended by the commenter, the department will monitor the impact of these rules and other changes on the market and continue to consider where an appropriate floor should be set. Further, the department has previously raised this issue with the legislature. See page 36 of the department's *Biennial Report to the 83rd Legislature*, which can be found on the department's website at tdi.texas.gov/reports/documents/finalbie13.pdf.

Comment: A commenter responds to a concern raised by other commenters during the public hearing that §3.3708(b)(1) could create a state mandate that the state must pay for under the Patient Protection and Affordable Care Act.

The commenter says that the U.S. Department of Health and Human Services has said that state rules related to provider types, cost-sharing, or reimbursement methods would not fall under its interpretation of state-required benefits. The commenter offers the following quote from the U.S. Department of Health and Human Services:

> HHS received many comments in response to the EHB [essential health benefits] Bulletin about how state-required benefits beyond EHB could be identified and how states would defray the cost of those benefits. In this proposed rule, we interpret state-required benefits to be specific to the care, treatment, and services that a state requires issuers to offer to its enrollees. Therefore, state rules related to provider types, cost-sharing, or reimbursement methods would not fall under our interpretation of state-required benefits. Even though plans must comply with those state requirements, there would be no federal

obligation for states to defray the costs associated with those requirements.

Agency response: The department agrees with the commenter that §3.3708(b) does not create a state mandate for which the state must pay.

Comment: A commenter responds to a concern raised by other commenters during the public hearing that the department lacks statutory authority to designate the usual and customary charge for a service as the floor for health insurance claim settlements.

The commenter argues that Insurance Code §542.003 prohibits insurers from engaging in unfair claim settlement practices and that the commissioner has authority to establish what constitutes an unfair claim settlement practice. The commenter says the commissioner could use the authority under Insurance Code Chapter 542 to address claim settlement to ensure that insurers act in good faith to achieve a prompt, fair, and equitable settlement of a claim submitted in which liability has become reasonably clear.

The commenter says that other commenters also testified that requiring payment of nonpreferred providers at the usual and customary rate or an agreed upon rate would lead to increased premiums and unlimited charges by providers. The commenter says this is a baseless prediction. The commenter points out that Insurance Code §1271.055 and §1271.155 require health maintenance organizations to pay certain out-of-network services at the usual and customary rate or an agreed upon rate, and it has not harmed the market.

The commenter says that the true risk of harm to consumers comes from insurers attempting to push more out-of-network costs onto insureds.

The commenter says that §3.3708(b) creates a regulatory framework which ensures consumers receive a valuable insurance product for their premium, and urges the department to retain it.

Agency response: The department appreciates the commenter's support for §3.3708(b)(1). The department notes that it has addressed its basis for §3.3708(b)(1) in response to a previous summary of comments in this proposal.

Section 3.3708(b)(3)

Comment: Two commenters say §3.3708(b)(3) creates a new requirement for insurers to credit amounts insureds agree to pay nonpreferred providers in "excess" of allowable amounts. Both commenters say this change is not supported by statutory language.

One of the commenters also says it is unprecedented and essentially modifies the definitions of "allowable amounts" that have been in place in approved policy form filings for decades. That commenter says the proposed rule would impair existing contracts that give credit only for amounts paid by an insured up to the "allowable amount" and would require an increased cost that could increase premiums.

The other commenter says emergency care services are an essential benefit under the Patient Protection and Affordable Care Act, and that under federal rules an insurer can require that an insured pay the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay. This means if the department adopts the rule, it would exceed federal health care reform requirements.

Agency response: The department disagrees with the comment and declines to make a change.

Insurance Code §1301.007 requires the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301. Insurance Code §1301.0055 requires the commissioner to adopt network adequacy standards. Insurance Code §1301.005 and §1301.155 requires that insurers' payment of inadequate network and emergency claims be at the preferred level of benefits.

This shows legislative intent to treat payment of claims where the network is inadequate or in emergency situations similar to in-network claims because of the insured's lack of choice in those situations. Section 3.3708(b)(3) clarifies that an insurer must also treat the payments made by consumers in those narrow situations in the same manner as they would have if they had been for in-network claims.

The department expects it will be uncommon that an insurer will need to credit an insured's out-of-pocket expenses to their out-of-pocket maximum because not all insureds will be balance billed by out-of-network providers under the requisite circumstances, not all of those insureds will actually pay the balance billed amount, not all of those insureds will submit evidence to insurers supporting requests that out-of-pocket amounts be credited to their deductibles and out-of-pocket maximums, and not all of those insureds will reach their deductible and out-of-pocket maximums and then incur additional claims. In addition, many nonpreferred providers negotiate balance bill amounts with insureds. In these cases there would be a further reduction in the out-of-pocket payments made by the insured.

Section 3.3708(b) represents a reasonable balance of interests between the insured, who has no choice in using an out-of-network provider under the narrow circumstances specified in §3.3708(a), and the insurer, whose responsibility it is to have an adequate network.

The department also notes that if an insurer has reason to believe that there is a substantial difference between a physician or provider's billed charges and a reasonable rate of reimbursement, the insurer may attempt to negotiate a reduction in overall charges.

Further, it is the department's position that a major medical insurance policy providing coverage under Insurance Code Chapter 1301 would be unjust and deceptive under Insurance Code Chapter 1701 if it did not provide credit for an insured's necessary and actual out-of-pocket expenses incurred as a result of an inadequate network or in an emergency.

Finally, recent federal guidance indicates that states' rules relating to cost-sharing and reimbursement methods are permitted and will not constitute state benefit mandates. See *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule*, available on the Government Printing Office website at gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm.

Comment: A commenter supports the amendments to §3.3708(b)(3) which clarify that in required cost-sharing and balance billing, an insurer must credit the amount an insured has paid out-of-pocket to the in-network deductible and out-of-pocket maximum

when a preferred provider is not reasonably available. The commenter observes that this scenario will only happen in emergencies or when a network is inadequate.

The commenter responds to a concern raised by another commenter during the public hearing that §3.3708(b)(3) might create a state mandate that the state must pay for under the Patient Protection and Affordable Care Act. The commenter says that the U.S. Department of Health and Human Services has said that states' rules related to provider types, cost-sharing, or reimbursement methods would not fall under its interpretation of state-required benefits.

Agency response: The department appreciates the supportive comment. The department agrees that §3.3708(b)(3) will not result in a state mandate that the state must pay for under the Patient Protection and Affordable Care Act.

Section 3.3708(c)

Comment: In regard to §3.3708(c), a commenter asserts that the department lacks statutory authority to establish standards for reimbursement methodology. The commenter requests that the department delete the provision.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3708(c) applies basic standards of fairness to whatever reimbursement methodology an insurer may choose to use for standard out-of-network claims. The rule permits an insurer to base its reimbursements on usual and customary charges, but if it does so, it must use generally accepted industry standards for determining billed charges.

An insurer may base reimbursements on claims data; but if it does so, it must use data that is updated periodically. Further, an insurer must use generally accepted bundling edits and logic when determining how to pay its claims.

An insurer that does not comply with these fundamental requirements would be selling a product that is unjust, encourages misrepresentation, or is deceptive under Insurance Code Chapter 1701. If insurers do not comply with these requirements, insureds will not have confidence that their claims are paid correctly or fairly.

Insurance Code §1301.007 requires the commissioner to adopt rules necessary to implement Insurance Code Chapter 1301. Failure to address the methodology by which out-of-network reimbursement is calculated could adversely affect insureds and providers, particularly if insurers use old data, statistically insignificant samples, or any other information described by §3.3708(c) to calculate out-of-network reimbursements.

Section 3.3708(e)

Comment: A commenter opposes the department's amendment to §3.3708(e). The commenter says the amendment would remove a provision that gives insureds considerable power and that the new text unnecessarily repeats language included in the notices in §3.3705 and misrepresents provisions in Insurance Code Chapter 1467 permitting teleconference and mediation.

The commenter says it is important that insureds not be misled into believing that remedies are available under Insurance Code Chapter 1467 when they are actually unavailable. The commenter says that thresholds set by Insurance Code Chapter 1467 make no mention of the difference between the allowed amount and billed charges.

This is an inaccuracy resulting from failure to communicate with stakeholders, and the department does not explain why it wants insureds to receive inaccurate information. The commenter suggests that the department should rely on the notice required under §3.3705(f).

The commenter says that under the version of §3.3708(e) adopted May 19, 2011, an insured receives notice that the insured may request additional pricing information from the insurer. The commenter supports that version of the text because it focuses on transparency and provides useful billing information to insureds. Without payment information, insureds would have difficulty acting as reasonable economic decision-makers.

Because of this, the commenter asks that the department maintain the text as adopted May 19, 2011, and not adopt the proposed amendment. However, the commenter adds that it is acceptable to require that an insurer's explanation of benefits note that information is available under §3.3708(e), so that insureds will know they can access this information.

The commenter also points out that a contract rate does not reflect the price of a medical service. The commenter says that the price is what a physician charges, and the commenter says that a contracted rate is only a fraction of the total economic transfer. The commenter describes ancillary benefits of a contract that add non-cash value to the contracted rate that equates to a provider's billed charge.

The commenter suggests that the department require insurers to offer median pricing information under §3.3708(e) that reflect like places of service. The commenter says that in some cases insurers might set different fee schedules based on place of

service and that this should not be reflected in the information offered under §3.3708(e). The commenter says that department should also not allow insurers to use Medicare payment guidelines in determining median pricing information because they are not a reflection of prevailing out-of-network market rates and may fluctuate based on political factors.

The commenter says that, because an insurer only needs to provide information under §3.3708(e) in response to a request from an insured, §3.3708(e) should not pose a burden to insurers.

Agency response: The department disagrees with the comment and declines to reinstate the text proposed for deletion.

The deleted text required insurers to provide payment information for comparison purposes when paying an out-of-network claim in circumstances where no preferred provider was reasonably available. The purpose of the requirement was to provide information to an insured that might be useful to negotiate payment of a balance bill issued by a provider in cases when the insurer paid the claim at an amount that it determined to be allowable, but that resulted in a balance bill.

However, under §3.3708(b), insurers must pay these claims at the usual and customary rate for the services. Because this will largely eliminate balance billing, the department has determined that the administrative cost of the requirement outweighs the relatively small benefit to consumers. As the commenter notes, the contracted rate insurers pay does not reflect the price for a medical service. The contract rate is just a fraction of the economic transaction between the provider and insurer.

Regarding the comment on the proposed new language in §3.3708(e), the department's interest is in making sure insureds are aware of their right to mediation. The rule provides a general guide for when the notice must be given to the insureds, and then directs insureds to more information available on the department's website. The department does not believe that insureds will be misled by this notice.

Section 3.3709(b)(3)

Comment: A commenter strongly supports retention of §3.3709 as adopted May 19, 2011. The commenter says that the section is the heart of the regulatory framework created by the department for network adequacy purposes and that removal of the section would be a capitulation to insurers' desire to keep the true condition of their networks shrouded from the scrutiny of their insureds and the department. The proposed changes to §3.3709 defeat the purpose of the annual report and indicate a misunderstanding of the value insurers' reports deliver to the department for oversight of insurer marketplace conduct.

The commenter opposes relocating waiver provisions to §3.3707 and urges the department to not strike local market access plan provisions in §3.3709. Retention of §3.3709 would prevent serious network gaps previously identified by the department.

Agency response: The department disagrees with the comment and declines to make a change.

The amendments to §3.3709 and §3.3707 do not alter the information the department will receive in the insurers' annual reports. Under §3.3707(m), an insurer must still file its local market access plan with the annual report under §3.3709, and the

provisions addressing the content of the local market access plan are still present in §3.3707(j) – (l). However, relocation of provisions to §3.3707 imposes a higher burden on insurers that would use a local market access plan, because under the adopted section an insurer must request a waiver to continue to use a local market access plan and must provide the department information that supports granting the waiver.

Comment: A commenter is concerned by the administrative burden of the annual report requirement under §3.3709(b)(3).

The commenter says this provision requires an insurer to make a statement regarding whether the network for each of its plans is adequate, but it does not define what constitutes adequate. The commenter notes that §3.3704(e) includes a list of eleven requirements for an adequate network, including the maximum distances to a point of service, but says that the lack of various provider types in different areas of the state make it impossible to meet mileage requirements in all areas of the state.

The commenter says that disclosure requirements based on impossible standards do not take into account the legislature's direction in §1301.055 that network adequacy standards be "adapted to local markets."

The commenter suggests that the department distinguish between areas of the state where no providers are available versus areas where a health benefit plan is unable to obtain a contract with providers.

The commenter thinks the complaint reporting requirement under subsection (c) is unduly burdensome because it requires a new and different categorization of

complaints than is provided in the existing complaint record requirements under 28 TAC §21.2504.

The commenter suggests deleting subsection (f), because it is not supported by statute.

The commenter also does not understand the requirement to identify services that are likely to require "directly or indirectly" the services of out-of-network providers, and recommends that the department delete the reference to "indirectly."

Finally, the commenter says the requirement to provide an estimate is not warranted because the preauthorization process generally does not require the detailed level and amount of information necessary to provide a cost estimate. The commenter says this requirement would be more appropriate for rules under Insurance Code Chapter 1456, which addresses insurer obligations to provide cost estimates to insureds.

In addition, the commenter provides a general list of issues that may impact compliance with network adequacy reporting requirements: an insurer can only report network access issues after the insurer has fully processed a provider addition or termination; there is a 60-day notification period before termination of a contract between a provider and an insurer, and in that time the contract might be renewed; there could be delays in receiving timely updates of provider demographic data; providers may not inform insurers of changes in office locations, group practice rosters, or group affiliations; and insurers may run into system maintenance issues or reporting errors.

Agency response: The department disagrees with the comment and declines to make a change.

Insurers seeking to sell preferred or exclusive provider benefit plan products in Texas decide which parts of the state to include in their service area. Insurers that are unable to provide an adequate network to consumers in a particular area should consider whether it is feasible or practicable to market policies there. Insurers that decide to market these types of policies in areas of the state where they have an inadequate network will be subject to additional requirements, beginning with the requirement in §3.3709 that they disclose areas where their network does not meet the network adequacy requirements of §3.3704.

Due to the requirement of Insurance Code §1301.005 that insurers make certain that preferred provider benefits are available to their insureds, it is reasonable for the department to require insurers to disclose this information to the department. The rule accommodates local markets by permitting insurers to obtain waivers of the network adequacy requirements where they are unable, despite due diligence, to obtain contracts with providers.

The reporting requirements in §3.3709(c) are necessary for the department and insurers to monitor whether preferred providers are reasonably available to insureds. A majority of health benefit plan issuers have reported that they do not separately monitor balance billing complaints and inquiries. See page 4 of the *Report of the Health Network Adequacy Advisory Committee: Health Benefit Plan Provider Contracting Survey Results* on the department's website at tdi.texas.gov/reports/life/documents/hlthnetwork409b.doc. Further, less than half of the

health benefit plan issuers the department surveyed reported that they have a process for monitoring the extent to which insureds receive treatment from nonpreferred facility-based physicians at preferred provider facilities. See also page 4 of the *Network Adequacy Advisory Report*.

The department notes that the phrase "directly or indirectly" was deleted in the current rule proposal and does not appear in the adopted rule.

Regarding the requirement that an insurer implement procedures in areas where the insurer uses an access plan to furnish insureds an estimate of the amount the insurer will pay non-network providers, the department notes that this requirement is limited to the narrow circumstance where no network provider is available. Insurance Code §1301.005 requires that insurers make preferred providers reasonably available. The department believes that where an insurer does not make preferred providers available in a service area, additional consumer protections are necessary. Because preferred providers may not balance bill a consumer, estimates of what an insurer will pay are not as useful to insureds. However, when the inadequacy of a network requires an insured to use a non-network provider, it is important that the insured be aware of how much the insurer will pay for the proposed procedures.

The department notes that the preauthorization process is administered by the insurer, who may request additional information where necessary to provide a good-faith estimate. In addition, Insurance Code Chapter 1456 addresses different issues than §3.3709 in that it is limited to facility-based physicians even if no access plan applies. The requirement in the rule for procedures to provide estimates applies in all inadequate network situations as a consequence of the inadequate network provided.

Compliance with the rule will generally constitute compliance with the estimate requirements found in Insurance Code Chapter 1456.

Section 3.3710

Comment: A commenter restates opposition to establishment of a "file and use" process for local market access plans. The commenter says that the department should not rely on the intentions of an insurer that is already out of compliance with department regulations, and the commenter suggests additional text for §3.3710 to affirmatively regulate insurers who sell defective products to consumers. The commenter suggests striking the reference to local market access plans in §3.3710(a) and adding the following new subsections (c) and (d):

> (c) A local market access plan shall be submitted to the department for approval prior to the implementation of the plan. The commissioner may disapprove a submitted local market access plan only after notice and opportunity for hearing."
> (d) The commissioner shall, as soon as practicable, publish in the *Texas Register* notice of approved local market access plans which includes:
> (1) the name of the insurer;
> (2) the name of the health benefit plan subject to the local market access plan; and
> (3) the specialties or provider type(s) which are addressed by the local market access plan.

Agency response: The department disagrees with the comment and declines to make a change.

The department declines to make the suggested change to §3.3710(a), because the change would reduce the department's ability to take enforcement action for inadequate access plans. If the department removes the reference to local market access plans from §3.3707(a), the section would only address department enforcement

actions concerning networks that become inadequate. The section would no longer address notice, opportunity for a hearing, or possible sanctions in instances where an insurer's local market access plan becomes inadequate.

The department declines to add §3.3710(c) as recommended by the commenter because the change would be redundant and would create unnecessary administrative burdens. Insurers are already required to request a waiver for use of a local market access plan under §3.3707. Insurers must provide their local market access plan at the time they request a waiver to use it, so it is unnecessary to add this requirement to §3.3710.

The suggested text would also change the waiver and local market access plan from a department review process to an enforcement process.

The suggested revision could actually create a "file and use" process because the text says the commissioner may not "disapprove" a local market access plan until after a hearing. This could allow for an insurer to argue that its access plan is valid until the State Office of Administrative Hearings issues an order permitting the commissioner to disapprove it.

The department declines to add §3.3710(d) as recommended by the commenter because this change would be redundant and would provide little or no benefit to insureds.

Under §3.3707(f), the department will post information relevant to waivers granted on the department's website. The website could include information related to an insurer's local market access plan, including that listed by the commenter. The department's website is a better place to post information related to a waiver and local

market access plan because it is more accessible to most consumers than issues of the *Texas Register.*

Section 3.3721

Comment: A commenter agrees with the requirement in proposed §3.3721 that an insurer establishing an exclusive provider benefit plan should obtain permission from the department before offering exclusive provider benefit plan products in Texas.

The commenter says that the permission should be in the form of a formal certificate of compliance for each exclusive provider benefit plan service area, based on the insurer's ability to create and maintain an adequate network. The commenter says that a certificate would be credible evidence that an insurer has adequate infrastructure and relationships with providers to manage its network successfully.

Agency response: The department agrees that it is important to review and approve exclusive provider benefit plan networks prior to the exclusive provider benefit plan product being marketed in Texas. However, the department does not agree that a formal certificate is necessary and declines to make the requested change.

The department intends to regulate exclusive provider benefit plans similar to how it regulates health maintenance organizations, by approving the exclusive provider benefit plan for operation in specific service areas without a formal certificate.

The department has not observed significant problems with the absence of a formal certificate in the health maintenance organization context. An insurer marketing a plan outside of its approved service area will be subject to administrative action by the department.

Section 3.3722(a)

Comment: A commenter recommends that the department specify minimum required standards for complaint systems. The commenter recommends the following language from an early working draft of the exclusive provider benefit plan rules:

> (a) Complaint system required. An insurer is required to implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant. The complaint system must include a process that complies with the requirements of this section.
>
> (1) Not later than seven calendar days after receipt of an oral or written complaint, the insurer must:
>
> (A) acknowledge receipt of the complaint in writing;
>
> (B) acknowledge the date of receipt; and
>
> (C) provide a description of the insurer's complaint procedures and deadlines.
>
> (2) An insurer shall investigate each complaint received in accordance with the insurer's policies and in compliance with this subchapter.
>
> (3) After an insurer has investigated a complaint, the insurer shall issue a resolution letter to the complainant not later than the 30th calendar day after the insurer receives the written complaint which:
>
> (A) explains the insurer's resolution of the complaint;
>
> (B) states the specific reasons for the resolution;
>
> (C) states the specialization of any health care provider consulted;
>
> (D) states that, if the complainant is dissatisfied with the resolution of the complaint or the complaint process, the complainant may file a complaint with the department; and
>
> (E) includes the department's mailing address, toll-free telephone number and website address.
>
> (b) Record of complaints.
>
> (1) An insurer shall maintain a complaint log regarding each complaint as required by this section.
>
> (2) Each insurer must maintain and make available to the department upon request a complaint log that:
>
> (A) is categorized and completed in accordance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions); and
>
> (B) includes the following additional categories:
>
> (i) quality of care or services;
>
> (ii) accessibility/availability of services;
>
> (iii) utilization review or management; and

(iv) complaint procedures.

(3) An insurer shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on each complaint until the third anniversary of the date the complaint was received.

(4) A complainant is entitled to a copy of the record of the complainant's complaint and any proceeding relating to that complaint.

(5) The department, during any investigation of an insurer, may review documentation maintained under paragraph (3) of this subsection, including original documentation, regarding a complaint and action taken on the complaint.

Agency response: The department agrees that insurers issuing exclusive provider benefit plans must have reasonable complaint systems. However, the department does not agree required details and prescriptive rule language is necessary. Such prescriptive requirements have not previously been imposed on health maintenance organizations or insurers offering preferred provider benefit plans.

The proposed rule text requires that insurers provide documentation of a reasonable complaint system. This is similar to the requirement for health maintenance organizations in 28 TAC §11.204. Insurers with exclusive provider benefit plans will also be required to comply with the general complaint record requirements in 28 TAC §21.2504. Insurers with exclusive provider benefit plans will also be required to include in all policies and certificates information on how to contact the department to file a complaint.

Because the department will be reviewing the complaint systems implemented by insurers with exclusive provider benefit plans for reasonableness, and because insureds will have recourse to file complaints with the department, the department declines to make the requested change.

Section 3.3722(c)

Comment: A commenter suggests that the department add additional requirements to the exclusive provider benefit plan approval application.

The commenter suggests that the department require that applications include an attestation sworn to before a notary, rather than just signed by a representative of the applicant, and that the application include a statement that the attesting person knows no reason under the Insurance Code why the applicant is not entitled to approval.

The commenter also recommends that the department require that applications include the form of any agreements the applicant has with third parties to perform management, data processing, or claims processing services; any monitoring plans regarding those agreements; and that new agreements or modifications of current agreements be filed as they are executed or modified.

The commenter also recommends that the department require that applications include all physician and provider contract templates, and also require that the applicant file any amendments made to those templates. The commenter suggests that the department require an attestation when an insurer files forms, to be under penalty of perjury.

The commenter further recommends that the insurer be required to file descriptions of its information systems, management structure, and personnel, as well as updates to the descriptions as they occur, demonstrating the insurer's capacity to meet the needs of insureds, physicians, and providers and to meet the requirements of regulatory and contracting entities.

Finally, the commenter recommends that the department require that the insurer's complaint system have reasonable procedures to resolve oral complaints, in addition to written complaints.

Agency response: The department does not agree with the comment and declines to make a change.

Regarding attestation under penalty of perjury as part of an insurer's exclusive provider benefit plan approval application, the department notes that an application for a health maintenance organization license currently does not require a signature before a notary. In addition, insurers seeking approval to market exclusive provider benefit plan products must have a certificate of authority to operate as an insurer in Texas. The department will already have the ability to take administrative action against an insurer for false statements. The department will also be able to order corrective action to remedy violations. Finally, the department notes that Insurance Code §841.704 says a material false statement to the department is punishable by imprisonment for not less than one year, regardless of whether the statement is sworn.

Regarding the second recommendation, the department declines to make a change to require filing of all administrative agreements. Insurers are legally permitted to enter into many different types of agreements with third parties, from data input to claims processing. The department holds an insurer ultimately responsible for compliance issues. If issues arise as to particular third party agreements, the department can request additional information, including copies of relevant documents. Requiring insurers to always file, and the department to process, third party contracts

that are not necessary to confirm compliance would add additional administrative expense without sufficient justification.

The department declines to require that an insurer file provider contract templates in every case. Section 3.3723 says the department may request copies of any contract with a physician or provider during an examination. Given resource limitations, review of every contract template may not be feasible, making routine filing of every template unnecessary. The department believes that its ability to take administrative action for the submission of false statements and to order restitution to impacted providers is sufficient to deter false statements in this context.

The department declines to require that insurers file descriptions of their information systems, management structure, and personnel, including updates. The listed descriptions are more appropriate to the larger issues of company licensure rather than approval to write a particular type of health insurance.

Regarding the fifth recommendation, the department declines to prescribe requirements for the handling of oral complaints. The department encourages insurers to have strong procedures for resolving oral complaints so that they do not escalate further. However, enforcement of such requirements is problematic, as it is often difficult to prove up what was voiced in an oral complaint, whether it constituted a complaint, and whether the insurer responded appropriately.

Section 3.3722(c)(4)(B)

Comment: A commenter requests that the department clarify that an insurer may attest that the insurer's network is adequate even if there are some areas where network

requirements are not met due to the absence of providers, if the insurer has provided a local market access plan.

Agency response: The department clarifies that an insurer may take into account waivers and local market access plans when attesting that the insurer's network is adequate for the services to be provided.

Section 3.3722(c)(10)

Comment: A commenter requests that the department revise §3.3722(c)(10) to include a reference to the phrase "if an insured cannot reasonably reach a preferred provider."

Agency response: The department declines to make a change because no change is necessary.

The comment appears to address a prior version of proposed rule text, not the text included in the proposed rule that the department adopts with this order. In the proposed §3.3722(c)(10) the department adopts, the text references §3.3725 generally, which includes reference to situations when insureds cannot reasonably reach preferred providers, so there is no need to include the specific language the commenter requested.

Section 3.3722(d)

Comment: A commenter requests that §3.3722(d) identify the following additional specific items that an insurer must make available during a qualifying examination:

> Administrative – policy and procedure manuals; physician and provider manuals; insured materials; organizational charts; and key personnel information, such as resumes and job descriptions.

Complaints – policies and procedures, examples of letters, and examples of complaint logs.

Health information systems – policies and procedures for accessing insureds' health records and a plan to provide for confidentiality of those records in accord with applicable law

Executed agreements – including management services agreements and administrative services agreements.

Executed preferred provider contracts – a copy of the first page, including the form number, and signature page of individual provider contracts and group provider contracts.

Executed subcontracts – a copy of the first page, including the form number, and signature page of all contracts with subcontracting preferred providers.

Current physician manual and current provider manual which shall be provided to each preferred provider. The manuals must contain details of the requirements by which the preferred providers will be governed.

Credentialing policies and procedures and credentialing files.

Statistical reporting system developed and maintained by the insurer which allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of services, and the accessibility and availability of services.

Claims systems – policies and procedures, and systems and processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers, and insureds.

Agency response: The department disagrees with this comment and declines to make a change.

The documents identified by the commenter could be relevant to approving an exclusive provider benefit plan network. However, the department does not agree it is necessary that the rule specifically identify these documents. Under §3.3723, the

department may examine the books and records of an insurer when it conducts an examination. It is not necessary or feasible to list every possible document that the department might request during an examination.

Section 3.3722(e)

Comment: A commenter requests that the department revise §3.3722(e) to require an insurer to file with the department prior to implementing network modifications that impact the adequacy of a network:

> Forms of any new or amended agreements, contracts, or monitoring plans in the new area, if applicable.
> The form of a physician contract and provider contract templates, if applicable.
> A description of the method by which the complaint procedure as specified in the subchapter will be made reasonably available in the new service area including a toll free number, and the information and complaint telephone number required by Insurance Code §521.102, where applicable.

Agency response: The department disagrees with the suggestion and declines to make the requested change.

Section 3.3722(e) requires an insurer wishing to make changes to network configuration that impact the adequacy of the network or service area to obtain prior approval of the department.

During that approval process, the department will be able to request any additional documentation it considers necessary. The section already references physician and provider contracts, and it is not necessary to specifically reference agreements with third parties or complaint procedures because the department can request them.

Section 3.3723

Comment: A commenter recommends that the department revise §3.3723 to include the following additional elements as items an insurer must make available during an examination:

Administrative – policy and procedure manuals; physician and provider manuals; insured materials; organizational charts; key personnel information, such as resumes and job descriptions.

Complaints – policies and procedures and templates of letters; complaint files and complaint logs, including documentation and details of actions taken.

Health information systems – policies and procedures for accessing insureds' health records and a plan to provide for confidentiality of those records in accord with applicable law.

Executed agreements, including management services agreements and administrative services agreements.

Credentialing policies and procedures and credentialing files.

Claims systems – policies and procedures, and systems and processes that demonstrate timely claims payments, and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, providers, and insureds.

Financial records – including statements, ledgers, checkbooks, inventory records, evidence of expenditures, investments, and debts.

Agency response: The documents identified by the commenters could be relevant to an examination of an exclusive provider benefit plan's network. However, the department disagrees with the comment and declines to make the requested change because the department can review the identified documents without the need to list them in the section.

Under §3.3723, the department may examine the books and records of an insurer when it conducts an examination. Further, it is not necessary or feasible to list every possible document that the department might request during an examination.

Section 3.3724(d)

Comment: A commenter supports the requirement under §3.3724(d) that insurers offering exclusive provider benefit plans maintain a strong quality improvement program. The commenter recommends that the department modify §3.3724(d) to emphasize accreditations or certifications specifically tailored to the insurer's quality improvement program. The commenter suggests that the department revise the first sentence of §3.3724(d) to provide that the nonconditional accreditation an insurer receives be "certification specific and germane to the insurer's quality improvement program."

Agency response: The department agrees with the comment and has made the requested change.

Comment: A commenter asks that the department clarify that §3.3724(d) permits the National Committee for Quality Assurance and URAC preferred provider organization accreditation to apply to exclusive provider benefit plans.

Agency response: In response to the comment, the department notes that currently preferred provider organization accreditation under National Committee for Quality Assurance or URAC could be submitted under §3.3724(d) as support for the approval of an insurer's quality improvement program. However, because credentialing programs are subject to change outside of the control of the department, the department will assess each credential presented to it on a case-by-case basis to determine whether the accreditation or certification addresses all material requirements.

This section is intended to provide flexibility for insurers, and the department declines to revise it to specifically reference preferred provider organization or preferred provider benefit plan credentialing by the National Committee for Quality Assurance or URAC.

Section 3.3725

Comment: A commenter says there is no statutory authority for the department to adopt the requirement in §3.3725 that an exclusive provider benefit plan hold an insured harmless when the insured receives care from an out-of-network provider for an emergency or when no network provider is available.

The commenter says this goes beyond language in HB 1772, conflicts with provisions in the Patient Protection and Affordable Care Act, and could have fiscal implications for the state under it. The commenter adds that the Patient Protection and

Affordable Care Act defines emergency services, and that the proposed section conflicts with federal regulations that do not require insurers to pay excess amounts.

The commenter says the department should use statutory language related to reimbursement for emergency care and services from nonpreferred providers when no preferred provider is available.

Agency response: The department disagrees with the comment and declines to make a change.

Prior to the bill's passage, the 82nd Legislature amended HB 1772 to include language regarding insurer payment of claims when no preferred provider was available, and provided for payment of claims in cases of emergency that tracks the health maintenance organization statutory language. The legislature was aware that the department has construed the health maintenance organization statutes to require that health maintenance organizations hold enrollees harmless in these situations. See pages 10-12 of the *TDI Biennial Report* on the department's website at tdi.texas.gov/reports/documents/finalbie07.pdf. As the House Research Organization Report on HB 1772 notes, the amendment requires insurers offering exclusive provider benefit plans to "fully reimburse" out-of-network providers in both of these situations. See the report on the House Research Organization's website at hro.house.state.tx.us/pdf/ba82r/hb1772.pdf#navpanes=0.

Review of the text of Insurance Code §1301.0052 and §1301.0053 reflects a superficial ambiguity as to when insurers are required to pay at a usual and customary rate and when they must pay at a rate agreed to by the provider. The adopted rule

resolves the ambiguity consistent with the department's longstanding interpretation of similar language in the health maintenance organization statute.

The department notes that an insured is still responsible for the insured's copayments, deductibles, and coinsurance required under the exclusive provider benefit plan.

Recent federal guidance indicates that states' rules relating to cost-sharing and reimbursement methods are permitted and will not constitute state benefit mandates. See *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule*, available on the Government Printing Office website at gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm.

Comment: A commenter asks that the department confirm that §3.3725 does not apply to out-of-network claims by facility-based physicians in the absence of an emergency situation or a gap in mileage requirements.

Agency response: The department confirms that §3.3725 applies to situations where an insured cannot reasonably reach a preferred provider in cases of emergency or where there is an inadequate provider network. Thus, if an insured were to voluntarily obtain services at an out-of-network facility from out-of-network facility-based physicians, the exclusive provider benefit plan might deny coverage.

The department notes, however, that the situation would be different with an in-network facility. The department is unlikely to approve an insurer's exclusive provider benefit plan network if it includes facilities where the insurer does not have contracted

facility-based physicians, due to absence of out-of-network benefits in exclusive provider benefit plans, except as required by Insurance Code Chapter 1301. Further, if an insured receives services at a contracted facility from an out-of-network physician, the department would be likely to view it as falling within §3.3725 if the insured had no choice of physicians.

Comment: A commenter says that the commenter raised concerns during the last legislative session about balance billing of insureds covered by exclusive provider benefit plans. The commenter notes insureds might receive out-of-network care in instances beyond the insured's control. To prevent balance billing the legislature included language in HB 1772 that mirrors language applicable to health maintenance organizations. The commenter says that under the these laws, health maintenance organizations make out-of-network providers whole either by negotiating an agreeable rate with the provider or paying the provider's billed charge. The commenter says that this long-standing practice works fine.

Agency response: The department agrees with the comment that HB 1772 includes language mirroring language applicable to health maintenance organizations.

The department has crafted the rule to protect insureds covered by exclusive provider benefit plans from balance billing in the same way that enrollees in health maintenance organizations are.

Comment: A commenter addresses the framework §3.3725 establishes for insurer payment of out-of-network exclusive provider benefit claims when services are not available from an in-network provider or are emergency services.

The commenter says HB 1772, in addressing insurer reimbursement of nonpreferred providers for medically necessary services not available through a preferred provider and for emergency care, uses language that is taken almost word-for word from the network adequacy requirements of Insurance Code Chapter 1271, which is applicable to health maintenance organizations. Because of this, the commenter says, the department should interpret HB 1772 the same way it does Insurance Code Chapter 1271, holding insurers to the same obligations it applies to health maintenance organizations when their networks fail to make a preferred provider available. The commenter notes that the department has required that health maintenance organizations hold enrollees harmless for necessary out-of-network and emergency care for the past six years. The commenter also points out that under Texas Attorney General Opinion GA-0040, the department cannot prohibit a nonpreferred provider from balance billing an insured.

The commenter says this interpretation is supported by Insurance Code §§1301.0041, 1301.0042, 1301.0052, and 1301.0053. Insurance Code §1301.0041 and §1301.0042 say that, unless otherwise specified, the provisions of Chapter 1301 apply to exclusive provider benefit plans in the same manner they apply to preferred provider benefit plans and that the commissioner may depart from a provision of this Code that "applies to a preferred provider benefit plan" to the extent it is inconsistent with the function of a exclusive provider benefit plan. Insurance Code §1301.0052 and

§1301.0053 create distinct obligations for exclusive provider benefit plans which are not applicable to preferred provider benefit plans.

These requirements mirror requirements applicable to health maintenance organizations. Because of this, the commenter says, the department must interpret and apply Insurance Code §1301.0052 and §1301.0053 in the same way as for health maintenance organizations. To achieve this, the commenter says the department must adopt the following text for §3.3725 in place of the text the department proposed:

> §3.3725. Settlement of certain claims for services provided by nonpreferred providers. (a) If an insured cannot reasonably reach a preferred provider for the following emergency services the insurer shall fully pay the nonpreferred provider and calculate the insurer's payment and the insured's coinsurance and deductibles for services otherwise available under the plan on the amount submitted on the claim as the nonpreferred provider's billed charge:
>
> (1) a medical screening examination or other examination required by state or federal law to be provided in a hospital emergency facility of a hospital or a freestanding emergency medical care facility, or comparable facility that is necessary to determine whether an emergency medical condition exists;
>
> (2) necessary emergency medical care services, including the treatment and stabilization of an emergency medical condition; and
>
> (3) following treatment or stabilization of an emergency medical condition, services for the medical condition stabilized originating in a hospital emergency facility or freestanding emergency medical care facility, or comparable emergency facility.
>
> (b) If a covered service for medical care, other than emergency care, is medically necessary and not reasonably available through a preferred provider, the insurer shall, in accord with Insurance Code §1301.0052, fully pay the nonpreferred provider and calculate the insurer's payment and the insured's coinsurance and deductibles for services otherwise available under the plan on the amount submitted on the claim as the nonpreferred provider's billed charge.

The commenter says that even if the department does not adopt the first set of alternative text the commenter suggests for §3.3725, the department must still adopt language to insure that an insured receives value for insurance the insured has purchased. The commenter says the following alternative text would be in line with the

Texas Attorney General Opinion that the department can only regulate insurers, and not providers, in addressing balance billing:

> §3.3725. Settlement of certain claims for services provided by nonpreferred providers. (a) If an insured cannot reasonably reach a preferred provider for the following emergency services, the insurer shall ensure the insured is held harmless and pay the nonpreferred provider an amount sufficient to ensure the provider will not bill the insured, the insured's family, or the insured's guardian for the following emergency services:
>
> (1) a medical screening examination or other examination required by state or federal law to be provided in a hospital emergency facility of a hospital or a freestanding emergency medical care facility, or comparable facility that is necessary to determine whether an emergency medical condition exists;
>
> (2) necessary emergency medical care services, including the treatment and stabilization of an emergency medical condition; and
>
> (3) following treatment or stabilization of an emergency medical condition, services for the medical condition, including complications associated with that condition, stabilized in a hospital emergency facility or freestanding emergency medical care facility, or comparable emergency facility.
>
> (b) If a covered service for medical care, other than emergency care, is medically necessary and not reasonably available through a preferred provider, the insurer shall, in accord with Insurance Code §1301.0052, ensure the insured is held harmless and pay the nonpreferred provider an amount sufficient to ensure the provider will not bill the insured, the insured's family, or the insured's guardian.

Agency response: The department disagrees with the comment and declines to make a change.

The department agrees that the legislature's intent was for insurers offering exclusive provider benefit plans to protect insureds from balance billing. However, no change is necessary because the adopted rule does this while also providing opportunities for insurers to mitigate this requirement's impact on premiums.

Regarding the recommendation that the department require insurers offering exclusive provider benefit plans to base their payments on the billed charge, the department believes that such a requirement is unnecessary in light of its potential

impact on premiums. This would also not be consistent with how the department has handled the same situation with health maintenance organizations.

Instead, the adopted rule requires insurers to base their payments on the usual and customary billed charge for the service or a rate agreed to by the provider, tracking the statutory language of §1301.0052 and §1301.0053.

When issuing payment, an insurer must also request that the insured notify the insurer if a balance bill is received. If so, the insurer must ensure that the insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider, thus protecting the insured from balance billed amounts. The rule also permits insurers to exercise some options if they believe the billed charge is excessive, again without harm to the insured.

The department maintains that, given the lack of substantive regulation of the rates charged by providers, the rule strikes a fair balance between the interests of all stakeholders.

The alternative suggestion that the rule require an insurer to pay an amount "sufficient to ensure the provider will not bill the insured," appears to, with only slightly more flexibility, effectively impose a similar requirement that the insurer base its payment on the billed charge, as only such a payment would ensure the provider would not bill the insured. The department believes that the adopted rule more closely tracks the statutory language and intent of the legislature.

Section 3.3725 in general, §3.3725(d) and (e)

Comment: A commenter is pleased with and supports the addition of explicit language generally shielding insureds under exclusive provider benefit plans from balance billing in the cases of emergencies or when an insured is forced to go out-of-network because a network is inadequate to provide medically necessary covered services.

The commenter supports the language in §3.3725(d) and (e) that explicitly addresses the obligation of an exclusive provider benefit plan to generally hold the insured harmless for amounts beyond in-network cost-sharing if an insured cannot reasonably reach a preferred provider or covered services are not available through preferred providers. The commenter says that maintaining this language will provide insureds in exclusive provider benefit plans with the same level of consumer protections as health maintenance organization enrollees in regard to balance billing.

Agency response: The department appreciates the supportive comment.

Section 3.3725(c)

Comment: A commenter says §3.3725(c), which addresses insurer facilitation of an insured's selection of a "non-par" provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider, is confusing and unnecessary.

The commenter asks whether, under §3.3725(c), an insurer could make a suggestion of fewer than three "non-par" providers. The commenter also asks what happens if there are fewer than three "non-par" providers in the service area.

The commenter says the provision creates a disincentive for an insurer to provide any suggestions, as it obligates an insurer to hold an insured harmless if the insured selects a provider from the list of those the insurer suggests.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3725(c) does not require an insurer to offer a list of "non-par" providers to an insured. Rather, it allows an insurer to provide a list of nonpreferred providers with whom the insurer has reached an agreement on payment, worked with previously, or otherwise wishes to suggest to the insured.

The rule states that a list an insurer provides cannot include fewer than three providers. If three providers are not available for an insurer to include on a list, the provision of the rule exempting the insurer from holding the insured harmless if they do not select one of the three providers would not be applicable.

The department does not agree that the requirement to hold an insured harmless if the insured selects a provider from the list will create a disincentive for an insurer to provide a list, because under §3.3725(d) – (f) the insurer must still hold the insured harmless if the insurer does not provide a list to facilitate the insured's selection of a nonpreferred provider. On the other hand, an insurer may benefit from making the offer of three providers to an insured. If the insured selects one of the providers, the insurer may be able to reach payment agreements with the provider in advance to limit the insurer's liability, and if the insured does not select one of them, the insurer will not be liable to hold the insured harmless for an unknown dollar amount.

Section 3.3725(c) and (e)

Comment: A commenter is opposed to proposed §3.3725(c), which establishes a process for an insurer to facilitate an insured's selection of a nonpreferred provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider and the insured has received a referral from a preferred provider. The commenter urges the department to not adopt the provision.

The commenter says the subsection allows an insurer to construct an ad hoc network when it has failed to make services from preferred providers reasonably available, noting that the insured must choose from the list of physicians provided or risk losing protections given under the Insurance Code, like being held harmless or receiving coverage for emergency care.

The commenter says that the provision inappropriately rewards insurers that wait to develop an adequate network and enables poor marketplace conduct. The provision fails to offer a solution. Instead it encourages inadequate networks to proliferate. Further, what the department attempts to address with Subsection (c) is already addressed by §3.3705(n), which the department has proposed to delete. Section 3.3705(n) requires insurers to continually monitor their networks, while 3.3725(c) merely gives insurers an additional method to control expenditures at the expense of insureds.

The commenter says that §3.3725(e) suffers from a similar malady and is also objectionable. Under §3.3725(e), if an exclusive provider benefit plan network is inadequate and payment is made, an insured must notify the insurer if the nonpreferred provider bills the insured for amounts beyond the amount paid by the insurer. This

provision is presumably designed so that an insurer has information it can use to decide if it should force an insured to mediate a claim.

The commenter says §3.3725(e) suffers from the same problems.

The commenter urges the department to reject adoption of §3.3725 (c) and (e) and adopt alternative language that the commenter offers in regard to all of §3.3725, which is included in a separate comment summary in this preamble.

Agency response: The department disagrees with the comment and declines to make a change.

The rule creates a voluntary option on the part of insurers, while other portions of the rule will limit the frequency of situations where an insured must receive treatment from an out-of-network provider due to network inadequacies. Because of this, it is unlikely that it will be common for insureds covered by exclusive provider benefit plans to be offered a choice of three nonpreferred providers. Regardless, the department believes it important to provide insurers offering exclusive provider benefit plans the opportunity to offer this choice to consumers. A consumer in such a case will be in the same position as if the three providers had been part of the exclusive provider benefit plan network and will be protected against balance billing if one is chosen.

Even if a consumer decides to choose a provider other than the ones suggested by the insurer, the insurer will at least pay part of the claim (an amount at the usual and customary rate), something it would not have done if the insured voluntarily went out of network. An insurer will have the opportunity to arrange one-time payment rates in advance, capping the insurer's potential liability prior to services being rendered,

regardless of which choice the insured makes and potentially reducing premium rates for the product.

The department does not believe insurers will regularly rely on the option provided under the rule. In the vast majority of cases it will be more cost effective for insurers to negotiate long-term contracts with individual providers, rather than negotiate one-time contracts with three providers every time a situation arises. Further, insurers will have to annually demonstrate to the department that there are grounds to support a waiver of network adequacy requirements. This may be difficult to do if providers are willing to repeatedly agree to one-time payment arrangements. The department intends to strictly review requests for waivers in those circumstances.

Section 3.3725(c)(3)

Comment: A commenter is concerned by §3.3725(c)(3), which provides for insurer-facilitated selection of a nonpreferred provider by an insured. The commenter says it is fine for an insurer to assist an insured in finding a nonpreferred provider, but the commenter does not support exceptions to hold-harmless provisions for insureds covered by exclusive provider benefit plans.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3725 includes a voluntary option for insurers. In addition, other portions of the rule will limit the frequency of situations where an insured must receive treatment from an out-of-network provider due to network inadequacies. Thus, it is

unlikely that insurers will frequently offer insureds covered by an exclusive provider benefit plan a choice of three nonpreferred providers.

Regardless, the department believes that it is important to provide insurers offering exclusive provider benefit plans an opportunity to provide this choice to insureds. In these situations, insureds will be in the same position as if the three providers had been the exclusive provider benefit plan's network, and will be protected against balance billing if one is chosen. If the insured chooses a different provider, the insured may be balance billed, but the insurer will at least pay part of the claim. The insurer will have the opportunity to arrange one-time payment rates in advance, capping the insurer's potential liability prior to services being rendered regardless of which choice the insured makes and potentially reducing premium rates for the product.

Section 3.3725(d)

Comment: A commenter says that §3.3725(d) appears to apply to more than just exclusive provider benefit plans and that it appears to apply in situations not involving exclusive provider plans where an insurer approves service by a non-network provider because no network provider is reasonably available and where an insurer facilitates an insurer's choice of a non-network provider by providing a list of non-network providers to an insured. The commenter says that §3.3725(d) presents a problem in that it requires an insurer to hold an insured harmless in the three situations addressed by the subsection. The commenter says there is no statutory authority for this provision.

The commenter says a hold harmless provision might be appropriate when an insurer has a contract with an exclusive provider but questions how an insurer can

achieve this in regard to a provider the insurer has no contract with. The commenter says that the term "hold harmless" is used in specific circumstances in Insurance Code Chapter 843, noting that Insurance Code §843.361 requires a hold harmless provision in a contract between a health maintenance organization and a provider. The commenter says it would also be also consistent with a health maintenance organization that has contracted with a provider under Insurance Code Chapter 843 or a workers' compensation health care network that has contracted with a provider under Insurance Code §1305.152(c). But the commenter concludes that hold harmless requirements are inappropriate in cases where there is no contract with the provider.

The commenter says that while the idea sounds good, it will create a great deal of confusion and liability for insurers and put them at a disadvantage in the marketplace, so the department should not adopt §3.3725(d).

Agency response: The department disagrees with the comment and declines to make a change.

The department notes that the legislature amended the language of HB 1772 to address the payment of claims when no preferred provider was available and in cases of emergency with text that tracks the health maintenance organization statutory language. The legislature was aware that the department has construed the health maintenance organization language to require that health maintenance organizations hold enrollees harmless in these situations. See *Biennial Report of the Texas Department of Insurance to the 80th Texas Legislature* at pages 10-12, tdi.texas.gov/reports/documents/finalbie07.pdf. As the House Research Organization's report on HB 1772 notes, the legislature amended the bill to require that insurers

offering exclusive provider benefit plans "fully reimburse" out-of-network providers in both of these situations. See *House Research Organization Bill Analysis for HB 1772* which can be found on the House Research Organization's website at hro.house.state.tx.us/pdf/ba82r/hb1772.pdf#navpanes=0.

The department's intent is to resolve any ambiguity in its interpretation of the statutory text, consistent with legislative intent that insureds be protected when they receive services outside of the exclusive provider benefit plan network through no fault of their own.

Health maintenance organizations have long operated under identical requirements and have been able to hold their enrollees harmless despite the absence of a contract with out-of-network providers. Though the nature of the health maintenance organization contract is different, the issue of payment for out-of-network care is largely the same.

Section 3.3725(d) – (e)

Comment: A commenter says that the different approach for exclusive provider plans in §3.3725(d) – (e) is necessary given the contrasting language of Insurance Code §1301.0053. The commenter says that the hold harmless provision is an obvious consequence of the requirement that plans fully reimburse nonpreferred emergency care providers at the usual and customary rate or at an agreed rate. Because of these requirements, the commenter says, the annual out-of-pocket maximum clarification at §3.3708(b) is unnecessary in §3.3725, as the insureds of exclusive provider benefits

plans will be held harmless by the plans on the balance bills contemplated in both proposed sections.

Agency response: The department agrees that an insured covered by an exclusive provider benefit plan should only be responsible for the insured's coinsurance, deductible, and copayment when treated by an out-of-network provider because of an emergency or an inadequate network. However, the department does not believe a change to the rule text is necessary. The insured will receive credit for these amounts toward the insured's out of pocket maximum under the plan.

Because the insured is not required to pay any balance bill, there is no need for the department to implement a requirement that insurers credit insureds for out-of-pocket expenses similar to the requirement in §3.3708(b) in the context of an exclusive provider benefit plan.

Section 3.3725(e)

Comment: A commenter says that §3.3725(e) creates a requirement for exclusive provider benefit plans to reimburse all out-of-network providers at the usual and customary rate. The commenter says this provision conflicts with law and should be deleted.

Agency response: The department disagrees with the comment and declines to make a change.

The reference in §3.3725(e) to "usual and customary" tracks the statutory requirements in Insurance Code §1301.0052 and §1301.0053 that out-of-network providers be reimbursed at the "usual and customary rate" or an agreed rate. The rule

does not create a requirement that all out-of-network providers be paid at the usual and customary rate, but only for those in the narrow circumstances stated in the rule. Review of the text of Insurance Code §1301.0052 and §1301.0053 reflects a superficial ambiguity as to when insurers are required to pay at a usual and customary rate and when they must pay at a rate agreed to by the provider. The adopted rule resolves the ambiguity consistent with the department's longstanding interpretation of similar language in the health maintenance organization statute.

Comment: A commenter opposes §3.3725(e), which the commenter says permits an insurer to contractually require insureds under exclusive provider benefit plans to mediate claims that are eligible for mediation under Insurance Code Chapter 1467 and related rules. The commenter says §3.3725(e)(2) allows insurers to force consumers to mediate. A second commenter says that §3.3725(e) is confusing. The second commenter also says there is no statutory authority for the provision and that the requirement goes far beyond the language of the statute. A third commenter says the provision conflicts with statutes and other rules, but the commenter does not specify the statute or rules that the provision conflicts with.

The first commenter says that when an insured receives care from an out-of-network provider, there is no privity of contract between the insurer and the provider. The commenter also says that Insurance Code Chapter 1467 solely gives an insured the choice to mediate, and the commenter says that the idea an insurer could force an insured to mediate is contrary to the legislature's intent.

The first commenter says §3.3725(e)(2) introduces unnecessary complications to a process that is already applicable to exclusive provider benefit plans under statute. The legislature developed the mediation process in Insurance Code Chapter 1467 to give insureds an option to request mediation, but the proposed rules give the insured's decision-making power to the insurer by threatening a penalty of the loss of the hold-harmless benefit.

The first commenter says this was not the intent of the legislature, because under HB 1722 insurers offering exclusive provider benefit plans must comply with all laws applicable to preferred provider benefit plans, including Insurance Code Chapter 1467, unless the commissioner determines a law applicable to a preferred provider benefit plan is inconsistent with the function or purpose of an exclusive provider benefit plan. The first commenter does not think it necessary to depart from laws applicable to preferred provider plans in regard to mediation under Insurance Code Chapter 1467 and says that the rule proposal does not provide an explanation for the non-alignment in the rule proposal.

The first commenter also asks why the department is now embracing a mandatory mediation process it rejected in May of 2011. The commenter references a comment in the May 19, 2011, adoption order in which a commenter asked the department to establish an alternative dispute resolution process to resolve billing disputes similar to a process established in Illinois in 2011. In response to the comment, the department said that it did not have authority to establish the requested process.

The first commenter also expresses concerns that insurers will rely on §3.3725(e) to draft contract provisions that rescind coverage when an insured does not pursue mediation. The commenter adds that the provision addresses this concern by threatening consumers with the loss of hold-harmless protections and asserts that the whole purpose of the proposed mandatory mediation framework is to ensure that insurers can mitigate their expenses when they fail to provide networks they have promised to insureds.

The first commenter concludes by asserting that §3.3725(e)(2)(A)(ii) and (iii) indicates intent to give insurers permission to penalize consumers for the benefit of insurers. The commenter says that §3.3725(e)(2)(A)(ii) says insurers cannot penalize insureds, but the commenter adds that §3.3725(e)(2)(A)(iii) creates a clear exception so that insurers can penalize insureds until they bend to the insurer's will. There is no recourse for insureds and no penalty on insurers who "demand mandatory mediation in bad faith." The concept that an insurer can escape promises made to an insured to cover losses due to medical expenses through the proposed regulatory scheme is poor public policy.

The first commenter asks that the department not adopt §3.3725(e) or any other provision that would allow an insurer to trigger mediation, that the department revise the figure in §3.3705(f)(2) to remove any mention that an insurer can force mediation, and that it drop the concept of forced mediation. As an alternative, the first commenter says that if the department does adopt provisions providing for mediation, it should give insureds the right to settle a claim with a nonpreferred provider at any amount and make this settlement binding on the insurer.

Agency response: The department does not agree with the comments and declines to make a change.

It is important to recognize that the mediation issue will occur very rarely under the proposed rules. First, the new network adequacy requirements will ensure that exclusive provider benefit plans have adequate networks, so insureds will seldom be required to receive out-of-network care. The rule also requires exclusive provider benefit plans to make an initial payment in these circumstances at the usual and customary billed charge for the services or an agreed rate.

The only time mediation is available under Insurance Code Chapter 1467 is when a facility-based physician's balance bill exceeds $1,000. The department believes that it will be very rare that a facility-based physician will balance bill an insured beyond the usual and customary charge. The department notes that Insurance Code Chapter 1467 became effective in 2009, yet the department has not referred a single case for formal mediation since that time.

Section 3.3725(e) does not allow an insurer to force an insured to mediate a claim. To the contrary, the text of §3.3725(e)(2)(A)(i) expressly provides that an insurer may not require that an insured participate in mediation. This is consistent with Insurance Code §1467.054, which says participation in mediation by an insured is elective.

Section 3.3725(e) is not a departure from the requirements of Insurance Code Chapter 1467 or other laws that apply to preferred and exclusive provider benefit plans. Nothing in Insurance Code Chapter 1467 prohibits insurers from including language in insurance policies requiring the initiation of mediation. Through the rule, the department

is regulating the use of such requirements by insurers and limiting the consequences that may be imposed under the policy for the refusal to initiate mediation.

It is important to recognize that requiring the insurer to pay the billed charge also imposes a burden on the insured to pay their coinsurance percentage of a facility-based physician's billed charge, an amount that may exceed $1,000 and that is not eligible for mediation under Insurance Code Chapter 1467. By creating a process for the insurer and the physician to mediate a charge, the consumer may substantially benefit if the coinsurance percentage is calculated on a smaller amount than the billed charge.

The department believes that the rule best effectuates the intent of the legislature in requiring that insurers pay the usual and customary rate or a "rate agreed to by the issuer and the nonpreferred provider."

Given that an insured is only required to initiate the mediation process, not participate in it, and that the result of the mediation process can only decrease the insured's out-of-pocket costs, not increase them, the department does not believe the rule creates an unreasonable burden on insureds.

Section 3.3725(e) is not contrary to the department's previous position addressed in the May 19, 2011, adoption order. The provision only addresses mediation under Insurance Code Chapter 1467 and related rules, and it does not establish alternative or additional processes.

Section 3.3725(e) does not apply Insurance Code Chapter 1467 differently to preferred or exclusive provider benefit plans. If an insured requests mediation under Insurance Code Chapter 1467, an insurer would follow the same procedure regardless of whether the claim resulted from care delivered through a preferred or an exclusive

provider benefit plan. Chapter 1467 does not address whether insurers may create incentives for requesting mediation.

Further, the department has not embraced the mandatory dispute resolution process it rejected in response to a comment in the May 19, 2011, adoption order. Under the Illinois law, certain billing disputes that an insurer and provider cannot settle through negotiation are resolved through binding arbitration. In response to the comment, the department noted that it lacked statutory authority to establish an alternative dispute process for mandatory claim settlement, except to the extent that Insurance Code Chapter 1467 already applies to the claim.

As pointed out in the comment, in situations where an insured receives care from a non-network provider, the department has no authority to limit what the non-network provider bills the insured. Insureds receiving out-of-network or emergency care generally have limited ability to negotiate with providers on what they will bill. The commenter also notes that in out-of-network care situations there is no privity of contract between the provider and the insurer, so the insurer has no say in regard to what the provider bills. So, in out-of-network situations the provider has all the power over billed charges.

Insurance Code Chapter 1467 provides options to address, to a limited extent, this unlevel playing field. In the situations it applies to, an insured that a provider has balance billed can request mediation, and the insurer and provider must come to the table in good faith to attempt to resolve the claim. However, because mediation under Insurance Code Chapter 1467 must be requested by the insured, the insurer has limited ability to initiate the process. Section 3.3725(e) opens an avenue for an insurer into the

mediation process by allowing the insurer's contract with an insured to require that an insured request mediation under Insurance Code Chapter 1467 and related rules when it is available.

To ensure that the burden on an insured is not too high, the department clarified in the rule proposal that even though an insurer is permitted to require an insured to request mediation, the insurer must inform the insured when mediation is available and may not penalize an insured for failing to request or failing to participate in mediation beyond delaying final adjudication of the claim until the insured requests. Under Insurance Code Chapter 1467, an insured is not subject to administrative penalties for failing to participate in mediation. Once the mediation is requested, an insured no longer needs to participate. At that point, it can become a process between the insurer and the non-network provider.

The department does not agree that an insurer faces no penalty for demanding "mandatory mediation in bad faith." Insurance Code Chapter 1467 and related rules provide for administrative action by the department when an insurer acts in bad faith in a mediation. Insurance Code Chapter 542 prohibits unfair claim settlement practices, such as failing to attempt in good faith to effect a prompt, fair, and equitable settlement of a claim.

Further, given the administrative costs for an insurer to participate in mediation, the department does not believe insurers will pursue mediation in bad faith. An insurer will have already paid the claim at the usual and customary billed rate for the service, and it is difficult to imagine circumstances where it would constitute bad faith to dispute a charge above the usual and customary rate.

The department does not believe it is necessary for the department to permit an insured to bind an insurer to a settlement amount. Both the insurer and the insured will have an aligned financial interest in reducing the billed charge as much as possible, because the insured remains liable for their coinsurance portion of the final charge. If the insured voluntarily participates in the mediation, then the mediator will work with all parties toward an agreeable resolution. If the insured does not participate, the department does not believe it is necessary to give the insured final say in the settlement amount reached through the mediation process.

Section 3.3725(e)(2)

Comment: A commenter references previous concerns the commenter had that an insurer might contractually require a consumer to participate in mediation under §3.3725(e)(2). The commenter says that the provisions proposed by the department in §3.3725(e)(2)(A)(i) – (iii) address the commenter's concerns and provide reasonable protections for consumers and insurers. The commenter says §3.3725(e)(2) will benefit consumers by providing a mechanism for providers and insurers to negotiate bills.

Agency response: The department appreciates the supportive comment and agrees with the commenter's conclusion that §3.3725(e)(2) will benefit consumers by providing a mechanism for providers and insurers to negotiate bills.

Section 3.3725(f)

Comment: A commenter says that §3.3725(f) appears to regulate how insurers determine usual and customary rates. The commenter contends there is no statutory authority for the department to legislate this by rule.

A second commenter also makes this point and requests that the department delete §3.3725(f) on the grounds that the department lacks statutory authority to establish standards for reimbursement methodology.

Agency response: The department disagrees with the comment and declines to make a change.

Section 3.3725(f) applies basic standards of fairness to reimbursements based on usual and customary charges, requiring insurers to use generally accepted industry standards for determining usual and customary billed charges. An insurer may base its reimbursements on claims data; but if it does so, it must use data that is updated periodically. Further, an insurer must use generally accepted bundling edits and logic when determining how to pay its claims. An insurer that fails to comply with these fundamental requirements would be selling a product that is unjust, encourages misrepresentation, or is deceptive under Insurance Code Chapter 1701. If insurers do not comply with these requirements, insureds will not be able to have any confidence that their claims are paid correctly or fairly.

Insurance Code §1301.007 requires the commissioner to adopt rules as necessary to implement Insurance Code Chapter 1301. Failure to address the methodology insurers use to calculate out-of-network reimbursement could adversely affect insureds and providers, particularly if insurers use old data, statistically

insignificant samples, or any other information described by §3.3725(f) to calculate out-of-network reimbursements.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For with changes: Coalition for Nurses in Advanced Practice, Texas Association of Health Plans, Texas College of Emergency Physicians, Aetna Insurance Company, Center for Public Policy Priorities, Texas Emergency Medicine Practice Alliance, Texas Association of Life and Health Insurers, Texas Association of Health Plans, and Emergency Service Partners.

Against: Texas Association of Business and Texas Medical Association.

6. STATUTORY AUTHORITY. The department adopts the amendments and new sections under Insurance Code §§1301.003, 1301.0042, 1301.007, 1301.005, 1301.006, 1301.0051, 1301.0052, 1301.0053, 1301.0055,1301.0056, 1301.1581, 1701.055, 1201.006, 1201.101, 1201.102, 1251.008, 1456.006, 1456.003, 1501.010, and 36.001.

Insurance Code §1301.003 provides that an exclusive provider benefit plan that meets the requirements of Chapter 1301, relating to Preferred Provider Benefit Plans, is not unjust under Insurance Code Chapter 1701; unfair discrimination under Insurance Code Chapter 55, Subchapter A or B; or a violation of Insurance Code, Chapter 1451, Subchapter B or C.

Insurance Code §1301.0042 provides that, except for dental care benefits, a provision of the Insurance Code or other insurance law that applies to a preferred

provider benefit plan also applies to an exclusive provider benefit plan, except to the extent that the commissioner determines the provision is inconsistent with the function and purpose of an exclusive provider benefit plan. Insurance Code §1301.0042 also authorizes the commissioner to determine whether a provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301, relating to Preferred Provider Benefit Plans, and to ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1301.005 provides that an insurer must reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider if services are not available through a preferred provider within a designated service area under a preferred provider benefit plan.

Insurance Code §1301.006 requires that an insurer that markets a preferred provider benefit plan contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

Insurance Code §1301.0051 provides that an insurer that offers an exclusive provider benefit plan must establish procedures to ensure that health care services are

provided to insureds under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of care or practice.

Insurance Code §1301.0052 provides that if a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider must approve the referral of an insured to a nonpreferred provider within a reasonable period and fully reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider. Insurance Code §1301.0052 also requires an exclusive provider benefit plan to provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested before the issuer of the plan may deny the referral.

Insurance Code §1301.0053 provides that if a nonpreferred provider provides emergency care as defined by Insurance Code §1301.155 to an insured in an exclusive provider benefit plan, the issuer of the plan must reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services.

Insurance Code §1301.0055 requires the commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the commissioner posts on the department's website the

name of the preferred provider plan, the insurer offering the plan, and the affected local market.

Insurance Code §1301.0056 authorizes the commissioner to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer under this chapter and requires an insurer examined under the section to pay the cost of the examination in an amount determined by the commissioner.

Insurance Code §1301.1581 requires an insurer that offers an exclusive provider benefit plan to provide to a current or prospective group contract holder or current or prospective insured notice that the benefit plan includes limited coverage for services provided by a physician or health care provider that is not a preferred provider.

Insurance Code §1701.055(a)(2) authorizes the commissioner to disapprove or, after notice and hearing, withdraw approval of a form if the form contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive, subject to the exception specified in subsection (d) of the section.

Insurance Code §1201.006 authorizes the commissioner to adopt reasonable rules as necessary to implement Insurance Code Chapter 1201.

Insurance Code §1201.101 and §1201.102 authorize the commissioner to adopt rules specifying the content of an individual accident and health insurance policy and to prohibit provisions in individual accident and health insurance policies that the commissioner determines to be unjust, unfair, or unfairly discriminatory.

Insurance Code §1251.008 authorizes the commissioner to adopt rules necessary to administer the group health insurance chapter of the Insurance Code.

Insurance Code §1456.006 authorizes the commissioner to adopt by rule specific requirements for the health benefit plan disclosure required under §1456.003.

Insurance Code §1501.010 requires that the commissioner adopt rules necessary to implement Insurance Code Chapter 1501, the Health Insurance Portability and Availability Act.

Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

7. TEXT.

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
Division 1. General Requirements
28 TAC §§3.3701 – 3.3710

§3.3701. Applicability and Scope.

(a) Except as otherwise specified in this subchapter, this subchapter applies to any preferred provider benefit plan or exclusive provider benefit plan as specified in this subsection.

(1) This subchapter applies to any preferred or exclusive provider benefit plan policy that is offered, delivered, issued for delivery, or renewed on or after 150 days from the effective date of this section. Any preferred or exclusive provider benefit plan policy delivered, issued for delivery, or renewed prior to this applicability date is subject to the statutes and provisions of this subchapter in effect at the time the policy was delivered, issued for delivery, or renewed.

(2) This subchapter does not apply to:

(A) provisions for dental care benefits in any health insurance policy; or

(B) an exclusive provider benefit plan regulated under Subchapter KK of this chapter (relating to Exclusive Provider Benefit Plan) written by an insurer pursuant to a contract with the Texas Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program, Medicaid, or with the Statewide Rural Health Care System.

(b) This subchapter is not an interpretation of and has no application to any law requiring licensure to act as a principal or agent in the insurance or related businesses including, but not limited to, health maintenance organizations.

(c) The provisions of this subchapter are subject to the Insurance Code §§1451.001, 1451.053, and 1451.054; Chapter 1301; §§1451.101 – 1451.127; and §1353.001 and §1353.002 as they relate to insurers and the practitioners named therein.

(d) These sections do not create a private cause of action for damages or create a standard of care, obligation, or duty that provides a basis for a private cause of action. These sections do not abrogate a statutory or common law cause of action, administrative remedy, or defense otherwise available.

(e) If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(f) A provision of this title applicable to a preferred provider benefit plan is applicable to an exclusive provider benefit plan unless specified otherwise.

§3.3702. Definitions.

(a) Words and terms defined in Insurance Code Chapter 1301 have the same meaning when used in this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--As defined in Insurance Code §4201.002(1).

(2) Allowed amount--The amount of a billed charge that an insurer determines to be covered for services provided by a nonpreferred provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(4) Complainant--As defined in §21.2502 of this title (relating to Definitions).

(5) Complaint--As defined in §21.2502 of this title.

(6) Contract holder--An individual who holds an individual health insurance policy, or an organization that holds a group health insurance policy.

(7) Exclusive provider network--The collective group of physicians and health care providers available to an insured under an exclusive provider benefit plan

and directly or indirectly contracted with the insurer of an exclusive provider benefit plan to provide medical or health care services to individuals insured under the plan.

(8) Facility--

(A) an ambulatory surgical center licensed under Health and Safety Code Chapter 243;

(B) a birthing center licensed under Health and Safety Code Chapter 244; or

(C) a hospital licensed under Health and Safety Code Chapter 241.

(9) Facility-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(10) Health care provider or provider--As defined in Insurance Code §1301.001(1-a).

(11) Health maintenance organization (HMO)--As defined in Insurance Code §843.002(14).

(12) In-network--Medical or health care treatment, services, or supplies furnished by a preferred provider, or a claim filed by a preferred provider for the treatment, services, or supplies.

(13) NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(14) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

(15) Out-of-network--Medical or health care treatment services, or supplies furnished by a nonpreferred provider, or a claim filed by a nonpreferred provider for the treatment, services, or supplies.

(16) Pediatric practitioner--A physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults.

(17) Rural area--

(A) a county with a population of 50,000 or less as determined by the United States Census Bureau in the most recent decennial census report;

(B) an area that is not designated as an urbanized area by the United States Census Bureau in the most recent decennial census report; or

(C) any other area designated as rural under rules adopted by the commissioner, notwithstanding subparagraphs (A) and (B) of this paragraph.

(18) Urgent care--Medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or

injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

(19) Utilization review--As defined in Insurance Code §4201.002(13).

§3.3703. Contracting Requirements.

(a) An insurer marketing a preferred provider benefit plan must contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must meet the following requirements:

(1) A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs.

(2) Any term or condition limiting participation on the basis of quality that is contained in a contract between a preferred provider and an insurer is required to be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that include the possession of practice privileges at preferred

hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider shall not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may not require the preferred provider to pay hospital, institutional, laboratory, x-ray, or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's contract with a physician, physician group, or practitioner must have a mechanism for the resolution of complaints initiated by an insured, a physician, physician group, or practitioner. The mechanism must provide for reasonable due process including, in an advisory role only, a review panel selected as specified in §3.3706(b)(2) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may not require any health care provider, physician, or physician group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must require a preferred provider who is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment

of clean claims with respect to payment to the provider for covered services rendered to insureds.

(12) A contract between a preferred provider and an insurer must require the provider to comply with the Insurance Code §§1301.152 – 1301.154, which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in the Insurance Code §1301.067 about any of the matters set forth therein.

(14) A contract between a preferred provider and an insurer conducting, using, or relying upon economic profiling to terminate physicians or health care providers from a plan must require the insurer to inform the provider of the insurer's obligation to comply with the Insurance Code §1301.058.

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to disclose in the contract all requirements of the Insurance Code §1301.059(b).

(16) A contract between a preferred provider and an insurer may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may not prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas

Pharmacy Act, Chapters 551 – 566 and Chapters 568 – 569 of the Occupations Code, and rules promulgated thereunder.

(18) A contract between a preferred provider and an insurer must require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must require the insurer to provide assistance to the provider as set forth in the Insurance Code §1301.160(b).

(19) A contract between a preferred provider and an insurer must require written notice to the provider on termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must include the provider's right to request a review, as specified in §3.3706(d) of this title.

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including e-mail, computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided pursuant to this paragraph are required to be made in

accordance with subparagraph (D) of this paragraph. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to include a preferred provider specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes or successor codes, and modifiers:

(I) by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is being requested if that information has not previously been provided to the preferred provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which are required to be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

(vi) any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided pursuant to this paragraph; and

(vii) the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according

to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will be effective as to the preferred provider, unless the insurer provides at least 90 calendar days written notice to the preferred provider identifying with specificity the amendment, revision or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon receipt of a request, the insurer is required to provide the information required by subparagraphs (A) – (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

(IV) communications with a governmental agency involved in the regulation of health care or insurance;

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided pursuant to this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred provider chooses to terminate the contract, the insurer is required to assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract.

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term batch submission is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured:

(A) that the physician, provider, or facility to whom the insured is being referred might not be a preferred provider; and

(B) if applicable, that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005 (relating to refunds of overpayments from enrollees).

(26) A contract between an insurer and a facility must require that the facility give notice to the insurer of the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

(27) A contract between an insurer and a preferred provider must require, except for instances of emergency care as defined under Insurance Code §1301.155(a), that a physician or provider referring an insured to a facility for surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information;

(B) notify the insurer that surgery has been recommended; and

(C) notify the insurer of the facility that has been recommended for the surgery.

(28) A contract between an insurer and a facility must require, except for instances of emergency care as defined under Insurance Code §1301.155(a), that the facility, when scheduling surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and

(B) notify the insurer that surgery has been scheduled.

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with Insurance Code Chapter 542, Subchapter A, and the provisions of that subchapter will be utilized insofar as

practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization, an exclusive provider network, or a health care collaborative for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of Insurance Code Chapter 1301 and this subchapter;

(2) ensure that the requirements of Insurance Code Chapter 1301 and this subchapter are met; and

(3) provide all documentation to demonstrate compliance with all applicable rules on request by the department.

§3.3704. Freedom of Choice; Availability of Preferred Providers.

(a) Fairness requirements. A preferred provider benefit plan is not considered unjust under Insurance Code §§1701.002 – 1701.005; 1701.051 – 1701.060; 1701.101 – 1701.103; and 1701.151, or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or §§544.051 – 544.054, or to violate §§1451.001, 1451.053, 1451.054, or 1451.101 – 1451.127 of the Insurance Code provided that:

(1) pursuant to Insurance Code §§1251.005, 1251.006, 1301.003, 1301.006, 1301.051, 1301.053, 1301.054, 1301.055, 1301.057 – 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds have the right to continuity of care as set forth in the Insurance Code §§1301.152 – 1301.154;

(5) insureds have the right to emergency care services as set forth in Insurance Code §1301.0053 and §1301.155, and §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims);

(6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 50 percent less than the higher level of coverage, except as provided under an exclusive provider benefit plan. A reasonable difference in deductibles is determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider, or in the selection of a preferred provider under an exclusive provider benefit plan, are not restricted by the insurer;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the basic level of coverage of a plan that is not an exclusive provider benefit plan is reasonably consistent with other

health insurance policies offered by the insurer that do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan is taken pursuant to the Insurance Code Chapter 4201 and Chapter 19, Subchapter R of this title (relating to Utilization Review Agents);

(10) a preferred provider benefit plan that is not an exclusive provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

(11) both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area; and

(12) if medically necessary covered services are not reasonably available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accord with Insurance Code §1301.005 and §1301.0052, and §3.3708 and §3.3725 of this title, as applicable.

(b) Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code §§1701.002 – 1701.005, 1701.051-1701.060, 1701.101 – 1701.103, and 1701.151; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or §§544.051 – 544.054, or to violate Insurance Code §§1451.101 – 1451.127, provided that:

(1) the exclusive provider benefit plan complies with subsection (a)(1) – (10) and (12) of this section; and

(2) for the purposes of subsection (a)(11) of this section, an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

(c) Payment of nonpreferred providers. Payment by the insurer must be made for covered services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(d) Retaliatory action prohibited. An insurer is prohibited from engaging in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider or has appealed a decision of the insurer.

(e) Access to certain institutional providers. In addition to the requirements for availability of preferred providers set forth in Insurance Code §1301.005, any insurer offering a preferred provider benefit plan must make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the service area to afford all insureds under the plan freedom of choice in the selection of institutional providers at which they will receive care, unless the mix is not feasible due to geographic, economic, or other operational factors. An insurer must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(f) Network requirements. Each preferred provider benefit plan must include a health care service delivery network that complies with Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements described in this section. An adequate network must:

(1) be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the:

(A) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and

(B) projected utilization of covered health care services;

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

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

(4) include 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;

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

(6) provide, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area;

(7) provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers;

(8) provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:

(A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and

(B) 75 miles for specialty care and specialty hospitals;

(9) 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;

(10) ensure that 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;

(11) ensure that preventive health 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 care services; and

(B) within three months for an adult.

(g) Network monitoring and corrective action. Insurers must monitor compliance with subsection (f) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate.

(h) Service areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but any service areas that are smaller than statewide must be defined in terms of one of the following:

(1) one or more of the 11 Texas geographic regions designated in §3.3711 of this title (relating to Geographic Regions);

(2) one or more Texas counties; or

(3) the first three digits of ZIP Codes in Texas.

§3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this chapter (relating to Plain Language Requirements).

(b) Disclosure of terms and conditions of the policy. The insurer is required, on request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement

provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. The written description must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written description or as otherwise required by law;

(2) a toll free number, unless exempted by statute or rule, and address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any authorization requirements, including preauthorization review, concurrent review, post-service review, and post-payment review; and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients. Both of these items may be provided electronically, if notice is also provided in the disclosure required by this subsection regarding how a nonelectronic copy may be obtained free of charge;

(13) the service area(s); and

(14) information that is updated at least annually regarding the following network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this title, if the plan is offered on a statewide service area basis:

(A) the number of insureds in the service area or region;

(B) for each provider area of practice, including at a minimum internal medicine, family/general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of preferred providers, as well as an indication of whether an active access plan pursuant to §3.3709 of this title (relating to Annual Network Adequacy Report; Access Plan) applies to the services furnished by that class of provider in the service area or region and how such access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 of this title applies to hospital services in that service area or region and how the access plan may be obtained or viewed.

(15) information that is updated at least annually regarding whether any waivers or local market access plans approved pursuant to §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) apply to the plan and that complies with the following:

(A) if a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner

practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the preferred provider benefit plan is not offered on a statewide service area basis, and, if by county, the aggregate of counties is not more than those within a region; or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the local market access plan.

(c) Filing required. A copy of the written description required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if applicable, must be submitted to the following email address: LifeHealth@tdi.texas.gov. Nonelectronic filings must be submitted to the department at: Life/Health and HMO Intake Team, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(d) Promotional disclosures required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider

benefit plan must clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of basic benefits, except in the case of an exclusive provider benefit plan.

(e) Internet website disclosures. Insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must provide:

(1) an Internet-based provider listing for use by current and prospective insureds and group contract holders;

(2) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP Code area, as applicable, that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) an Internet-based listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1), for a preferred provider benefit plan that is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2), for an exclusive provider benefit plan, in all policies, certificates, disclosures of policy terms

and conditions provided pursuant to subsection (b) of this section, and outlines of coverage in at least 12 point font:

(1) Preferred provider benefit plan notice.

Figure: 28 TAC §3.3705(f)(1)

Texas Department of Insurance Notice

- *You have the right to an adequate network of preferred providers (also known as "network providers").*
  - *If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.*
  - *If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.*
- *You have the right, in most cases, to obtain estimates in advance:*
  - *from out-of-network providers of what they will charge for their services; and*
  - *from your insurer of what it will pay for the services.*
- *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If*

the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- *If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.*
- *If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.*

(2) Exclusive provider benefit plan notice.

Figure: 28 TAC §3.3705(f)(2)

Texas Department of Insurance Notice

- *An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.*
- *You have the right to an adequate network of preferred providers (known as "network providers").*
    - *If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.*

- *If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.*
- *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.*

(g) Untrue or misleading information prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure concerning access to preferred provider listing. The insurer must provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required updates of available provider listings. The insurer must ensure that it updates all electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of provider listing required in certain cases. If no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if an alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance on provider listing in certain cases. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(b) – (d) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725(d) – (f) of this title (relating to Payment of Certain Out-of-Network Claims), as applicable, if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

(B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) – (9) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

(3) In determining the percentages specified in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The provider information must indicate whether each preferred provider is accepting new patients.

(5) The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(6) The provider information must provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities.

(7) The provider information must be provided in at least 10 point font.

(8) The provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable provider class.

(9) The provider information must be dated.

(m) Annual policyholder notice concerning use of a local market access plan. An insurer operating a preferred provider benefit plan that relies on a local market access plan as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must provide notice of this fact to each individual and group policyholder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available pursuant to subsection (e)(2) of this section;

(2) information on how to obtain or view any local market access plan or plans the insurer uses; and

(3) a link to the department's website where the department posts information relevant to the grant of waivers.

(n) Disclosure of substantial decrease in the availability of certain preferred providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that

specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) of this title (relating to Contracting Requirements).

(2) Notwithstanding paragraph (1) of this subsection, no notice of a substantial decrease is required if the requirements specified in either subparagraph (A) or (B) of this paragraph are met:

(A) alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer provides to the department, by e-mail to mcqa@tdi.texas.gov, a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers), as those standards apply to the applicable provider specialty.

(3) An insurer must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of this subsection;

(B) six months from the date that the insurer initially posts the notice; or

(C) the date on which the insurer provides to the department, by e-mail to mcqa@tdi.texas.gov, a certification as specified in paragraph (2)(B) of this subsection indicating the insurer's determination that the termination of provider contract does not cause non-compliance with adequacy standards.

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

(o) Disclosures concerning reimbursement of out-of-network services. An insurer must make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

(1) An insurer must disclose how reimbursements of nonpreferred providers will be determined.

(2) Except in an exclusive provider benefit plan, if an insurer reimburses nonpreferred providers based directly or indirectly on data regarding usual, customary, or reasonable charges by providers, the insurer must disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.

(3) Except in an exclusive provider benefit plan, if an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer must:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method to obtain a real time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

(p) Plan designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this title without reliance on an access plan may be designated by the insurer as having an "Approved Hospital Care Network" (AHCN). If a

preferred provider benefit plan utilizes a preferred provider service delivery network that does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this title, the insurer is required to disclose that the plan has a "Limited Hospital Care Network":

(1) on the insurer's outline of coverage; and

(2) on the cover page of any provider listing describing the network.

(q) Loss of status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this title and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer must:

(1) notify the department in writing concerning such change in status at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104;

(2) cease marketing the plan as an AHCN; and

(3) inform all insureds of such change of status at the time of renewal.

§3.3706. Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process.

(a) Access to designation as a preferred provider. Physicians, practitioners, institutional providers, and health care providers other than physicians, practitioners, and institutional providers, if other health care providers are included by an insurer as preferred providers, that are licensed to treat injuries or illnesses or to provide services covered by the preferred provider benefit plan and that comply with the terms and

conditions established by the insurer for designation as preferred providers, are eligible to apply for and must be afforded a fair, reasonable, and equitable opportunity to become preferred providers, subject to subsection (b) of this section.

(1) An insurer initially sponsoring a preferred provider benefit plan is required to notify all physicians and practitioners in the service area covered by the plan of its intent to offer the plan and of the opportunity to apply to participate.

(2) Subsequently, an insurer is required to annually notify all non-contracting physicians and practitioners in the service area covered by the plan of the existence of the plan and the opportunity to apply to participate in the plan.

(3) An insurer is required, upon request, to make available to any physician or provider information concerning the application process and qualification requirements, including the use of economic profiling by the insurer, used by the insurer to admit a provider to the plan.

(4) All notifications required to be made by an insurer pursuant to this subsection are required to be made by publication or distributed in writing to each physician and practitioner in the same manner.

(5) Selection standards used by the insurer in choosing participating preferred providers must not directly or indirectly:

(A) avoid high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization; or

(B) exclude a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses or health services utilization.

(b) Withholding preferred provider designation. An insurer may not unreasonably withhold designation as a preferred provider except that, unless otherwise limited by the Insurance Code or rule promulgated by the department, an insurer may reject an application from a physician or health care provider on the basis that the preferred provider benefit plan has sufficient qualified providers.

(1) An insurer is required to provide written notice of denial of any initial application to a physician or health care provider, which includes:

(A) the specific reason(s) for the denial; and

(B) in the case of physicians and practitioners, the right to a review of the denial as set forth in paragraph (2) of this subsection.

(2) An insurer must provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel.

(A) The advisory review panel is required to be composed of not less than three individuals selected by the insurer from the list of physicians or practitioners in the applicable service area contracting with the insurer.

(B) At least one of the three individuals on the advisory review panel must be a physician or practitioner in the same or similar specialty as the physician or practitioner requesting review unless there is no physician or practitioner in the same or similar specialty contracting with the insurer.

(C) The list of physicians or practitioners required by subparagraph (A) of this paragraph is required to be provided to the insurer by the physicians or practitioners who contract with the insurer in the applicable service area.

(D) The recommendation of the advisory review panel is required to be provided upon request to the affected physician or practitioner.

(E) In the event that the insurer makes a determination that is contrary to the recommendation of the advisory review panel, a written explanation of the insurer's determination is required to be provided to the affected physician or practitioner upon request.

(c) Credentialing of preferred providers. Insurers must have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. At a minimum, an insurer's credentialing standards must meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC to the extent that those standards do not conflict with other laws of this state. Insurers will be presumed to be in compliance with statutory and regulatory requirements regarding credentialing if they have received nonconditional accreditation or certification by the NCQA, the Joint Commission, URAC, or the Accreditation Association for Ambulatory Health Care.

(d) Notice of termination of a preferred provider contract. Before terminating a contract with a preferred provider, the insurer must provide written notice of termination, which includes:

(1) the specific reason(s) for the termination; and

(2) in the case of physicians or practitioners, notice of the right to request a review prior to termination that is conducted in the same manner as the review mechanism set forth in subsection (b)(2) of this section and that complies with the timelines set forth in subsections (e) – (h) of this section for requesting review, except in cases involving:

(A) imminent harm to patient health;

(B) an action by a state medical or other physician licensing board or other government agency which impairs the physician's or practitioner's ability to practice medicine or to provide services; or

(C) fraud or malfeasance.

(e) Review of a decision to terminate. To obtain a standard review of an insurer's decision to terminate him or her, a physician or practitioner must:

(1) make a written request to the insurer for a review of that decision within 10 business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 20 business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

(f) Completion of the review process. The review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, must be completed and the results

provided to the physician or practitioner within 60 calendar days of the insurer's receipt of the request for review.

(g) Expedited review process. To obtain an expedited review of an insurer's decision to terminate him or her, a physician or practitioner must:

(1) make a written request to the insurer for a review of that decision within five business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 10 business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

(h) Completion of the expedited review process. The expedited review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, must be completed and the results provided to the physician or practitioner within 30 calendar days of the insurer's receipt of the request for review.

(i) Confidentiality of information concerning the insured.

(1) An insurer is required to preserve the confidentiality of individual medical records and personal information used in its termination review process. Personal information of the insured includes, at a minimum, the insured's name, address, telephone number, social security number, and financial information.

(2) An insurer may not disclose or publish individual medical records or other confidential information about an insured without the prior written consent of the

insured or unless otherwise required by law. An insurer may provide confidential information to the advisory review panel for the sole purpose of performing its advisory review function. Information provided to the advisory review panel is required to remain confidential.

(j) Notice to insureds.

(1) If the contract of a physician or practitioner is terminated for reasons other than at the preferred provider's request, an insurer may not notify insureds of the termination until the effective date of the termination or at such time as an advisory review panel makes a formal recommendation regarding the termination, whichever is later.

(2) If a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, the insurer must provide assistance to the physician or provider in assuring that the notice requirements are met as required by §3.3703(a)(18) of this title (relating to Contracting Requirements).

(3) If the contract of a physician or practitioner is terminated for reasons related to imminent harm, an insurer may notify insureds immediately.

§3.3707. Waiver Due to Failure to Contract in Local Markets.

(a) In accord with Insurance Code §1301.0055(3), where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a portion of the state that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. The

commissioner may grant the waiver if there is good cause based on one or more of the criteria specified in this subsection and may impose reasonable conditions on the grant of the waiver. The commissioner may find good cause to grant the waiver if the insurer demonstrates that providers or physicians necessary for an adequate local market network:

(1) are not available to contract; or

(2) have refused to contract with the insurer on any terms or on terms that are reasonable.

(b) At a minimum, each waiver an insurer requests must include either the information specified by paragraph (1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.

(1) If providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must include:

(A) a list of the providers or physicians within the relevant service area that the insurer attempted to contract with, identified by name and specialty or facility type;

(B) a description of how and when the insurer last contacted each provider or physician;

(C) a description of any reason each provider or physician gave for refusing to contract with the insurer;

(D) an estimate of total claims cost savings per year the insurer anticipates will result from using a local market access plan instead of contracting with providers located within the service area, and its impact on premium; and

(E) steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary.

(2) If no providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.

(c) At the same time an insurer files a request for waiver, it must file a local market access plan, as specified in subsection (i) of this section, to be taken into consideration by the commissioner in deciding whether to grant or deny a waiver request.

(d) An insurer seeking a waiver under subsection (a) of this section must electronically file the request with the department at the Office of the Chief Clerk through the following email address: chiefclerk@tdi.texas.gov. The insurer must also submit a copy of the request to any provider or physician named in the waiver request at the same time the insurer files the request with the department, but is permitted to redact information from the copy where provision of the information to the provider or physician would violate state or federal law. The insurer may use any reasonable means to submit the copy of the request to the provider or physician. The insurer must maintain proof of the submission and include a copy of the redacted version with the waiver request submitted to the department.

(e) Any provider or physician may elect to provide a response to an insurer's request for waiver by filing the response within 30 days after the insurer files the request with the department. The response, if filed, must be filed at the same address specified in subsection (d) of this section for filing the request for waiver.

(f) If the department grants a waiver under subsection (a) of this section, the department will post on the department's website information relevant to the grant of a waiver, including:

(1) the name of the preferred provider benefit plan for which the request is granted;

(2) the insurer offering the plan; and

(3) the affected service area.

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually.

(1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section at least 30 days prior to the anniversary of the department's grant of waiver.

(2) At the same time the insurer files an application for renewal of a waiver, the insurer must file any applicable local market access plan the insurer uses pursuant to the waiver, in the manner specified by subsection (i)(2) of this section.

(3) A waiver granted by the department will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver or the department denies the application for renewal.

(h) A waiver will expire one year after the date the department granted it if an insurer fails to timely request a renewal under subsection (g) of this section or if the department denies the insurer's request for renewal.

(i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this title for a specific service area, the insurer must establish a local market access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver pursuant to subsection (a) of this section requesting that the department approve the continued use of the local market access plan.

(1) The local market access plan must contain all the information specified in subsection (j) of this section.

(2) The insurer must file the local market access plan with the department by email at: mcqa@tdi.texas.gov or through the National Association of Insurance Commissioner's System for Electronic Rate and Form Filing.

(j) A local market access plan required under subsection (i) of this section must specify for each service area that does not meet the network adequacy requirements:

(1) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this title, including a specification of the class of provider that is not sufficiently available;

(2) a map, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, or providers are not available;

(3) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this title;

(4) procedures that the insurer will utilize to assist insureds in obtaining medically necessary services when no preferred provider is reasonably available, including procedures to coordinate care to limit the likelihood of balance billing; and

(5) procedures detailing how out-of-network benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims).

(k) An insurer must establish and implement documented procedures, as specified in this subsection, for use in all service areas for which a local market access plan is submitted.

(1) The insurer must utilize a documented procedure to:

(A) identify requests for preauthorization of services for insureds that are likely to require the rendition of services by physicians or providers that do not have a contract with the insurer;

(B) furnish to insureds, prior to the services being rendered, an estimate of the amount the insurer will pay the physician or provider; and

(C) except in the case of an exclusive provider benefit plan, notify insureds that they may be liable for any amounts charged by the physician or provider that are not paid in full by the insurer.

(2) The insurer must utilize a documented procedure to:

(A) identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and

(B) make initial and, if required, subsequent payment of the claims in the manner required by this subchapter.

(l) A local market access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(m) An insurer must submit a local market access plan established pursuant to this section as a part of the annual report on network adequacy required under §3.3709 of this title (relating to Annual Network Adequacy Report).

(n) An insurer that is granted a waiver under this section concerning network adequacy requirements for hospital based services is required to comply with §3.3705(p) of this subchapter (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations). The insurer is required to designate such plan as having a "Limited Hospital Care Network".

§3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures.

(a) An insurer must comply with the requirements of subsections (b) and (c) of this section when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:

(1) requiring emergency care;

(2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and

(3) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider.

(b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer must:

(1) pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;

(2) pay the claim at the preferred benefit coinsurance level; and

(3) in addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for charges for covered services that were above and beyond the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

(1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary

billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;

(2) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(3) is updated no less than once per year;

(4) does not use data that is more than three years old; and

(5) is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) An insurer is required to pay all covered basic benefits for services obtained from health care providers or physicians at least at the plan's basic benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan shall not be a basis for denial of a claim.

(e) When services are rendered to an insured by a nonpreferred facility-based physician and the difference between the allowed amount and the billed charge is at least $1,000, the insurer must include a notice on the applicable explanation of benefits that the insured may have the right to request mediation of the claim of an uncontracted facility-based provider under Insurance Code Chapter 1467 and may obtain more information at www.tdi.texas.gov/consumer/cpmmediation.html. An insurer is not in violation of this subsection if it provides the required notice in connection with claims that are not eligible for mediation.

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

§3.3709. Annual Network Adequacy Report.

(a) Network adequacy report required. An insurer must file a network adequacy report with the department on or before April 1 of each year and prior to marketing any plan in a new service area.

(b) General content of report. The report required in subsection (a) of this section must specify:

(1) the trade name of each preferred provider benefit plan in which insureds currently participate;

(2) the applicable service area of each plan; and

(3) whether the preferred provider service delivery network supporting each plan is adequate under the standards in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers).

(c) Additional content applicable only to annual reports. As part of the annual report on network adequacy, each insurer must provide additional demographic data as specified in paragraphs (1) – (6) of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The report must include the number of:

(1) claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;

(2) claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for basic benefits or concerning balance billing;

(5) complaints by insureds relating to the availability of preferred providers; and

(6) complaints by insureds relating to the accuracy of preferred provider listings.

(d) Filing the report. The annual report required under this section must be submitted electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following email address: LifeHealth@tdi.texas.gov.

§3.3710. Failure to Provide an Adequate Network.

(a) If the commissioner determines, after notice and opportunity for hearing, that the insurer's network and any local market access plan supporting the network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions pursuant

to the authority of the commissioner in Insurance Code Chapters 82 and 83 to issue cease and desist orders:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and/or

(3) cessation of marketing entirely and withdrawal from the preferred provider benefit plan market.

(b) This section does not affect the authority of the commissioner to order any other appropriate corrective action, sanction, or penalty pursuant to the authority of the commissioner in the Insurance Code in addition to or in lieu of the sanctions specified in subsection (a) of this section.

Division 2. Exclusive Provider Benefit Plan Requirements
28 TAC §§3.3720 – 3.3725

§3.3720. Exclusive Provider Benefit Plan Requirements. The provisions of this division apply only to exclusive provider benefit plans offered pursuant to Insurance Code Chapter 1301 in commercial markets.

§3.3721. Exclusive Provider Benefit Plan Network Approval Required. An insurer may not offer, deliver, or issue for delivery an exclusive provider benefit plan in this state unless the commissioner has completed a qualifying examination to determine compliance with Insurance Code Chapter 1301 and this subchapter and has approved the insurer's exclusive provider network in the service area.

§3.3722. Application for Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications.

(a) Where to file application. An insurer that seeks to offer an exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance at the following address: Texas Department of Insurance, Mail Code 106-1A, P.O. Box 149104, Austin, Texas 78714-9104. A form titled Application for Approval of Exclusive Provider Benefit Plan is available on the department's website at www.tdi.texas.gov/forms. An insurer may use this form to prepare the application.

(b) Filing requirements.

(1) An applicant must provide the department with a complete application that includes the elements in the order set forth in subsection (c) of this section.

(2) All pages must be clearly legible and numbered.

(3) If the application is revised or supplemented during the review process, the applicant must submit a transmittal letter describing the revision or supplement plus the specified revision or supplement.

(4) If a page is to be revised, a complete new page must be submitted with the changed item or information clearly marked.

(c) Contents of application. A complete application includes the elements specified in paragraphs (1) – (12) of this subsection.

(1) The applicant must provide a statement that the filing is:

(A) an application for approval; or

(B) a modification to an approved application.

(2) The applicant must provide organizational information for the applicant, including:

(A) the full name of the applicant;

(B) the applicant's Texas Department of Insurance license or certificate number;

(C) the applicant's home office address, including city, state, and ZIP code; and

(D) the applicant's telephone number.

(3) The applicant must provide the name and telephone number of an individual to be the contact person who will facilitate requests from the department regarding the application.

(4) The applicant must provide an attestation signed by the applicant's corporate president, corporate secretary, or the president's or secretary's authorized representative that:

(A) the person has read the application, is familiar with its contents, and asserts that all of the information submitted in the application, including the attachments, is true and complete; and

(B) the network, including any requested or granted waiver and any access plan as applicable, is adequate for the services to be provided under the exclusive provider benefit plan.

(5) The applicant must provide a description and a map of the service area, with key and scale, identifying the area to be served by geographic region(s),

county(ies), or ZIP code(s). If the map is in color, the original and all copies must also be in color.

(6) The applicant must provide a list of all plan documents and each document's associated form filing ID number or the form number of each plan document that is pending the department's approval or review.

(7) The applicant must provide the form(s) of physician contract(s) and provider contract(s) that include the provisions required in §3.3703 of this title (relating to Contracting Requirements) or an attestation by the insurer's corporate president, corporate secretary, or the president's or secretary's authorized representative that the physician and provider contracts applicable to services provided under the exclusive provider benefit plan comply with the requirements of Insurance Code Chapter 1301 and this subchapter.

(8) The applicant must provide a description of the quality improvement program and work plan that includes a process for medical peer review required by Insurance Code §1301.0051 and that explains arrangements for sharing pertinent medical records between preferred providers and for ensuring the records' confidentiality.

(9) The applicant must provide network configuration information, including:

(A) maps for each specialty demonstrating the location and distribution of the physician and provider network within the proposed service area by geographic region(s), county(ies) or ZIP code(s); and

(B) lists of:

(i) physicians and individual providers who are preferred providers, including license type and specialization and an indication of whether they are accepting new patients; and

(ii) institutional providers that are preferred providers.

(10) The applicant must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3725(a) of this title (relating to Payment of Certain Out-of-Network Claims) and that the policy contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement to provide items or services to insureds, the provisions and procedures for coverage of emergency care services as set forth in §3.3725 of this title.

(11) The applicant must provide documentation demonstrating that the insurer maintains a complaint system that provides reasonable procedures to resolve a written complaint initiated by a complainant.

(12) The applicant must provide notification of the physical address of all books and records described in subsection (d) of this section.

(d) Qualifying examinations; documents to be available. The following documents must be available during the qualifying examination at the physical address designated by the insurer pursuant to subsection (c)(12) of this section:

(1) quality improvement--program description and work plan as required by §3.3724 of this title (relating to Quality Improvement Program);

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and independent review organization logs;

(3) network configuration information demonstrating adequacy of the exclusive provider network, as outlined in subsection (c)(9) of this section, and all executed physician and provider contracts applicable to the network, which may be satisfied by contract forms and executed signature pages;

(4) credentialing files;

(5) all written materials to be presented to prospective insureds that discuss the exclusive provider network available to insureds under the plan and how preferred and nonpreferred physicians or providers will be paid under the plan;

(6) the policy and certificate of insurance; and

(7) a complaint log that is categorized and completed in accord with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions).

(e) Network modifications.

(1) An insurer must file an application for approval with the department before the insurer may make changes to network configuration that impact the adequacy of the network, expand an existing service area, reduce an existing service area, or add a new service area.

(2) Pursuant to paragraph (1) of this subsection, if an insurer submits any of the following items to the department and then replaces or materially changes them, the insurer must submit the new item or any amendments to an existing item along with an indication of the changes:

(A) descriptions and maps of the service area, as required by subsection (c)(5) of this section;

(B) forms of contracts, as described in subsection (c) of this section; or

(C) network configuration information, as required by subsection (c)(9) of this section.

(3) Before the department grants approval of a service area expansion or reduction application, the insurer must comply with the requirements of §3.3724 of this title in the existing service areas and in the proposed service areas.

(4) An insurer must file with the department any information other than the information described in paragraph (2) of this subsection that amends, supplements, or replaces the items required under subsection (c) of this section no later than 30 days after the implementation of any change.

§3.3723. Examinations.

(a) The commissioner may conduct an examination relating to an exclusive provider benefit plan as often as the commissioner considers necessary, but no less than once every five years.

(b) On-site financial, market conduct, complaint, or quality of care exams will be conducted pursuant to Insurance Code Chapter 401, Subchapter B; Insurance Code Chapter 751; and §7.83 of this title (relating to Appeal of Examination Reports).

(c) An insurer must make its books and records relating to its operations available to the department to facilitate an examination.

(d) On request of the commissioner, an insurer must provide to the commissioner a copy of any contract, agreement, or other arrangement between the

insurer and a physician or provider. Documentation provided to the commissioner under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056.

(e) The commissioner may examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, as necessary to implement the purposes of this subchapter, including commencement and prosecution of an enforcement action under Insurance Code Title 2, Subtitle B, and §3.3710 of this title (relating to Failure to Provide an Adequate Network). Information obtained under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056. In this subsection, "medical peer review committee" has the meaning assigned by the Occupations Code §151.002.

(f) The following documents must be available for review at the physical address designated by the insurer pursuant to §3.3722(c)(12) of this title (relating to Application for Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications):

(1) quality improvement--program description, work plans, program evaluations, and committee and subcommittee meeting minutes;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(3) complaints--complaint files and complaint logs, including documentation and details of actions taken. All complaints must be categorized and

completed in accord with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions);

(4) satisfaction surveys--any insured, physician, and provider satisfaction surveys, and any insured disenrollment and termination logs;

(5) network configuration information as required by §3.3722(c)(9) of this title demonstrating adequacy of the exclusive provider network;

(6) credentialing--credentialing files; and

(7) reports--any reports the insurer submits to a governmental entity.

§3.3724. Quality Improvement Program.

(a) An insurer must develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided within an exclusive provider benefit plan and to pursue opportunities for improvement. The QI program must be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The insurer must dedicate adequate resources, like personnel and information systems, to the QI program.

(1) Written description. The QI program must include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

(2) Work plan. The QI program must include an annual QI work plan designed to reflect the type of services and the population served by the exclusive

provider benefit plan in terms of age groups, disease categories, and special risk status. The work plan must:

(A) include objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, responsible individuals, and evaluation methodology; and

(B) address each program area, including:

(i) network adequacy, which includes availability and accessibility of care, including assessment of open and closed physician and individual provider panels;

(ii) continuity of medical and health care and related services;

(iii) clinical studies;

(iv) the adoption and periodic updating of clinical practice guidelines or clinical care standards that:

(I) are approved by participating physicians and individual providers;

(II) are communicated to physicians and individual providers; and

(III) include preventive health services;

(v) insured, physician, and individual provider satisfaction;

(vi) the complaint process, complaint data, and identification and removal of barriers that may impede insureds, physicians, and providers from effectively making complaints against the insurer;

(vii) preventive health care through health promotion and outreach activities;

(viii) claims payment processes;

(ix) contract monitoring, including oversight and compliance with filing requirements;

(x) utilization review processes;

(xi) credentialing;

(xii) insured services; and

(xiii) pharmacy services, including drug utilization.

(3) Evaluation. The QI program must include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

(4) Credentialing. An insurer must implement a documented process for selection and retention of contracted preferred providers that complies with §3.3706(c) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(5) Peer review. The QI program must provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Occupations Code Chapters 151 – 164. The insurer must designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

(b) The insurer's governing body is ultimately responsible for the QI program.

(1) The governing body must appoint a quality improvement committee (QIC) that:

(A) must include practicing physicians and individual providers;

(B) may include one or more insured(s) from throughout the exclusive provider benefit plan's service area; and

(C) must ensure that any insured appointed to the QIC is not an employee of the insurer.

(2) The governing body must approve the QI program.

(3) The governing body must approve an annual QI plan.

(4) The governing body must meet no less than annually to receive and review reports of the QIC or its subcommittees and take action when appropriate.

(5) The governing body must review the annual written report on the QI program.

(c) The QIC must evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians, individual providers, and insureds from the service area.

(A) All committees must collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

(B) All committees must meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC must use multidisciplinary teams, when indicated, to accomplish QI program goals.

(d) In reviewing an insurer's quality improvement program, the department will presume that the insurer is in compliance with statutory and regulatory requirements regarding the insurer's quality improvement program if the insurer has received nonconditional accreditation or certification specific and germane to the insurer's quality improvement program by the National Committee for Quality Assurance, the Joint Commission, URAC, or the Accreditation Association for Ambulatory Health Care. However, if the department determines that an accreditation or certification program does not adequately address a material Texas statutory or regulatory requirement, the department will not presume the insurer to be in compliance with that requirement.

§3.3725. Payment of Certain Out-of-Network Claims.

(a) If an insured cannot reasonably reach a preferred provider, the insurer must fully reimburse a nonpreferred provider for the following emergency care services at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in a hospital emergency facility of a hospital, freestanding emergency medical care facility, or comparable facility that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and

(3) following treatment or stabilization of an emergency medical condition, services originating in a hospital emergency facility or freestanding emergency medical care facility or comparable emergency facility.

(b) If medically necessary covered services, excluding emergency care, are not available through a preferred provider upon the request of a preferred provider, the insurer must:

(1) approve a referral to a nonpreferred provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(2) provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested under paragraph (1) of this subsection before the insurer may deny the referral.

(c) An insurer may facilitate an insured's selection of a nonpreferred provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider and an insured has received a referral from a preferred provider.

(1) If an insurer chooses to facilitate an insured's selection of a nonpreferred provider pursuant to this subsection, the insurer must offer an insured a list of at least three nonpreferred providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the insured.

(2) If the insured selects a nonpreferred provider from the list provided by the insurer, subsections (d) – (f) of this section are applicable.

(3) If the insured selects a nonpreferred provider that is not included in the list provided by the insurer, then:

(A) subsections (d) – (f) of this section are not applicable; and

(B) notwithstanding §3.3708(f) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures), the insurer must pay the claim in accord with §3.3708 of this title.

(d) An insurer reimbursing a nonpreferred provider under subsection (a), (b), or (c)(2) of this section must ensure that the insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider.

(e) Upon determining that a claim from a nonpreferred provider under subsection (a), (b), or (c)(2) of this section is payable, an insurer must issue payment to the nonpreferred provider at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider. When issuing payment, the insurer must provide an explanation of benefits to the insured along with a request that the insured notify the insurer if the nonpreferred provider bills the insured for amounts beyond the amount paid by the insurer.

(1) The insurer must resolve any amounts that the nonpreferred provider bills the insured beyond the amount paid by the insurer in a manner consistent with subsection (d) of this section.

(2) The insurer may require in its policy or certificate issued to an insured that, if a claim is eligible for mediation under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title (relating to Out-of-Network Claim Dispute Resolution), the insured must request mediation.

(A) The insurer must notify the insured when mediation is available under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title, and inform the insured of how to request mediation.

(i) The insurer may not require that the insured participate in a mediation requested under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title.

(ii) The insurer may not penalize the insured for failing to request mediation.

(iii) Notwithstanding clause (ii) of this subparagraph, after the insurer requests that the insured initiate mediation, the insurer is not responsible for any balance bill the insured receives from the provider, until the insured requests mediation.

(B) For purposes of determining eligibility for mediation under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title the entire unpaid amount of the amount the nonpreferred provider bills should be taken into consideration, less any applicable copayment, deductible, and coinsurance.

(C) If the amount of a claim is changed as a result of mediation required by the insurer, the insurer's payment must be based on the amount that results from the mediation process.

(f) Any methodology utilized by an insurer to calculate reimbursements of nonpreferred providers for services that are covered under the health insurance policy must comply with the following:

(1) if based on usual, reasonable, or customary charges, the methodology must be based on generally accepted industry standards and practices for determining the customary billed charge for a service and fairly and accurately reflect market rates, including geographic differences in costs;

(2) if based on claims data, the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

(3) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than three years old; and

(4) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adopted section and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 29, 2013.

Sara Waitt
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to 28 TAC §§3.3701 – 3.3710 and new §§3.3720 – 3.3725.

2250

Eleanor Kitzman
Commissioner of Insurance

Commissioner's Order No. 2250

JAN 30 2013