SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
DIVISION 1. GENERAL REQUIREMENTS
28 TAC §3.3705 and §3.3708

INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC Chapter 3, Subchapter X, Division 1, §3.3705 (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations) and §3.3708 (relating to Payment of Certain Basic Benefit Claims and Related Disclosures). Both sections are adopted with changes to the proposed text published in the May 27, 2016, issue of the *Texas Register* (41 TexReg 3832).

REASONED JUSTIFICATION. The amendments to the rules are necessary because of amendments made to Texas Insurance Code Chapter 1467. Senate Bill 481, 84th Legislature, Regular Session (2015), amended Insurance Code Chapter 1467 (concerning Out-of-Network Claim Dispute Resolution). As a result, the department must make conforming changes to 28 TAC Chapter 3, Subchapter X.

Parts of both §3.3705 and §3.3708 relate to the mediation process mandated by Chapter 1467. Senate Bill 481 lowered the threshold for mediation to amounts greater than $500 for services provided on or after September 1, 2015. The rules at §3.3705 and §3.3708 need to be updated to include these provisions and to make nonsubstantive changes to conform to agency style and usage guidelines.

The department has made the following changes to the proposed language in response to comments:

1. left the word "facility" in the fifth bullet in the figure for 28 TAC §3.3705(f)(1), made the fifth bullet more closely track the language in Insurance Code §1467.051, and added "including the amount unpaid by the administrator or insurer" when describing the amount billed; and

2. added "in a preferred hospital" after "[w]hen services are rendered to an insured by a nonpreferred facility-based physician," changed the term "facility-based physician" to "hospital-based physician" and added a reference to the definition in 28 TAC §21.5003(6) in §3.3708(e).

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received timely written comments from two commenters. Commenters on the proposal were: one individual and the Texas Medical Association. The commenters were for the proposal, with changes.

General Comment.

One commenter stated that the proposed amendments do not address a situation where an individual is balance billed by the health care provider for special equipment used in a surgical operation. The commenter stated that many consumers of health care are familiar with the issue of inadvertently receiving care from an out-of-network doctor, even though the treatment was at an in-network hospital, but that most people probably are unaware that an in-network doctor's surgical equipment might be classified as out-of-network. The commenter suggested that a global solution to the issue of inadvertent out-of-network charges should be undertaken to obviate mediation services. The commenter noted that the solution must apply to any major medical health insurance plan and not be limited to hospital-based physicians.

Agency Response to General Comment.

The department appreciates the comment and acknowledges that balance billing can occur in contexts other than the physician services covered in Insurance Code Chapter 1467. However, the Insurance Code does not currently provide for the global solution advocated by the commenter. The department therefore respectfully declines to make the changes suggested by the commenter.

Comment on Figure: §3.3705(f)(1).

One commenter expressed concern about the department's proposal to change "hospital" to "facility" in the fifth bullet in the figure for 28 TAC §3.3705(f)(1). The commenter contended that this change might be construed to broaden the scope of Texas' mediation law because a hospital is the only type of facility at which certain physician services are rendered that are subject to mediation. The commenter recommended that the fifth bullet more closely track the language in Insurance Code §1467.051, and that the department should add "including the amount unpaid by the administrator or insurer" when describing the amount billed.

Agency Response to Comment on Figure: §3.3705(f)(1).

The department agrees that the proposed change might cause some confusion, and agrees to make the changes suggested by the commenter.

Comment on §3.3708(e).

One commenter suggested that notices provided on explanations of benefits might be misleading by giving the impression that mediation is available when it is not. The commenter suggested that adding "in a preferred hospital" after "[w]hen services are rendered to an insured by a nonpreferred facility-based physician" in §3.3708(e) would make this less likely, as would adding a definition of "facility-based physician."

Agency Response to Comment on §3.3708(e).

The department agrees that the first proposed change might lessen the possibility of confusion and has made the change. However, the department believes that adding a definition of "facility-based physician" would not be as useful as simply changing the term to "hospital-based physician" and referring to the definition in 28 TAC §21.5003(6), because this would require amending only one section of the department's rules should the definition change in the future. The department has made these changes.

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1467.001, 1467.003, 1467.051, 1301.007, 1301.0042, and 36.001, and amendments made by Section 5 of SB 481, 84th Legislature, Regular Session (2015), to Insurance Code §1467.051(a)(1).

Insurance Code §1467.001 contains definitions, including a definition for the facility-based physicians to whom Chapter 1467 applies.

Insurance Code §1467.003 requires the commissioner to adopt rules as necessary to implement the commissioner's powers and duties under Chapter 1467. Section 1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of Texas.

Insurance Code §1301.0042 provides that 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.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the department's powers and duties under the Insurance Code and other laws of this state.

TEXT.

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS

DIVISION 1. GENERAL REQUIREMENTS

§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 (relating to Geographic Regions), 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 to comply with 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.

• You have the right, in most cases, to obtain estimates in advance:

o from out-of-network providers of what they will charge for their services; and

o 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 a 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 are treated by a provider or facility 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, neonatologist, or assistant surgeon, including the amount unpaid by the administrator or insurer, is greater than $500 (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.

• If directory information is materially inaccurate and you rely on it, 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.

(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").

o 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.

§3.3708. 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 hospital-based physician in an in-network hospital and the difference between the allowed amount and the billed charge is at least $500, 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. In this paragraph, "facility-based physician" has the meaning given to it by §21.5003(6) of this title (relating to Definitions).

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

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on October 12, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to 28 TAC §3.3705 and §3.3708.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **2016-4724**