SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
28 TAC §§3.3702, 3.3705, 3.3708, and 3.3725

INTRODUCTION. The Texas Department of Insurance proposes limited amendments to parts of 28 TAC §§3.3702, 3.3705, 3.3708, and 3.3725 concerning information and disclosures related to listings of preferred providers. The amendments implement changes made to Insurance Code Chapter 1467 by Senate Bill 507, 85th Legislature, Regular Session (2017) and changes made to Insurance Code §1451.505 by House Bill 1624, 84th Legislature, Regular Session (2015). The amendments also correct some references and make nonsubstantive editorial changes to conform the amended rules to the agency's current style and to improve the rule's clarity.

To the extent that changes are not proposed to specific subsections of the current rules, the department does not propose to change or amend those subsections.

EXPLANATION. SB 507 amended Insurance Code Chapter 1467, concerning Out-of-Network Claim Dispute Resolution. HB 1624 amended Insurance Code §1451.505, concerning Physician and Health Care Provider Directory on Internet Website. As a result, the department must make conforming changes to 28 TAC Chapter 3, Subchapter X.

As amended, Insurance Code Chapter 1467 provides for mediation of certain claims for services provided to enrollees of preferred provider benefit plans issued under Insurance Code Chapter 1301, and to enrollees of health benefit plans—other than health maintenance organization plans—provided under Insurance Code Chapters 1551, concerning the Texas Employees Group Benefits Act; 1575, concerning the Texas Public

School Employees Group Benefits Program; and 1579, concerning the Texas School Employees Uniform Group Health Coverage.

Chapter 1467 also expands the types of covered providers whose services can be subject to mediation and authorizes an enrollee to request mediation of an out-of-network health benefit claim for services provided on or after January 1, 2018, if the claim is for emergency care or for health care or a medical service or supply provided by a facility-based provider in a facility that is a covered plan's preferred provider or that has a contract with the plan's administrator. The limited amendments proposed to parts of 28 TAC §§3.3702, 3.3705, 3.3708, and 3.3725 are necessary for the sections to include these changes.

HB 1624 amended Insurance Code §1451.505 to require insurers to update all electronic listings of preferred providers at least monthly. As a result, the department must make conforming changes to 28 TAC §3.3705.

The department is also proposing amendments to increase the transparency of disclosures, achieve a more orderly flow of information, and make disclosures more useful to enrollees.

A description of changes to specific sections follows.

Section 3.3702. The proposal shortens and simplifies the section by adopting definitions already contained in Insurance Code Chapter 1467, rather than repeating them. By doing so, the proposal conforms to the definitions amended by SB 507 in Insurance Code §1467.001. The proposal also renumbers definitions and makes nonsubstantive editorial changes to conform the section to the agency's current style and to improve the section's clarity.

Section 3.3705(a). No changes are proposed to §3.3705(a).

Section 3.3705(b). To minimize confusion between the written plan description required by Insurance Code §1301.158 and other documents, such as the state-required outline of coverage and the federally required summary of benefits and coverage, the department proposes titling the required written plan description "Texas Plan Summary."

The written plan description must clearly identify the plan that it describes. As proposed to be amended, the section allows an insurer to combine the Texas Plan Summary with its outline of coverage or summary plan description. The proposal modifies the order of required disclosures to increase transparency, achieve a more orderly flow of information, and make disclosures more useful to enrollees. The proposal also requires insurers to update electronic listings of preferred providers at least once a month to comply with amendments made to Insurance Code §1451.505 by HB 1624.

The proposal clarifies the scope of the disclosures required by the section concerning reimbursement of out-of-network services and adopts more enrollee-friendly notices, which vary by the type of plan and kind of coverage. The changes proposed to the subsection simplify the development and maintenance of plan-specific Texas Plan Summaries. Combining provisions in paragraphs (b)(4) and (b)(7) will enable issuers to use other existing documents, such as the schedule of benefits or summary of benefits and coverage, to describe the plan's benefits alongside the associated cost-sharing requirements.

Changes to paragraph (b)(5) eliminate the need to separately describe emergency care benefits and emphasize the function that urgent care plays as a source of after-hours care, consistent with other consumer education initiatives.

The proposal combines §3.3705(b)(14)(B) and (C) for clarity. The department permits inclusion of network information in a direct electronic link and streamlines §3.3705(b)(14) and (15) to eliminate repetitive requirements.

The proposal also makes nonsubstantive editorial changes to conform the subsection to the agency's current style and to improve the rule's clarity.

Section 3.3705(c). Amendments to paragraph (1) remove prescriptive submission directions and replaces them with a reference to the form filing procedures generally applicable to submission under 28 TAC Chapter 3. Amendments to paragraph (2) clarify that new requirements resulting from the changes made to subsection (b) are only effective for new filings or when material changes occur to the already required underlying information. Thus, new filings would not need to comply with the section until the underlying information changes.

Section 3.3705(d). No changes are proposed to this subsection.

Section 3.3705(e). The proposal adds a reference to Texas Plan Summaries to conform to the change in subsection (b) and conforms the subsection's description of notices to the changes proposed to subsection (f). The proposal also makes nonsubstantive editorial changes to the subsection to conform it to the agency's current style and to improve the rule's clarity.

Section 3.3705(f). The proposal replaces existing notices with ones that reflect the SB 507 amendments to Insurance Code §1467.051 and §1467.0511, and it clarifies that plans are not required to notify insureds about the availability of mediation in the limited instance where the plans do not provide benefits for emergency care or for care in a facility, and thus mediation is not available. This will have the effect of lowering costs for insurers that issue these plans.

Section 3.3705(g) and (h). No changes are proposed to these subsections.

Section 3.3705(i). The proposal requires monthly updates to electronic listings of preferred providers to conform to the HB 1624 amendments to Insurance Code §1451.505.

Section 3.3705(j). No changes are proposed to this subsection.

Section 3.3705(k). The proposal only makes nonsubstantive editorial changes to this subsection to conform it to the agency's current style and to improve the rule's clarity.

Section 3.3705(l). The proposal requires compliance with Insurance Code §1451.505. The proposal also makes a nonsubstantive editorial changes to conform it to the agency's current style and to improve the rule's clarity.

Section 3.3705(m). The proposal only makes nonsubstantive editorial changes to this subsections to conform it to the agency's current style and to improve the rule's clarity.

Section 3.3705(n). The proposal moves the email address for certifications required by subparagraphs (2)(B) and (4)(C) to a new paragraph (6) and provides for the department to change that address on its website or by bulletin. The proposal also makes nonsubstantive editorial changes to these subsections to conform the subsection to the agency's current style and to improve the rule's clarity.

Section 3.3705(o). The proposal adds Texas Plan Summaries to the documents on which disclosures must be made. The proposal also makes a nonsubstantive editorial change to the subsection to conform it to the agency's current style and to improve the rule's clarity.

Section 3.3705(p) and (q). No change is proposed to these subsections.

Section 3.3708(a) - (d). No change is proposed to these subsections.

Section 3.3708(e) The proposal conforms the notice required in the subsection to the SB 507 amendments to Insurance Code §1467.051 and §1467.0511, which expanded the scope of mediation and notices to enrollees. The proposal also eliminates outdated references to the definitions of "facility" and "facility-based physician," which are replaced

by a definition in §3.3702. The proposal also makes nonsubstantive editorial changes to conform the subsection to the agency's current style and to improve the rule's clarity.

Section 3.3708(f). No change is proposed to this subsection.

Section 3.3725(a) - (d). No change is proposed to these subsections.

Section 3.3725(e). No change is proposed in this subsection until the beginning of §3.3725(e)(2)(A), where the department proposes to conform the notification required in the subparagraph to SB 507 amendments made to Insurance Code §1451.0511, which require a notice in the applicable explanation of benefits and require the notice to include a reference to the department's website on mediation to ensure that insureds are advised of their rights in a more useful manner. The amended language clarifies that mediation is available for exclusive provider plans.

Section 3.3725(f). No change is proposed to this subsection.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Patricia Brewer, team lead for the Life and Health Regulatory Initiatives Team, has determined that during each year of the first five years that the proposed amendments are in effect, there will be no fiscal impact on state or local governments as a result of enforcing or administering the sections, other than that imposed by the statute, because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments. Ms. Brewer does not anticipate any measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Brewer expects that administering the proposed sections

will have the public benefits of: (i) ensuring that the department's rules comply with Insurance Code Chapter 1467; (ii) clarifying changes made to Insurance Code Chapter 1467 by SB 507 for affected plans, administrators, and enrollees; and (iii) possibly reducing the amount of balance billing some patients are required to pay by giving them better notice of their rights to mediation and simplifying the presentation of plan provisions.

Ms. Brewer expects that the proposed amendments will not increase the cost of compliance with Insurance Code Chapters 1301 and 1467 because they do not impose requirements beyond those in the statutes. The proposed amendments in §3.3705(b) simplify the development and maintenance of plan-specific Texas Plan Summaries. Combining the provisions in paragraphs (b)(4) and (b)(7) will enable issuers to use other existing documents, such as the schedule of benefits or summary of benefits and coverage, to describe the plan's benefits alongside the associated cost-sharing requirements. Paragraphs (b)(4) and (b)(5) are revised to more specifically require information on coverage for emergency care and after-hours care, consistent with other consumer education initiatives. The department permits inclusion of network information in a direct electronic link and streamlines paragraphs (b)(14) and (b)(15) to eliminate repetitive requirements. To the extent that issuers may incur costs to reorder the presentation of information, amendments to §3.3705(c) clarify that new requirements resulting from the changes made to §3.3705(b) are only effective for new filings or when material changes occur to the already required underlying information. Thus, new filings would not need to comply with the section until the underlying information changes. The department believes that any costs to reorganize the presentation of information will be more than offset by the simplifications in the proposed rule. The amendments to §3.3705(f) should have the effect of lowering administrative costs for the small number of issuers whose plans do not provide benefits for emergency care or for care in a facility.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that these proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities, because to the extent they contain requirements, they simply implement statutory requirements or contain minor revisions to existing forms. As a result, and in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that this proposal does not impose a cost on regulated persons and the proposed rule amendments are necessary to implement legislation.

GOVERNMENT GROWTH IMPACT STATEMENT. The department has determined that for each year of the first five years that the proposed amendments are in effect, the proposed amendments:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will both expand and limit an existing regulation, resulting in no net increase to regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. The department will consider any written comments on the proposal received by the department no later than 5:00 p.m., Central time, on January 22, 2019. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. To request a public hearing, submit a written request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The request for public hearing must be separate from any comments and received by the department no later than 5:00 p.m., Central time, on January 22, 2019. If the department holds a public hearing, the department will consider written and oral comments presented at the hearing.

SUBCHAPTER X.

Division 1.

28 TAC §3.3702, 3.3705, and 3.3708

STATUTORY AUTHORITY. The department proposes amendments to 28 TAC §§3.3702, 3.3705, and 3.3708 under Insurance Code §§36.001, 1301.0042, 1301.007, 1301.158, 1301.159, 1301.1591, 1451.504, 1451.505, 1467.001, 1467.003, 1467.051, and 1467.0511.

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.

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 also 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 §1301.007 provides that the Commissioner adopt rules as necessary to implement Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1301.158 provides that insurers provide certain information concerning preferred provider benefit plans.

Insurance Code §1301.159 provides that a current list of preferred providers be provided to each insured at least annually.

Insurance Code §1301.1591 provides that an insurer subject to Chapter 1301 that maintains an internet site must list on the internet site the preferred providers that insureds may use in accordance with the terms of the insured's preferred provider benefit plan; the insurer must update the internet site at least quarterly; and the Commissioner may adopt rules as necessary to implement the section.

Insurance Code §1451.504 provides that a health benefit plan issuer that offers coverage for health care services through preferred providers, exclusive providers, or a network of physicians or health care providers must develop and maintain a physician and health care provider directory, and the section sets content requirements for directories.

Insurance Code §1451.505 provides that a health benefit plan issuer display the directory required by §1451.504 on a public internet website, and that a direct electronic link to the directory must be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the internet website. The section also requires that the health benefit plan issuer clearly indicate in the directory each health benefit plan issued by the issuer that may provide coverage for services provided by each physician or health care provider included in the directory.

Insurance Code §1467.001 contains definitions, including a definition for the facility-based providers whose billings are subject to Chapter 1467.

Insurance Code §1467.003 requires the Commissioner to adopt rules as necessary to implement the Commissioner's powers and duties under Chapter 1467.

Insurance Code Insurance Code §1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Insurance Code Insurance Code §1467.0511 sets out requirements for notices of the mediation process in explanations of benefits sent to enrollees by insurers or administrators for out-of-network claims eligible for mediation under Chapter 1467.

CROSS REFERENCE TO STATUTE. The proposed amendments to 28 TAC §3.3702 implement Insurance Code §1467.001. The proposed amendments to 28 TAC §3.3705 implement Insurance Code §§1301.158, 1301.159, 1301.1591, 1451.505, 1467.051, and

1467.0511. The proposed amendments to 28 TAC §3.3708 implement Insurance Code §§1467.001, 1467.051, and 1467.0511. The proposed amendments to 28 TAC §3.3725 implement Insurance Code §1467.0511.

TEXT.

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS

DIVISION 1. GENERAL REQUIREMENTS

§3.3702. Definitions.

(a) Words and terms defined in Insurance Code Chapters [~~Chapter~~]1301 and 1467 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 [~~§4201.002(1)~~].

(2) - (7) (No change.)

[~~(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.~~]

(8)[~~(10)~~] Health care provider or provider--As defined in Insurance Code §1301.001 [~~§1301.001(1-a)~~].

(9)[~~(11)~~] Health maintenance organization (HMO)--As defined in Insurance Code §843.002 [~~§843.002(14)~~].

(10)[~~(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.

(11)[~~(13)~~] NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(12)[~~(14)~~] Nonpreferred provider--A physician, health care practitioner, or health care provider, or an organization of physicians, health care practitioners, 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.

(13)[~~(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.

(14)[~~(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.

(15)[~~(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 [~~commissioner~~], notwithstanding subparagraphs (A) and (B) of this paragraph.

(16)[~~(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.

(17)[~~(19)~~] Utilization review--As defined in Insurance Code §4201.002 [~~§4201.002[(13)~~].

§3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

(a) (No change).

(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 combine this disclosure with its outline of coverage or

other summary plan description or may use [~~utilize~~] its handbook to satisfy this requirement, provided that the insurer complies with all requirements set forth in this subsection, including the order of information and the level of disclosure required. The written description must be titled "Texas Plan Summary" and clearly identify the plan that it describes. It must also 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, that 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 [~~toll-free~~] number, unless exempted by statute or rule, and an address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) (No change).

(4) information that, in whole or in part, may be provided using a schedule of benefits or a summary of benefits and coverage and that is inserted into the Texas Plan Summary, including:

(A) all covered services and benefits, including payment for services of a preferred provider, a nonpreferred provider and prescription drug coverage, both generic and name brand; and

(B) an explanation of the insured's financial responsibility for payment for any deductibles, copayments, coinsurance, or other out-of-pocket expenses

for noncovered or nonpreferred services, including the information required by subsection (o) of this section and information relating to coverage under §3.3708 or §3.3725 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures and Payment of Certain Out-of-Network Claims), as applicable;

(5) [~~emergency care services and benefits and~~] information on how to access [~~to~~] after-hours care, including urgent care and emergency care;

(6) (No change).

(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) (No change).

(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) and (11) (No change).

(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 through a direct electronic link [~~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 summarizing the network that applies to the plan, which may be provided through a direct electronic link, that is updated at least annually regarding the following network demographics for each service area or county, 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; and

(B) for facilities and 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:[,]

(i) the number of preferred providers;[, as well as]

(ii) an indication of whether an active access plan under [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 county, service area, or region; and

(iii) a direct electronic link to the access plan that applies to the particular network, or an explanation of how the [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 about [regarding] whether any waivers or local market access plans approved under [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) the information must specifically note 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; but[~~,~~]

(D) information provided under paragraph (14) of this subsection is not required to be duplicated.

(c) Filing required.

(1) A copy of the Texas Plan Summary [~~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 Texas Plan Summary filings must be made consistently with the form filing procedures contained in Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) [~~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~~].

(2) This subsection applies to filings required on or after the effective date of this subsection. Filings required before the effective date of this subsection are governed by the rules in effect immediately before the effective date of this subsection, and those rules are continued in effect for that purpose.

(d) (No change).

(e) Internet website disclosures. Insurers that maintain an internet [~~Internet~~] website providing information about [~~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 [~~Internet-based~~] provider listing for use by current and prospective insureds and group contract holders;

(2) an internet-based [~~Internet-based~~] listing of the state regions, counties, or three-digit ZIP code [~~Code~~] areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP code [~~Code~~] area, as applicable, that the insurer has:

(A) and (B) (No change).

(3) an internet-based [~~Internet-based~~] listing of each Texas Plan Summary [~~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 notices [~~notice~~] specified in this subsection [~~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, and Texas Plan Summaries [~~disclosures of policy terms and conditions provided to comply with~~

~~subsection (b) of this section~~], and in outlines of coverage, in at least 12-point font.[:] Information bracketed in the notices, including department contact information, is subject to change, and insurers must use the most recent online information from the department website.

(1) For plans providing benefits for emergency care or for care in a facility:

(A) a preferred [~~Preferred~~] provider benefit plan notice[.]

Figure: 28 TAC §3.3705(f)(1)(A)

Preferred provider benefit plan notice

You have a preferred provider network.

If you get health care from a provider that is not a preferred provider, you will probably have to pay more. Make sure your insurance company gives you a list of preferred providers in your network.

Find a provider in your network:

The Texas Department of Insurance (TDI) requires your insurance company to give you a list of the providers in your network. To get a copy of the list:

- Call [insurer's phone number] or visit [insurer web address].
- If you can't find a network provider for a service covered by your health insurance, you can file a complaint with TDI.

If you get care from a provider that is not in your network:

- You have a right to a cost estimate in advance from your insurance company and the provider. They have up to 10 business days to provide it.
- Sometimes, when it's not your choice to see a provider out of network, the insurer might have to pay more. For instance, if you have an emergency or if there was a mistake on the provider list, the insurer might have to apply your in-network coinsurance.

If you get a surprise bill, the Texas Department of Insurance can provide a free mediation process to help resolve the bill if:

The bill is more than $500, not including copays, deductibles, and coinsurance, and you received:

- Emergency care from a provider, hospital, or clinic that is not in your network.

or

- Treatment at a network hospital from a provider who is not in your network.

Visit www.tdi.texas.gov or call 1-800-252-3439 to:

- Get help with a surprise bill.
- Learn how the mediation process works. You will need to fill out a form to start the process.
- File a complaint.

[~~Figure 28 TAC §3.3705(f)(1)~~]

(B) an exclusive[~~(2) Exclusive~~] provider benefit plan notice[~~.~~]

Figure: 28 TAC §3.3705(f)(1)(B)

Exclusive provider benefit plan notice

You have an exclusive provider benefit plan.

Your plan will cover care from only providers in your network. Check your policy or contact your health insurance company to see if there are exceptions.

Find a provider in your network:

The Texas Department of Insurance (TDI) requires your insurance company to give you a list of the providers in your network. To get a copy of the list:

- Call [insurer's phone number] or visit [insurer web address].

- If you can't find a network provider for a service covered by your health insurance, you can file a complaint with TDI.

If you get care from a provider that is not in your network:

- You have a right to a cost estimate in advance from your insurance company and the provider. They have up to 10 business days to provide it.
- If it was not your choice to get care from a provider that is not in your network, for example, if there was a mistake on the provider list or an emergency, you might have to pay only your copay, deductible, and coinsurance.

If you get a surprise bill, the Texas Department of Insurance can provide a free mediation process to help resolve the bill if:

The bill is more than $500, not including copays, deductibles, and coinsurance, and you received:

- Emergency care from a provider, hospital, or clinic that is not in your network.

or

- Treatment at a network hospital from a provider who is not in your network.

Visit www.tdi.texas.gov or call 1-800-252-3439 to:

- Get help with a surprise bill.
- Learn how the mediation process works. You will need to fill out a form to start the process.
- File a complaint.
-

[~~Figure 28 TAC §3.3705(f)(2)~~]

(2) For plans not providing benefits for emergency care or for care in a facility:

(A) a preferred provider benefit plan notice

Figure: 28 TAC §3.3705(f)(2)(A)

Preferred provider benefit plan notice

You have a preferred provider network.

If you get health care from a provider that is not a preferred provider, you will probably have to pay more. Make sure your insurance company gives you a list of preferred providers in your network.

Find a provider in your network:

The Texas Department of Insurance (TDI) requires your insurance company to give you a list of the providers in your network. To get a copy of the list:

- Call [insurer's phone number] or visit [insurer web address].
- If you can't find a network provider for a service covered by your health insurance, you can file a complaint with TDI.

If you get care from a provider that is not in your network:

- You have a right to a cost estimate in advance from your insurance company and the provider. They have up to 10 business days to provide it.
- Sometimes, when it's not your choice to see a provider out of network, the insurer might have to pay more. For instance, if you have an emergency or if there was a mistake on the provider list, the insurer might have to apply your in-network coinsurance.

Visit www.tdi.texas.gov **or call 1-800-252-3439 to:**

- Get help with a bill.
- File a complaint.

(B) an exclusive provider benefit plan notice

Figure: 28 TAC §3.3705(f)(2)(B)

Exclusive provider benefit plan notice

You have an exclusive provider benefit plan.

Your plan will cover care from only providers in your network. Check your policy or contact your health insurance company to see if there are exceptions.

Find a provider in your network:

The Texas Department of Insurance (TDI) requires your insurance company to give you a list of the providers in your network. To get a copy of the list:

- Call [insurer's phone number] or visit [insurer web address].
- If you can't find a network provider for a service covered by your health insurance, you can file a complaint with TDI.

If you get care from a provider that is not in your network:

- You have a right to a cost estimate in advance from your insurance company and the provider. They have up to 10 business days to provide it.
- If it was not your choice to get care from a provider that is not in your network, for example, if there was a mistake on the provider list, you might have to pay only your copay, deductible, and coinsurance.

Visit www.tdi.texas.gov or call 1-800-252-3439 to:

- Get help with a bill.
- File a complaint.

(g) (No change).

(h) (No change).

(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, and that it updates all electronic listings of preferred providers at least once each month.

(j) (No change).

(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 on [~~upon~~] a statement that a physician or provider was a preferred provider as specified in:

(A) and (B) (No change).

(2) (No change).

(3) the provider listing or website information was obtained not more than 30 days before [~~prior to~~] the date of services; and

(4) (No change).

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any internet-based [~~Internet-based~~] postings of information made available by the insurer to provide information to insureds about preferred providers consistent with Insurance Code §1451.505, 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 use [~~utilize~~] preferred providers.

(B) In those instances in which a particular facility-based physician or physician group is assigned at least 48 hours before [~~prior to~~] services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours before [~~prior to~~] services being rendered; and

(ii) (No change).

(2) - (5) (No change).

(6) The provider information must include [~~provide~~] a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities.

(7) - (9) (No change).

(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 before [~~prior to~~] renewal of an existing policy. The notice must include:

(1) a link to any web page [~~webpage~~] listing of regions, counties, or ZIP codes made available under [~~pursuant to~~] subsection (e)(2) of this section;

(2) (No change).

(3) a link to the department's website where the department posts information about [~~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) (No change).

(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 before [~~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) (No change).

(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) - (B) (No change).

(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 noncompliance [~~non-compliance~~] with adequacy standards.

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its internet-based [~~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.

(6) Certifications required by subparagraphs (2)(B) and (4)(C) of this subsection must by be provided by email to mcqa@tdi.texas.gov or any updated email address designated by the department on its website or by bulletin.

(o) Disclosures concerning reimbursement of out-of-network services. An insurer must make disclosures in all insurance policies, certificates, Texas Plan Summaries, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

(1) and (2) (No change).

(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) - (C) (No change).

(D) provide to insureds a method to obtain a real-time [~~real time~~] estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

(p) and (q) (No change).

§3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures.

(a) - (d) (No change).

(e) An explanation of benefits sent to an enrollee by an insurer or administrator for an out-of-network health benefit claim eligible for mediation under Insurance Code Chapter 1467 must comply with Insurance Code §1467.0511 and contain a statement that is substantially similar to the following: "You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at www.tdi.texas.gov and 1 (800) 252-3439." 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. The webpage and toll-free number are subject to change and insurers must use the most recent online information from the department website. [~~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) (No change).

SUBCHAPTER X.

Division 2.

28 TAC §3.3725

STATUTORY AUTHORITY. The department proposes amendments to 28 TAC §3.3725 under Insurance Code §§36.001, 1301.0042, 1301.007, 1467.003, 1467.051, and 1467.0511.

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.

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 also 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 §1301.007 provides that the Commissioner adopt rules as necessary to implement Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Insurance Code §1467.003 requires the Commissioner to adopt rules as necessary to implement the Commissioner's powers and duties under Chapter 1467.

Insurance Code Insurance Code §1467.051 sets out the availability of mandatory mediation under Chapter 1467.

Insurance Code Insurance Code §1467.0511 sets out requirements for notices of the mediation process in explanations of benefits sent to enrollees by insurers or administrators for out-of-network claims eligible for mediation under Chapter 1467.

CROSS REFERENCE TO STATUTE. The proposed amendments to 28 TAC §3.3725 implement Insurance Code §1467.0511.

TEXT.

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS

DIVISION 2. EXCLUSIVE PROVIDER BENEFIT PLAN REQUIREMENTS

§3.3725. Payment of Certain Out-of-Network Claims.

(a) - (d) (No change).

(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) (No change).

(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) An explanation of benefits sent to an enrollee by an insurer or administrator for an out-of-network health benefit claim eligible for mediation under Insurance Code Chapter 1467 must comply with Insurance Code §1467.0511 and contain a statement that is substantially similar to the following: "You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at www.tdi.texas.gov and 1 (800) 252-3439." 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. The webpage and toll-free number are subject to change and insurers must use the most recent online information from the department website. [~~The insurer must notify the insured when mediation is available under Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title.~~]

(i) - (iii) (No change).

(B) and (C) (No change).

(f) (No change).

CERTIFICATION. This agency certifies that legal counsel has reviewed the proposed amendments and found them to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on December 3, 2018.

/s/ Norma Garcia
Norma Garcia, General Counsel
Texas Department of Insurance