SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS

DIVISION 1. GENERAL REQUIREMENTS
28 TAC §§3.3701, 3.3702, 3.3705, and 3.3709

DIVISION 2. PREFERRED AND EXCLUSIVE PROVIDER BENFIT PLAN REQUIREMENTS
28 TAC §§3.3720, 3.3721, 3.3722, and 3.3723

SUBCHAPTER KK. EXCLUSIVE PROVIDER BENEFIT PLAN
[~~28 TAC §3.9208~~]

INTRODUCTION. The Texas Department of Insurance proposes to amend 28 TAC §§3.3701, 3.3702, 3.3705, 3.3709, 3.3720, 3.3721, 3.3722, and 3.3723, and to repeal 28 TAC §3.9208, concerning preferred provider benefit plans (PPBPs) and exclusive provider benefit plans (EPBPs). Section 3.3701 implements House Bill 1757, 86th Legislature, Regular Session (2019); §§3.3702, 3.3720, 3.3721, 3.3722, and 3.3723 implement House Bill 3911, 86th Legislature, Regular Session (2019); and §§3.3702, 3.3705, and 3.3722 implement Senate Bill 1742, 86th Legislature, Regular Session (2019). The amendments also eliminate certain health care provider network adequacy review requirements that are duplicative of reviews conducted by the Health and Human Services Commission (HHSC) for provider networks associated with the Texas Children's Health Insurance Program (CHIP), Medicaid, or the State Rural Health Care System.

EXPLANATION. Amending §§3.3701, 3.3702, 3.3705, 3.3709, 3.3720, 3.3721, 3.3722, and 3.3723 implements HB 1757, HB 3911, and Article 1 of SB 1742. HB 1757 amended Insurance Code Chapter 1451, Subchapter C to add pharmacists among other health care providers in Subchapter C giving an insured the authority to select a pharmacist as a health care provider under the insured's health insurance policy.

HB 3911 amended Insurance Code §1301.0056 to provide that the Commissioner examine both PPBPs and EPBPs at least once every three years. The examinations should

include qualifying examinations. Previously, the statute only required that EPBPs be examined at least once every five years.

Article 1 of SB 1742 amended Insurance Code Chapter 1451, Subchapter K to add more detailed requirements for health care provider directories, including a requirement for more information regarding facilities and facility-based physicians.

The amendments to §3.3709 and §3.3722 and the repeal of §3.9208 eliminate certain network adequacy review requirements for a PPBP or EPBP written by an insurer for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System. HHSC conducts its own network adequacy reviews of insurers with which it contracts that are duplicative of TDI's review. The changes will conserve agency resources and reduce the regulatory burden and costs imposed on HHSC program participants.

The proposed amendments to the sections are described in the following paragraphs.

Section 3.3701. Applicability and Scope. An amendment to Subsection (c) modifies the reference to provisions to which 28 TAC Chapter 3, Subchapter X is subject, changing the reference to the specific sections of Insurance Code Chapter 1451, Subchapter C to cite the subchapter as a whole, in order to simplify the citation and incorporate the section added to the subchapter by HB 1757. The amendment also reorganizes the referenced provisions into numerical order.

Section 3.3702. Definitions. Amendments to this section implement HB 3911 and SB 1742. The proposed amendments to Subchapter X, Division 2 generally broaden the division's applicability to both PPBP and EPBP networks. The definition of "exclusive provider network" in §3.3702(b)(7) is being amended to broaden its applicability to both PPBP and EPBP networks to conform to the generally broadened applicability of Subchapter X, Division 2. Specifically, the amendments replace the defined term "exclusive

provider network" with "provider network" and add a reference to PPBPs where EPBPs are referenced in that definition. The amendments also move the new definition of "provider network" to §3.3702(b)(16) to keep the definitions in alphabetical order. As a result of the relocation of the definition of "provider network," §3.3702(b)(8) – (15) are renumbered. The definition of "facility" in current §3.3702(b)(8) is amended by replacing the definition with a reference to the new definition of "facility" in Insurance Code §1451.501. The definition of "facility-based physician" in current §3.3702(b)(9) is amended by deleting the "or" and adding the words "or an assistant surgeon." Amending §3.3702(8) - (9) aligns the definitions with the new definitions of "facility" and "facility-based physician" in Insurance Code §1451.501 added by SB 1742. In addition to these amendments, the period at the end of §3.3702(b) is changed to a colon and the word "subparagraphs" in §3.3702(b)(17)(C) is capitalized, for consistency with agency rule drafting style.

Section 3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. Amendments to this section implement SB 1742 and clarify existing requirements. Section 3.3705(b)(12) is amended by requiring a provider's "street address" instead of "location" and a provider's telephone number and specialty, if any, in order to align with the requirements of Insurance Code §1451.504 and §1451.505 as amended by SB 1742. Section 3.3705(c) is amended to replace the specific provider listing submission instructions with directions to follow submission instructions on TDI's website. This amendment will allow TDI to specify an electronic means of submitting notices and update submission instructions as needed. The amendment to §3.3705(l) clarifies the second sentence to make it more readable and the reference to §3.3705(l)(1) - (9) is expanded to include new Paragraphs (10) and (11). Section 3.3705(l)(2) is amended by deleting the current "and" and adding the words "and assistant surgeons" at the end of the paragraph to align with the new definition of "facility-based physician" in Insurance Code §1451.501 added by SB 1742.

Amendments add new §3.3705(l)(10) and (11) to implement the new facility and facility-based physician provider directory information requirements in Insurance Code §1451.504 as amended by SB 1742. Section 3.3705(q)(1) is amended by replacing the direction to mail the notice with directions to follow submission instructions on TDI's website. This amendment will allow TDI to specify an electronic means of submitting notices and update submission instructions as needed. In addition to these amendments, the words "subsection," "paragraph," "paragraphs," "subparagraph," and "subparagraphs" are capitalized where they appear throughout the section, for consistency with agency rule drafting style.

Section 3.3709. Annual Network Adequacy Report. An amendment to this section adds new §3.3709(e). This subsection provides that §3.3709 does not apply to a PPBP or EPBP written by an insurer for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System. TDI's review of the annual network adequacy report is duplicative of HHSC's review of its contractors' networks. In addition to this amendment, the words "subsection" and "paragraphs" are capitalized where they appear in the section, for consistency with agency rule drafting style.

Division 2. <u>Preferred and</u> Exclusive Provider Benefit Plan Requirements. The heading for Division 2 is revised to add the words "Preferred and." This amendment is made to reflect that some of the sections in the division are being expanded to apply to both PPBPs and EPBPs.

Section 3.3720. <u>Preferred and</u> Exclusive Provider Benefit Plan Requirements. The heading of §3.3720 is amended to add the words "Preferred and," and the text is revised to specify which sections are applicable to both PPBPs and EPBPs, and which sections are applicable only to EPBPs. The amendments to this section implement HB 3911 by making §§3.3721 - 3.3723 applicable to both PPBPs and EPBPs instead of only EPBPs while specifying that §3.3724 and §3.3725 remain applicable only to EPBPs.

Section 3.3721. Preferred and Exclusive Provider Benefit Plan Network Approval Required. The heading of §3.3721 is amended to add the words "Preferred and," and the text of the section is revised to address both PPBPs and EPBPs. The amendments to this section implement HB 3911 by making provider benefit plan network approval required for both PPBPs and EPBPs instead of only EPBPs. Both PPBPs and EPBPs are now required to undergo qualifying examinations under Insurance Code §1301.0056 as amended by HB 3911.

Section 3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications. The heading of §3.3722 is amended to add the words "Preferred and," and the text of Subsections (a), (c)(4)(B), and (c)(7) is revised to address both PPBPs and EPBPs. These amendments implement HB 3911 by making this section applicable to both PPBPs and EPBPs instead of only EPBPs. Section 3.3722(a) is amended by replacing the direction to mail the application with a reference to follow submission instructions on TDI's website. This amendment will allow TDI to specify an electronic means of submitting applications and update submission instructions as needed. New §3.3722(c)(9)(C) - (D) is added to implement the new facility and facility-based physician provider directory information requirements in Insurance Code §1451.504 from SB 1742. New §3.3722(f) is added, which provides that §3.3722(c)(9) and (d)(3) do not apply to a PPBP or EPBP written by an insurer for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System from submitting network configuration information or applying for approval for network modifications under §3.3722. It is not necessary for TDI to review network configuration information or require an application for approval for network modifications because it is duplicative of HHSC's review of its contractors' networks. In addition to these amendments, the words "subsection," "paragraph," and "paragraphs" are capitalized where they appear throughout the section, for consistency with agency rule drafting style.

Section 3.3723. Examinations. Amendments to this section implement HB 3911 and clarify applicable law. Section 3.3723(a) is amended to address both PPBPs and EPBPs and to require an examination at least once every three years instead of five years. Both PPBPs and EPBPs must now be examined at least once every three years under Insurance Code §1301.0056 as amended by HB 3911. Section 3.3723(b) is amended to clarify that examinations are conducted pursuant to Insurance Code Chapter 1301 in addition to the other listed authorities.

Section 3.9208. Provider Network: Accessibility and Availability. TDI proposes the repeal of §3.9208. Repeal of this section removes the requirement that EPBPs subject to Subchapter KK must comply with the network accessibility and availability requirements as outlined in 28 TAC §11.1607. Section 3.9208 is not necessary, because the requirements of §11.1607 are duplicative of HHSC's review of its contractors' networks.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Debra Diaz-Lara, director of the Managed Care Quality Assurance Office, has determined that during each year of the first five years the proposed amendments and repeal are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by statute. This determination was made 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. Diaz-Lara does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments and repeal are in effect, Ms. Diaz-Lara expects that administering the

proposed amendments and repeal will have the public benefits of ensuring that TDI's rules conform to Insurance Code §§1301.0056, 1451.128, 1451.501, 1451.504, and 1451.505, conserve agency resources, and reduce the regulatory burden and costs imposed on participants in HHSC's CHIP, Medicaid program, and State Rural Health Care System.

Ms. Diaz-Lara expects that the proposed amendments and repeal will not increase the cost of compliance with Insurance Code §§1301.0056, 1451.128, 1451.504, and 1451.505 because they do not impose requirements beyond those in statute. Insurance Code §1301.0056 provides that the Commissioner examine PPBPs and EPBPs at least once every three years, and that such examinations include qualifying examinations. Insurance Code §1451.128 gives an insured the authority to select a pharmacist as a health care provider under the insured's health insurance policy. Insurance Code §1451.504 and §1451.505 require certain information be included in a provider directory. As a result, the cost associated with complying with these requirements does not result from the enforcement or administration of the proposed amendments and repeal.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments and repeal will not have an adverse economic effect or a disproportionate economic impact on small or micro businesses, or on rural communities. Because the proposed rule is designed to implement Insurance Code §§1301.0056, 1451.128, 1451.501, 1451.504, and 1451.505, any economic impact results from the statute itself. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. Therefore, no additional rule amendments are required under Government Code

§2001.0045. In addition, the proposed rule implements Insurance Code §1301.0056, as added by HB 3911; Insurance Code §1451.128, as added by HB 1757; and Insurance Code §§1451.501, 1451.504, and 1451.505, as added by SB 1742. The proposed rule also reduces the burden and responsibilities imposed on regulated persons and decreases the persons' cost for compliance with the rules by eliminating certain network adequacy review requirements for a PPBP or EPBP written by an insurer for a contract with HHSC to provide services under CHIP, Medicaid, or with the State Rural Health Care System.

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

- 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 expand and eliminate existing regulations and will repeal an existing regulation;

- will decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI 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. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on October 26, 2020. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

To request a public hearing on the proposal, submit a request before the end of the comment period, and separate from any comments, to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The request for public hearing must be received by the department no later than 5:00 p.m., central time, on October 26, 2020. If TDI holds a public hearing, TDI will consider written and oral comments presented at the hearing.

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
DIVISION 1. GENERAL REQUIREMENTS
28 TAC §§3.3701, 3.3702, 3.3705, and 3.3709

STATUTORY AUTHORITY. TDI proposes §§3.3701, 3.3702, 3.3705, and 3.3709 under Insurance Code §§1301.007, 1301.1591, and 36.001.

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

Insurance Code §1301.1591 allows the Commissioner to adopt rules as necessary to implement Insurance Code §1301.1591, which requires an insurer offering a PPBP or

EPBP to list network providers on its website. The rules may govern the form and content of the information required.

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

CROSS-REFERENCE TO STATUTE. The amendment to §3.3701 implements Insurance Code §1451.128. The amendments to §3.3702 implement Insurance Code §1301.0056. The amendments to §3.3702 and §3.3705 implement Insurance Code §§1451.501, 1451.504, and 1451.505. The amendment to §3.3709 affects Insurance Code Chapter 1301.

TEXT.

§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 Chapter 1301; Insurance Code §§1353.001, 1353.002, 1451.001, 1451.053, and 1451.054; and Insurance Code Chapter 1451, Subchapter C [~~§§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.~~]

(7) [~~(8)~~] Facility--As defined in Health and Safety Code §324.001(7).

[~~(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.~~]

(8) [~~(9)~~] Facility-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, [~~or~~] a neonatologist, or an assistant surgeon:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

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

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

(11) [~~(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.

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

(13) [~~(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.

(14) [~~(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.

(15) [~~(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.

(16) Provider network--The collective group of physicians and health care providers available to an insured under a preferred or exclusive provider benefit plan and directly or indirectly contracted with the insurer of a preferred or exclusive provider benefit plan to provide medical or health care services to individuals insured under the plan.

(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 [~~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).

§3.3705. 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 the name, street address, telephone number, and specialty, if any, of each physician and health care provider [~~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 [~~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 [~~subsection~~] (b) of this section. Submission of listings of preferred providers as required in Subsection [~~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. Submit provider listings as specified on the department's website. [~~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 [~~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 [~~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 [~~paragraphs~~] (1) - (11) [~~(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 [~~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, and assistant surgeons.

(3) In determining the percentages specified in Paragraph [~~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 [~~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.

(10) For each health care provider that is a facility included in the listing, the insurer must:

(A) create separate headings under the facility name for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, and assistant surgeons;

(B) under each heading described by Subparagraph (A) of this paragraph, list each preferred facility-based physician practicing in the specialty corresponding with that heading;

(C) for the facility and each facility-based physician described by Subparagraph (B) of this paragraph, clearly indicate each health benefit plan issued by the insurer that may provide coverage for the services provided by that facility, physician, or facility-based physician group;

(D) for each facility-based physician described by Subparagraph (B) of this paragraph, include the name, street address, telephone number, and any physician group in which the facility-based physician practices; and

(E) include the facility in a listing of all facilities and indicate:

(i) the name of the facility;

(ii) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and

(iii) each health benefit plan issued by the insurer that may provide coverage for the services provided by the facility.

(11) The listing must list each facility-based physician individually and, if a physician belongs to a physician group, also as part of the physician group.

(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 [~~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 [~~paragraph~~] (1) of this subsection, no notice of a substantial decrease is required if the requirements specified in either Subparagraph [~~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 [~~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 [~~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 [~~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 [~~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 [~~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 [~~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 [~~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 [~~paragraph~~] (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in Paragraph [~~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 [~~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 as specified on the department's website [~~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.

§3.3709. 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 [~~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 [~~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.

(e) Exceptions. This section does not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
DIVISION 2. PREFERRED AND EXCLUSIVE PROVIDER BENEFIT PLAN REQUIREMENTS
28 TAC §§3.3720, 3.3721, 3.3722, and 3.3723

STATUTORY AUTHORITY. TDI proposes §§3.3720, 3.3721, 3.3722, and 3.3723 under Insurance Code §§1301.007, 1301.1591 and 36.001.

Insurance Code §1301.007 requires the Commissioner adopt rules as necessary to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to Texas residents.

Insurance Code §1301.1591 allows the Commissioner to adopt rules as necessary to implement Insurance Code §1301.1591, which requires an insurer offering an PPBP or

EPBP to list network providers on its website. The rules may govern the form and content of the information required.

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

CROSS-REFERENCE TO STATUTE. The amendments to §§3.3720, 3.3721, 3.3722, and 3.3723 implement Insurance Code §1301.0056, as enacted by HB 3911. The amendments to §3.3722 implement Insurance Code §1451.504, as enacted by SB 1742, and affect Insurance Code Chapter 1301.

TEXT.

§3.3720. Preferred and Exclusive Provider Benefit Plan Requirements.

Sections 3.3721 - 3.3723 of this title (relating to Preferred and Exclusive Provider Benefit Plan Network Approval, Application for Preferred and Exclusive Provider Benefit Plan Approval and Qualifying Examination, and Examinations) [~~The provisions of this division~~] apply [~~only~~] to preferred and exclusive provider benefit plans offered pursuant to Insurance Code Chapter 1301 in commercial markets. Sections 3.3274 - 3.3725 of this title (relating to Quality Improvement Program and Payment of Certain Out-of-Network Claims) apply only to exclusive provider benefit plans offered pursuant to Insurance Code Chapter 1301 in commercial markets.

§3.3721. Preferred and Exclusive Provider Benefit Plan Network Approval Required.

An insurer may not offer, deliver, or issue for delivery a preferred or [~~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 Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications.

(a) Where to file application. An insurer that seeks to offer a preferred or [~~an~~] exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance as specified on the department's website [~~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 [~~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 [~~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 preferred or 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 preferred or 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.

(C) For each health care provider that is a facility included in the list under Subparagraph (B) of this paragraph, the applicant must:

(i) create separate headings under the facility name for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, and assistant surgeons;

(ii) under each heading described by Clause (i) of this subparagraph, list each preferred facility-based physician practicing in the specialty corresponding with that heading;

(iii) for the facility and each facility-based physician described by Clause (ii) of this subparagraph, clearly indicate each health benefit plan issued by the insurer that may provide coverage for the services provided by that facility, physician, or facility-based physician group;

(iv) for each facility-based physician described by Clause (ii) of this subparagraph, include the name, street address, telephone number, and any physician group in which the facility-based physician practices; and

(v) include the facility in a listing of all facilities and indicate:

(I) the name of the facility;

(II) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and

(III) each health benefit plan issued by the insurer that may provide coverage for the services provided by the facility.

(D) The list required by Subparagraph (B) of this paragraph must list each facility-based physician individually and, if a physician belongs to a physician group, also as part of the physician group.

(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 [~~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 [~~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 [~~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 [~~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 [~~subsection~~] (c)(5) of this section;

(B) forms of contracts, as described in Subsection [~~subsection~~] (c) of this section; or

(C) network configuration information, as required by Subsection [~~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 [~~paragraph~~] (2) of this subsection that amends, supplements, or replaces the items required under Subsection [~~subsection~~] (c) of this section no later than 30 days after the implementation of any change.

(f) Exceptions. Paragraphs (c)(9) and (d)(3) and Subsection (e) of this section do not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§3.3723. Examinations.

(a) The commissioner may conduct an examination relating to a preferred or [~~an~~] exclusive provider benefit plan as often as the commissioner considers necessary, but no less than once every three [~~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; Insurance Code Chapter 1301; 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.

SUBCHAPTER KK. EXCLUSIVE PROVIDER BENEFIT PLAN
Repeal of 28 TAC §3.9208

STATUTORY AUTHORITY. TDI proposes the repeal of §3.9208 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires the Commissioner adopt rules as necessary to implement Insurance Code Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to Texas residents.

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

CROSS-REFERENCE TO STATUTE. The repeal of §3.9208 affects Insurance Code Chapter 1301.

TEXT.

§3.9208. Provider Network: Accessibility and Availability.

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

Issued in Austin, Texas, on September 4, 2020.

DocuSigned by:
James Person
75578E954EFC48A...

James Person, General Counsel
Texas Department of Insurance