Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies
28 TAC §3.3038

Subchapter X. Preferred and Exclusive Provider Plans
Division 1. General Requirements
28 TAC §§3.3702 - 3.3705 and 3.3707 - 3.3712

Division 2. Application, Examination, and Plan Requirements
28 TAC §§3.3720, 3.3722, and 3.3723
Repeal of 28 TAC §3.3725

INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC §§3.3038, 3.3702 - 3.3705, 3.3707 - 3.3711, 3.3720, 3,3722, and 3.3723; new §3.3712; and the repeal of §3.3725. Proposed §3.3713 is not adopted. The commissioner also adopts amendments to the title of Division 2 of 28 TAC Chapter 3, Subchapter X. These sections concern preferred and exclusive provider benefit plans. The amendments and new sections are adopted with changes to the proposed text published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7129). The commissioner adopts §§3.3038, 3.3710, and 3.3720 without changes to the proposed text. The commissioner adopts §§3.3702 - 3.3705, 3.3707 - 3.3709, 3.3711 - 3.3712, 3.3722, and 3.3723 with nonsubstantive changes to the proposed text. Sections 3.3703 - 3.3705, 3.3707 - 3709, 3.3712, 3.3722, and 3.3723 were revised in response to public comments. Sections 3.3702 and 3.3711 are adopted with nonsubstantive changes to update punctuation and grammar and to reflect current agency drafting style and plain language references.

REASONED JUSTIFICATION. The repeal, amendments, and new sections are necessary to implement House Bill 711, 88th Legislature, 2023, which prohibits anticompetitive

contract provisions; House Bill 1647, 88th Legislature, 2023, which provides protections for certain clinician-administered drugs; House Bill 1696, 88th Legislature, 2023, which expands protections for optometrists and therapeutic optometrists in contracts with managed care plans; House Bill 2002, 88th Legislature, 2023, which requires insurers to credit certain out-of-network payments to the enrollee's deductible and maximum out-of-pocket amounts; House Bill 3359, 88th Legislature, 2023, which provides network adequacy standards and requirements; Senate Bill 1003, 88th Legislature, 2023, which expands facility-based provider types that must be listed in provider directories; and Senate Bill 2476, 88th Legislature, 2023, which creates new payment standards and balance billing protections for emergency medical services.

The adopted text also makes additional amendments in Subchapter S and throughout Subchapter X. The amendments remove payment rules that were invalidated by court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020) (TAHP Order); provide new payment requirements and protections for preferred and exclusive provider plans consistent with Senate Bill 1264, 86th Legislature, 2019; expand exceptions to guaranteed renewability requirements; affirm the Texas Department of Insurance's (TDI's) prohibition on referral requirements; prohibit penalties on insureds for failure to obtain a preauthorization; restrict misrepresentation of cost-sharing incentives in advertisements; streamline disclosure requirements for policy terms; require that certain filings be submitted to TDI via the National Association of Insurance Commissioners (NAIC) System for Electronic Rates & Forms Filing (SERFF) instead of email; remove references to a repealed section; and revise sections as necessary to conform to changes in other sections. In addition, an amendment revises the title of Subchapter X, Division 2, to reflect

that the division addresses application, examination, and plan requirements and applies to both preferred and exclusive provider benefit plans.

The adopted repeal, amendments, and new section are described in the following paragraphs, organized by subchapter.

Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies

Section 3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions. The amendments to §3.3038 expand the exceptions related to guaranteed renewability to permit coverage under a preferred or exclusive provider benefit plan to be discontinued or nonrenewed if the insured no longer resides, lives, or works in the service area of the issuer by removing a reference to subsection (c) in subsection (a), amending subsection (c)(4) to include Insurance Code Chapter 1301, and adding references to the insurer's service area to subsections (c), (e), and (f). These changes implement Insurance Code §1202.051, which addresses guaranteed renewability, and §1301.0056, which addresses qualifying examinations for preferred and exclusive provider benefit plans. As amended by HB 3359, Insurance Code §1301.0056 provides that an insurer may not offer a preferred or exclusive provider benefit plan before the commissioner determines that the network meets the quality-of-care and network adequacy standards in Insurance Code Chapter 1301 or the insurer receives a waiver.

Amendments to subsection (d) require insurers to notify the commissioner of a discontinuance and revise subsection (h) to clarify requirements for uniform modifications. They also add a definition of "uniform modification" in new subsection (i); clarify notice requirements by adding new subsection (j), which states that a notice

provided to the commissioner under §3.3038 must be submitted as an informational filing consistent with the procedures specified in 28 TAC Chapter 3, Subchapter A; and clarify network filing requirements by adding new subsection (k).

In addition, an amendment to the section title adds a comma, and another amendment adds a reference to the title of Insurance Code Chapter 842 in a citation to the chapter in subsection (c)(4).

Subchapter X. Preferred and Exclusive Provider Plans

Division 1. General Requirements

28 TAC §§3.3702 - 3.2705, 3.3707 - 3.3711, and new §3.3712

Section 3.3702. Definitions. The amendments to §3.3702 expand the definition of "facility-based physician" in subsection (b)(8) by changing the defined term to "facility-based physician or provider," thereby including non-physician providers, and by deleting the reference to specific specialists listed in the current definition, consistent with SB 1003. For greater rule precision and to capture any future changes in the statutory definition, the definition of "facility-based physician or provider" as proposed has been changed to reference the statutory definition in Insurance Code Chapter 1451 rather than reproducing the same text in the rule.

An amendment also revises subsection (b)(17) to remove the definition of "rural area," which is no longer needed due to the county classification guidance in Insurance Code §1301.00553(b), and replace it with a definition for SERFF. The definition of SERFF as proposed has been updated with a few stylistic changes to more closely conform with the official name.

Amendments also add the titles of a cited Insurance Code chapter and cited Insurance Code sections in subsections (a) and (b)(1), (7), and (10).

Section 3.3703. Contracting Requirements. Amendments to §3.3703 implement HB 711 by adding requirements in new paragraph (29) of subsection (a) that a contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning contract requirements, including the prohibitions on contractual anti-steering, anti-tiering, most favored nation, and gag clauses. Similarly, amendments implement HB 1696 by adding requirements in new subsection (a)(30) that contracts comply with Insurance Code Chapter 1451, Subchapter D, concerning access to optometrists used under managed care plans, including protections for optometrists and therapeutic optometrists in managed care plans that cover vision or medical eye care. Amendments also update a reference to "facility-based physician group" in subsection (a)(26) by adding the words "or provider" to conform with an amended definition in §3.3702.

Amendments also clarify language in the section by changing "assure" to "ensure" in subsection (a); "shall" to "must" in subsection (a)(4); "x-ray" to "X-ray" in subsection (a)(5); "therein" to "in the contract" in subsection (a)(13); "such immunizations or vaccinations" to "they" and "rules promulgated thereunder" to "implementing rules" in subsection (a)(17); "e-mail" to "email," "pursuant to" to "in accordance with," and "in accordance with" to "under" in subsection (a)(20); "methodologies" to "methods" in subsection (a)(20)(A); "pursuant to" to "in accordance with" in subsection (a)(20)(G)(iii); and "utilized insofar as" to "employed to the extent" in subsection (b). In addition, amendments add an apostrophe following the word "days" in subsection (a)(20)(D) and quotation marks around the words "batch submission" in subsection (a)(20)(D); remove parenthetical information following a citation to Insurance Code §1661.005; add the titles

of cited Insurance Code sections in paragraphs (13), (14), (15), (18), (25), and (27) of subsection (a) and subsections (b) and (c); and delete an unnecessary use of the word "the" in a citation to Insurance Code §1661.005 in subsection (a)(25). Also, a citation to Insurance Code §1301.0053 is added to subsection (a)(28).

The following changes to the text of subsection (a) as proposed have been made in response to comments. The word "assures" in §3.3703(a) as proposed has been changed to "ensures" for consistency. Paragraph (20) as proposed has been changed to add subparagraph (J) to prohibit certain adverse material changes to provider contracts; in addition, a reference to new subparagraph (J) has been added to the text of paragraph (20) that appears before the subparagraphs. Paragraph (29) as proposed has been changed to clarify that compliance with Insurance Code §1458.101 is required "to the extent applicable." Paragraph (30) as proposed has been changed to clarify its applicability to contracts with optometrists and therapeutic optometrists.

Section 3.3704. Freedom of Choice; Availability of Preferred Providers. The amendments to §3.3704 remove references to repealed §3.3725 and add the titles of cited Insurance Code sections in subsection (a), including in paragraphs (1), (4), (5), (9), and (12). Citations in subsections (a) and (b) to specific Insurance Code sections are replaced with broader chapter and subchapter citations. The citation to §3.3708 in subsection (a)(5) is changed to reflect the amendment to the section title, and the citation to 28 TAC Chapter 19, Subchapter R, in subsection (a)(9) is updated to reflect the current name of that subchapter. References in subsection (a) to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Amendments in subsection (a)(7) affirm TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care, and

amendments in subsection (a)(9) prohibit an insurer from penalizing an insured based solely on a failure to obtain a preauthorization, as TDI views such practices as unjust under Insurance Code §1701.055(a)(2). An amendment in subsection (a)(12) removes a citation to 28 TAC §3.3725 to reflect the repeal of that section. In addition, amendments clarify language in subsection (a) by changing "pursuant to" to "in accordance with" in subsection (a)(1), "50 percent" to "50%" in subsection (a)(6), "is taken pursuant to the" to "are taken under" in subsection(a)(9), and "accord" to "accordance" in subsection (a)(12).

The amendments implement Insurance Code §1458.101(i), as added by HB 711, by replacing the current subsection (e) with a new subsection (e) that contains provisions restricting the use of steering or a tiered network to encourage an insured to obtain services from a particular provider. New subsection (e) restricts the use of steering or a tiered network to encourage an insured to obtain services from a particular provider only to situations in which the insurer engages in such conduct for the primary benefit of the insured. In response to comment, subsection (e) as proposed has been revised and paragraph (3) has been added to the subsection to provide more clarity on compliance with Insurance Code §1458.101 and an insurer's fiduciary duty as applied to steering activities or a tiered network.

Amendments implement HB 3359 by amending subsection (f) to add requirements that preferred provider plans comply with new network adequacy standards, provide sufficient choice and number of providers, monitor compliance, report material deviations to TDI, and promptly take corrective action. Subsection (f) is also amended to delete the previous network adequacy standards and reference to local market adequacy requirements, consistent with the statutory changes in HB 3359. Paragraph (1)(C) of subsection (f) as proposed has been revised to reflect the withdrawal of proposed §3.3713.

In response to comment, paragraphs (2) and (3) of subsection (f) as proposed have been revised to clarify network adequacy requirements, and new paragraph (4) has been added to clarify network adequacy requirements for specialty care and specialty hospitals for which time and distance standards are not specified in Insurance Code §1301.00553.

Subsection (g) is amended to address requirements if a material deviation from network adequacy standards occurs. In response to comment, subsection (g) as proposed has been changed to clarify network monitoring and corrective action requirements.

Amendments to subsection (h) also implement Insurance Code §1301.005(d), as added by HB 3359, by requiring a service area to be defined in terms of one or more Texas counties, removing options to define a service area by ZIP codes or 11 Texas geographic regions, and specifying that a plan may not divide a county into multiple service areas.

Section 3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. Amendments to subsections (l) and (n) in §3.3705 implement SB 1003 by updating references to "facility-based physician" and by deleting the related listing of included specialist categories. Amendments to subsection (l) also clarify that the applicability of paragraphs (10) and (11) is consistent with Insurance Code Chapter 1451, Subchapter K.

The amendments modernize and streamline the disclosure requirements, including by shortening the name of the written description to a plan disclosure in subsections (b), (c), and (f); requiring insurers to provide the plan disclosure in any plan promotion and link to the plan disclosure from the federally required summary of benefits and coverage in subsection (b); removing the requirement that a plan disclosure follow a specified order and permitting the insurer to use its policy or certificate to provide the disclosure in subsection (b); requiring availability via a website address instead of a mailing address in

subsection (b)(2); requiring an explanation relating to preauthorization requirements in subsection (b)(9); conforming to the waiver disclosure requirements in HB 3359 in subsections (b)(14) and (m)(1); conforming prescription drug coverage disclosures requirements to §21.3030 in subsection (b)(4); streamlining network disclosure requirements in in subsection (b)(12); replacing service area disclosures with county disclosures to conform with HB 3359 in subsections (b)(13) and (e)(2); and conforming disclosure requirements concerning reimbursements of out-of-network claims to adopted changes in other sections, such as removing disclosure requirements for preauthorization penalties, consistent with the proposed amendment in §3.3704(a)(9).

In response to comment, subsection (b) as proposed has been revised to require provision of plan disclosures "on request" rather than in any promotion, advertisement, or enrollment opportunity. Also in response to comment, beginning at subsection (b)(14)(B) and continuing throughout the adopted rules, the words "preferred" or "physician or" have been inserted before the word "provider" for clarity.

Amendments to subsection (c) remove filing requirements for listings of preferred providers, consistent with the changes in subsection (b).

A reference in subsection (d) to "basic benefits" is updated to clarify that the term refers to out-of-network coverage. In response to comment, subsection (d) as proposed has been revised to add paragraph (2) to clarify requirements for promotions and advertisements.

Amendments to subsection (f) replace the preferred and exclusive provider benefit plan notices to reflect balance billing protections contained in SB 1264 from 2019, to remove outdated references and to limit the notice requirements to apply only to major

medical insurance plans. In response to comment, both notices as proposed have been revised for clarity.

Amendments also add the titles of cited Insurance Code sections and update citations in subsection (k) to §3.3708 and §3.3725 to conform with the adopted amendments and repeal.

Subsection (m)(1) as proposed has been changed in response to comment to make clearer what information must be contained in the annual policyholder notice concerning use of an access plan.

In recognition of the network adequacy requirements contained in HB 3359, amendments remove requirements in subsection (n) to notify TDI of provider terminations that do not impact network compliance and requirements in subsections (p) and (q) to designate a plan network as an approved or limited hospital care network. In response to comment, subsection (n)(2) as proposed has been changed to clarify that, for purposes of determining whether the insurer must disclose a substantial decrease in the availability of certain preferred providers, decreases in numbers of physicians and other providers must be assessed separately. For example, if an insurer is assessing whether a decrease in the availability of anesthesiologists is substantial, the insurer should not include the count of nurse anesthetists in the assessment.

Amendments to subsection (o) update disclosure of payment standards for out-of-network services, consistent with the adopted changes in §3.3708.

In addition, amendments clarify language in the section by changing "chapter" to "title" in subsection (a), "address" to "website address" in subsection (b)(2), and "pursuant to" to "under" in subsections (b)(14)(B) and (m)(1). Amendments to subsections (e), (i), (j), (l), and (n)(5) make changes to simplify the text addressing information on an insurer's

website by removing the words "internet" and "internet-based" and adding language using the term "website."

Section 3.3707. Waiver Due to Failure to Contract in Local Markets. Amendments to §3.3707 implement HB 3359 by updating the requirements for a finding of good cause for granting a waiver from network adequacy standards, subject to statutory limits referenced in subsection (a); requiring that a waiver request include certain information, including information demonstrating a good faith effort to contract (if providers are available) and describing any exclusivity arrangements or other external factors impacting the ability of the parties to contract in subsections (b) and (c); and clarifying the commissioner's consideration of an access plan for waiver requests in subsection (c).

In response to public comment, subsection (a) as proposed has been changed to remove the listed criteria for finding good cause.

Amendments in subsections (b) and (c) specify that an insurer must use the process and electronic form specified in §3.3712 to file a waiver request and access plan, which will enable TDI to publish data on waivers as required by statute.

Additional amendments in subsections (b) and (d) require an insurer to use TDI's electronic forms to submit the evidence supporting the waiver request and mark the document as confidential if it contains proprietary information. Required documents must be submitted in SERFF, which makes filed information publicly available, unless the insurer marks a document as confidential.

The text of subsection (b)(1) as proposed has been changed in response to comment. As adopted, subsection (b)(1)(B) expressly references the definition of "good faith effort" in Insurance Code §1301.00565(a). Subsection (b)(1)(C), which would have

required a description of the best offer of reimbursement rates made by the issuer, is not adopted. Because proposed subsection (b)(1)(C) is not adopted, the subparagraphs that follow it have been redesignated. The text of adopted subsection (b)(1)(C) (which was proposed as subsection (b)(1)(D)) has been modified to change the word "refusing" to "declining" and to clarify that insurers should submit a description of any reason each provider or physician gave for declining to contract, such as their participation in any exclusivity arrangement.

In response to comment, the text of subsection (b)(2) as proposed has been changed to require insurers to state if there are no providers or physicians available with whom a contract would allow the insurer to meet a network adequacy standard.

The form requirements in subsection (b) include the requirement for insurers to submit information on the new attempt to contract template. A draft template was posted on TDI's website along with the proposal. In response to comment, TDI has changed the template available at time of proposal to improve clarity, usefulness, and ease of use, and to better align with statutory language. The finalized template will be made available on TDI's website at www.tdi.texas.gov. Some of the changes include the following:

- Reformatting the template's cover page.

- Relabeling the "Compliance Access Plan & Waiver Request" heading on filer's information box in the Cover Page as "Filing Information."

- Adding the SERFF tracking number information to the cover page. When the insurer fills in the SERFF tracking numbers on the cover page, using the tracking number assigned by the SERFF system upon the filing of a waiver request, the information will auto-populate in other parts of the template.

- Relabeling the "Waiver Request ID" column in the data worksheet as "SERFF tracking No."

- Adding a "County type" column in the data worksheet to enable TDI to track county types associated with each attempt to contract.

- Removing the "Actions to eliminate network adequacy gaps included in waiver request and access plan" column in the data worksheet. Similar information is already requested in the cover sheet.

- Removing the two columns seeking rate information in the data worksheet.

- Adding a "Deficient county waiver is being requested for" column in the data worksheet to enable TDI to identify the applicable waiver associated with each attempt to contract.

- Relabeling the "Associated hospital name, if applicable" column to replace "hospital" with "facility."

- Adding columns in the data worksheet for the description of the contact method used by the insurer.

- Relabeling the "Comments (as applicable)" column in the data worksheet as "Additional information demonstrating that the insurer made a good faith effort to contract, as defined in Insurance Code 1301.00565(a)." This change clarifies TDI's expectation that insurers provide sufficient detail to allow the agency to evaluate whether the insurer's contracting attempts satisfy the good faith efforts standard.

- Adding new "NA Standards" and "County Designation" reference worksheets that illustrate the applicable time and distance standards for each specialty type and county classification; the classification of each Texas county, consistent with

Insurance Code §1301.00553; and the public health region that each county is assigned to, consistent with §3.3711.

In response to comment, subsection (c)(2) and subsection (m) as proposed have been changed to provide an updated citation to access plan requirements in §3.3712(c)(2)(C)(iv).

Amendments in subsection (d) also remove the requirement for insurers to send notices of waiver requests to physicians and providers; instead, TDI will send notices to those providers in advance of a waiver hearing. Amendments to subsection (e) clarify the process for providers to respond to a waiver request.

An amendment to subsection (h) clarifies that TDI will specify the one-year period for which the waiver will apply and will post information relating to the waiver on its website, and an amendment to subsection (g) clarifies that an insurer may request to renew a waiver in conjunction with filing the annual report as required in §3.3709.

Existing subsections (i)(1) and (2) and (j) are deleted to conform with the amended access plan requirements of §3.3707 and filing requirements in §3.3712; references in this section to "local market access plan" are changed to remove references to local markets to conform with the changes in HB 3359.

In response to comment, subsection (j)(2) as proposed has been changed to require insurers to make at least two physicians or providers (rather than at least one) available to insureds when no preferred provider is available.

Amendments in the text of existing subsection (k) (which is redesignated as subsection (j)) and the text of new subsection (k) update the required processes that an insurer must develop to facilitate access to covered services, provide insureds with an

option to obtain care without being subject to balance billing, and ensure that insureds understand what options they have when no in-network provider is reasonably available.

New subsection (m) replaces previous access plan requirements with the requirement that insurers submit a general access plan that will apply in any unforeseen circumstance where an insured is unable to access in-network care within the network adequacy standards.

Subsection (n) is deleted, as it is outdated in view of the changes relating to network waivers in this section.

Also, an amendment to subsection (a) corrects an Insurance Code citation and adds the name of the cited section. In addition, amendments clarify language in the section by changing "in accord with" to "consistent with" in subsection (a) and "pursuant to" to "in accordance with" in subsections (g)(2) and (i).

Section 3.3708. Payment of Certain Out-of-Network Claims. Amendments to §3.3708 change the section title to replace "Basic Benefit" with "Out-of-Network" and to delete "and Related Disclosures." Amendments also replace previous subsections (a) and (b), which contained provisions invalidated by the TAHP Order, with new subsections (a) and (b). New subsection (a) provides payment standards for certain out-of-network claims and to reflect balance billing protections, consistent with SB 2476 and SB 1264. New subsection (b) provides consumer protections for network gaps. Subsection (b)(2)(B) as proposed has been corrected to end with a period rather than a semicolon.

Amendments consolidate the requirements for preferred and exclusive provider benefit plans by moving some provisions from §3.3725 to §3.3708. The adopted repeal of §3.3725 is discussed in a subsequent paragraph of this adoption order. Section 3.3708(d) is amended to clarify that exclusive provider benefit plans are exempt from certain

payment requirements for out-of-network services, and references to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Previous subsection (e) is deleted, as it is no longer in effect. It is replaced by a new subsection (e), which implements HB 2002 by clarifying that an insurer must credit certain direct payments to nonpreferred providers toward the insured's in-network cost-sharing maximums. To address a discrepancy raised by a comment and for closer alignment with Insurance Code §1301.140, the text of new subsection (e) as proposed has been changed to remove references to nonpreferred providers. This removal will clarify that insureds may claim a credit regardless of whether they obtain services from a preferred or nonpreferred provider.

Previous subsection (f) is deleted because, with the other adopted amendments, application of the section should no longer be limited to exclusive provider plans. The subsection is replaced by a new subsection (f), which implements HB 1647 by clarifying that insurers must cover certain clinician-administered drugs at the in-network benefit level. In response to a comment, subsection (f) as proposed has been modified to more closely reference the requirements of coverage under Insurance Code Chapter 1369, Subchapter Q.

Section 3.3709. Annual Network Adequacy Report. Amendments to subsection (a) restructure the language of the section for clarification. Amendments to subsections (b) and (c) revise the text of the subsections to expand the content to be included in the annual network adequacy report, including requirements for insurer identifying information and information relating to network configuration, facility access, waiver requests and access plans, enrollee demographics, complaints, and actuarial data. An amendment to subsection (c)(4) also updates a reference to "basic benefits" to clarify that

the term refers to out-of-network benefits. In response to a comment, subsection (c) as proposed has been changed to move the phrase "the number of" to subsection (c)(1) for clarity.

Amendments to subsection (d) require that annual network adequacy reports be submitted to TDI via the SERFF system using the electronic template provided by TDI and remove the option to file the report via email. A draft of the annual network adequacy report template was posted on TDI's website along with the proposal. In response to comments, TDI has changed the template available at time of proposal to improve clarity, usefulness, and ease of use, and to better align with statutory language. The finalized template will be made available on TDI's website at www.tdi.texas.gov. Some of the changes include the following:

- Removed the word "Annual" from the "Network Adequacy Report (LHL706)" form name.

- Updating the formatting of the "Network Info and Checklist" worksheet.

- Adding "preferred provider benefit plan" and "exclusive provider benefit plan" checkboxes to the cover page for the filer to identify the network type.

- Adding "SERFF tracking No. of last approved waiver(s) for this network" and "Network ID" fields to the cover page.

- Updating citations to the Administrative Code.

- Relabeling the "Number of providers in network as submitted" and Number of preferred providers" columns in the claims data worksheet as "Number of preferred providers in network as submitted in current filing" and "Number of preferred providers in the network submitted in the previous year," respectively.

- Expanding the specialty types listed in the claims data worksheet to include all applicable specialty types reviewed on the network compliance and waiver request form.

- Adding a new "County Designation" reference worksheet that illustrates the classification of each Texas county, consistent with Insurance Code §1301.00553, and the public health region that each county is assigned to, consistent with §3.3711.

Section 3.3710. Failure to Provide an Adequate Network. Amendments to subsection (a) clarify the scope of the commissioner's sanction authority. Additional amendments to subsection (a) add the titles of cited Insurance Code sections; remove references to the term "local market"; and change "and/or" to "and"; and amendments to subsections (a) and (b) change "pursuant to" to "under."

Section 3.3711. Geographic Regions. Amendments to §3.3711 proposed to replace the ZIP code listing with a county listing, based on the regional map available at www.hhs.texas.gov and consistent with the requirement in HB 3359 that service areas may not divide a county.

TDI has modified the proposed text of §3.3711 to remove the county listing and instead refer to the public health regions designated under Health and Safety Code §121.007 and listed in the annual network adequacy report form, for increased flexibility and to accommodate future updates to region designations. TDI has also modified the proposed text to correct a punctuational error by adding a closing parenthesis to the first sentence.

Section 3.3712. Network Configuration Filings. New §3.3712 implements HB 3359 by requiring submission of network configuration information. This information was addressed in §3.3722. Subsections (a) and (b) clarify that network configuration filings

must be submitted in SERFF and are required in connection with a waiver request under §3.3707, an annual report under §3.3709, or an application or modification under §3.3722. Subsection (c) specifies that insurers must use TDI's electronic templates when making network configuration filings and lists the information that must be included within the templates.

The purposes of these electronic templates are to assist the insurer in demonstrating compliance with the network adequacy requirements contained in HB 3359 and to allow TDI to aggregate and publish information concerning networks and waivers consistent with Insurance Code §§1301.0055(a)(3), 1301.00565(g), and 1301.009.

Drafts of the new network compliance and waiver request template and provider listings template were posted on TDI's website along with the proposal. In response to comment, TDI has modified the templates available at time of proposal to improve clarity, usefulness, and ease of use, and to better align with statutory language. The finalized templates will be made available on TDI's website at www.tdi.texas.gov.

Some of the changes to the network compliance and waiver request template include the following:

- Relabeling the "Compliance Access Plan & Waiver Request" heading on filer's information box in the Cover Page as "Filing Information."

- Relabeling the "Waiver request ID" column on the network report worksheets as "SERFF tracking No."

- Adding the SERFF tracking No. information to the template's cover page. When the insurer fills in the SERFF tracking numbers on the cover page, using the tracking number assigned by the SERFF system upon the filing of a waiver request, the information will auto-populate in other parts of the template.

- Repositioning the county list on the cover page to allow filers to more easily select the counties in a service area.

- Revising the county list and the county designations to correct typographic errors identified by a commenter.

- Relabeling the "Specialty" column in the network report worksheet to "Specialty type" for consistency.

- Relabeling the "Number of preferred providers" column in the network report worksheets to add "within the county."

- Relabeling the "Access Plan Required" column in the network report worksheets to "Are network adequacy standards met? (Yes: Adequate; No: Waiver requested)."

- Relabeling the "Years a waiver for this deficiency has been requested (starting 2024)" column in the network report worksheets as "Years a waiver for this deficiency has been granted." Instructions were added to clarify that insurers must specify each year and separate with commas. This will first be reported in 2025, as 2024 is the first year a waiver will be granted under the new rules.

- Relabeling the "Reason Network Providers Not Available" column as "Reason preferred providers not available" for clarity.

- Adding a column for insurers to indicate, "Is waiver needed because there are no physicians or providers available to contract within the service area and applicable time and distance standards?" This information is needed to identify waiver requests that meet the criteria under Insurance Code §1301.0055(a)(6).

- Relabeling the "Number of providers available" column in the network report worksheets to "Number of non-contracted physicians and providers available

within the service area and applicable time and distance standards," for major medical and vision providers, and "Number of non-contracted physicians and providers available within the facility" for facility-based physicians and providers.

- Relabeling the "Source System" column as "Source for available physicians and providers."

- Relabeling the "General Plan for Access" column in the network report worksheets as "Access plan."

- Removing the "Percentage of insureds with access to only one provider," "Compliant with at least one (yes/no)," and "Compliant with at least two (yes/no)" columns in the network report worksheet to align with changes to §3.3704(f)(2).

- Removing the "Actions to eliminate network adequacy gaps included in waiver request and access plan" column in the network report worksheet in response to comment, since similar information is collected in the cover page of the attempt to contract form.

- Expanding the "FB Physician or Provider" worksheet, which was inadvertently truncated in the version available at the time of proposal, to separately collect compliance information and waiver requests relating to facility-based physicians and providers.

- Amending the "NA Standards" worksheet, which summarizes network adequacy time and distance standards that apply to various types of physicians and providers, to include the following additional specialty types: durable medical equipment, home health, pharmacy, optometrists, and therapeutic optometrists. This updated worksheet is added as a reference to the attempt to contract and provider listing forms.

- Updating the "NA Standards" worksheet to list the applicable facility types and specialty types for evaluating facility-based physicians and providers, consistent with Insurance Code §1301.0055(b)(4).

- Making available a separate network compliance and waiver request template for vision networks so that vision insurers can more easily provide information specific to vision provider types.

Some of the modifications to the Provider Listing template include:

- Adding a "Cover Page" worksheet to capture the insurer name, NAIC number, Network name, Network ID, and SERFF tracking number.

- Adding "SERFF tracking No." column for consistency.

- Refining formatting, including splitting the "Provider's Last and First Name" column into two separate columns.

- Converting open text fields into dropdown menus.

- Relabeling the "Does this provider offer telehealth?" column in the Individual worksheet as "Does this provider offer telehealth/telemedicine?"

- Adding "FB Physician or Provider" and "Facility" worksheets, which were inadvertently omitted in the version available at the time of proposal, to separately collect physician and provider listing information relating to facilities and facility-based physicians and providers.

- Adding in the Individual worksheet an "if available" notation to the column label for the name of the facility at which the provider has privileges.

- Adding new "NA Standards" and "County Designation" reference worksheets that illustrate the applicable time and distance standards for each specialty type and county classification; the classification of each Texas county, consistent with

Insurance Code §1301.00553; and the public health region that each county is assigned to, consistent with §3.3711.

The text of subsection (c)(1)(B) as proposed has been changed to clarify that network configuration filings must include information about the licenses of preferred providers and whether they offer telemedicine. The text of subsection (c)(2)(C)(i) as proposed has been changed to better align with Insurance Code §1301.0055(a) and conform to changes made to §3.3707(b)(2), by replacing the reference to "of an insufficient number of physicians or providers available within the network adequacy standards" with "there are no physicians or providers available with whom a contract would allow the insurer to meet the network adequacy standards." The text of subsection (c)(2)(C) as proposed has also been changed to remove clause (v), because similar information is required in §3.3707(b)(1(D) and collected on the cover page of the attempt to contract form template.

Subsection (d) clarifies that information submitted under §3.3712 is considered public information and will be subject to publication by TDI.

In response to comment, new subsection (e) has been added to clarify that, upon request by TDI, an insurer must provide access to any additional information needed to evaluate and make a determination of compliance with quality-of-care and network adequacy standards.

Section 3.3713. County Classifications for Maximum Time and Distance Standards. The commissioner declines to adopt proposed §3.3713. To capture any future changes in the statutory classification of counties, proposed §3.3713 has been withdrawn. Instead, TDI has listed the county classifications consistent with Insurance Code §1301.00553(b) within the network compliance and waiver request form. That form lists each Texas county

and identifies whether it is classified as large metro, metro, micro, rural, or a county with extreme access considerations.

Division 2. Application, Examination, and Plan Requirements

28 TAC §§3.3720, 3.3722, 3.3723, and 3.3725

Section 3.3720. Preferred and Exclusive Provider Benefit Plan Requirements. The amendments to §3.3720 update the titles of administrative code sections referenced in the section; revise an incorrect citation in the section; remove a reference to repealed §3.3725; add the title to a citation to the Insurance Code; and change "pursuant to" to "under."

Section 3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications. The amendments to §3.3722 implement HB 3359 by updating network configuration filing requirements and cross-references to conform to changes made in §§3.3038, 3.3707, 3.3708, and 3.3712, and the repeal of §3.3725. Requirements for network modifications are clarified to align with current practices.

Amendments to subsection (a) clarify that insurers must use the specified form to file an application for approval of a plan.

An amendment to subsection (b)(4) clarifies the rule text by changing passive voice to active voice.

Amendments to subsection (c) update references to service areas to refer to counties, consistent with HB 3359; update a reference to "medical peer review" to conform to statute; replace the listing of required network configuration information with a reference to new §3.3712; replace citations to §3.3725, which has been repealed; change

"pursuant to" to "under"; and add titles to citations to the Insurance Code. In response to comment, paragraph (c)(10) as proposed has been changed to clarify the reference to §3.3707.

Amendments to subsection (d) clarify that the documents required for a qualifying examination must include network configuration information described in new §3.3712 that demonstrates network adequacy compliance. Amendments to subsection (d) also change "pursuant to" to "in accordance with" and "under."

Amendments to subsection (e) add a reference to new §3.3712; require that for nonrenewals resulting from a service area reduction, insurers must comply with §3.3038, as adopted; and remove the requirement that insurers must comply with §3.3724 to receive approval of a service area expansion or reduction application for certain exclusive provider benefit plans.

Section 3.3723. Examinations. Amendments to §3.3723 change "pursuant to" to "under" or "in accordance with," as appropriate, and also change "in accord with" to "in accordance with"; add the titles of cited Insurance Code, Administrative Code, and Occupations Code provisions; and add a citation to new §3.3712. Section 3.3723 as proposed has been changed to make the term "Commissioner" lowercase and to remove an erroneous use of "the," to reflect current agency drafting style.

In response to comment, paragraph (f)(7) as proposed has been changed to make clear that the documents an insurer must make available to TDI include the most recent demographic data provided by the insurer under §3.3709.

Section 3.3725. Payment of Certain Out-of-Network Claims. Section 3.3725 is repealed to conform with the amendments to §3.3708 and to remove sections invalidated by the TAHP Order.

In addition, amendments to the sections as previously described include nonsubstantive editorial and formatting changes to conform the sections to the agency's current style and to improve the rule's clarity. These changes appear throughout the amended sections and include adding headings to cited statutes and rules; removing references to repealed §3.3725; updating cross-references to other rules; updating terminology, including references to access plans, out-of-network level of coverage, and service areas; nonsubstantive text edits, including removing extraneous words such as "the" from statutory citations; and grammatical, punctuational, and format changes to reflect current agency drafting style and plain language preferences.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI provided an opportunity for public comment on the rule proposal for a period that ended on January 22, 2024. TDI received comments from 27 commenters during the comment period. A public hearing on the proposal was held on January 10, 2024; the hearing notice was published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7129) with a corrected notice published in the January 5, 2024, issue (49 TexReg 85). One commenter spoke at the public hearing. Commenters in support of the proposal were the Office of Public Insurance Counsel and the Texas Academy of Anesthesiologist Assistants. One commenter, the National Association of Vision Care Plans, was against the proposal.

Commenters in support of the proposal with changes were the American Association of Payers, Administrators and Networks; MultiPlan, Inc.; Superior Health Plan; Texas 2036; Texas Allergy, Asthma and Immunology Society; Texas Association of Health Plans; Texas Association of Neurological Surgeons; Texas Chapter of the American College

of Physicians; Texas College of Emergency Physicians; Texas Dermatological Society; Texas Hospital Association; Texas Medical Association; Texas Oncology; Texas Ophthalmological Association; Texas Orthopaedic Association; Texas Osteopathic Medical Association; Texas Pediatric Society; Texas Radiological Society; Texas Society for Gastroenterology and Endoscopy; Texas Society of Anesthesiologists; Texas Society of Pathologists; State Representative Greg Bonnen; State Representative Tom Oliverson; and State Senator Charles Schwertner.

General Comments

Comment: A commenter states that they appreciate TDI's codifying internal policies, as this reduces confusion as to how to navigate agency processes. The commenter also appreciates TDI streamlining and updating Subchapters S and X.

Agency Response: TDI appreciates the commenter's support.

Comment: A commenter states that, as it pertains to TDI's deferment to Centers for Medicare & Medicaid Services (CMS) regulations for HMOs to reduce their administrative burdens given new regulations for exclusive provider benefit plans, they are in support of this recommendation.

Agency Response: TDI appreciates the commenter's support but notes that while HMO plans are not affected by this rulemaking, TDI continues to review HMO networks for compliance with Texas requirements.

Comment: Several commenters express concern that the required implementation timeline is too short. Several commenters suggest extending the April 1, 2024, submission deadline for annual network adequacy reports to September 1, 2024. Another commenter

notes that the annual filing is a snapshot of the network as it currently stands, and the April 1, 2024, due date essentially moves the effective date of HB 3359 up from September 1, 2024, to April 1, 2024. That commenter suggests that TDI can maintain the April filing date but allow plans to continue good faith negotiations, and provide an opportunity to submit a second filing to demonstrate compliance as late as August 2024. Several other commenters collectively express support for the proposed timeline and questioned whether TDI needs to amend language in §3.3701 that addresses the effective date of previous rule changes.

Agency Response: To provide adequate time for insurers to submit filings after the rule is adopted, TDI will allow insurers until May 1, 2024, to submit their annual report filings for 2024. The due date will remain April 1 for future years.

While TDI agrees that network adequacy submissions reflect a snapshot in time, HB 3359 was signed by the governor in June 2023. HB 3359 applies to policies delivered, issued for delivery, or renewed on or after September 1, 2024. Insurance Code §1301.0056 requires TDI to examine network adequacy before a plan is offered, and Insurance Code §1301.00565 requires TDI to hold a public hearing before approving a waiver request. TDI will need sufficient time to review the network adequacy filings, hold public hearings, and make determinations of whether there is good cause to grant a waiver. TDI anticipates a high volume of hearings, as there were over 140 separate network waiver requests in 2023.

TDI does not believe that amendment of §3.3701 is necessary to clarify the effective date of these rule amendments because nothing in that section prevents these amendments from becoming effective. In addition, amending §3.3701 is outside the scope of this rulemaking because it was not included in the proposal.

Comment: Several commenters collectively seek clarification that the amendments and new sections will apply to both preferred provider benefit plans and exclusive provider benefit plans.

Agency Response: The provision at 28 TAC §3.3701(f) states that a provision of Title 28 applicable to a preferred provider benefit plan is also applicable to an exclusive provider benefit plan unless specified otherwise. Under §3.3701(f), the amendments and new sections that are applicable to preferred provider benefit plans also apply to exclusive provider benefit plans unless specified otherwise. This provision is consistent with Insurance Code §1301.0041.

Comments on §3.3703 - Contracting Requirements.

Comment: Several commenters collectively note that Insurance Code §1301.0642 prohibits certain adverse material preferred provider contract changes and state that these protections are essential in ensuring that insured patients' networks remain strong; however, the protections are not contemplated by the proposed rules. These commenters state that TDI must reference the new definition of an "adverse material change" to make clear what is and is not allowed and that explicit rules are necessary to direct the process. The commenters also recommend that TDI develop a process for reviewing and enforcing contract amendments to ensure compliance with the statute.

Several other commenters similarly note that TDI did not appear to implement Insurance Code §1301.0642 and recommend adding appropriate language to §3.3703(a)(20) and a new subparagraph (J), stating that "no adverse material change to a preferred provider contract will be effective as to the preferred provider unless the adverse material change is made in accordance with Insurance Code §1301.0642,

concerning Contract Provisions Allowing Certain Adverse Material Changes Prohibited." These commenters would also like TDI to clarify that Insurance Code §1301.0642 supplements the existing requirements, so the existence of an adverse material change does not alter the existing requirements of §3.3703(a)(20).

Agency Response: TDI believes the requirements in Insurance Code §1301.0642 are enforceable without repeating it in the Administrative Code. Nevertheless, the text of §3.3703(a)(20) as proposed has been changed to add a reference to Insurance Code §1301.0642. TDI declines to make additional changes at this time but encourages providers to file complaints with TDI when appropriate so that the agency can take appropriate action if any carriers violate the requirements of Insurance Code §1301.0642. At this time, TDI declines to require that every contract change be filed for review but will continue to monitor complaints that are received to see whether additional processes and agency action are necessary. TDI agrees that the provisions of §3.3703(a)(20) continue to apply, so the existence of an adverse material change does not alter the existing requirements.

Comment: Several commenters collectively note that in the introductory clause to §3.3703(a), TDI changes the word "assure" to "ensure" in one instance. However, the commenters note that the introductory clause has two references to "assure" that should be "ensure."

Agency Response: TDI agrees and has made the suggested changes.

Comment: Several commenters collectively recommend that TDI clarify the reference in §3.3703(a)(29) to Insurance Code §1458.101 because the applicability of the statutory

provisions depends on whether an entity meets the definition of a "contracting entity," a "general contracting entity," or both.

Agency Response: TDI agrees and has added "to the extent applicable" to the end of §3.3703(a)(29).

Comment: Several commenters collectively suggest TDI clarify that §3.3703(a)(30) applies only to a contract between an insurer and a preferred provider that is an optometrist or therapeutic optometrist. One commenter states that the relevant provisions are limited to Insurance Code §1451.155, rather than the entire subchapter. Another commenter expresses concern with the provisions enacted by HB 1696.

Agency Response: TDI agrees with the first comment and has added the words "that is an optometrist or therapeutic optometrist" to §3.3703(a)(30), as suggested. TDI disagrees that the only provisions in Insurance Code Chapter 1451, Subchapter D, that could affect contracts are limited to §1451.155. TDI is involved in active litigation challenging HB 1696 and its implementation.

Comments on §3.3704 - Freedom of Choice; Availability of Preferred Providers.

Comment: A commenter notes that TDI's amendment to §3.3704(a)(7) affirms TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care, and TDI's amendment to §3.3704(a)(9) prohibits an insurer from penalizing an insured solely on the basis of a failure to obtain a preauthorization. The commenter agrees that such practices are unjust under Insurance Code §1701.055(a)(2) and strongly supports these amendments. The commenter adds that the amendment to §3.3701(a)(9) is especially beneficial to Texas consumers "because insurers

and providers are best equipped to navigate the sometimes-bewildering preauthorization process" and will help prevent insureds from unintentionally subjecting themselves to penalties for failure to complete a process they might not have been aware of. Several other commenters collectively agree that preferred and exclusive provider benefit plans cannot engage in these kinds of practices and support the intent of TDI's proposed amendment.

Agency Response: TDI appreciates the commenters' support.

Comment: A commenter seeks clarification of §3.3704(a)(9), asking, "If members can go in- and out-of-network at will, what is the purpose of network adequacy standards?"

The commenter states that allowing members to go out-of-network with no primary care physician (PCP), referral, or prior authorization circumvents an insurer's ability to ensure quality of care. The commenter notes that there are providers that refuse to work with insurers, resulting in members being unknowingly treated and then billed for all services. The commenter states that the purpose of a PCP is to take care of general services and assist the member in obtaining care and directing care for more complex services. The commenter notes that many specialists will not make an appointment or see members with another physician's referral. The commenter notes that PCPs typically have a network of specialists they work with, providing the member with coordinated medical care, and without this, members will need to navigate a complex medical system. The commenter states that this may lead to members being noncompliant with medical recommendations, physicians under risk arrangements could be responsible for members who seek care out-of-network, and members may end up paying additional out-of-pocket costs that could be avoided. The commenter notes that members electively going out-of-

network are more likely to pay higher out-of-pocket costs for non-emergent care, as the nonparticipating providers most often will not agree to the health plan's fee schedule. The commenter notes that prior authorization requirements ensure that elective services are medically necessary and are covered benefits; without this, members might later find that they are obligated to pay an unexpected bill. The commenter notes that HEDIS/CAHPS/Provider Survey data collection will be difficult, as nonparticipating providers are not obligated to supply any information. This makes it more difficult for members to make informed decisions when choosing a health plan.

Agency Response: TDI declines to make a change. TDI agrees that PCPs provide a valuable role in coordinating care and making referrals. The rule does not prevent insurers from encouraging insureds to select a PCP; insurers just cannot require insureds to do so. While some insureds prefer to let their PCP refer them to a specialist, others prefer to self-direct their care and use a specialist of their own choosing. A key difference between insurance plans and HMOs is the insured's right to use any provider without a PCP acting as a gatekeeper to specialty care. This has been TDI's long-standing position, evidenced, for example, by TDI's response to a comment on this issue in 1999 that "nothing in the statute or rules authorizes the use of a 'gatekeeper' in a preferred provider plan." 24 Tex. Reg. 5204, 5207. TDI also notes that the definition of a preferred provider benefit plan in Insurance Code §1301.001(9) is a plan that provides "for the payment of a level of coverage that is different from the basic level of coverage . . . if the insured person uses a preferred provider." This indicates that the out-of-network coverage is not secondary or incidental--it is the basic level. That the basic level of coverage must be accessible is made clear in Insurance Code §1301.005, which provides that an insurer offering such a plan "shall ensure that both preferred provider benefits and basic level benefits . . . are

reasonably available to all insureds. . . ." The rule also does not prohibit preauthorization requirements; it prevents penalizing the insured, since insureds cannot navigate those requirements independently from physicians and providers.

Insureds who choose to use out-of-network care generally understand that they will be responsible for substantially more out-of-pocket expenses, and depending on their chosen physician's or provider's policies, may also be responsible for seeking reimbursement from their insurer. Given this increased responsibility on the part of the insureds, they have plenty of incentive to work with their out-of-network provider to pursue verification and prior authorization before obtaining care. The Texas Legislature has empowered TDI via Insurance Code §1701.055 to disapprove insurance policy forms that violate TDI rules or contain unjust provisions. The prohibitions on these PCP, referral, and prior authorization requirements are based on TDI's assessment that it would be unjust to apply them to an insured in the context of a preferred provider benefit plan, particularly considering the structure of such plans under current law.

Comment: Several commenters collectively note that TDI states it is proposing language to prohibit an insurer from penalizing an insured solely on the basis of failure to obtain a preauthorization. The commenters state that, "given TDI's very vague and limited explanation of this proposal, we do not have sufficient information to meaningfully comment on this proposal." The commenters request more information on the penalties TDI references and the impetus for this amendment and its impact, and they request another opportunity to comment after additional information is made available to stakeholders.

Agency Response: TDI disagrees that its explanation of the proposal is vague and limited. Both the plain language of the rule text and the explanation clearly state that the amendments prohibit an insurer from penalizing an insured based solely on a failure to obtain preauthorization. TDI notes that the preamble on this issue contains an error. Specifically, TDI stated in the proposal, "This does not impact contractual requirements with preferred providers related to preauthorization requirements and does prevent an insurer from retrospectively reviewing a claim for a service that was not preauthorized and denying a claim if it fails to meet medical necessity standards." 48 TexReg 7134. The phrase "does prevent" should have been "does not prevent." TDI apologizes for the confusion.

Comment: Several commenters request clarification in §3.3704(e) on what limits to steering and tiering apply beyond those in HB 711. One of the commenters specifically asks for clarification on the reference to "full freedom of choice under this section." A commenter asks that TDI clarify whether there are any further rules that would limit a health benefit plan from developing a tiered network--specifically, any rules that require separate network tiers to meet network adequacy standards independently. Two of the commenters support giving insurers broad authority to steer and tier, citing a study proving that tiered network designs saved 5% in health spending. Several commenters collectively oppose TDI's proposed language because it could be misconstrued as "granting blanket permission to steer and use a tiered network provided that the insurer meets only one requirement--i.e., engages in that conduct for the primary benefit of the insured or policyholder." The commenters note that HB 711 does not supersede other applicable laws, including Insurance Code §1251.006, §1301.068, and Chapter 1460.

Agency Response: TDI agrees that proposed §3.3704(e) could lead to a misinterpretation that steering and the use of a tiered network was governed exclusively by Insurance Code §1458.101(i) and §3.3704. TDI also agrees that HB 711 did not supersede other applicable law and notes that some steering approaches and tiered network designs meet the definition of a provider ranking system that is subject to additional requirements under Insurance Code Chapter 1460. To clarify the rule, TDI has changed §3.3704(e) as proposed to remove the "freedom of choice" reference and to reference the requirement under Insurance Code §1458.101(i). TDI has also changed the proposed text to provide additional guidance for insurers in new §3.3704(e)(3). TDI is not adopting rules that would strictly require separate network tiers to meet network adequacy standards independently. However, TDI will monitor this issue to ensure that network and benefit designs provide fair and reasonable access and that advertised cost-sharing levels are not illusory due to a lack of physicians and providers being reasonably available at preferred cost-sharing tiers.

Comment: A commenter notes that §3.3704 creates anti-steering provisions and restricts the use of a tiered network designed to encourage an insured to obtain services from a particular provider to only situations in which the insurer uses steering or a tiered network for the primary benefit of the insured. The commenter states their concern that this section does not specify the provider types it is applicable to, and this concern is applicable throughout the rule's network adequacy provisions wherever providers are referenced. The commenter seeks clarity with respect to a list of providers in the rule or an explicit cross-reference to an applicable Administrative Code section.

Agency Response: TDI agrees to change the rule text as proposed to clarify its applicability to various provider types. Accordingly, TDI has changed §3.3704(e) to add "as defined under Insurance Code Chapter 1458," following the reference to a "provider" under §3.3704(e). References to provider in other parts of the rule have the meaning as defined in Insurance Code §1301.001(1-a), as stated in §3.3702(b)(9). TDI has also made similar clarifying edits in the rule text to change provider references to a "preferred provider" or a "physician or provider," as appropriate.

Comment: A commenter welcomes that §3.3704(e) explicitly states that steering and tiering in compliance with Insurance Code §1458.101 do not run afoul of the insured's "freedom of choice" but notes that it is unclear what "full freedom of choice" means and wonders how it could have been construed to prohibit steering or tiered networks. The commenter suggests that TDI should clarify the meaning of §3.3704(a)(7) by explaining the statutory basis for the rule and providing a more explicit definition of "freedom of choice."

Agency Response: TDI agrees that the reference to "freedom of choice" in §3.3704(e) is unnecessary and has changed the subsection's proposed text to remove it. Regarding the statutory basis for the phrase "full freedom of choice" in §3.3704(a)(7), that phrase has existed in the preferred provider benefit plan rules since they were first adopted in 1986. The phrase is consistent with the subsequent requirement in Insurance Code §1301.0055 that TDI adopt rules that ensure the "availability of, and accessibility to" providers and ensure "choice, access, and quality of care. . . ." Similarly, Insurance Code §1301.006 requires that insurers contract with providers "in a manner ensuring availability and accessibility. . . ." Finally, Insurance Code §1301.007 requires that TDI adopt rules to

"ensure reasonable accessibility and availability of preferred provider services to residents of this state."

The Legislature is aware of TDI's interpretation that preferred provider benefit plans may not require the use of a "gatekeeper" to manage an insured's care. For instance, in adopting amendments to §3.3704 in 1999, TDI responded to a comment on this issue by stating that "nothing in the statute or rules authorizes the use of a 'gatekeeper' in a preferred provider plan" 24 TexReg 5204, 5207. In light of TDI's long-standing interpretation and the legislative language consistent with that position, TDI declines to make a change to §3.3704(a)(7). While carriers have been able to comply with the "freedom of choice" requirement for many years, TDI is providing additional guidance in the meaning of the phrase through its amendment to §3.3704(a)(7) and does not believe additional changes are needed at this time.

Comment: Multiple commenters note that Insurance Code §1458.101(i) imposes a fiduciary duty on an insurer to its enrollees when it engages in steering or modifies a tiered network, but TDI's proposal fails to reference this fiduciary duty.

One commenter asks that TDI consider the following revision to §3.3704 so that the rule follows the statute: "(e) Steering and tiering. An insurer may use steering or a tiered network to encourage an insured to obtain a health care service from a particular provider without impeding the insured's freedom of choice under this section *but only if by doing so such conduct allows the insurer to meet its fiduciary duty to the insured or policyholder that such conduct is for the primary benefit of the insured or policyholder,* consistent with Insurance Code §1458.101(i), concerning Contract Requirements." The commenter cites *Orbison v. Ma-Tex Rope Company Inc.*, 553 S.W.3d 17, 21 (Tex. App.

Texarkana, 2018) for the proposition that "the term fiduciary 'applies to any person who occupies a position of peculiar confidence towards another' and 'contemplates fair dealing and good faith.'" The commenter asserts that, left unchecked, insurers could begin steering patients toward providers that accept the cheapest reimbursement rate without considering the quality of care provided. The commenter adds that imposing a fiduciary relationship ensures that insurers engage in steering or modify tiered networks only if patients will receive high-quality health care at an affordable cost--not to increase insurers' profit margins.

Another commenter also requests that TDI include information and guidance on how it will evaluate steering or tiered benefits in the context of the fiduciary duty. The commenter suggests that TDI clarify practices that might result in enhanced scrutiny, such as situations where the potential for self-dealing could occur. The commenter notes as an example an insurer steering enrollees toward a practice group in which the insurer has a financial interest and suggests that this might require the presentation of evidence as to why the provider represents the best value to the insured, taking into account both the price and quality of the provider.

Several commenters collectively note that the Legislature created this fiduciary duty as a matter of law and that otherwise there is no general fiduciary duty between an insurer and an insured, and thus suggest that TDI add an explicit set of fiduciary duties in the rule to ensure that insurers are aware of their duties. The commenters suggest that TDI explain the penalties for violating the fiduciary duty as well as the remedies available to insureds for a violation. Finally, the commenters request that TDI require insurers to provide notice of steering or a tiered network in its plan disclosures, and state that this is part of an insurer's fiduciary duty.

Agency Response: TDI agrees that it would be appropriate to incorporate "fiduciary duty" into §3.3704(e) and has changed the text to both expressly reference the statutory requirement and provide additional guidance to insurers. Specifically, §3.3704(e)(3) has been added to include examples of acts that are presumed to violate an insurer's fiduciary duty, such as using a tiered network as an inducement to limit medically necessary services. However, the fiduciary duty is a new statutory requirement, so TDI encourages consumers and providers to file complaints as appropriate on this issue so that TDI can be better informed of compliance issues. TDI will continue to monitor complaints that are received to ascertain whether additional guidance and agency action are necessary. Further, when a form filing indicates that a tiered network is involved, TDI may request additional information that demonstrates the insurer's compliance with the fiduciary duty requirements. TDI welcomes discussions with insurers who have questions about compliance. Regarding explaining the penalties and remedies for violating the fiduciary duty, TDI believes that existing law provides sufficient guidance but will continue to monitor the issue. Regarding plan disclosures, TDI declines to require by rule that insurers provide notice of steering or a tiered network and believes that carriers will provide information to consumers regarding these aspects of plan design but is not ready at this time to find that every failure to do so would be a violation of fiduciary duties.

Comment: A commenter notes that TDI proposed to delete the old §3.3704(e) and requests that TDI confirm that insurers will still be required to include access to institutional providers and facilities.

Agency Response: TDI agrees that insurers will still be required to include access to institutional providers and facilities under §3.3704(f), which incorporates the requirements as to institutional providers found in Insurance Code §1301.0055.

Comment: One commenter opposes the minimum standards in §3.3704(f)(2) that require at least 90% of insureds to have access to a choice of at least two preferred providers within the statutory time and distance standards, arguing that stakeholders negotiated to codify federal requirements into state law, and the federal standard for qualified health plans offered on the exchange requires 90% of insureds to have access to at least one provider of each type. The commenter notes that while TDI network reviews have historically required access to at least two providers, the distance standard applied was 75 miles for most specialty providers; the effect of coupling the more stringent federal distance standards with the state requirement of "at least two" has a compounding effect that exceeds the law's intent. Several other commenters oppose the 90% minimum standard on the ground that it would leave 10% of insureds without the choice required by Insurance Code §1301.0055(b)(3).

Other commenters collectively note that there are significant differences between Texas and federal standards and encourage TDI to apply the plain language of the Texas statutes.

Another commenter offers support for the standards as proposed, which ensure a sufficient number of providers and reasonable choice to insureds.

Agency Response: TDI appreciates the commenter's support. TDI agrees that Insurance Code §1301.0055(b)(12) provides that TDI's rules "require sufficient numbers and classes of preferred providers to ensure choice. . . ." Accordingly, TDI has changed the text to

require that all insureds have access to a choice of at least two preferred providers within the statutory time and distance standards. This approach provides more equal treatment for all insureds, guarantees choice, and leverages the distance standards specified in Insurance Code §1301.00553. TDI declines to apply or adopt federal standards. TDI is implementing state statutes that, as one commenter notes, are in variance from federal standards; for example, federal network adequacy standards do not include a "sufficient choice" requirement.

Comment: Several commenters collectively request clarification in §3.3704(f)(2) that the time and distance standards must be met for each physician specialty and class of health care providers identified in Insurance Code §1301.00553 and §1301.00554.

Agency Response: TDI agrees to provide clarification and has changed the proposed text of §3.3704(f)(2) accordingly. TDI notes that the comment also indirectly raises the question of which network adequacy requirements apply to specialty care and specialty hospitals that are not specifically addressed in Insurance Code §1301.00553. TDI had proposed deletion of §3.3704(f)(8), which provided a general rule of a 75-mile requirement for specialty care and specialty hospitals but has determined that it is necessary to maintain that general requirement for situations not otherwise addressed so that insurers are not left without any network adequacy requirements in those circumstances. Accordingly, TDI has changed the text of §3.3704(f) as proposed to require in new paragraph (4) that insureds be able to access at least two preferred providers within 75 miles for specialty care and specialty hospitals for which time and distance standards are not otherwise specified in Insurance Code §1301.00553.

Comment: Several commenters collectively express a concern that §3.3704(f)(2) fails to address the interactions among time and distance, appointment wait time, and other access standards.

Agency Response: Section 3.3704(f)(1), including §3.3704(f)(1)(E), requires compliance with the new maximum appointment wait time standards and other access standards. TDI agrees that for insurance policies delivered, issued for delivery, or renewed on or after September 1, 2025, a network must simultaneously comply with both the appointment wait time standards and the time and distance standards for each type of health care service the plan covers. That is, a network is not adequate if an insured is unable to access preferred providers within a given physician specialty or provider class within the appointment wait time standards in Insurance Code §1301.0055(b) and §1301.00555 and the time and distance standards applicable to that specialty or class. TDI declines to change the rule text, as it does not imply that an insurer can comply by meeting only one of the applicable network adequacy standards. The network compliance and waiver request form has separate columns in which an insurer must report compliance with the "at least two" and "appointment wait time" standards. Unless all requirements are met, the insurer must request a waiver.

Comment: Several commenters collectively request that §3.3704(f)(3) be modified to strictly conform with Insurance Code §1301.0055(b)(4), which includes both "radiology and laboratory services" in addition to preferred providers, by amending it as follows: "(3) To provide a sufficient number of the specified types of preferred providers with the specialty types *and diagnostic services, including radiology and laboratory services* listed in Insurance Code §1301.0055(b)(4), a network must include at least two preferred physicians

for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility*, including diagnostic services*" (new text is indicated by italics).

Agency Response: TDI agrees that it is appropriate to modify §3.3704(f)(3) to expressly include a reference to the "diagnostic" providers listed in Insurance Code §1304.0055(b)(4) and has changed the text as proposed to reflect this. TDI notes that the network compliance and waiver request form already includes diagnostic radiology under specialty types, and radiology and pathology under facility-based provider types.

Comment: Several commenters collectively oppose the proposed language in §3.3704(f)(3) because they say it improperly implements Insurance Code §1301.0055(b)(4) by arbitrarily determining that the sufficient number of preferred physicians for each applicable specialty at each preferred hospital, ambulatory surgical center, or freestanding emergency center is always two. The commenters add that this ignores the fact-specific nature of the statutory requirement to "ensure all insureds are able to receive covered benefits, at that preferred location." The commenters note, for example, that two in-network physicians may be enough at a small ambulatory surgery center but "woefully inadequate" at a large urban hospital. The commenters also assert that the rule conflicts with Insurance Code §1301.00565(e), which prohibits considering a prohibition on balance billing in determining whether to grant a waiver from network adequacy standards. The commenters also provide draft rule text for TDI's consideration.

Agency Response: TDI disagrees and declines to make a change. Section 3.3704(f)(3), as modified in response to other comments, sets a clear-cut minimum baseline by specifying that the network must include at least two preferred physicians for each applicable

specialty and diagnostic type at each preferred hospital, ambulatory surgical center, or freestanding medical care facility that credentials the particular specialty. The text states "at least" two, and §3.3704(f)(1)(B) incorporates the requirements of Insurance Code §1301.0055, including its requirement in subsection (a)(2) to ensure accessibility to contracted physicians and providers, its requirement in subsection (b)(3) that there be sufficient access to be capable of providing the health care services covered by the plan from preferred providers, and its requirement in subsection (b)(11) to ensure an adequate number of preferred providers. It is also important to factor in the impact of appointment wait time standards, which would likely be violated by a carrier that failed to provide an adequate number of preferred providers. Between the rules and the statutes, insurers will be required to show at least two preferred physicians and then also show that the number of preferred physicians in any particular situation is adequate to provide access.

Comment: A commenter notes that Insurance Code §1301.0055 requires an insurer to report any material deviation from the network adequacy standards to TDI within 30 days of the date the material deviation occurred and, unless there are no available providers or unless a waiver is requested, the insurer must take corrective action to ensure that the network is compliant not later than the 90th day. The commenter requests guidance on what constitutes a material deviation, what format or template should be used to notify TDI of a material deviation, and how the insurer should indicate that the issue has been remedied by the 90-day deadline.

Agency Response: The text of Insurance Code §1301.0055(a)(1) is clear: any violation of the network adequacy standards and requirements would be a material deviation that must be reported to TDI and promptly addressed through a corrective action or a request

for a waiver. An insurer would notify TDI of a material deviation by submitting a network configuration filing in the SERFF system for a network modification, consistent with §3.3712 and §3.3722(e). TDI has changed the text of §3.3704(g) as proposed to clarify that the filing requirements in §3.3712 apply to a notification of a material deviation. Such a submission should include an access plan and description of corrective action taken by the insurer. If the insurer is unable to ensure that the network is compliant by the 90-day deadline, it should request a waiver, consistent with §1301.0055(a)(1)(B)(ii). If, after reporting a material deviation, the insurer has remedied the issue, the insurer can update its network configuration filing in SERFF.

Comment: Several commenters collectively recommend changing §3.3704(g) to require that an insurer must "promptly" take corrective action required to ensure a compliant network by no later than the 90th day after the occurrence of the material deviation.
Agency Response: TDI agrees and has changed the text of §3.3704(g) as proposed to include the word "promptly" in conformance with Insurance Code §1301.0055(a)(1)(B).

Comment: Several commenters collectively recommend changing §3.3704(g) to replace the word "area" with "county" to better conform with the underlying statute.
Agency Response: TDI agrees that clarification is appropriate but disagrees that the use of the term "county" in this context is the best way to conform the rule to HB 3359. The recommended change could be interpreted inconsistently with Insurance Code §1301.0055(a)(6), which references "no uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area." TDI has changed the text of §3.3704(g) as proposed to align with this reference.

Comment: A commenter asks whether insurers are able to measure network adequacy using physician or provider distance to insureds versus the CMS beneficiary file.

Agency Response: Section 3.3704(f)(2) provides that "an adequate network must, for each insured residing in the service area, ensure that all insureds can access a choice of at least two preferred providers for each physician specialty and each class of health care providers within the time and distance standards. . . ." Carriers must be able to demonstrate compliance with this requirement whether they are an established insurer or a new entrant to the market with no insureds. TDI does not currently prescribe the method that carriers must use to demonstrate compliance, but TDI may evaluate the method used to ensure that it provides a reasonable estimation of where current and future insureds reside.

Comment: Regarding the network compliance and waiver request form, a commenter asks for clarification of the statement in §3.3704(f)(3) that "a network must include at least two preferred physicians for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility." Specifically, the commenter asks, given the "or" statement, whether the expectation is to report on just one of these types or all three.

Agency Response: TDI agrees that additional clarifying language would be helpful to confirm that the requirement applies to all applicable facilities. TDI has revised the proposed text to add the phrase "that credentials the particular specialty" to §3.3704(f)(3), consistent with Insurance Code §1301.0055(b)(4).

Comment: A commenter requests clarification regarding whether compliance with appointment wait time requirements starts in 2025, with insurers submitting this detail in network adequacy reports beginning April 1, 2025. The commenter also asks whether a waiver is required if an insurer meets the time and distance requirements but not the appointment wait time requirements.

Agency Response: Section 3.3704(f)(1)(E) provides that Insurance Code §1301.00555, concerning Maximum Appointment Wait Time Standards, will be effective for a policy delivered, issued for delivery, or renewed on or after September 1, 2025, and thus data on wait times is not required in the network compliance and waiver request form in 2024. However, TDI is requiring the data beginning April 1, 2025, to ensure that policies sold after September 1, 2025, will be compliant with this requirement. As the appointment wait times and the time and distance requirements are separate and independent requirements under Insurance Code §1301.0055, an insurer meeting time and distance requirements would also have to meet the appointment wait time requirements to be compliant. An insurer that does not meet the appointment wait time standards would be required to request a waiver, even if the insurer's network meets the time and distance standards.

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

Comment: Two commenters express concern that the inclusion of the phrase "in any promotion, advertisement, or enrollment opportunity" in §3.3705(b) is overly broad and goes beyond statute. These commenters request clarification that the disclosure requirements apply only to waiver-related disclosures in promotional materials for a

specific insurance plan. These commenters also request flexibility for insurers to satisfy the disclosure requirements via a website link. Other commenters collectively argue that, by statute, the waiver-related disclosures must be in the actual promotion or advertisement. These commenters request limitations on an insurer's ability to use its policy, certificate, or handbook to satisfy disclosure requirements and also request reinstatement of the "upon request" provision to expressly permit insureds to request a description of policy terms and conditions. These commenters oppose removal of the requirement that policy disclosures be made in a prescribed order.

Agency Response: TDI has changed the text of §3.3705 as proposed to separately address waiver-related advertisement disclosures in subsection (d) and to reinstate the "upon request" language in subsection (b). TDI disagrees that the phrase "promotion, advertisement" goes beyond statute, as this language aligns with Insurance Code §1301.0055(a)(4).

TDI has changed the text of §3.3705(d) as proposed to clarify that the requirement applies to advertisements for a specific plan. A general advertisement at the company level encouraging consumers to shop for plans would not be subject to the requirement. TDI agrees that an insurer can fulfill this requirement by providing a statement that the plan received a network adequacy waiver and an electronic link from advertising materials for a particular plan to the plan disclosure required under §3.3705(d), which contains detailed information on any network waivers.

TDI declines to revert to the prescribed order requirement, as the federal summary of benefits and coverage disclosure requirements already allows for a meaningful comparison between plans, using a format that went through consumer testing. Allowing companies to include plan disclosures within policies and certificates helps both insurers

and consumers by reducing the number of separate documents that insurers must develop and that consumers must review. In addition, policies and certificates are subject to plain language requirements under Insurance Code §1301.157.

Comment: Multiple commenters suggest that TDI make bold or more conspicuous the following sentence in each consumer notice in §3.3705(f): "If you don't think the network is adequate, file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439." A commenter notes that this will ensure that consumers are aware that they have the right to file complaints with TDI if they believe their plan is not providing an adequate network of health care providers and physicians to meet their needs.

Agency Response: TDI agrees this language should be made more conspicuous and has put the sentence in bold in both consumer notices.

Comment: Regarding the consumer notices in §3.3705(f), several commenters collectively state a concern that the notices fail to clearly inform insureds that a preferred provider is the same as an in-network provider or that preferred providers make up the plan's network. The commenters also state that the description of network adequacy does not mention or indicate network adequacy requirements. The commenters also state that the notice does not reference that an insured might be protected from balance billing when they relied on the plan's directory to pick an in-network provider. The commenters state their concern that the phrase "and you didn't pick the doctor or facility" is confusing since it is referring to care received at an in-network facility. The commenters also note their concern that the exclusive provider benefit plan notice implies that the plan does not have

to pay for medically necessary covered services that are not available in the network. The commenters also provide a draft of the consumer notices that reflects specific editing suggestions.

Agency Response: TDI agrees with the commenters and has changed the proposed text of the consumer notices in §3.3705(f)(1) and (2) to address their points. TDI has based its changes on wording suggested by the commenters but has adapted the suggested language for additional clarity and consistency with agency rule drafting style.

Comment: A commenter notes that TDI's proposed amendments to §3.3705(l)(10) and (11) faithfully reflect the changes in law found in SB 1003 from the 88th Legislative Session. SB 1003 expanded the specialty and licensure types that must be organized by facility in provider directories.

Agency Response: TDI appreciates the commenter's support.

Comment: Several commenters collectively note that §3.3705(m)(1) requires an insurer to provide a link in its annual policyholder notice concerning the use of an access plan to a webpage listing of information on network waivers and access plans "made available under subsection (e)(2)" of §3.3705. The commenters note, however, that §3.3705(e)(2) would only require an insurer to link to a limited set of information regarding each county's network adequacy and would not require providing a link to a webpage listing of information regarding network waivers and access plans. Thus, the commenters suggest changing §3.3705(m)(1) to add a reference to subsection (b)(14)(B) and strike paragraph (2) from the reference to subsection (e)(2).

Agency Response: TDI agrees with the comment and has changed the proposed text to reference subsection (d)(2) rather than (b)(14)(B) (as suggested by the commenters) to align with other changes related to the waiver disclosure requirements.

Comment: Several commenters collectively assert that §3.3705(n) equates physician specialists and non-physician specialties when calculating and defining a substantial decrease in the availability of preferred facility-based physicians, and equating physicians with non-physicians artificially increases the number of available network physicians if a plan terminates a contract. These commenters suggest that because physicians and non-physicians provide different services and are trained to provide different levels of care, especially in a facility-based setting, TDI should not equate the two when calculating a substantial decrease in availability of a provider type. Several other commenters similarly note that, because "specialty" is undefined, inserting "or provider" could be interpreted as including non-physicians within a physician specialty. The commenters recommend TDI add language to clarify that facility-based physicians are separate from non-physician facility-based providers for purposes of calculating a substantial decrease.

Agency Response: TDI agrees that decreases in physician availability and other provider availability should be assessed separately. Accordingly, TDI has changed the text as proposed to add a clarifying clause to §3.3705(n)(2).

Comment: Several commenters collectively oppose TDI's removal of a requirement in §3.3705(n) for an insurer to certify to TDI that the termination of a provider contract will not cause their provider network to be noncompliant with network adequacy standards because enforcement of network adequacy standards is best upheld when TDI is informed

of any substantial decrease of preferred providers at a preferred facility. The commenters state that the removal would allow an insurer to unilaterally determine that the termination will not cause its network to be noncompliant.

Agency Response: TDI disagrees and declines to make a change. TDI believes the new network adequacy requirements contained in statute and rule are sufficient to provide for compliance, and notes that a requirement for such a certification is not a common regulatory practice. While an insurer's determination that its network is compliant is to some extent unilateral, so is the decision by the insurer on whether to seek a waiver of network adequacy standards. TDI has found limited benefit in the prior requirement for insurers to send numerous certifications to TDI. Instead, TDI has found, for example, that complaints from consumers are effective sources of information for TDI to identify a network issue.

Comment: A commenter supports streamlining disclosure requirements for policy terms and believes that the proposed amendments to §3.3705, especially in new subsection (o)(2), will result in more transparent and understandable disclosures to Texas insurance consumers, as well as enabling them to determine how to obtain assistance in accessing care.

Agency Response: TDI appreciates the commenter's support.

Comment: Several commenters collectively oppose the deletion of approved and limited hospital care network designations and other disclosures and requirements in §3.3705(p) and (q) because these have been important consumer protections and will continue to

be. The commenters assert that TDI may not consider balance billing protections in making the decision to delete these requirements.

Agency Response: TDI disagrees and declines to make a change. The labels of "approved" and "limited" hospital care networks were essentially shorthand to inform consumers whether an insurer had an adequate network. Under new Insurance Code §1301.0055(a)(3), insurers are now required to disclose in all promotions and advertisements that they are operating under a waiver. This renders the prior rule language duplicative and unnecessary.

Comments on §3.3707 - Waiver Due to Failure to Contract in Local Markets.

Comment: A number of commenters express concern that the rules do not allow providers to submit information for TDI's evaluation in determining whether a waiver from network adequacy standards should be granted. These commenters request that the rules require TDI to consider all pertinent information submitted in connection with a waiver request. Several commenters collectively request that TDI add language expressly stating that the commissioner may not consider a prohibition on balance billing, as required under Insurance Code §1301.00565(e).

Agency Response: TDI declines to make a change because the amendments to §3.3707(a) already state that the commissioner will determine whether to grant a waiver "after considering all pertinent evidence in a public hearing under Insurance Code §1301.00565. . . ." TDI will provide opportunities for providers and the public to submit information pertinent to a waiver request, consistent with the requirements of HB 3359, and the commissioner will make a determination on each waiver request in accordance

with statutory guidelines. TDI will comply with its statutory obligations and declines to restate those statutory provisions in agency rules applicable to regulated entities.

Comment: A number of commenters suggest that insurers be required to provide, as part of a waiver request, substantive information about the insurer's efforts to contract and negotiate with uncontracted providers. Some of these commenters note that the determination of good faith efforts to contract requires a "highly fact-specific analysis" and that the rules do not explain how the information required in the attempt to contract form will demonstrate a good faith effort. Several other commenters request that the waiver rules should not limit the information to be provided regarding the insurer's good faith efforts to contract but should instead allow the insurer and providers to offer proof of such efforts.

Agency Response: TDI agrees that it is appropriate to require an insurer to provide substantive information about its attempts to contract. The attempt to contract form requires the number of attempts made, the dates of the attempts, the method of contact used, and the reason for the provider declining to contract--information pertinent to the assessment of whether the insurer engaged in good faith efforts. TDI has changed the form to clarify TDI's expectations that the insurer provide additional information showing that the insurer made a good faith effort to contract, as defined in Insurance Code §1301.00565(a). In addition, TDI plans to provide public notice of each waiver hearing, and all interested stakeholders and the general public will be given the opportunity to provide TDI with evidence relating to the waiver request.

As several commenters note, the analysis of good faith efforts is highly fact-specific, and TDI declines to strictly define what will or will not constitute a good faith

effort, beyond the framework provided in the statute. As part of its good faith analysis, TDI will consider all information pertinent to the waiver request, including the information provided in the request and associated forms, as well as all information submitted by insurers, providers, and members of the public, to determine whether the insurer's efforts reflect the requirements under Insurance Code §1301.00565. The information requirements in the attempt to contract form are not intended to constitute the entirety of the information considered by TDI, nor will such information be automatically included in TDI's consideration if it is not pertinent to the waiver request.

Comment: One commenter notes that the associated facility information required in §3.3707(b)(1)(A) is not always known to the insurer. The commenter requests clarification on whether the insurer may mark this information as unknown or unavailable.

Agency Response: If an uncontracted provider's facility association is not known by the insurer filing a waiver request, the insurer may mark such information as "N/A" (not available) for non-facility-based providers.

Comment: A commenter suggests that disclosure of the steps that an insurer will take to improve its network, as required in §3.3707(b)(1)(E), is not necessary because the attempt to contract form requires a description of recruitment efforts.

Agency Response: TDI disagrees that recruitment efforts provide the same information as the steps the insurer will take to improve its network. However, because the cover page of the attempt to contract form requests information on the steps the insurer will take to improve its network, TDI has modified the attempt to contract form and the network compliance and waiver request form as available when the text of §3.3707 was proposed

to remove the table column labeled "Actions to eliminate network adequacy gaps included in waiver request and access plan."

Comment: Several commenters collectively argue that the criteria for good cause for a waiver as specified in §3.3707(a)(1) and (2) and TDI's reliance on the waiver request templates are not authorized by statute and are contrary to legislative intent because Insurance Code §1301.0055(a)(3) requires the commissioner to consider good faith efforts and all pertinent evidence received. These commenters express concern that the rule will allow the commissioner to ignore an insurer's failure to engage in good faith efforts with any uncontracted provider.

Agency Response: TDI agrees that it is appropriate to remove the criteria for good cause and adopts §3.3707(a) without paragraphs (1) and (2). As previously discussed, TDI will consider all pertinent evidence in determining whether good cause exists to grant a waiver. TDI notes that the information that the commissioner will consider in determining good cause is not limited to the specific items included in the attempt to contract template. Both insurers and providers are encouraged to present any relevant evidence.

Comment: Several commenters collectively oppose the reference to "insufficient number" of providers in §3.3707(a)(1) and §3.3707(b)(2) as contrary to statute. These commenters cite HB 3359 as requiring the commissioner to consider whether there are "no" uncontracted providers to meet a network adequacy standard, and they argue that the "insufficient number" reference provides for a much lower threshold for granting a waiver, thereby encouraging insurers not to contract with providers and allowing the commissioner to disregard whether the insurer made good faith efforts.

Agency Response: TDI notes that the "insufficient number" phrase was used to reflect the practical realities that some network standards require more than one physician or provider and, for network gaps in more distant parts of a county, there could be additional uncontracted providers in the county that are located in areas that would not address the network gap. TDI has changed the proposed text of §3.3707(a)(1) and §3.3707(b)(2) to reflect a "no providers" threshold. TDI has made a conforming change to §3.3712(c)(2)(C)(i). Under the adopted text, for a waiver from the §3.3704(f)(2) standard that all insureds must have access to at least two preferred providers, the threshold is met if there are no additional uncontracted providers available that would fill the network gap. For a waiver from maximum appointment wait time standards, the threshold is met if there are no additional providers available to contract that would fill the network gap.

Comment: One commenter requests that the statutory definition of "good faith effort" be added to §3.3707 and that insurers be required to attest that "they did not offer reimbursement rates designed to disincentivize providers from entering into contracts" with the insurers.

Agency Response: TDI has modified §3.3707(b)(1)(B) to include a reference to the statutory definition of "good faith effort." TDI declines to require the proposed attestation because it is unlikely to be helpful to TDI's assessment of the insurer's efforts.

Comment: Multiple commenters oppose the §3.3707(b)(1)(C) requirement for a description of the best offer of reimbursement rates made by the insurer, including computations based on Medicare rates and the insurer's average contracted rates. These commenters argue that (1) HB 3359 does not authorize TDI to collect this information, (2)

Medicare rates do not reflect a fair market rate, and (3) the use of average contracted rates would allow the low and high ends of contract rates to distort rate computations. One commenter suggests that TDI instead require reporting consistent with CMS recruiting activity reporting and requests clarification on the disclosure requirements. Another commenter notes that the current industry standard is to use median rates. Several commenters suggest that, instead of rates information, TDI consider the insurer's ongoing efforts to bring providers in network and all circumstances surrounding contract negotiations and outcomes.

Agency Response: In consideration of the concerns raised by commenters, TDI has modified §3.3707(b)(1) as proposed to remove subparagraph (C). TDI will provide insurers, providers, and the public with opportunities to provide relevant information in connection with a waiver request. TDI will consider all relevant information.

Comment: Several commenters collectively object to the use of the terms "refusing" and "refused" in §3.3707 to refer to a physician's decision not to enter into a contract with an insurer on terms unacceptable to the physician. Several commenters oppose the requirement in §3.3707(b)(1)(D) that the waiver request include information on any exclusivity arrangement because HB 3359 does not expressly include this requirement and the information concerns private contract matters.

Agency Response: TDI has deleted the term "refused to contract" in §3.3707(a)(2) as proposed in response to another comment. TDI has changed §3.3707(b)(1)(D), now renumbered as §3.3707(b)(1)(C), to replace the term "refusing" with "declining" and to clarify that the requirements apply to information about the provider's participation in an exclusivity arrangement, rather than information about the exclusivity arrangement itself.

The amendments require insurers to describe any reason a provider or physician gave for declining to contract, including if the reason includes an exclusivity arrangement or other external factors. These factors that are outside the insurer's control are relevant in determining whether (1) the insurer made a good faith effort to contract, (2) an issue may be remedied through good faith efforts, and (3) there is good cause to grant a waiver. For example, if Hospital A has an exclusive contract with Physician Group B, which prevents any physicians outside Physician Group B from practicing at the hospital, the existence of the exclusivity arrangement is relevant in understanding the insurer's efforts to contract with a sufficient number of facility-based physicians at Hospital A to comply with the network adequacy standards applicable to Hospital A. TDI requires the insurer to report the total number of available physicians, the number of contracted physicians, and each physician with whom they attempted to contract. For each attempt to contract with a given physician or provider, the insurer must also report, if applicable, the group name and the associated facility name.

The existence of an exclusivity arrangement helps TDI understand why an insurer may focus its contracting efforts on Physician Group B, even if several other physicians appear to be available. TDI is authorized to seek this information under Insurance Code §1301.0055(a), requiring TDI to assess good cause for a waiver and good faith efforts; §1301.00565(c), requiring TDI to consider all information pertinent to a waiver request; and §1301.0056(e), authorizing TDI to require information necessary to evaluate compliance with network adequacy standards or to ensure the use of the plan in the most efficient and effective manner possible.

Comment: A commenter opposes TDI's consideration of whether a provider has refused to contract with the insurer on reasonable terms, as set forth in §3.3707(a)(2). The commenter asserts that this standard is highly subjective and recommends that TDI instead require reporting that aligns with CMS recruiting activity reporting.

Agency Response: TDI has deleted §3.3707(a)(2) in response to a different comment. With respect to the reporting requirements, TDI's attempt to contract form does align closely with the CMS spreadsheet on which qualified health plans report recruitment activity. For example, the CMS column "Status of Recruitment Efforts" provides information that is similar to the column in TDI's attempt to contract form labeled "The reason given for declining to contract." While TDI does not constrain the insurer's description in this field, the insurer could report information similar to the options within the CMS form, which include the following: Good faith offer rejected; Provider has entered into an exclusivity contract with another organization prohibiting the provider from contracting with us; Not licensed, accredited, or certified by the state; Moved/retired or facility closed; Does not contract with any commercial insurance organizations; and Contract negotiations being conducted.

Comment: A commenter supports TDI's proposed clarification of expectations for access plans and the proposed updates to the waiver process in §3.3707, especially in the proposed amendments in redesignated subsection (j), new subsection (k), and new subsection (m). The commenter adds that these rule updates represent important improvements to Texas insurance consumers' ability to obtain the proper services at a reasonable cost, without being blindsided by unexpected billing for services they believed were covered.

Agency Response: TDI appreciates the commenter's support.

Comment: A commenter notes that the rule proposal updates requirements and processes relating to the filing and consideration of requests for waivers from network adequacy standards and access plans. The commenter seeks clarification regarding adjudication of an insurer's waiver request, including the process for waiver hearings, and states that proper process is needed to ensure fairness.

Another commenter similarly states that insurers need more information surrounding the waiver and public hearing processes, particularly considering that network adequacy reports are due April 1, 2024.

In addition, a commenter proposes adding a provision requiring that waivers be granted for any county in a service area in which the counties do not meet standards. This would bring counties into compliance and simplify the waiver process. The commenter also asserts that waivers for partial county service areas, consistent with CMS, would also simplify the process, be in the best interest of the insured, and promote targeted recruitment. The commenter also suggests that there should be a mechanism for appeal to provide parties with administrative recourse in the event of an adverse ruling that they believe is defective.

Agency Response: Regarding waiver procedures, detailed procedural information is not required to be adopted by rule. However, TDI plans to post additional process information on its website. Regarding county-level waivers, §3.3707 of the rule addresses waiver requests at the county level, as contemplated by the Insurance Code. Section 1301.0055(a)(3) of the Insurance Code provides that when waivers are granted, TDI must post the "affected county" and other information on its website. Insurance Code

§1301.0055(a)(5) places limits on waivers from being granted multiple times "in the same county" or in "each county in a service area" under certain circumstances. These provisions are consistent with Insurance Code §1301.005, which provides that service areas may not divide counties; thus, TDI will similarly not permit waiver requests that divide counties.

Regarding administrative recourse in the event of an adverse ruling on a waiver, TDI notes that, unlike some other TDI functions, network adequacy review decisions have not been delegated within TDI as a "routine matter" under Insurance Code §36.102. Instead, TDI's denial of a waiver request is a final action that is subject to direct judicial review under Insurance Code Chapter 36, Subchapter D.

Comment: A commenter asks under what circumstances average rates and contract offer rates will be published.

Agency Response: In response to other comments, TDI has changed the forms as available when the rule text was proposed to delete the columns regarding rates in the attempt to contract form, and has deleted the corresponding requirement in §3.3707(b)(1)(C) to provide rate information, making this comment moot. If carriers believe that the information they choose to submit to TDI is confidential, they should mark it as such.

Comment: Several commenters collectively note that §3.3707(c)(2) includes an erroneous citation to "§3.3712(c)(2)(E)(iii)."

Agency Response: TDI has changed the proposed text of §3.3707(c)(2) and §3.3707(m) to correct the citation and apologizes for any confusion. The correct citation is §3.3712(c)(2)(C)(iv).

Comment: Multiple commenters object to the provision in §3.3707(d) stating that TDI will specifically notify providers named in a waiver request of the public hearing on that request. These commenters recommend that TDI be required to notify all providers in the affected county or counties of the waiver request and hearing and provide all providers with the opportunity to respond to the request and submit evidence, as required by statute. One commenter recommends that the rule describe the specific process for when, how, and to whom TDI will provide notice and seek consent in connection with the waiver hearings; the commenter criticizes the rule as placing the burden on providers to notify TDI of their consent to be named at the hearing.

Agency Response: TDI disagrees that Insurance Code §1301.00565(c) requires TDI to notify all providers, rather than "affected physicians and health care providers that may be the subject of a discussion of good faith efforts on behalf of the insurer. . . ." Similarly, the consent requirement does not apply to all providers. In addition, even if it were possible for TDI to specifically contact and notify each and every provider in all affected counties, these efforts would be cost prohibitive and would require significant agency resources. TDI plans to provide public notice of waiver hearings, which will allow all providers the opportunity to attend the hearings and submit evidence for TDI's consideration. All providers attending waiver hearings will have the opportunity to consent to be identified, consistent with Insurance Code §1301.00565(c), which provides that out-of-network providers may not be identified at the hearing unless they consent. TDI declines to adopt rules specifically describing agency procedures relating to waiver requests and hearings; TDI will comply with its statutory obligations and declines to

restate those statutory provisions in rules applicable to regulated entities. However, TDI plans to provide additional process information on its website.

Comment: Multiple commenters assert that the 15-day period in §3.3707(e) for certain providers to respond to a waiver request is insufficient. One commenter suggests that TDI be required by rule to provide 60-day notice of the waiver hearing, and several commenters collectively suggest that the 15-day response period be extended to 30 days to give providers ample time to gather evidence and determine whether to give consent. **Agency Response:** TDI declines to make a change to the notice period. Because of the anticipated volume of waiver hearings and the need for TDI to provide timely decisions on waiver requests before applicable statutory deadlines, TDI will need to promptly schedule and hold waiver hearings. To implement HB 3359 by September 1, 2024, TDI will not be able to provide 60-day notice and a 30-day response period. Evidence will be accepted from all providers and the public following the expiration of the 15-day period and up to one week after the hearing date, but prompt submission of evidence will allow TDI to be better informed of all pertinent evidence before a hearing.

Comment: Several commenters collectively recommend reinstating the requirement that an access plan include maps identifying the geographic areas in which a sufficient number of providers are available. These commenters claim that the maps would be an important and useful tool to TDI to monitor and verify compliance with network adequacy standards. **Agency Response:** TDI declines to require the inclusion of maps in an access plan. Because it is not practical to measure driving distances via maps, TDI does not view maps as a helpful tool to verify compliance. While maps were useful under the prior network

requirements, TDI does not believe they are necessary in the context of driving distance requirements. Under the prior network requirements, TDI measured distance standards based on radius, which could be easily illustrated using maps. In contrast, specialized software is needed to measure compliance with the driving distance requirements. Also, there is no reference in Insurance Code Chapter 1301 to requiring the submission of maps by insurers.

Comment: Several commenters collectively assert that the requirement in §3.3707(j)(2) for the insurer to recommend at least one provider to address a network gap does not provide sufficient choice consistent with HB 3359. These commenters suggest instead requiring the insurer to recommend at least three physicians or providers.

Agency Response: TDI agrees that consumers should have a choice of providers when there is a network gap, consistent with HB 3359. Accordingly, §3.3707(j)(2) has been modified to require the insurer to recommend a choice of at least two physicians or providers, consistent with other network adequacy choice requirements in §3.3704(f).

Comments on §3.3708 - Payment of Certain Out-of-Network Claims.

Comment: A commenter strongly supports TDI's proposal in §3.3708 providing payment standards for certain out-of-network claims and reflecting balance billing protections, to implement SB 2476 and SB 1264, and providing consumer protections for network gaps. The commenter notes that the rules protect insureds who do not have the ability to reasonably obtain in-network care, which has been a consistent problem for insureds, and the amendments provide important improvements to the existing rules. The commenter concludes that the amendments, especially those in subsection (b) and new subsection

(e), will help ensure Texas insurance consumers' ability to obtain the proper services at a reasonable cost without being blindsided by unexpected billing for services they believed were covered.

Agency Response: TDI appreciates the commenter's support.

Comment: A commenter requests that TDI consider changing the maximum number of days in which an exclusive provider plan must process a referral to a nonpreferred provider from five business days to, at most, three calendar days. The commenter notes that businesses often adopt different definitions for what constitutes a business day, and delays in the processing of referrals and transfers for care have a negative effect on the health and well-being of patients. The commenter continues, saying that waiting five business days can easily compound to nine or more days when including weekends and holidays, which can lead to irreversible consequences for patients who need timely care.

Agency Response: TDI notes that the language added in §3.3708(b)(2) is not new, but duplicates language previously included in repealed §3.3725. The old and new language provides that if services are not available through a preferred provider, the exclusive provider plan issuer must "process a referral to a nonpreferred provider *within the time appropriate* to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation. . . ." TDI has not received a significant number of specific complaints that this language has had a negative impact on patient care and declines to change the minimum number of days at this time.

Regarding the reference to "business days," TDI notes that the Legislature has used that phrase many times in the Insurance Code. More specifically, regarding the time to

process a referral, the Legislature in Insurance Code §1272.301, concerning Access to Out-of-Network Services, has provided that a contract between an HMO and a limited provider network or delegated entity must require that, if medically necessary services are not available in-network, the network or entity "shall allow the referral within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee who is a patient, but not later than the fifth business day. . . ." TDI declines to adopt a more restrictive standard than the Legislature at this time.

Comment: Several commenters collectively oppose the deletion of §3.3708(c)(1), which provides a standard for calculating usual, reasonable, or customary charges. These commenters note that the paragraph was not invalidated by the court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020).

Agency Response: TDI declines to restore deleted §3.3708(c)(1). Because the TAHP lawsuit challenged rules providing for the calculation of usual and customary rates based on provider billed charges, deletion of the paragraph providing for calculations based on billed charges is consistent with the court order.

Comment: A commenter requests that TDI revise §3.3708(e) to align with the text of the statute in Insurance Code §1301.140 because the proposed rule places the burden on insureds to identify the discounted average rate paid by an insurer in order to claim the credit, which is not consistent with the statute. The commenter adds that HB 2002 imposed a duty on the applicable insurers to provide credits toward an insured's

deductible and out-of-pocket maximum expenses if certain conditions are met and did not place the duty on the insured to undertake another administrative burden.

Agency Response: TDI disagrees with the comment and declines to make a change. Insurance Code §1301.140 requires that the insurer establish the "procedure by which an insured may claim a credit" and "identify documentation necessary to support a claim. . . ." The insurer must make information about the procedure readily accessible on its website, and TDI's rule clarifies that this includes identifying the average discounted rate. However, instead of merely requiring the insurer to give the credit any time the insured pays a claim out of pocket or otherwise placing the burden on the insurer to proactively identify when the insured has saved money over what the insurer would have paid, the statute is intended to reward consumers that shop for lower-priced care. As the May 13, 2023, Bill Analysis for HB 2002 states, the author's intent was to provide incentive for patients to seek out deals and encourage cost-saving behavior. Under the statute, the insured is provided the necessary information to shop for care and then make a claim for the credit. Only the insured will know what they have ultimately paid out of pocket to a particular provider.

Comment: A commenter welcomes rules regarding implementation of HB 2002 and expresses support for the clarification that credit to the deductible and out-of-pocket maximum must be provided at the preferred level of coverage (§3.3708(e)(3)), as this specification most naturally follows the legislative purpose to reward patients who find good value outside of the network. The commenter adds that applying the credit toward any other level of coverage would already be required under existing law, so the

regulatory interpretation here gives effect and meaning to the statutory language of HB 2002.

Agency Response: TDI appreciates the commenter's support. TDI notes that the comment indirectly raises a discrepancy between the proposed rule text and the language of the statute. Specifically, the proposed rule text referenced the credit being available in situations where the insured pays a "nonpreferred" provider without a traditional claim being filed with the insurer. However, HB 2002 contains no such reference to nonpreferred, or out-of-network, providers. Because the rule text was inconsistent with statute, TDI has deleted references to nonpreferred providers in §3.3708.

Comment: A commenter suggests that TDI specify at least one procedure that would satisfy §3.3708(e)(1)--specifically, that insurers may satisfy this requirement by providing the "average discounted rate paid by the insurer . . . for a covered service or supply" through the self-service tool that insurers are required to provide enrollees to identify real, negotiated, provider-specific rates under the federal Truth in Coverage rules (and corresponding state requirements).

Agency Response: TDI agrees that insurers are already required to provide price comparison information for participating providers under 42 USC §300gg-114, and information on negotiated rates and estimated cost-sharing information under 45 CFR §147.211. However, these federal requirements are different from the "average discounted rate," which insurers must disclose under Insurance Code §1301.140. If an insurer wishes to leverage existing price transparency websites to comply with HB 2002, they must update those websites to include information on the insurer's average discounted rate.

Comment: A commenter suggests that TDI consider clarifying that the "average discounted rate paid" under §3.3708(e)(1) must be calculated from actual paid claims, rather than an average of negotiated rates. The commenter states that this can prevent the inclusion rates that are negotiated in contracts, but rarely or never actually used, usually because the rates are included in contracts with providers that do not provide the service on a regular basis. The commenter also suggests specifying a time period over which the average must be calculated and the frequency of updates in the publication of the calculation.

Agency Response: TDI disagrees that the proposed change is needed. Insurance Code §1301.140 and §3.3708(e) both require that insurers identify the average discounted rate "paid." A carrier disclosing a discounted rate based on average negotiated rates would be noncompliant with this requirement. Regarding specifying data time frames and updates, in TDI's experience, it is important to give insurers some flexibility as they develop their initial compliance procedures, and it is unlikely that carriers would use time frames or update frequencies that would materially affect consumers' ability to obtain the required credit. However, TDI will continue to monitor this issue for complaints in case additional clarification is needed in the future.

Comment: A commenter notes that the rule text in §3.3708(f) accurately reflects the intent of HB 1647 regarding the coverage of certain drugs at the preferred level, even if administered by a nonpreferred provider. However, the commenter recommends the following definition be added: "Preferred level of coverage--the highest level of coverage that an insured receives under the applicable policy with a preferred provider benefit plan for drugs or services administered or provided by a preferred provider, which includes the

amount of financial liability allocated to the insured for such drugs or services, including any applicable copayment, coinsurance, and deductible."

Agency Response: TDI declines to make a change at this time. TDI agrees that payment is required at the in-network level of benefits but does not believe that the suggested definition would add any material clarification beyond the detailed language of HB 1647 found in Insurance Code §1369.764(a)(4).

Comment: A commenter notes that proposed §3.3708(f) requires an insurer to cover a clinician-administered drug under the preferred level of coverage if certain criteria are met, even if it is dispensed by a nonpreferred provider. However, the commenter notes that HB 1647 was carefully drafted to apply only to nonpreferred "pharmacies." The commenter notes that not only pharmacists can dispense; for example, §158.003 of the Texas Occupations Code allows physicians to dispense certain drugs in rural areas. The commenter asks that TDI either cite to the relevant Insurance Code section or replace "provider" with "pharmacy." In addition, the commenter notes that Insurance Code §1369.763 contains an exception that the coverage requirements do not apply "to a prescription drug administered in a hospital, hospital facility-based practice setting, or hospital outpatient infusion center," but the proposed rule does not account for this exemption because it is not part of the criteria in Insurance Code §1369.764. The commenter asks that TDI add this key provision to the rule. Several commenters collectively oppose the first commenter's request to replace "provider" with "pharmacy," and propose suggested language to address the exemptions in Insurance Code §1369.763.

Agency Response: While the applicability of HB 1647 is sufficiently clear and enforceable based on the statutory language, in light of the comments, TDI has revised the proposed text of §3.3708(f) to eliminate any misinterpretation that TDI's rule modifies the scope of Insurance Code Chapter 1369, Subchapter Q, by deleting the phrase "even if it is dispensed by a nonpreferred provider." TDI retains the text otherwise, in order to emphasize insurers' duty to comply with the Insurance Code requirements.

Comments on §3.3709 - Annual Network Adequacy Report.

Comment: Several commenters note that HB 3359 amends Insurance Code §1301.009 to add new reporting requirements for health plans in their annual reports to include any waiver requests made and any waivers granted; any material deviation from network adequacy standards; and any corrective actions, sanctions, or penalties assessed against the insurer by TDI for deficiencies related to the preferred provider benefit plan. The commenters recommend adding "any corrective actions, sanctions, or penalties assessed against the insurer by the department for deficiencies related to the preferred provider benefit plan" to §3.3709(b).

Agency Response: TDI is preparing to implement Insurance Code §1301.009(b)(3)(C), as written, without adopting rules, and continues to view the statute as self-executing. TDI has created www.texashealthplancompare.com to enable consumers to compare health plans. TDI is currently assessing the additional information that it will need to collect to implement Insurance Code §1301.009(b)(3)(C), but believes that it already has, or will have, the information raised by the commenters regarding waivers; material deviations; and corrective actions, sanctions, or penalties.

Comment: Several commenters collectively note that §3.3709(c)(1) requires insurers to provide in their annual network adequacy report the number of insureds in the most recent year and the number projected to be served in the upcoming year, but Insurance Code §1301.0056(e)(2) requires that this information be provided by county. The commenters also state that the projected number of insureds should be provided for the next two years to enable TDI to determine whether a plan is compliant. The commenters also note that §3.3709(c)(7) requires that the annual report include actuarial data but fails to require actuarial data of current and projected utilization of each provider type by county. The commenters also state that the annual report should include information regarding the current and projected utilization of physicians credentialed at each of the institutional providers by specialty (e.g., pain versus anesthesia) to give TDI information that is necessary to ensure the preferred provider benefit plan is used in the most efficient and effective manner possible.

Agency Response: TDI notes that Insurance Code §1301.0056(e) requires that TDI's rules "require insurers to provide access to or submit data or information. . . ." At this time, TDI is not requesting that the very detailed information described by the commenters be provided in advance of TDI's review. For instance, TDI believes that the granularity of county-level data would be less useful than what is currently requested in the annual report. Instead, TDI intends to request this information from insurers when relevant to a determination. In order to make this clear, TDI has changed the proposed text to add new §3.3712(e), which requires that insurers make this information available to TDI upon request.

Comments on §3.3712 - Network Configuration Filings.

Comment: A commenter notes that §3.3712 addresses reporting of network configuration information and seeks clarification of the provider types that must be listed on the provider listing form. The commenter recommends that the provider listing form include the provider types listed in Insurance Code §1301.00553, as included on the draft waiver request form, and facility-based providers as required by Insurance Code §1301.0055(b)(4).

Agency Response: Section 3.3712(c)(2) requires that insurers use the network compliance and waiver request form to provide data for each county, including "the number of each type of preferred provider in the plan's network, using the provider specialty types specified in the form. . . ." Consistent with the commenter's suggestion, the specialty types specified in the form are primarily based on those listed in Insurance Code §1301.00553 and §1301.0055(b)(4). While insurers are required to provide an adequate network of providers for all covered services, TDI does not currently require data on all provider types. Insurers should review the network compliance and waiver request form, as changed from the versions available when these sections were proposed, and contact TDI staff if there are questions.

Comment: Multiple commenters state that HB 3359 added Insurance Code §1301.0056(e), which requires the information provided by the petitioning health plan in a waiver request to include credentialling information of the providers. They note that this information is especially important for facility-based physicians like anesthesiologists because their credentials include medical staff privileges, which distinguishes them from physicians who provide only limited medical treatment, such as clinic-based pain

management specialists. One of the commenters asserts that this will ensure the plans are considering practicing anesthesiologists and not using inappropriate providers to create the appearance of an adequate network. The commenter suggests that credentialling information should also be listed in the waiver directories for transparency purposes, and recommends that TDI add language to §3.3712 to require that physician and medical provider specialty and credentialling information be included in the network configuration filings submitted by the health plan in its waiver request and in the waiver directory to ensure physicians are being appropriately considered according to their specific facility privileges or credentialling, in addition to specialty.

Agency Response: TDI notes that "facility-based physician or provider" is defined in §3.3702(b) as a physician or health care provider to whom a facility has granted clinical privileges and who provides services to patients of the facility. TDI's credentialing requirements are found in §3.3706. In addition, the network analysis and waiver request form contains a facility-based provider tab, which is limited to reporting providers who are actually practicing at facilities. TDI agrees that credentialling information could be important in analyzing a carrier's network adequacy but believes that instances of carriers disguising an inadequate network through the use of inappropriately credentialed providers will most often be identified by other providers in the same field of practice. TDI encourages providers to make complaints on this issue and has added new §3.3712(e) to make it clear that this information must be made available to TDI on request.

Comment: A commenter requests that TDI clarify when the first network configuration information must be submitted by an insurer to TDI. The commenter notes that, in the preamble to the proposal, TDI explained that the first annual report would be due April 1,

2024, and asks whether the same will apply to the network configuration filing, or whether a different date will be allowed.

Agency Response: To provide adequate time for insurers to submit filings after the rule is adopted, TDI will allow insurers until May 1, 2024, to submit their annual report filings for 2024. The due date will remain April 1 for future years. As specified in §3.3709(b)(2), the network configuration information must be included in each annual report. The rules as adopted will apply to any network configuration filing that is submitted on or after the day the rule becomes effective.

Comment: A commenter requests that TDI consider a rule that would require insurers to indicate whether the insurer includes particular pediatric specialties in its network configuration to illustrate compliance with the network adequacy standards in §1301.055(b)(4), (6), and (8) of the Insurance Code and in proposed §3.3704(f). The commenter notes that specialists who see only adult patients should not be permitted to meet network adequacy requirements for pediatric patients who need specialty care.

Agency Response: With respect to the standards in Insurance Code §1301.0055(b)(4), TDI has expanded the worksheet in the network compliance and waiver request form on which insurers will list each in-network facility and demonstrate that a sufficient number of applicable types of specialty and diagnostic physicians and providers are available at the facility, consistent with §3.3712(c)(2)(A) - (C). The initial posting of the form included only a truncated version of this worksheet; TDI apologizes for any confusion. With respect to the standards in Insurance Code §1301.0055(b)(6), including pediatric specialties, the cover page of the network compliance and waiver request form requires insurers to explain how they comply, consistent with §3.3712(c)(2)(D). With respect to the standards

for hospital services in Insurance Code §1301.0055(b)(8), TDI has a major medical worksheet in the network compliance and waiver request form on which insurers will list each in-network hospital, consistent with the types of institutional providers listed in Insurance Code §1301.00553.

Comment: A commenter requests that TDI create more thorough guidance for plans on how to fill out the new form templates and what certain fields mean, and provide acceptable examples, as this will save time for both plans and TDI because the filed forms will need fewer corrections and amendments. The commenter also provides suggestions for technical corrections: (1) that Deaf Smith County should be FIPS Code 48117, Region 1, Rural; (2) that Delta County should be FIPS Code 48119, Region 4, Metro; and (3) that Denton County should be FIPS Code 48121, Region 3, Metro.

Another commenter asks TDI to confirm that blanks or "N/A" will be accepted, as not all providers have facility privileges. The commenter also asks whether provider types will be reported by separate tabs, asks TDI to specifically list the provider types required on the provider listing, and, if separate tabs are required, asks TDI to clarify what data points will be required on each tab.

Agency Response: Regarding the request for additional guidance on how to fill out forms, TDI has provided additional information within the form, for example, by filling out the first row of data as an example. Regarding the technical corrections, TDI agrees and has made the suggested changes to the County Designation reference worksheets, except for classifying Delta as a metro county. As of March 1, 2023, CMS classifies Delta as a rural county. TDI confirms that "N/A" will be accepted for the reporting of facility privileges within the provider listing form since not all providers have facility privileges. Finally, TDI

confirms that the required preferred provider types are included in a drop-down list under the Provider type column.

The attempt to contract and network compliance and waiver request forms include a table listing applicable network adequacy standards and a worksheet illustrating each county's classification, consistent with Insurance Code §1301.00553. The network compliance and waiver request form includes separate worksheets for hospital-based providers and all other major medical providers. TDI also created a separate network compliance and waiver request form for single service vision filings that has a single worksheet for all applicable vision care providers.

Comment: Several commenters collectively note that the provisions in §3.3712(c) fail to capture all the information specified in Insurance Code §1301.0056(e)(1), which requires TDI to adopt rules that require insurers to provide access to or submit data or information that includes "a searchable and sortable database of network physicians and health care providers by national provider identifier, county, physician specialty, hospital privileges and credentials, and type of health care provider or licensure, as applicable." The commenters add that §3.3712(c)(1)(B)(iii) and the provider listings form both erroneously conflate a "physician specialty" with "type of health care provider or licensure," in conflict with the underlying statute.

In addition, the commenters note that §3.3712(c)(1)(C) fails to require an insurer to include information related to "hospital privileges and credentials," also in conflict with the underlying statute. The commenters also assert that §3.3712(c)(2) and the network compliance and waiver request form both erroneously conflate a "physician specialty" with "type of health care provider or licensure," in conflict with the underlying statute. The

commenters next oppose §3.3712(c), as it fails to capture all the information specified in Insurance Code §1301.0056(e)(1), contains problematic language concerning telehealth, and ceases to require the submission of maps for each physician specialty demonstrating the location and distribution of each physician and the provider network within the insurer's service area.

Next, the commenters note that §3.3712(c)(1)(B)(iv) and the corresponding spreadsheet in the provider listing form references telehealth but should also reference telemedicine, which is provided by physicians. The commenters also oppose counting physicians or providers that offer only telemedicine or telehealth services toward network adequacy requirements, as this would severely diminish the strength of the networks and undermine the Legislature's intent. The commenters recommend that TDI's forms be updated to instruct insurers that physicians and providers offering solely these services either must not be listed or must be clearly identified as such so that TDI can exclude them from network adequacy calculations. Finally, the commenters recommend that TDI amend §3.3704 to include a new subsection expressly stating that physicians or health care providers who offer only telemedicine or telehealth services, respectively, will not be counted toward network adequacy requirements.

Agency Response: Regarding the comment that §3.3712(c) fails to capture all the information specified in Insurance Code §1301.0056(e)(1), TDI notes that its intent was not to require provision of all the statutory information by insurers in advance of TDI's review, but for TDI to request some of the information as needed for the review. TDI has clarified this by changing the proposed text to add §3.3712(e), requiring that insurers provide access upon request to any necessary information, including information contained in Insurance Code §1301.0056(e). TDI is also capturing relevant information for assessing

compliance with §3.3704(f)(3) within the new form templates. The network compliance and waiver request form includes a separate worksheet that includes information on the number of preferred providers of each applicable specialty type that are available within each in-network facility. Insurers will also submit information on facility privileges in the provider listing form and the attempt to contract form.

Regarding the use of the phrases "provider's specialty type" in §3.3712(c)(1)(B)(iii), TDI has changed the proposed text to add clarifying language to the subsection. Based on comment, TDI has also changed the proposed text to clarify other instances throughout the adopted sections where TDI referenced only "provider."

Regarding telehealth, TDI agrees that the reference to telehealth in §3.3712(c) as proposed was too limited and thus, in the adopted text, has added the reference to telemedicine. While TDI will collect data on telehealth (and telemedicine) providers, TDI agrees that a provider that offers services only in this manner would not count toward meeting network adequacy requirements in a particular area of the state. Permitting this would render the mileage requirements in the statute meaningless. However, in light of the language of the statute, TDI does not believe a change in rule text is necessary.

Regarding TDI's decision to discontinue requirements for network maps, TDI notes that, while maps were useful under the prior network requirements, the agency does not believe they are necessary in the context of driving distance requirements. Under the prior network requirements, TDI measured distance standards based on radius, which could be easily illustrated using maps. In contrast, specialized software is needed to measure compliance with the driving distance requirements. Further, there is no reference in Insurance Code Chapter 1301 to requiring the submission of maps by insurers.

Comment: One commenter requests that TDI clarify what responses regarding telehealth data will be acceptable, asking that "Yes, No, or Unknown" be permitted, since this information is self-reported by the provider and not consistently available.

Agency Response: TDI agrees that these responses will be acceptable, as long as the carrier has made good faith efforts to obtain the requested information.

Comment: A commenter requests clarification regarding page 6 of the network compliance and waiver request form, where there is a hospital listing, as to whether this is solely a hospital listing or is a hospital-based form meant to indicate if at least two preferred physicians are available for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility.

Agency Response: The network compliance and waiver request form includes a worksheet on which insurers will report all facility types described in Insurance Code §1301.0055(b)(4), and each specialty type that is applicable to each facility. The worksheet is designed to reflect compliance with the standards for facility-based physicians and providers in §3.3704(f)(3).

Comments on §3.3722 - Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications, and §3.3723 - Examinations.

Comment: Several commenters collectively note that, in §3.3722 and §3.3723, TDI did not add language to implement the provisions of Insurance Code §1301.0056, which requires (1) that an insurer is subject to a qualifying examination and subsequent quality of care and network adequacy examinations, and (2) that insurers must provide access to or

submit data or information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards, including the information described by Insurance Code §1301.0056(e)(1) - (4).

Agency Response: TDI partially agrees and has changed the text of §3.3722(c)(10) as proposed to add a requirement that the applicant provide documentation showing that its plan procedures and documents are compliant with §3.3707(j) - (m). TDI has also changed the text of §3.3723(f)(7) as proposed to require demographic data for an exam. However, TDI disagrees that it is necessary to restate the statutory requirement that TDI conduct an exam.

Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies
28 TAC §3.3038

STATUTORY AUTHORITY. The commissioner adopts amendments to §3.3038 under Insurance Code §§1202.051, 1301.0056, and 36.001.

Insurance Code §1202.051 requires the commissioner to adopt rules necessary to implement the section.

Insurance Code §1301.0056 requires the commissioner to adopt rules establishing a process for examining a preferred provider benefit plan before an insurer offers the plan for delivery.

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.

TEXT.

§3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions.

(a) Except as provided by this section, all individual hospital, medical, or surgical coverage (as defined in §3.3002(b)(12) of this title (relating to Definitions)) must be renewed or continued in force at the option of the insured.

(b) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of individual hospital, medical, or surgical coverage; however, such coverage sold to an insured before the insured attains Medicare eligibility may contain a clause that excludes payments for benefits under the policy to the extent that Medicare pays for such benefits.

(c) Individual hospital, medical, or surgical coverage may only be discontinued or nonrenewed based on one or more of the following circumstances:

(1) the policyholder has failed to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;

(2) the policyholder has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy;

(3) the insurer is ceasing to offer individual hospital, medical, or surgical coverage under the particular type of policy, or is ceasing to offer any form of individual hospital, medical, or surgical coverage in this state or in the insurer's service area, in accordance with subsections (d) and (e) of this section;

(4) in regard only to coverage offered by an issuer under Insurance Code Chapter 842, concerning Group Hospital Service Corporations, or Chapter 1301,

concerning Preferred Provider Benefit Plans, the insured no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health-status-related factor of covered individuals.

(d) An insurer may elect to discontinue offering a particular type of individual hospital, medical, or surgical coverage plan in the individual market only if the insurer:

(1) provides written notice to the commissioner and each covered individual of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage;

(2) offers to each covered individual on a guaranteed issue basis the option to purchase any other individual hospital, medical, or surgical insurance coverage offered by the insurer at the time of the discontinuation; and

(3) acts uniformly without regard to any health-status related factors of a covered individual or dependents of a covered individual who may become eligible for the coverage.

(e) An insurer may elect to refuse to renew all individual hospital, medical, or surgical coverage plans delivered or issued for delivery by the insurer in this state or in the insurer's service area, only if the insurer:

(1) notifies the commissioner of the election not later than the 180th day before the date coverage under the first individual hospital, medical, or surgical health benefit plan terminates;

(2) notifies each affected covered individual not later than the 180th day before the date on which coverage terminates for that individual; and

(3) acts uniformly without regard to any health-status related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(f) An insurer that elects not to renew all individual hospital, medical, or surgical coverage in Texas or in the insurer's service area in accordance with subsection (e) of this section may not issue any such coverage in Texas or in the insurer's service area during the five-year period beginning on the date of discontinuation of the last such coverage not renewed.

(g) Nothing in this section prohibits or restricts an insurer's ability to make changes in premium rates by classes in accordance with applicable laws and regulations.

(h) Nothing in this section may be interpreted as prohibiting an insurer from making policy modifications mandated by state law, or, acting consistently with §3.3040(b) of this title (relating to Prohibited Policy Provisions), from honoring requests from a policyholder for modifications to an individual policy or offering policy modifications uniformly to all insureds under a particular policy form, if:

(1) the modification meets the definition of a uniform modification under subsection (i) of this section; and

(2) the notice describes the uniform modifications and includes any rate change notice required under Insurance Code §1201.109, concerning Notice of Rate Increase for Major Medical Expense Insurance Policy.

(i) For the purposes of this section, a "uniform modification" is a change to coverage that is made at the time of coverage renewal, applies uniformly for all insureds covered under the policy form, and complies with the requirements of 45 CFR §147.106(e) and (f), concerning Guaranteed Renewability of Coverage.

(j) A notice that is required to be provided to the commissioner under this section must be submitted as an informational filing consistent with the procedures specified in Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(k) If a nonrenewal addressed under this section occurs in connection with a change to the insurer's service area, the insurer must make network configuration filings consistent with requirements in Chapter 3, Subchapter X, of this title (relating to Preferred and Exclusive Provider Plans).

Subchapter X. Preferred and Exclusive Provider Plans
Division 1. General Requirements
28 TAC §§3.3702 - 3.3705 and 3.3707 - 3.3712

STATUTORY AUTHORITY. The commissioner adopts amendments to §§3.3702 - 3.3705 and 3.3707 - 3.3711 and new §3.3712 under Insurance Code §§541.401, 1301.0055, 1301.0056, 1301.007, 1369.057, 1458.004, 1701.060, and 36.001.

Insurance Code §541.401 authorizes the commissioner to adopt reasonable rules necessary to accomplish the purposes of Chapter 541.

Insurance Code §1301.0055 requires the commissioner to adopt network adequacy standards that include requirements set out in the section.

Insurance Code §1301.0056 requires the commissioner to adopt rules establishing a process for examining a preferred provider benefit plan before an insurer offers the plan for delivery.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services.

Insurance Code §1369.057 authorizes the commissioner to adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1458.004 authorizes the commissioner to adopt rules to implement Chapter 1458.

Insurance Code §1701.060 authorizes the commissioner to adopt reasonable rules necessary to implement the purposes of Chapter 1701.

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.

TEXT.

§3.3702. Definitions.

(a) Words and terms defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, 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), concerning Definitions.

(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) Facility--As defined in Health and Safety Code §324.001(7), concerning Definitions.

(8) Facility-based physician or provider--As defined in Insurance Code §1451.501, concerning Definitions.

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

(10) Health maintenance organization (HMO)--As defined in Insurance Code §843.002(14), concerning Definitions.

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

(13) 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) 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) 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) SERFF--The National Association of Insurance Commissioners (NAIC) System for Electronic Rates & Forms Filing.

(18) Urgent care--Medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

(19) Utilization review--As defined in Insurance Code §4201.002(13).

§3.3703. Contracting Requirements.

(a) An insurer marketing a preferred provider benefit plan must contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that ensures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must meet the following requirements:

(1) A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs.

(2) Any term or condition limiting participation on the basis of quality that is contained in a contract between a preferred provider and an insurer is required to be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider must not, as a condition of staff membership or privileges, require a physician or

practitioner to enter into a preferred provider contract. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may not require the preferred provider to pay hospital, institutional, laboratory, X-ray, or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's contract with a physician, physician group, or practitioner must have a mechanism for the resolution of complaints initiated by an insured, a

physician, physician group, or practitioner. The mechanism must provide for reasonable due process, including, in an advisory role only, a review panel selected as specified in §3.3706(b)(2) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may not require any health care provider, physician, or physician group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must require a preferred provider who is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to insureds.

(12) A contract between a preferred provider and an insurer must require the provider to comply with the Insurance Code §§1301.152 - 1301.154, which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in Insurance Code §1301.067, concerning Interference with Relationship Between Patient and Physician or Health Care Provider Prohibited, about any of the matters set forth in the contract.

(14) A contract between a preferred provider and an insurer conducting, using, or relying upon economic profiling to terminate physicians or health care providers from a plan must require the insurer to inform the provider of the insurer's obligation to comply with Insurance Code §1301.058, concerning Economic Profiling.

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to disclose in the contract all requirements of Insurance Code §1301.059(b), concerning Quality Assessment.

(16) A contract between a preferred provider and an insurer may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may not prohibit a pharmacist from administering immunizations or vaccinations if they are administered in accordance with the Texas Pharmacy Act, Chapters 551 - 566 and Chapters 568 - 569 of the Occupations Code, and implementing rules.

(18) A contract between a preferred provider and an insurer must require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must require the insurer to provide assistance to the provider as set forth in Insurance Code §1301.160(b), concerning Notification of Termination of Participation of Preferred Provider.

(19) A contract between a preferred provider and an insurer must require written notice to the provider on termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must include the provider's right to request a review, as specified in §3.3706(d) of this title.

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including email, computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided in accordance with this paragraph are required to be made under subparagraph (D) of this paragraph and, when applicable subparagraph (J) of this paragraph. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to include a preferred provider specific summary and explanation of all payment and reimbursement methods that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes or successor codes, and modifiers:

(I) by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is being requested if that information has not previously been provided to the preferred provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which are required to be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

(vi) any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided under this paragraph; and

(vii) the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to clearly identify the source and explain the procedure by which the preferred provider may

readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will be effective as to the preferred provider, unless the insurer provides at least 90 calendar days' written notice to the preferred provider identifying with specificity the amendment, revision, or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon receipt of a request, the insurer is

required to provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

(IV) communications with a governmental agency involved in the regulation of health care or insurance;

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided in accordance with this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred provider chooses to terminate the contract, the insurer is required to assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract.

(J) No adverse material change to a preferred provider contract will be effective as to the preferred provider unless the adverse material change is made in accordance with Insurance Code §1301.0642, concerning Contract Provisions Allowing Certain Adverse Material Changes Prohibited, to the extent applicable.

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured:

(A) that the physician, provider, or facility to whom the insured is being referred might not be a preferred provider; and

(B) if applicable, that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of Insurance Code §1661.005, concerning Refund of Overpayment.

(26) A contract between an insurer and a facility must require that the facility give notice to the insurer of the termination of a contract between the facility and a facility-based physician or provider group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

(27) A contract between an insurer and a preferred provider must require, except for instances of emergency care as defined under Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care and §1301.155(a), concerning Emergency Care, that a physician or provider referring an insured to a facility for surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information;

(B) notify the insurer that surgery has been recommended; and

(C) notify the insurer of the facility that has been recommended for the surgery.

(28) A contract between an insurer and a facility must require, except for instances of emergency care as defined under Insurance Code §1301.0053 and §1301.155(a), that the facility, when scheduling surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and

(B) notify the insurer that surgery has been scheduled.

(29) A contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning Contract Requirements, to the extent applicable.

(30) A contract between an insurer and a preferred provider that is an optometrist or therapeutic optometrist must comply with Insurance Code Chapter 1451, Subchapter D, concerning Access to Optometrists Used Under Managed Care Plan.

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, and the provisions of that subchapter will be employed to the extent practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization, an exclusive provider network, or a health care collaborative for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter;

(2) ensure that the requirements of Insurance Code Chapter 1301 and this subchapter are met; and

(3) provide all documentation to demonstrate compliance with all applicable rules on request by the department.

§3.3704. Freedom of Choice; Availability of Preferred Providers.

(a) Fairness requirements. A preferred provider benefit plan is not considered unjust under Insurance Code Chapter 1701, concerning Policy Forms, or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, or Chapter 544, Subchapter B, concerning Other General Prohibitions Against Discrimination by Insurers, or to violate Insurance Code Chapter 1451, Subchapter A, concerning General Provisions; Subchapter B, concerning Designation of Practitioners Under Accident and Health Insurance Policy; or Subchapter C, concerning Selection of Practitioners, provided that:

(1) in accordance with Insurance Code §§1251.005, concerning Payment of Benefits; 1251.006, concerning Policy May Not Specify Service Provider; 1301.003, concerning Preferred Provider Benefit Plans and Exclusive Provider Benefit Plans Permitted, 1301.006, concerning Availability of and Accessibility to Health Care Services; 1301.051, concerning Designation as Preferred Provider; 1301.053, concerning Appeal Relating to Designation as Preferred Provider; 1301.054, concerning Notice to Practitioners of Preferred Provider Benefit Plan; 1301.055, concerning Complaint Resolution; 1301.057 - 1301.062, concerning Termination of Participation; Expedited Review Process, Economic Profiling, Quality Assessment, Compensation on Discounted Fee Basis, Preferred Provider Networks, and Preferred Provider Contracts Between Insurers

and Podiatrists; 1301.064, concerning Contract Provisions Relating to Payment of Claims; 1301.065, concerning Shifting of Insurer's Tort Liability Prohibited; 1301.151, concerning Insured's Right to Treatment; 1301.156, concerning Payment of Claims to Insured; and 1301.201, concerning Contracts with and Reimbursement for Nurse First Assistants, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds have the right to continuity of care as set forth in Insurance Code §§1301.152 - 1301.154, concerning Continuing Care in General, Continuity of Care, and Obligation for Continuity of Care of Insurer, respectively;

(5) insureds have the right to emergency care services as set forth in Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care; and §3.3708 of this title (relating to Payment of Certain Out-of-Network Claims and Related Disclosures);

(6) the out-of-network (basic) level of coverage, excluding a reasonable difference in deductibles, is not more than 50% less than the higher level of coverage, except as provided under an exclusive provider benefit plan. A reasonable difference in deductibles is determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider, or in the selection of a preferred provider under an exclusive provider benefit plan, are not restricted by the insurer, including by requiring an insured to select a primary care physician or provider or obtain a referral before seeking care;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the out-of-network level of coverage of a plan that is not an exclusive provider benefit plan is reasonably consistent with other health insurance policies offered by the insurer that do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan are taken under Insurance Code Chapter 4201, concerning Utilization Review Agents, and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy) and the insurer does not penalize an insured solely on the basis of a failure to obtain a preauthorization;

(10) a preferred provider benefit plan that is not an exclusive provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

(11) both preferred provider benefits and out-of-network level benefits are reasonably available to all insureds within a designated service area; and

(12) if medically necessary covered services are not reasonably available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accordance with Insurance Code §1301.005, concerning Availability of Preferred Providers, and §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services, and §3.3708 of this title, as applicable.

(b) Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code Chapter 1701; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or Chapter 544, Subchapter B; or to violate Insurance Code Chapter 1451, Subchapter C, provided that:

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

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

(c) Payment of nonpreferred providers. Payment by the insurer must be made for covered services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(d) Retaliatory action prohibited. An insurer is prohibited from engaging in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider or has appealed a decision of the insurer.

(e) Steering and tiering. An insurer that uses steering or a tiered network to encourage an insured to obtain a health care service from a particular provider, as defined

under Insurance Code Chapter 1458, concerning Provider Network Contract Arrangements, must do so in a manner that complies with the requirements of the Insurance Code, including the fiduciary duty imposed by Insurance Code §1458.101(i), concerning Contract Requirements, to act only for the primary benefit of the insured or policyholder. For the purposes of this section:

(1) "steering" refers to offering incentives to encourage enrollees to use specific providers;

(2) a "tiered network" refers to a network of preferred providers in which an insurer assigns preferred providers to tiers within the network that are associated with different levels of cost sharing; and

(3) violations of the fiduciary duty under Insurance Code §1458.101(i) will be determined by TDI based on assessment of the insurer's conduct. Examples of conduct that would violate the insurer's fiduciary duty include, but are not limited to:

(A) using a steering approach or a tiered network to provide a financial incentive as an inducement to limit medically necessary services, to encourage receipt of lower quality medically necessary services, or in violation of state or federal law;

(B) failing to implement reasonable processes to ensure that the preferred providers that insureds are encouraged to use within any steering approach or tiered network are not of a materially lower quality as compared with preferred providers that insureds are not encouraged to use;

(C) failing to implement reasonable processes to ensure that the insurer does not make materially false statements or representations about a physician's or health care provider's quality of care or costs; or

(D) failing to use objectively and verifiably accurate and valid information as the basis of any encouragement or incentive under this subsection.

(f) Network requirements.

(1) Each preferred provider benefit plan must include a health care service delivery network that complies with:

(A) Insurance Code §1301.005;

(B) Insurance Code §1301.0055, concerning Network Adequacy Standards;

(C) Insurance Code §1301.00553, concerning Maximum Travel Time and Distance Standards by Preferred Provider Type, which applies maximum travel time in minutes and maximum distance in miles for a county based on the county's classification as specified in the network compliance and waiver request form available at www.tdi.texas.gov;

(D) Insurance Code §1301.00554, concerning Other Maximum Distance Standard Requirements; Commissioner Authority;

(E) Insurance Code §1301.00555, concerning Maximum Appointment Wait Time Standards, effective for a policy delivered, issued for delivery, or renewed on or after September 1, 2025; and

(F) Insurance Code §1301.006.

(2) An adequate network must, for each insured residing in the service area, ensure that all insureds can access a choice of at least two preferred providers for each physician specialty and each class of health care provider within the time and distance standards specified in Insurance Code §1301.00553 and §1301.00554.

(3) To provide a sufficient number of the specified types of preferred providers with the specialty and diagnostic types listed in Insurance Code §1301.0055(b)(4), a network must include at least two preferred physicians for each applicable specialty and diagnostic type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility that credentials the particular specialty.

(4) For specialty care and specialty hospitals for which time and distance standards are not otherwise specified in Insurance Code §1301.00553, an adequate network must ensure that all insureds residing in the service area can access a choice of at least two preferred providers within a distance not greater than 75 miles.

(g) Network monitoring and corrective action. Insurers must monitor compliance with subsection (f) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. Consistent with Insurance Code §1301.0055, an insurer must report any material deviation from the network adequacy standards to the department within 30 days of the date the material deviation occurred, by submitting a network configuration filing as specified in §3.3712 of this title (relating to Network Configuration Filings). Unless there are no uncontracted licensed physicians or providers within the service area to meet the standard in the affected county, or the insurer requests a waiver, the insurer must promptly take corrective action to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred.

(h) Service areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but may not divide a

county. Any service areas that are smaller than statewide must be defined in terms of one or more Texas counties.

§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 title (relating to Plain Language Requirements).

(b) Plan disclosure. 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 (plan disclosure) 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 policy, certificate, or handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection, including the level of disclosure required. An insurer that is required by federal law to provide a summary of benefits and coverage (SBC) must include in the SBC a link to the plan disclosure required in this subsection. The written plan disclosure must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items:

(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 website 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, if prescription drug coverage is included, the name of the formulary used by the plan, a link to the online formulary, and an explanation regarding how a nonelectronic copy may be obtained free of charge;

(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 an explanation that unless a provider obtains preauthorization, a claim could be denied if a service is not medically necessary or appropriate, or if a service is experimental or investigational;

(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) the name of the provider network used by the plan, a link to the online provider listing, and information on how a nonelectronic copy may be obtained free of charge;

(13) the counties included in the plan's service area; and

(14) information that is updated at least annually regarding the following network demographics for each county:

(A) the number of insureds in the service area or region;

and

(B) for each preferred provider area of practice and applicable network adequacy standard, the number of preferred providers, as well as an indication of whether an active waiver and access plan under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) applies to the services furnished by that class of provider in the county and how such access plan may be obtained or viewed, if applicable.

(c) Filing required. A copy of the plan disclosure 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.

(d) Promotional disclosures required.

(1) 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 out-of-network benefits, except in the case of an exclusive provider benefit plan.

(2) All promotion and advertisement of the preferred provider benefit plan for which a waiver has been granted must contain a statement that the plan received a waiver for a departure from network adequacy requirements and a website link where the following information about the waiver may be obtained:

(A) the name of the plan and the insurer offering the plan;

(B) the specific network adequacy standards waived;

(C) each county affected by the waiver; and

(D) the access plan procedures the insurer will use to assist insureds in obtaining medically necessary services, consistent with §3.3707(j) of this title.

(e) Website disclosures. Insurers that 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 must provide on their website a:

(1) preferred provider listing for use by current and prospective insureds and group contract holders;

(2) listing of the counties within the insurer's service area, indicating as appropriate for each county 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) listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1) for a preferred provider benefit plan that provides major medical insurance and is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2) for an exclusive provider benefit plan that provides major medical insurance, in all policies, certificates, plan disclosures provided to comply with subsection (b) of this section, and outlines of coverage in at least 12-point font:

(1) Preferred provider benefit plan notice.

Figure: 28 TAC §3.3705(f)(1)

Your rights with a preferred provider benefit plan (PPO)

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

Health care costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at [enter website] or by calling [enter phone number].

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Health care bills

If you want to see a doctor or facility that isn't in your plan's network, you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

(2) Exclusive provider benefit plan notice.

Figure 28 TAC §3.3705(f)(2)

Your rights with an exclusive provider benefit plan (EPO)

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including: emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at [enter website] or by calling [enter phone number].

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

(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 preferred provider listings. The insurer must ensure that it updates its listing of preferred providers on its website at least once a month, as required by Insurance Code §1451.505, concerning Physician and Health Care Provider Directory on Internet Website. The insurer must ensure that it updates all other electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of preferred provider listing required in certain cases. If no preferred provider website 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 preferred 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(a)(5) of this title (relating to Payment of Certain Out-of-Network Claims), and the insurer must take responsibility for any balance bill amount the nonpreferred provider may charge in excess of the insurer's payment 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 preferred provider listing; or

(B) preferred provider information on the insurer's website;

(2) the preferred 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 preferred provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the preferred 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 website postings by the insurer to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) - (11) of this subsection.

(1) The preferred provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good-faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or provider 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 provider or physician group is a preferred provider.

(2) The preferred provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

(3) In determining the percentages specified in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The preferred provider information must indicate whether each preferred provider is accepting new patients.

(5) The preferred 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 preferred provider information must provide a method by which insureds may identify preferred provider facility-based physicians or providers able to provide services at preferred provider facilities, if applicable.

(7) The preferred provider information must be provided in at least 10-point type.

(8) The preferred 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 preferred provider information must be dated.

(10) Consistent with Insurance Code Chapter 1451, Subchapter K, concerning Health Care Provider Directories, 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, anesthesiologist assistants, nurse anesthetists, nurse midwives, pathologists, emergency department physicians, neonatologists, physical therapists, occupational therapists, speech-language pathologists, and surgical assistants, except

that a physician or health care provider who is employed by the facility is not required to be listed;

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

(C) for the facility and each facility-based physician or provider 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 provider, or facility-based physician or provider group;

(D) for each facility-based physician or provider described by subparagraph (B) of this paragraph, include the name, street address, telephone number, and any physician or provider group in which the facility-based physician or provider 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) Consistent with Insurance Code Chapter 1451, Subchapter K, the listing must list each facility-based physician or provider individually and, if a physician or provider belongs to a physician or provider group, also as part of the physician or provider group.

(m) Annual policyholder notice concerning use of an access plan. An insurer operating a preferred provider benefit plan that relies on an 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 information on network waivers and access plans disclosed under subsection (d)(2) of this section and made available under subsection (e) of this section;

(2) information on how to obtain or view any 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 or providers at a preferred provider facility.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician or provider group that comprises 75% 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 or provider group that comprises 75% 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) For purposes of this subsection, decreases in numbers of physicians and other providers must be assessed separately, but 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 or provider group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer determines that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) as those standards apply to the applicable provider specialty.

(3) An insurer must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of this subsection; or

(B) six months from the date that the insurer initially posts the notice.

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its website preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

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

(1) An insurer must disclose how reimbursements of nonpreferred providers will be determined.

(2) An insurer must disclose how the plan will cover out-of-network services received when medically necessary covered services are not reasonably available through a preferred provider, consistent with §3.3708 of this title and how an enrollee can obtain assistance with accessing care in these circumstances, consistent with §3.3707(k) of this title.

(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, unless balance billing protections apply, as specified in §3.3708(a)(1) - (4) of this title;

(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.

§3.3707. Waiver Due to Failure to Contract in Local Markets.

(a) Consistent with Insurance Code §1301.0055(a)(3), concerning Network Adequacy Standards, where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a county that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. After considering all pertinent evidence in a public hearing under Insurance Code §1301.00565, concerning Public Hearing on Network Adequacy Standards Waivers, the commissioner may grant the waiver if the requestor shows good cause, subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5). The

commissioner may deny a waiver request if good cause is not shown and may impose reasonable conditions on the grant of the waiver.

(b) An insurer seeking a waiver under subsection (a) of this section must submit waiver and access plan information required under §3.3712(c) of this title (related to Network Configuration Filings) and information justifying the waiver request as specified in this subsection using the attempt to contract form available at www.tdi.texas.gov. An insurer must submit the network compliance and waiver request form and the attempt to contract form to the department using SERFF or another electronic method that is acceptable to the department. For each waiver requested with respect to a type of physician or provider in a given county, the insurer must provide either the information specified by paragraph (1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.

(1) If providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must include, within the attempt to contract form:

(A) a list of the providers or physicians within the relevant service area that the insurer attempted to contract with, identified by name and specialty or facility type, and including the physician or provider's address and county; national provider identifier, contact name, email, and phone number; and for facility-based physicians or providers, the group name and associated facility;

(B) a description of how and when the insurer last contacted each provider or physician that demonstrates that the insurer made a good faith effort to contract, as defined in Insurance Code §1301.00565(a), including:

(i) in the case of a waiver that is being requested more than two consecutive times for the same network adequacy standard in the same county, evidence that the insurer made multiple good faith attempts during each of the prior consecutive waiver periods;

(ii) in the case of a waiver that is being requested more than four times within a 21-year period for the same network adequacy standard in the same county, evidence that the insurer has been unable to remedy the issue through good faith efforts;

(C) a description of any reason each provider or physician gave for declining to contract with the insurer, such as the provider's or physician's participation in any exclusivity arrangement or other external factors that affect the ability of the parties to contract;

(D) a description of all steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary;

(E) a description of the source or sources the insurer uses to identify physicians and providers that are available in the service area, and how often the insurer monitors these sources for new physicians and providers entering the service area; and

(F) a description of the insurer's policies and procedures for reaching out to available physicians and providers, including how many attempts the insurer makes and if different policies and procedures apply for different specialty types.

(2) If there are no providers or physicians available within the relevant service area with whom a contract would allow the insurer to meet the specific standard for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.

(c) At the same time an insurer files a request for waiver or a request to renew a waiver, it must file an access plan, to be taken into consideration by the commissioner in deciding whether to grant or deny a waiver request, subject to Insurance Code §1301.00566, concerning Effect of Network Adequacy Standards Waiver on Balance Billing Prohibitions. The insurer must:

(1) develop access plan procedures consistent with subsection (j) of this section; and

(2) file the access plan as required in §3.3712(c)(2)(C)(iv) of this title.

(d) If the insurer believes that the information provided under subsection (b) of this section in the attempt to contract form includes proprietary information that is confidential and not subject to disclosure as public information under Government Code Chapter 552, concerning Public Information, the insurer must mark the document as confidential in SERFF. If the insurer marks the document as confidential, it must include in the filing an explanation of which information contained in the document is proprietary, and which information is not. However, consistent with Insurance Code 1301.00565(g), certain information is subject to release regardless of marking, and the department may publish or otherwise release such information. The insurer is not permitted to mark the entire filing as confidential. When scheduling a hearing related to a waiver request, the department will send a notice of the hearing to any provider or physician named in the waiver request.

(e) Any provider or physician may elect to provide a response to an insurer's request for waiver by sending an email to networkwaivers@tdi.texas.gov within 15 days after receiving notice from the department. The response, if filed, must indicate whether the provider or physician consents to being identified at a hearing related to the waiver

request and may include evidence that is pertinent to the waiver request for the commissioner's consideration.

(f) If the department grants a waiver under subsection (a) of this section, the department will post on the department's website information relevant to the grant of a waiver, consistent with Insurance Code §1301.0055(a)(3).

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually.

(1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section and submitted at the time the insurer files its annual report under §3.3709 of this title (relating to Annual Network Adequacy Report).

(2) At the same time the insurer files an application for renewal of a waiver, the insurer must develop and file any applicable access plan the insurer uses in accordance with the waiver, in the manner specified by subsection (c) of this section.

(h) When granting a waiver, the department will specify the one-year period for which the waiver will apply. A waiver will expire at the end of the period specified by the department unless the insurer requests a renewal under subsection (g) of this section and the department approves the insurer's request for renewal.

(i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this title for a specific county, the insurer must establish an access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver in accordance with subsection (a) of this section requesting that the department approve the continued use of the access plan.

(j) An insurer must establish and implement documented procedures, as specified in this subsection, for use in all service areas for which an access plan is submitted, as required by subsections (c), (i), or (m) of this section. These procedures must be made available to the department upon request. When a preferred provider is not available within the network adequacy standards under §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers) to provide a medically necessary covered service, the insurer must use a documented procedure to:

(1) identify requests for preauthorization of services for insureds that are likely to require the rendition of services by physicians or providers that do not have a contract with the insurer;

(2) upon request by an insured or an individual acting on behalf of an insured, and within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient but in no event to exceed five business days, approve a network gap exception and facilitate access to care by recommending at least two physicians or providers that:

(A) have expertise in the necessary specialty;

(B) are reasonably available considering the medical condition and location of the insured; and

(C) the insured may choose to use without being liable for any amount charged by the physician or provider that exceeds the insured's cost-sharing responsibilities under the preferred provider benefit level;

(3) furnish to insureds, prior to the services being rendered, an explanation of their rights, consistent with §3.3708(b)(1)(B) of this title (relating to Payment of Certain Out-of-Network Claims);

(4) except when a physician or provider is prohibited from balance billing, as specified in §3.3708(a)(1) - (4) of this title, notify insureds that they may be liable for any amounts charged by the physician or provider that are more than the insurer's reimbursement rate, unless the insured uses a physician or provider recommended by the insurer.

(5) identify claims filed by nonpreferred providers in instances in which no preferred provider was available to the insured; and

(6) make initial and, if required, subsequent payment of the claims in the manner required by this subchapter.

(k) For the purposes of paragraph (j)(2) of this section, a network gap exception means an insurer's approval for an insured to receive care from a nonpreferred provider under the preferred provider benefit level because access to care through a preferred provider is not available within network adequacy standards. When facilitating care as required under paragraph (j)(2) of this section, a recommended physician or provider is reasonably available if they are:

(1) a nonpreferred provider within the network adequacy standards in §3.3704(f) of this title; or

(2) a preferred or nonpreferred provider outside of the network adequacy standards in §3.3704(f) of this title, only if the distance to reach the recommended physician or provider is not more than 15% farther than the distance to reach the nearest available physician or provider.

(l) An access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(m) As a contingency, and to protect insureds from any unforeseen circumstance in which an insured is unable to reasonably access covered health care services within the network adequacy standards provided in §3.3704 of this title, an insurer must submit an access plan that applies broadly to all counties within the service area and all types of physicians and providers, and includes the information specified in §3.3712(c)(2)(C)(iv) of this title.

§3.3708. Payment of Certain Out-of-Network Claims.

(a) For an out-of-network claim for which the insured is protected from balance billing under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, or when no preferred provider is reasonably available, an insurer must pay the claim at the preferred level of coverage, including with respect to any applicable copay, coinsurance, deductible, or maximum out-of-pocket amount. The insurer must pay the claim according to the following payment standards:

(1) for emergency care and post-emergency stabilization care, the applicable payment standards are under §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care;

(2) for certain care provided in a health care facility, the applicable payment standards are under §1301.164, concerning Out-of-Network Facility-Based Providers;

(3) for certain diagnostic imaging or laboratory services performed in connection with care provided by a preferred provider, the applicable payment standards are under §1301.165, concerning Out-of-Network Diagnostic Imaging Provider or Laboratory Service Provider;

(4) until August 31, 2025, for certain services and transports provided by an emergency medical services provider, other than air ambulance, the applicable payment standards are under §1301.166, concerning Out-of-Network Emergency Medical Services Provider; and

(5) for services provided by a nonpreferred provider when a preferred provider is not available within the network adequacy standards established in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers), the applicable payment standards are under Insurance Code §1301.005, concerning Availability of Preferred Providers; Service Area Limitations, and Insurance Code §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services.

(b) If medically necessary covered services are not available through a preferred provider within the network adequacy standards under §3.3704(f) of this title (relating to Network Requirements) and the services are not subject to subsection (a)(1) - (4) of this section, the insurer must:

(1) for a preferred or exclusive provider benefit plan:

(A) facilitate the insured's access to care consistent with the access plan and documented plan procedures specified in §3.3707(j) of this title (relating to Waiver Due to Failure to Contract in Local Markets); and

(B) inform the insured that:

(i) the out-of-network care the insured receives for the identified services will be covered under the preferred level of coverage with respect to any applicable cost-sharing and will not be subject to any service area limitation;

(ii) the insured can choose to use a physician or provider recommended by the insurer without being responsible for an amount in excess of the cost sharing under the plan, or an alternative nonpreferred provider chosen by the insured, with the understanding that the insured will be responsible for any balance bill amount the alternative nonpreferred provider may charge in excess of the insurer's reimbursement rate; and

(iii) the amount the insurer will reimburse for the anticipated services.

(2) for an exclusive provider plan:

(A) process a referral to a nonpreferred provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(B) provide for a review by a physician or provider with expertise in the same specialty as or a specialty similar to the type of physician or provider to whom a referral is requested under subparagraph (A) of this paragraph before the insurer may deny the referral.

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

(1) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(2) is updated no less than once per year;

(3) does not use data that is more than three years old; and

(4) is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) Except for an exclusive provider benefit plan, an insurer is required to pay all covered out-of-network benefits for services obtained from health care providers or physicians at least at the plan's out-of-network benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan must not be a basis for denial of a claim.

(e) Consistent with Insurance Code §1301.140, concerning Out-of-Pocket Expense Credit, an insurer must establish a procedure by which an insured may:

(1) identify the average discounted rate paid by the insurer to a given type of preferred provider for a covered service or supply;

(2) obtain a covered service or supply; and

(3) claim a credit, under the preferred level of coverage, toward the insured's deductible and annual maximum out-of-pocket amount, for the amount paid by the insured, if:

(A) the amount the insured paid is less than the insurer's average discounted rate;

(B) the insurer has not paid a claim for the service or supply; and

(C) the insured submits the documentation identified by the insurer, according to the process set forth on the insurer's website and in the insured's certificate of insurance.

(f) An insurer must cover a clinician-administered drug under the preferred level of coverage if it meets the criteria under Insurance Code Chapter 1369, Subchapter Q, concerning Clinician-Administered Drugs.

§3.3709. Annual Network Adequacy Report.

(a) Network adequacy report required. On or before April 1 of each year and prior to marketing any plan in a new service area, an insurer must submit a network adequacy report for each network to be used with a preferred or exclusive provider benefit plan. The network adequacy report must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(b) General content of report. The report required in subsection (a) of this section must specify:

(1) the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(2) the network configuration information specified in §3.3712 of this title (relating to Network Configuration Filings);

(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); and

(4) if applicable, the waiver request and access plan information as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets).

(c) Additional content applicable only to annual reports. As part of the annual report on network adequacy, each insurer must provide additional demographic data as specified in paragraphs (1) - (7) 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:

(1) the number of insureds served by the network in the most recent calendar year and the number of insureds projected to be served by the network in the upcoming calendar year;

(2) total complaints;

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for out-of-network benefits or concerning balance billing;

(5) complaints relating to the availability of preferred providers;

(6) complaints relating to the accuracy of preferred provider listings; and

(7) actuarial data on the current and projected utilization of each type of physician or provider within each region, including:

(A) the current and projected number of preferred providers of each specialty type;

(B) claims data for the most recent calendar year, including:

(i) the number of preferred provider claims;

(ii) the number of claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;

(iii) the number of claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;

(iv) the number of unique enrollees with one or more claims; and

(v) the number of unique physicians or providers with one or more claims.

(d) Filing the report. The annual report required under this section must be submitted electronically in SERFF or another electronic method that is acceptable to the department using the annual network adequacy report form available at www.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.

§3.3710. Failure to Provide an Adequate Network.

(a) If the commissioner determines, after notice and opportunity for hearing, that the insurer's network and any access plan supporting the network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered under the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more sanctions under the authority of the commissioner in Insurance Code Chapters 82, concerning Sanctions, and 83, concerning Emergency Cease and Desist Orders, including:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and

(3) cessation of marketing entirely and withdrawal from the preferred provider benefit plan market.

(b) This section does not affect the authority of the commissioner to order any other appropriate corrective action, sanction, or penalty under the authority of the commissioner in the Insurance Code in addition to or in lieu of the sanctions specified in subsection (a) of this section.

§3.3711. Geographic Regions.

For the purposes of this subchapter, the 11 Texas geographic regions that an insurer is required to use for reporting data under §3.3709 of this title (relating to Annual Network Adequacy Report) are defined based on the public health regions designated under Health and Safety Code §121.007, concerning Public Health Regions, and listed in the annual network adequacy report form.

§3.3712. Network Configuration Filings.

(a) An insurer must submit network configuration information as specified in this section in connection with a request for a waiver under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), an annual network adequacy report required under §3.3709 of this title (relating to Annual Network Adequacy Report), or an application for a network modification under §3.3722 of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications).

(b) A network configuration filing must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(c) A network configuration filing must contain the following items.

(1) Provider listing data. The insurer must use the provider listings form available at www.tdi.texas.gov to provide a comprehensive searchable and sortable listing of physicians and health care providers in the plan's network that includes:

(A) information about the insurer, including the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(B) information about each preferred provider, including:

(i) the preferred provider's name, address of practice location, county, and telephone number;

(ii) the preferred provider's national provider identifier (NPI) number and Texas license number;

(iii) the preferred provider's specialty type, license, or facility type, as applicable, using the categories specified in the form; and

(iv) whether the preferred provider offers telemedicine or telehealth; and

(C) information about a preferred provider that is not a facility, including information on the preferred provider's facility privileges.

(2) Network compliance analysis. The insurer must use the network compliance and waiver request form available at www.tdi.texas.gov to provide a listing of each county in the insurer's service area and data regarding network compliance for each county, including:

(A) the number of each type of preferred provider in the plan's network, using the provider specialty types specified in the form;

(B) information indicating whether the network adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) are met with respect to each type of physician or provider, including specifying the nature of the deficiency (such as insufficient providers, insufficient choice, or deficient appointment wait times);

(C) if the network adequacy standards are not met for a given type of physician or provider, a waiver request and an access plan consistent with §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), including an explanation of:

(i) the reason the waiver is needed, including whether the waiver is needed because there are no physicians or providers available with whom a contract would allow the insurer to meet the network adequacy standards, or because of a failure to contract with available providers;

(ii) if the waiver is needed because of a failure to contract with available providers, each year for which the waiver has previously been approved, beginning with 2024;

(iii) the total number of currently practicing physicians or providers that are located within each county and the source of this information; and

(iv) the access plan procedures the insurer will use to assist insureds in obtaining medically necessary services when no preferred provider is available within the network adequacy standards, including procedures to coordinate care to limit

the likelihood of balance billing, consistent with the procedures established in §3.3707(j) of this title; and

(D) except for a network offered in connection with an exclusive provider benefit plan, an insurer must include a description of how the insurer provides access to different types of facilities, as required by Insurance Code §1301.0055(b)(6), concerning Network Adequacy Standards.

(3) Online provider listing. The insurer must include a link to the online provider listing made available to insureds and a pdf copy of the provider listing that is made available to insureds that request a nonelectronic version.

(4) Access plan for unforeseen network gaps. The insurer must include a copy of the access plan required in §3.3707(m) of this title, which applies to any unforeseen circumstance in which an insured is unable to access covered health care services within the network adequacy standards provided in §3.3704 of this title.

(d) The information submitted as required under this section is considered public information under Government Code Chapter 552, concerning Public Information, and the insurer may not submit the provider listings form or network compliance and waiver request form in a manner that precludes the public release of the information. The department will use the data submitted under this section to publish network data consistent with Insurance Code §§1301.0055(a)(3), concerning Network Adequacy Standards, 1301.00565(g), concerning Public Hearing on Network Adequacy Standards Waivers, and 1301.009, concerning Annual Report.

(e) Upon request by TDI, an insurer must provide access to any information necessary for the commissioner to evaluate and make a determination of compliance with

quality of care and network adequacy standards, including the information set forth in Insurance Code §1301.0056(e), concerning Examinations and Fees.

Subchapter X. Preferred and Exclusive Provider Plans
Division 2. Application, Examination, and Plan Requirements
28 TAC §§3.3720, 3.3722, and 3.3723

STATUTORY AUTHORITY. The commissioner adopts amendments to §§3.3720, 3.3722, and 3.3723 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services.

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.

TEXT.

§3.3720. Preferred and Exclusive Provider Benefit Plan Requirements.

Sections 3.3721 of this title (relating to Preferred and Exclusive Provider Benefit Plan Network Approval Required), 3.3722 of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications), and 3.3723 of this title (relating to Examinations) apply to preferred and exclusive provider benefit plans offered pursuant to Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, in commercial markets. Section 3.3724 of this

title (relating to Quality Improvement Program) applies only to exclusive provider benefit plans offered under Insurance Code Chapter 1301 in commercial markets.

§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 exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance as specified on the department's website and use the form titled Application for Approval of Provider Benefit Plan, which is available at www.tdi.texas.gov/forms.

(b) Filing requirements.

(1) An applicant must provide the department with a complete application that includes the elements in the order set forth in subsection (c) of this section.

(2) All pages must be clearly legible and numbered.

(3) If the application is revised or supplemented during the review process, the applicant must submit a transmittal letter describing the revision or supplement plus the specified revision or supplement.

(4) If a page is to be revised, the applicant must submit a complete new page with the changed item or information clearly marked.

(c) Contents of application. A complete application includes the elements specified in paragraphs (1) - (12) of this subsection.

(1) The applicant must provide a statement that the filing is:

(A) an application for approval; or

(B) a modification to an approved application.

(2) The applicant must provide organizational information for the applicant, including:

(A) the full name of the applicant;

(B) the applicant's Texas Department of Insurance license or certificate number;

(C) the applicant's home office address, including city, state, and ZIP code; and

(D) the applicant's telephone number.

(3) The applicant must provide the name and telephone number of an individual to be the contact person who will facilitate requests from the department regarding the application.

(4) The applicant must provide an attestation signed by the applicant's corporate president, corporate secretary, or the president's or secretary's authorized representative that:

(A) the person has read the application, is familiar with its contents, and asserts that all of the information submitted in the application, including the attachments, is true and complete; and

(B) the network, including any requested or granted waiver and any access plan as applicable, is adequate for the services to be provided under the 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 county or counties to be served. 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, concerning Preferred Provider Benefit Plans, and this subchapter.

(8) The applicant, if applying for approval of an exclusive provider benefit plan offered under Insurance Code Chapter 1301 in commercial markets, must provide a description of the quality improvement program and work plan that includes a process for physician review required by Insurance Code §1301.0051, concerning Exclusive Provider Benefit Plans: Quality Improvement and Utilization Management, 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, as specified in §3.3712 of this title (relating to Network Configuration Filings).

(10) The applicant must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3707(j)-(m) of this title (relating to Waiver Due to Failure to Contract in Local Markets) and §3.3708 of this title (relating to Payment of Certain Out-of-Network Claims).

(11) The applicant must provide documentation demonstrating that the insurer maintains a complaint system that provides reasonable procedures to resolve a written complaint initiated by a complainant.

(12) The applicant must provide notification of the physical address of all books and records described in subsection (d) of this section.

(d) Qualifying examinations; documents to be available. The following documents must be available during the qualifying examination at the physical address designated by the insurer in accordance with 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) if the applicant is applying for approval of an exclusive provider benefit plan offered under Insurance Code Chapter 1301, in commercial markets;

(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 as outlined in §3.3712 of this title that demonstrates compliance with network adequacy requirements described in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers), 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 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 accordance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions).

(e) Network modifications.

(1) An insurer must file a network configuration filing as specified in §3.3712 of this title 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. If any insured will be nonrenewed as a result of a service area reduction, the insurer must comply with the requirements under §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions).

(2) In accordance with paragraph (1) of this subsection, if an insurer submits any of the following items to the department and then replaces or materially changes them, the insurer must submit the new item or any amendments to an existing item along with an indication of the changes:

(A) descriptions and maps of the service area, as required by subsection (c)(5) of this section;

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

(C) network configuration information, as required by §3.3712 of this title.

(3) An insurer must file with the department any information other than the information described in paragraph (2) of this subsection that amends, supplements, or

replaces the items required under subsection (c) of this section no later than 30 days after the implementation of any change.

(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 exclusive provider benefit plan as often as the commissioner considers necessary, but no less than once every three years.

(b) On-site financial, market conduct, complaint, or quality of care exams will be conducted under Insurance Code Chapter 401, Subchapter B, concerning Examination of Carriers; Insurance Code Chapter 751, concerning Market Conduct Surveillance; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; 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, concerning Examinations and Fees.

(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, concerning Discipline and Enforcement, 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 Occupations Code §151.002, concerning Definitions.

(f) The following documents must be available for review at the physical address designated by the insurer in accordance with §3.3722(c)(12) of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications):

(1) quality improvement--program description, work plans, program evaluations, and committee and subcommittee meeting minutes as required by §3.3724 of this title (relating to Quality Improvement Program) must be available for examinations of an exclusive provider benefit plan offered under Insurance Code Chapter 1301 in the commercial market;

(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 accordance 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 §3.3712 of this title (relating to Network Configuration Filings) demonstrating adequacy of the provider network;

(6) credentialing--credentialing files; and

(7) reports--any reports the insurer submits to a governmental entity, including the most recent demographic data provided by the insurer in accordance with §3.3709 of this title (relating to Annual Network Adequacy Report).

Subchapter X. Preferred and Exclusive Provider Plans
Division 2. Application, Examination, and Requirements
28 TAC §3.3725

STATUTORY AUTHORITY. The commissioner adopts the repeal of §3.3725 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonably accessibility and availability of preferred provider services.

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.

TEXT.

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

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

Issued at Austin, Texas, on April 5, 2024.

DocuSigned by:
Jessica Barta
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Jessica Barta, General Counsel
Texas Department of Insurance

The amendments to 28 TAC §§ 3.3038, 3.3702 - 3.3705, 3.3707 - 3.3711, 3.3720, 3.3722, and 3.3723; new 28 TAC §3.3712; and the repeal of 28 TAC §3.3725 are adopted.

DocuSigned by:
C Brown
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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. 2024-8601