**SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS**

**Division 1. General Requirements**

**28 TAC §§3.3701 – 3.3710**

**Division 2. Exclusive Provider Benefit Plan Requirements**

**28 TAC §§3.3720 – 3.3725**

**1. INTRODUCTION.** The Texas Department of Insurance proposes amendments to 28 TAC Chapter 3, Subchapter X, Preferred Provider Plans, §§3.3701 – 3.3710, concerning the regulation of preferred provider benefit plans, and new §§3.3720 – 3.3725, concerning the regulation of exclusive provider benefit plans. The proposed amendments include the addition of two new divisions. The first new division includes current §§3.3701 – 3.3711 and 3.3713, and the second new division includes new §§3.3720 – 3.3725. The proposed amendments and new sections are necessary to implement those portions of House Bill (HB) 1772, enacted by the 82nd Legislature, Regular Session, effective September 1, 2011, that amend the Insurance Code Chapter 1301 to allow insurers to offer exclusive provider benefit plans in the commercial insurance market in Texas.

The department previously proposed amendments and new sections for 28 TAC Chapter 3, Subchapter X, which were published in the June 29, 2012, edition of the *Texas Register* (37 TexReg 4783). A public hearing was held on the previously proposed rule on July 16, 2012, and the department also received numerous comments on the June 29 proposed rules. Based on comments received during the public hearing and in response to the rule proposal, the department decided to withdraw the June 29 proposed rules and prepare a new rule proposal to ensure that all parties are afforded appropriate opportunities to review and comment on the rule. The June 29 proposed rules are withdrawn elsewhere in this edition of the *Texas Register*.

 The bulk of the comments the department received in response to the June 29 proposed rules related to concerns about network adequacy and about the proposed deletion of provisions adopted in 2011 concerning certain insurer reporting requirements.

 Regarding network adequacy, some commenters were concerned that the proposed rules relaxed requirements for insurers. Regarding the proposed deletion of insurer reporting provisions, some commenters were concerned that deletion of the provisions would result in less transparency for consumers.

 After reexamining the issues in light of the comments, the department determined that the best approach is to propose revised rules that more clearly express the department’s intent to require that insurers provide consumers complete networks, limit insurers’ reliance on alternatives to complete networks which provide only limited protections from balance billing, and provide additional substantive protections against balance billing for insureds obtaining out-of-network care in cases of emergency or because no network providers are available.

 Amendments to Subchapter X are necessary to implement HB 1772 and to conform existing provisions of Subchapter X with HB 1772. The intent of HB 1772 is to provide health insurers offering health plan coverage in Texas with additional options to offer lower cost health plans to employers and individual consumers by permitting plans with closed networks where, as with health maintenance organizations (HMOs), “only services provided by network providers are covered, with the exception of emergency services and out-of-network services provided when no network provider is available.” *House Comm.on Insurance, Bill Analysis*, HB 1772, 82nd Legislature, Regular Session (2011).

 The amended and new sections are proposed under and intended to implement: the Insurance Code §1301.003, which permits exclusive benefit plans that meet the requirements of the Insurance Code Chapter 1201; the Insurance Code §1301.007, which authorizes the commissioner to adopt rules to implement Chapter 1301; and the Insurance Code §1301.0042, which provides that a provision of the Insurance Code or other insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan unless the provision is determined to be inconsistent with the function and purpose of an exclusive provider benefit plan and authorizes the commissioner to determine whether a provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

 In accord with the Insurance Code §1301.0042(a), a provision of this code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan unless the department makes a determination that the provision is inconsistent with the function and purpose of an exclusive provider benefit plan. In addition to this extension of applicability of current insurance law, the HB 1772 amendments to Chapter 1301 require an insurer that offers an exclusive provider benefit plan to establish quality improvement and utilization management procedures to ensure that health care services are provided to insureds under reasonable standards of quality of care consistent with prevailing professionally recognized standards of care or practice. The amendments made by the bill also require that the department conduct qualifying and ongoing examinations of the plan. Additionally, the bill establishes requirements for: emergency care services, referrals to nonpreferred providers when medically necessary covered services are not available through a preferred provider, network adequacy, and information that must be provided to prospective and current insureds.

 Amendments to Subchapter X revise the subchapter’s heading to be “Preferred and Exclusive Provider Plans” and divide the subchapter into two new divisions. New Division 1, relating to General Requirements, addresses general requirements that are applicable to both preferred provider benefit plans and exclusive provider benefit plans, unless otherwise indicated. New Division 1 encompasses the sections that are currently contained in Subchapter X, §§3.3701 – 3.3711 and 3.3713. No amendments are proposed for existing §3.3711 or §3.3713 in this rule proposal, though the proposed repeal of §3.3713 is included elsewhere in this edition of the *Texas Register*. Amendments to §§3.3701 – 3.3710 revise the sections as necessary to address exclusive provider benefit plans and align regulation of the two types of plans. The amendments also specify minimum requirements for the content of a waiver request and strengthen the review process for a local market access plan by requiring that an insurer submit a waiver request to the department to approve use of a local market access plan in instances where the status of a network utilized in any network plan changes so that the plan no longer complies with the network adequacy requirements specified in §3.3704. New Division 2, relating to Exclusive Provider Benefit Plan Requirements, addresses requirements that are applicable only to exclusive provider benefit plans, and consists of new §§3.3720 – 3.3725.

 Amendments throughout new Division 1 revise capitalization in catchlines, replace the phrase “is required to” with the word “must,” and remove or revise the word “such” where necessary for consistency with department rule drafting style. Amendments also change the word “subchapter” to “title” where necessary for consistency with department style for references to other sections within rule text. Amendments also update references to “access plan” to state “local market access plan” for consistent use of terminology. Additionally, amendments throughout new Division 1 make nonsubstantive revisions to correct punctuation errors in the current rule text.

 Amendments to §3.3701 provide effective dates for the rules to preferred provider benefit plans and exclusive provider benefit plans and also address applicability of rules in Title 28 to exclusive provider plans. These provisions are necessary to provide sufficient notice to insurers of the applicability and effective dates of amended and new regulations under the subchapter, to clarify certain limitations on the scope of the amended subchapter, and to ensure conformity with amendments throughout the Insurance Code Chapter 1301 as provided by HB 1772.

 Amendments to §3.3701(a) provide that the subchapter applies to any preferred or exclusive provider benefit plan that is offered, delivered, or issued for delivery on or after 150 days from the effective date of §3.3701. This effective date is intended to supersede Commissioner’s Bulletin #B-0050-11, in which the department suspended its enforcement of amendments to the preferred provider benefit plan rules that were to become effective May 19, 2012. It is the department’s expectation that insurers whose networks do not comply with the network adequacy requirements of the rule will either cease marketing in service areas where their networks are inadequate or file requests for waivers with accompanying access plans for those service areas where they seek to continue marketing. The amendments also provide that the subchapter does not apply to exclusive provider benefit plans providing services for the Texas Children’s Health Insurance Program, Medicaid, or the Statewide Rural Health Care System.

 New §3.3701(f) provides that provisions in Title 28 applicable to preferred provider benefit plans are also applicable to exclusive provider benefit plans unless specified otherwise.

 Amendments to §3.3702 incorporate definitions for terms defined in the Insurance Code Chapter 1301, add necessary definitions for additional terms used in the subchapter, redesignate paragraphs as necessary for inclusion of the new definitions, and remove terms that are defined solely by references to the Insurance Code Chapter 1301. The amendments to §3.3702 ensure consistent terminology throughout Subchapter X. The amendments add subsections (a) and (b) to the section and incorporate the terms currently defined in the section into subsection (b).

 Proposed §3.3702(a) provides that words and terms defined in the Insurance Code Chapter 1301 have the same meaning when used in Subchapter X. Amendments to §3.3702(b) add the following defined terms: “adverse determination,” “allowed amount,” “complainant,” “complaint,” “exclusive provider network,” “in-network,” and “out-of-network.” Additionally, the proposal amends the definition of “urgent care.”

 Section 3.3702(b) removes the following defined terms, which are unnecessary due to the addition of proposed §3.3702(a): “emergency care,” “health insurance policy,” “hospital”, “institutional provider,” “insurer,” “physician,” “practitioner,” “preferred provider,” “preferred provider benefit plan,” “prospective insured,” “quality assessment,” and “service area.”

 Amendments to §3.3703 clarify language and address the current standards and requirements for contracting, enforcement of contracting standards and rights, and delegation of contracting to exclusive provider benefit plans, exclusive provider organizations, and health care collaboratives. The amendments also establish contracting requirements that provide for notice to insurers and insureds in specific instances where a recommended or scheduled surgery may result in care being provided to an insured by an out-of-network provider.

 An amendment to §3.3703(a)(1) updates the reference to preferred provider organizations to include networks or organizations and inserts a reference to exclusive provider benefit plans, exclusive provider networks or organizations, and health care collaboratives. An amendment to §3.3703(a)(11) removes a reference to the Insurance Code Chapter 1301, Subchapter C, and 28 TAC §§21.2801 – 21.2820 because it is unnecessary. The subchapter and sections are applicable without specific citation to them in §3.3703.

 The amendment to §3.3703(b)(26) clarifies the language without making a substantive change.

 Amendments also add new §3.3703(b)(27) – (29).

 Section 3.3703(b)(27) provides that a contract between an insurer and a preferred provider require that a physician or provider referring an insured to a facility for surgery notify the insured of the possibility that out-of-network providers may provide treatment, notify the insurer that surgery has been recommended, and notify the insurer of the facility that has been recommended for the surgery.

 Section 3.3703(b)(28) provides that a contract between an insurer and a facility must require that the facility, when scheduling surgery, notify the insured of the possibility that out-of-network providers may provide treatment, and notify the insurer that surgery has been scheduled.

 Section 3.3703(b)(29) addresses the impact of §3.3703(b) on contractual provisions not directly addressed by subsection (b). It provides that the subsection does not prohibit other contractual provisions not prohibited by law.

 The amendment to §3.3703(c) clarifies that delegation requirements apply to exclusive provider networks and health care collaboratives. The amendment also provides that an insurer may not delegate its responsibility to provide to the department upon request all documentation necessary to demonstrate compliance with applicable rules. It is necessary that an insurer remain responsible for compliance with these standards and requirements, even if the insurer delegates them to an exclusive provider benefit plan, an exclusive provider organization, an exclusive provider network, or a health care collaborative, 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 new plans in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities.

 Amendments to §3.3704 add clarifying language and provide consistency with department style for rules.

 Amendments to §3.3704(a) remove several unnecessary section symbols. Amendments to §3.3704(a)(1), (6), (8), (10), and (11) exempt exclusive provider benefit plans from the general application of fairness requirements specified in the paragraphs to the extent necessary to conform with the statutorily permitted structure of exclusive provider benefit plans, which are only required to provide benefits for the services of nonpreferred providers in limited circumstances. An amendment to §3.3704(a)(5) clarifies that the right of the insured to emergency care services includes providing payment for the services in accord with the Insurance Code Chapter 1301.0053, and also §3.3725 and §3.3708. An amendment to §3.3704(a)(7) applies the right of insureds to exercise full freedom of choice in the selection of preferred providers under exclusive provider benefit plans. The amendment to §3.3704(a)(12) incorporates the existing right of insureds to receive nonpreferred provider care for medically necessary covered services that are not available through a preferred physician or provider.

 The amendment to §3.3704(b) clarifies that only covered services of nonpreferred providers must be paid in the same prompt and efficient manner as are preferred providers.

 Amendments to §3.3705 update or clarify language throughout the section. These amendments are necessary to ensure conformity with amendments throughout the Insurance Code Chapter 1301 as provided by HB 1772.

 An amendment to §3.3705(b) clarifies that required written descriptions of requirements are to be included as applicable. An amendment to §3.3705(b)(1) imposes a requirement to disclose to current or prospective group contract holders or insureds that, in the case of an exclusive provider benefit plan, the contract only provides benefits for services received from preferred providers, except as otherwise noted. An amendment to §3.3705(b)(9) clarifies that the disclosure requirements for prior authorizations encompass any authorization requirements, regardless of when the authorization process is initiated. An amendment to §3.3705(b)(12) modifies the electronic disclosure requirements of provider listings to allow for electronic disclosure when notice regarding how to obtain a nonelectronic copy is provided with the electronic disclosure. An amendment to §3.3705(b)(14) revises reporting requirements by eliminating provisions that, based on stakeholder input, the department has determined will not provide a substantial benefit to consumers, but would likely increase premiums.

 The deleted provisions in §3.3705(b)(14) require information regarding network demographics related to the number of insureds in a service area, the number of specified provider types, and the number of preferred provider hospitals in a service area or region. However, §3.3705(b)(14) only requires insurers to update the required information annually, which means that it may not provide a current snapshot of the network to a consumer, and might be misleading.

 Reporting requirements related to an insurer’s waivers and local market access plans replace the reporting requirements removed from §3.3705(b)(14). As revised, §3.3705(b)(14) requires an insurer to provide information on whether a waiver or a local market access plan applies to specified types of facilities or providers. The revised paragraph also requires that the information be categorized by service area, county, or geographic region, and that it identify how the local market access plan may be obtained or viewed. The department believes that this information will be of more practical use to a current or prospective group contract holder or a current or prospective insured.

 An amendment to §3.3705(c) updates the email address and mailing address that insurers should use when submitting provider listings under §3.3705(b)(12).

 An amendment to §3.3705(d) exempts exclusive provider benefit plans from the illustration proximity requirements of the subsection since exclusive provider benefit plans are not required to contain basic benefits.

 An amendment to §3.3705(f) updates the reference to the figure currently in the subsection to be FIGURE: 28 TAC §3.3705(f)(1) and updates the reference to the department’s website within the figure. The current figure is also amended to clarify terms and conform to substantive changes elsewhere in the rule. Additionally, the amendment to §3.3705(f) adds a second figure, FIGURE: 28 TAC §3.3705(f)(2), which provides information equivalent to that in FIGURE: 28 TAC §3.3705(f)(1), but in regard to exclusive provider benefit plans.

 An amendment to §3.3705(k) updates the subsection to address both preferred and exclusive provider benefit plan requirements.

 Amendments to §3.3705(l) modify additional listing-specific disclosure requirements. The deleted provisions require that an insurer provide information related to 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. Under the deleted provisions, an insurer may base this information on claims filed in a 12-month period ending not more than 12 months before the date the information is provided to an insured. However, such information does not provide a view of providers currently available in the network or give an insured information on specific instances where the insured may be receiving care from an out-of-network provider in the future.

 Another amendment to §3.3705(l) revises a reference to required font point size to provide consistency in how font point is addressed in the sections.

 An amendment to §3.3705(m) revises a citation to the section that addresses local market access plans for conformity with changes made elsewhere in the rule proposal.

 The amendments to §3.3705(o), which the department proposes to redesignate as §3.3705(n), modify disclosures concerning reimbursement of out-of-network services to update language and to exempt exclusive provider benefit plans from required notice provisions as necessary to conform with amendments to Chapter 1301.

 Finally, amendments to §3.3705 also delete the current §3.3705(n), along with §3.3705(p) and (q), to remove requirements regarding disclosure of substantial decreases in the availability of certain preferred providers, plan designations, and loss of status as an approved hospital care network.

 According to stakeholders, network contracts between insurers and providers sometimes terminate for short periods of time until contract terms are agreed upon. These changes in provider in-network status may only temporarily impact a network to the degree addressed by the deleted provisions without reflecting a true failure of the insurer to satisfy network requirements. Additionally, under §3.3705(i) and (j) an insurer must make provider listings available to insureds and update the listings regularly, and under §3.3705(k), an insured is entitled to rely on the listings provided by the insurer.

 If a provider’s in-network status is permanently changed, the insurer should update its provider listings to reflect this. If the listings are not updated and an insured relies on them, the insured will be protected by §3.3705(k). Therefore, the department has determined that the deleted provisions are unnecessary.

 Amendments to §3.3706 correct an error and make changes for consistency with department style.

 An amendment to §3.3706(b)(2)(B) replaces an erroneous reference to “insured” with a reference to “insurer.”

 An amendment to §3.3706(c) changes “shall” to “will” and an amendment to §3.3706(h) changes “shall” to “must” for consistency with department rule drafting style. Additional amendments to §3.3706(c) revise the subsection to clarify that “NCQA” stands for “National Committee for Quality Assurance” and to remove a reference to the American Accreditation HealthCare Commission. “American Accreditation HealthCare Commission, Inc.” is an alternative name occasionally used by URAC. Because the subsection references URAC, it is not necessary to also list the alternative name occasionally used by URAC.

 Amendments to §3.3707 revise the waiver process to clarify information that must be provided in a waiver request, and link insurer use of local market access plans to department approval and annual renewal of waivers. Additionally, amendments to §3.3707 update statutory references, clarify language regarding the application process for a waiver from one or more of the network adequacy requirements, and exempt exclusive provider benefit plans from the application of the section.

 The amendments create new §3.3707(b) and (c).

 New §3.3707(b) establishes minimum requirements for the contents of a waiver request. This required information is necessary to confirm the need for a waiver and address the steps the insurer intends to take to avoid a need to renew the waiver in the future.

 New §3.3707(c) establishes a requirement that an insurer file a local market access plan at the same time it files a request for a waiver so that the commissioner can take the insurer’s local market access plan into consideration in deciding whether to grant or deny its waiver request. This provision is necessary to ensure that a department grant of a waiver does not leave insureds without access to care.

 The amendment to current §3.3707(b), which the department proposes to redesignate as §3.3707(d), clarifies that an insurer is not required to disclose information to providers that would violate state or federal law and requires filing of waivers electronically rather than through mail.

 The amendment to current §3.3707(d), which the department proposes to redesignate as §3.3707(f), clarifies that the department will post information relevant to the grant of a waiver, including the statutorily required items listed in the provision.

 The amendments to current §3.3707(e), which the department proposes to redesignate as §3.3707(g), provides clear application and renewal deadlines to allow simpler administration of the waiver process. The amendments also require that at the same time the insurer files an application for renewal of a waiver, the insurer file any applicable local market access plan the insurer uses pursuant to the waiver, in the manner specified by subsection (i)(2) of this section. Finally, the amendment provides that a waiver the department has granted will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver with any applicable local market access plan or the department denies the application for renewal.

 An amendment creates new §3.3707(h), which provides that a waiver will expire one year after the date the department granted it if an insurer fails to timely request a renewal under subsection (g) of the section or if the department denies the insurer’s request for renewal.

 New §3.3707(i) specifies when an insurer must file a waiver request and local market access plan with the department. The section also addresses the content of a local market access plan and states how an insurer should file its local market access plan.

 New §3.3707(j) – (l) provide details on the content and procedures an insurer must include in a local market access plan. These provisions are relocated from current §3.3709(e) – (g).

 Amendments to the text that this proposal moves from §3.3709(e) to new §3.3707(j) revise a reference to benefit claims to reference out-of-network benefit claims. The amendments also delete a provision in current §3.3709(e)(2) of the section specifying that the department may request additional information necessary to assess the local market access plan. Other rules and statutes already provide the department sufficient authority to access information necessary to assess a local market access plan. Removal of paragraph (2) necessitates that the department incorporate paragraph (1) into subsection (j), and redesignate the subparagraphs within paragraph (1). Additionally, an amendment inserts a necessary reference to new §3.3725 (relating to Payment of Certain Out-of-Network Claims).

 An amendment to the text that this proposal moves from §3.3709(f)(1)(C) to new §3.3707(k)(1)(C) exempts exclusive provider benefit plans from the requirement to notify an insured that the insured may be liable for any amounts charged by a physician or provider when charges are not paid in full by the insurer due to other protections afforded insureds covered by exclusive provider benefit plans. An amendment to the text that this proposal moves from §3.3709(f)(2)(B) to new §3.3707(k)(2)(B) clarifies that when an insurer utilizes a documented procedure to make initial or subsequent payment of claims, the insurer must do so in the manner required by Subchapter X.

 New §3.3707(m) requires an insurer to submit a local market access plan established pursuant to §3.3707 as a part of the annual report on network adequacy required under §3.3709.

 In the withdrawn rule proposal for 28 TAC Subchapter X, the department proposed excluding exclusive provider benefit plans from §3.3707. However, the department has determined that this exclusion is not necessary. Under the current proposed §3.3707, the department will grant a waiver to an exclusive provider benefit plan in appropriate cases to allow it to provide coverage in additional parts of the state. As a part of the waiver process, the exclusive provider benefit plan will be required to submit an adequate local market access plan demonstrating that the insurer will hold the insured harmless for any balance billing.

 An amendment deletes current §3.3707(f). Current §3.3707(f) references a requirement under current §3.3705(p), but the department has proposed to delete that subsection in this proposal.

 Amendments to §3.3708 address payment of claims when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, add clarification to the section, and address inapplicability of the section to exclusive provider plans.

 An amendment to §3.3708(b) provides that when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, the insurer must pay the claim based on usual or customary charges.

 This requirement is based on and clarifies the provisions of the Insurance Code §1301.005(b) and §1301.155(b), which require that claims in these circumstances be paid at the same level of reimbursement as for a preferred provider. It also is based on the requirement of the Insurance Code §1301.005(a) that an insurer make out-of-network (basic level) benefits “reasonably available” to all insureds. TDI has received complaints that some carriers pay these claims at rates that are a fraction of usual and customary rates. This can be seen in a survey of carriers the department reported on in a 2009 report: www.tdi.texas.gov/reports/life/documents/hlthnetwork09.doc. Table 4 of that report, on page 24, reflected the average allowed amounts for uncontracted providers by five health plans.

 Taking radiology as an example, one plan paid uncontracted providers on average 95 percent of their billed charges, while another plan paid 38.7 percent, with insureds thus responsible for their share of the 38.7 percent under their plans and 100 percent of the remaining 61.3 percent. In cases of large bills, such low reimbursements could result in a consumer with major medical coverage being responsible for paying the majority of the billed charge, an amount that in some cases could result in bankruptcy or make the out-of-network benefits effectively unavailable.

 The rule clarifies the legislature’s intent in requiring payment of these particular claims at the preferred level by specifying that the calculation must be based at a minimum on the usual and customary rate for such services, rather than any arbitrary amount chosen by a carrier. By requiring payment at the usual and customary rate in situations where the insured has no choice in whether to see an out-of-network provider, either due to emergency or due to the insurer’s own failure to provide an adequate network, the statute and this clarifying rule attempt to give the insured some certainty in their insurance coverage and their financial security.

 The amendments to §3.3708(b) also clarify that, when an insured receives services from a nonpreferred provider because no preferred provider is reasonably available and the insured actually pays a balance bill to the nonpreferred provider, the insurer must credit the full amount paid by the insured to the insured’s deductible and annual out-of-pocket maximum applicable to in-network services.

 An amendment revises §3.3708(e) to remove a notice requirement regarding the right to request information concerning negotiated rates for comparison purposes. As amended, §3.3708(e) requires an insurer to provide notice on explanations of benefits that an insured may have the right to request mediation under the Insurance Code Chapter 1467 and Chapter 21, Subchapter PP when services are rendered to the insured by a nonpreferred provider.

 An amendment adds new §3.3708(f), which exempts exclusive provider benefit plans from application of the section because those insured under exclusive provider benefit plans have other protections against balance billing.

 Amendments to §3.3709 revise the section to reflect the department’s incorporation of local market access plans into the waiver process of §3.3707. Additionally, amendments to §3.3709 update references to benefit claims to address out-of-network claims, add a reference to a proposed new section, and exempt exclusive provider benefit plans from a notification requirement inapplicable to the plans. The amendments also delete an unnecessary catch-all provision and redesignate the subparagraphs in a subsection.

 An amendment to the heading of §3.3709 removes the words “access plan.”

 The amendments to §3.3709(c) revise references to claims for benefits in paragraphs (1) and (2) to reference claims for out-of-network benefits.

 Amendments to §3.3709(d) – (g) and (i) delete provisions applicable to local market access plans. Additional amendments in this proposal relocate these provisions to §3.3707 and update them as necessary for consistency with the other amendments in the proposal.

 An amendment to current §3.3709(h), which this proposal redesignates as §3.3709(d), updates the email address to which an insurer must submit the annual report required under §3.3709.

 Amendments to §3.3710 address applicability to exclusive provider networks and update a statutory citation. The amendments revise §3.3710(a) to remove the description “preferred provider service delivery” to encompass applicability to exclusive provider networks and update a statutory reference concerning cease and desist orders to include the Insurance Code Chapter 82.

 New Division 2, relating to Exclusive Provider Benefit Plan Requirements, addresses requirements that are applicable only to exclusive provider benefit plans.

 New §3.3720 addresses applicability of the division. It is only applicable to exclusive provider benefit plans.

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

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

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

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

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

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

 New §3.3722(e) addresses approval and notification requirements for any changes implemented by an insurer after the department has granted approval of a certificate of compliance. New §3.3722(e)(1) requires an insurer to file an application for approval with the department prior to making changes to network configuration that impact the adequacy of the network, expand or reduce an existing service area, or add a new service area. New §3.3722(e)(2) requires an insurer to file with the department changes in maps of service areas, forms of contracts, or network configuration information. New §3.3722(e)(3) provides that, before the department grants approval of a service area expansion or reduction application, an insurer must be in compliance with the requirements of §3.3724 in existing and proposed service areas. New §3.3722(e)(4) requires that an insurer file with the department any information other than the information described in §3.3722(e)(2) that amends, supplements, or replaces the items required under subsection §3.3722(c) no later than 30 days after the implementation of any change.

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

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

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

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

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

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

 New §3.3723(f) requires the insurer to make available for review by the department documents relating to quality improvement, utilization management, complaints, satisfaction surveys, network configuration information, credentialing files, and reports.

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

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

 New §3.3724(b) requires the insurer’s governing body to appoint a quality improvement committee, approve the quality improvement program, approve an annual quality improvement plan, meet at least once a year to review reports of the quality improvement committee, and review the annual written report on the quality improvement program.

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

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

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

 New §3.3725(a) requires an insurer to fully reimburse a nonpreferred provider for emergency care services specified in the subsection at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider for emergency care services when an insured cannot reasonably reach a preferred provider, until the insured can reasonably be expected to transfer to a preferred provider.

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

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

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

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

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

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

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

 On February 7, 2012, the department posted a call for comments from the public on the substance of an informal draft rule and on the costs of implementing the rule. In addition to receiving written comments on the informal draft, the department held a stakeholder meeting on February 23, 2012, to discuss the rule and the potential costs of implementation. The department appreciates all comments received and discussions held during the drafting process.

**2. FISCAL NOTE.** Doug Danzeiser, manager, Regulatory Matters, has determined that for each year of the first five years the proposal will be in effect, there will be no measurable fiscal impact to state or local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

**3. PUBLIC BENEFIT/COST NOTE.** Mr. Danzeiser also has determined that for each year of the first five years the proposed amendments and new sections are in effect, there are several public benefits anticipated as a result of the enforcement and administration of this proposal, as well as potential costs of compliance for insurers with preferred provider benefit plans or insurers choosing to enter the exclusive provider benefit plan market. The department has drafted the proposed rules to maximize public benefits consistent with the authorizing statutes while mitigating costs.

 The anticipated public benefits are: (i) implementation of rules necessary to comply with HB 1772; (ii) establishment of regulatory standards for the new exclusive provider benefit plan, including standards for certification, contracting, network adequacy, preferred provider designation, and claims payment; (iii) establishment of transparency of information for consumers utilizing exclusive provider benefit plans, through required notices, preferred provider directory requirements, complaint resolution requirements, and quality improvement program requirements; and (iv) efficient regulation and operation of preferred and exclusive provider benefit plans in Texas.

 On February 7, 2012, the department posted a call for comments on its website that included a request for comments regarding the costs of implementing the proposed rule. As a result, the department received general input on the cost of compliance, but did not receive specific cost estimates. In addition, the department received a comment on the withdrawn proposal addressing costs to implement §3.3708 and §3.3725. The commenter was unable to provide specific cost estimates, but felt that the department had underestimated the costs of implementing those sections. The department has modified the rule text in a number of ways to minimize potential costs and has developed estimated costs for compliance with the proposed rules based on cost components previously used by the department for similar compliance requirements. Individual insurers that identify, based on their own operations, differing costs for those cost components will be able to calculate their particular costs using the department’s cost analysis approach.

 The department has identified eight categories of labor reasonably necessary to implement the proposed changes to the subchapter. Insurers may calculate the total cost of labor for each category by multiplying the number of estimated hours for each cost component by the median hourly wage for each category of labor. The median hourly wage for each category of labor is published online by the Texas Workforce Commission as follows:

 (i) a general operations manager or functional director: $58.64

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=11-1021&compare=2);

 (ii) a computer programmer: $38.60

(www.texasindustryprofiles.com/apps/win/eds.php?indcode=5241&indclass=8);

 (iii) an administrative assistant: $21.69

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=43-6011&compare=2);

 (iv) a staff attorney: $51.56

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=23-1011&compare=2);

 (v) a medical director: $105.65

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=6221&occcode=11-1011&compare=2);

 (vi) a registered nurse: $31.87

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=6221&occcode=29-1111&compare=2);

 (vii) a desktop publisher: $19.64

(www.texasindustryprofiles.com/apps/win/eds.php?indcode=52&indclass=6); and

 (viii) a paralegal: $26.69

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=23-2011&compare=2).

 The department estimates that an insurer’s overall printing, copying, mailing, and transmitting costs will likely be impacted as a result of implementation of the new subchapter. According to the United States Postal Service business price calculator, available at dbcalc.usps.gov, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP code in the United States is 26 cents. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the 26 cents. This estimate is based on an anticipated use of six pages of standard printing paper, with a total weight of one ounce. The department has determined that the cost of a standard business envelope is 1.6 cents. The department further estimates that the cost of printing or copying is between 6 and 8 cents per page.

 It is not feasible for the department to estimate the total increased printing, copying, mailing, and transmitting costs attributable to compliance with the proposed changes to the subchapter because there are numerous factors involved that are not suited to reliable quantification by the department, including the size of the insurer’s service area, the number of insureds enrolled in the plan, the number of contracted physicians and providers, and the number of complaints generated annually. The department estimates that each insurer has the information necessary to determine its individual printing, copying, mailing, and transmitting costs necessary to meet the requirements of the subchapter, and the department has identified factors throughout the sections that may contribute to an increased cost for printing, copying, mailing, and transmitting where applicable.

 The department has determined that the actual cost of implementation could be significantly lower than estimated because insurers sometimes contract with independent provider networks (networks) in order to meet network adequacy requirements. An arrangement like this is likely to occur in the context of exclusive provider plans. Specifically, insurers could contract with one or more networks that would assume primary responsibility for undertaking one or more of the steps necessary to comply with §§3.3703 – 3.3706, 3.3709, and 3.3722 – 3.3724 of this proposal. While it would still remain the responsibility of the insurer to either meet the requirements or ensure that the requirements are met in accord with §3.3703(c), the factors and components affecting the cost of compliance with the requirements would vary for each requirement. The department estimates that this variation would be based upon the size of the network used by an insurer, the scope of the underlying contract between the insurer and the network, and the fees charged by the network for performance of the contract.

 Many of the requirements of the proposed rule may also be substantially less costly than the estimates set forth in this proposal in the case of insurers already offering preferred provider benefit plans. Many of the proposed requirements for exclusive provider benefit plans are identical to regulations already applicable to preferred provider benefit plans, and the department estimates that most, if not all, of the insurers that will be offering exclusive provider benefit plan products will already be offering preferred provider benefit plan products that are compliant with the common provisions.

 ***Section 3.3703: Notices required by additional required contract terms.*** Amendments to §3.3703(b) provide that a contract between an insurer and a preferred provider must require that a physician or provider referring an insured to a facility for surgery provide notice to the insured and the insurer so that the insured will be aware that out-of-network providers may provide treatment and that the insured can contact the insurer to coordinate the insured’s care, and so that the insurer is aware of the facility that the physician recommended and has the opportunity to coordinate coverage. This requirement could result in costs to a physician or provider to provide the required notice. However, physicians and providers already generally provide information to insureds and insurers related to referrals and recommendations for care, and the department anticipates that physicians and providers can reduce costs by combining this notice with the other information they already provide.

 The department expects that a physician or provider may incur a cost for printing additional pages to address the required notice. The department estimates that this cost will be approximately 6 to 8 cents per page for printing and paper and that each notice will require approximately one page.

 ***Section 3.3705: Nature of communications with insureds; readability, mandatory disclosure requirements, and plan designations.*** Amendments to §3.3705(b)(1) impose a requirement on exclusive provider plans to disclose to current or prospective group contract holders or insureds that the exclusive provider contract only provides benefits for services received from preferred providers, except as otherwise noted. Amendments to §3.3705(f) modify the notice requirements concerning rights of insured participants by requiring that the notice of rights required by §3.3705(f) also be provided in disclosures made under §3.3705(b) and by requiring a separate notice template with language tailored to exclusive provider benefit plans. These requirements could result in costs to comply for insurers.

 The department expects that insurers will avoid any mailing costs as a result of compliance with the §3.3705(b) and (f) amendments by providing the notice along with the policy or certificate at issuance or renewal and within the disclosure document that is already required by §3.3705(b). The department’s estimate of costs for an insurer to comply with the amendments to §3.3705(b) and (f) is based on: (i) the cost of administrative staff to amend the current documents and prepare the new required notice of rights for inclusion in all policies, certificates, disclosures, and outlines of coverage; and (ii) the cost to print additional pages for printed documents.

 *(i) Cost of administrative staff to prepare the required notice of rights for inclusion in all policies, certificates, disclosures, and outlines of coverage.* The department estimates that preparation of the required amendments and notice of rights for inclusion in policies, certificates, disclosures, and outlines of coverage as specified in §3.3705(b) and (f) will likely require a one-time cost of approximately two to 10 hours of administrative staff time. In a comment on the withdrawn proposal, a commenter suggested that the required time might be longer than this and could subject an insurer to filing fees, but did not list specific forms the commenter thought would need to be filed and was unable to provide a specific cost estimate. The cost to the insurer will vary depending on whether the insurer elects to have an administrative assistant, a general operations manager, or a combination of both positions, perform this function.

 *(ii) Cost to print additional pages.* The department expects that an insurer will incur a cost for printing the required notice of rights specified in §3.3705(f) in all policies, certificates, disclosures, and outlines. The department estimates that this cost will be approximately 6 to 8 cents per page for printing and paper and that each notice of rights will require approximately one or two printed pages. It is likely that the insurer has the information necessary to determine its individual printing costs necessary for compliance with §3.3705(f), including the number of pages that will need to be printed and in-house or out-of-house printing costs. An insurer’s potential printing costs may vary if the insurer does not use in-house printing. An insurer’s costs will also vary based upon the number of policies, certificates, and outlines of coverage for which the insurer must include the notice of rights. The total cost to comply with §3.3705(f) could also vary depending on the insurer’s administrative processes.

 ***Section 3.3707: Required content of waiver request.*** An amendment to §3.3707 requires an insurer to include in a waiver request either five specified categories of information related to the insurer’s attempts to contract with providers or physicians or an assertion that that no providers or physicians are available within the relevant area for the covered service or services for which a waiver is requested. This information is data an insurer should have available based on its attempts to contract, and the department anticipates that an insurer’s administrative staff or general operations manager will prepare the information in response to this requirement. The department estimates that it would be reasonably necessary for an administrative assistant or a general operations manager to spend an average of three to six hours preparing this information.

 Preparation of a waiver renewal request is estimated to take less time to prepare than the original renewal. In cases where a waiver is denied, a carrier will receive reduced premiums as it ceases to market in that service area. The department is unable to quantify at this time how many waiver requests will be denied because it has not reviewed any preferred provider benefit plan networks for adequacy and has not ascertained the reasons for insurers’ failure to contract in some areas. Insurers, familiar with their own attempts to contract, are in the best position to estimate this potential cost.

 **Section 3.3708: Payment of Certain Basic Benefit Claims and Related Disclosures.** New text in §3.3708(b)(1) requires an insurer to pay claims, at a minimum, at the usual and customary charge for the service, less any patient responsibility, in cases of emergency or when no network provider is reasonably available. New text in §3.3708(b)(3) requires that insurers credit amounts shown by the insured to have been actually paid to the insured’s in-network deductible and out-of-pocket maximums, in addition to any amounts that would have been credited had the provider been a preferred provider.

 The cost of compliance with these requirements will depend on a number of factors, which will be known or subject to estimation by the insurer, including the insurer’s current rate of reimbursement of claims compared to the usual and customary charges and how often such claims occur. Insurers may have their own information on usual and customary billed charges, and at least one website makes usual and customary information available at no charge. Carriers may also reduce this expense by working to increase their networks or by ceasing to market in areas where they are unable to contract for complete networks.

 New text in §3.3708(e) requires that insurers provide a notice of the right to request mediation. The department anticipates that the cost to comply with this requirement will vary depending on whether the insurer provides the notice on all explanations of benefits or some subset, with the cost of programming potentially increasing with more selective use of the notice.

 The department anticipates that a simple amendment of all explanations of benefits issued by the insurer would require two to 10 hours work by a computer programmer. More specific programming would potentially require additional time.

 **Section *3.3721 and §3.3722: Required network approval, application, qualifying examination, and modifications.***  New §3.3721 requires an insurer to complete a qualifying examination and obtain approval from the department that the insurer’s exclusive provider network is in compliance with the requirements of Subchapter X prior to entering the exclusive provider benefit plan market. New §3.3722 provides the content and filing requirements for the initial application, requirements that specified documents be available for the qualifying examination, and requirements for any subsequent modifications of the network.

 The department estimates that an insurer’s administrative staff or general operations manager will provide most, if not all, of the labor necessary to assemble and file an application for approval. The department estimates that it would be reasonably necessary for an administrative assistant or a general operations manager to spend an average of six hours copying, printing, and combining the required documents, filling out the required application, and filing the completed application packet with the department. In a comment on the withdrawn proposal, a commenter suggested that the required time might be longer than this and could total 40 to 50 hours. The commenter also suggested that some insurers may chose to have an attorney assist in the preparation of the application, resulting in additional cost for the attorney’s time, but did not indicate how much attorney time an insurer might need. The department estimates that the labor cost to an insurer may vary depending on whether the insurer elects to have an administrative assistant, a general operations manager, an attorney, or a combination of these individuals, assemble and file the application packet with the department.

 The department also estimates that it would be reasonably necessary for an insurer to employ a computer programmer to assist with the compilation of application contents required in §3.3722(c)(5), regarding the submission of a map of the service area, and in §3.3722(c)(9), regarding the submission of a map for each specialty and lists of physicians, individual providers, and institutional providers. The department estimates that the number of hours necessary to determine service areas, maps, and provider lists will vary from plan to plan with a range from five to 15 hours of computer programmer labor to assist with the compilation of the required application contents.

 New §3.3722(d) requires insurers to make available seven categories of documents for review during a qualifying exam, as set forth in new §3.3722(d)(1) – (7). The department estimates that it would be reasonably necessary for an insurer to temporarily employ both a general operations manager and an administrative assistant to ensure compliance with the proposed new section during the qualifying examination.

 The department estimates that it would be reasonably necessary for a general operations manager to spend an average of three hours identifying and collecting the applicable documents for the qualifying examination. The department further estimates that it would be reasonably necessary for an administrative assistant to spend an average of two hours copying or printing and combining the required documents. The department estimates insurers may incur additional costs necessary to print or copy the required documents. The average print and copy costs necessary for compliance could vary slightly for each plan depending on the number of pages necessary to print or copy.

 Though the department has identified factors attributable to the cost of compliance with new §3.3722(d), it is not possible for the department to estimate the total compliance costs an insurer could incur because there are numerous factors involved that prevent a general quantification for all insurers, including the size of a plan and the number of additional relevant documents requested by the department during any given examination. If an insurer has a larger than average plan and the department determines that additional relevant documents need to be reviewed during an examination, the cost for making the required documents available for a qualifying examination will be accordingly higher. The estimated cost to comply with the new subsection represents an estimate for an insurer with an average plan size, with documents stored in electronic format, and with a simple qualifying examination that does not require the department to request numerous additional documents.

 New §3.3722(e) provides the application content and filing requirements for the approval of an expansion or reduction of an existing service area and for the approval of a new service area. The department estimates that an insurer’s administrative staff or general operations manager will provide most if not all of the labor necessary for an insurer to apply for the certificate of compliance for the network modification. The department estimates that it would be reasonably necessary for an administrative assistant or a general operations manager to spend an average of six hours copying, printing and combining the required documents, filling out the required application, and filing the completed application packet with the department. The department estimates that the labor cost to an insurer will vary depending on whether the insurer elects to have an administrative assistant, a general operations manager, or a combination of both, complete and file the application.

 The department also estimates that it would be reasonably necessary for an insurer to employ a computer programmer to assist with the compilation of the application contents required in §3.3722(e) regarding the submission of a map of the existing and proposed service areas; a map for each specialty; and lists of physicians, individual providers, and institutional providers.

 The department estimates that the number of hours necessary to compare the existing and proposed service areas for changes, compile maps, and compile the required network configuration information will vary from plan to plan with a range from five to 15 hours of computer programmer labor to assist with the compilation of the required application contents. The department estimates that an insurer may incur additional costs necessary to print and copy the application, procedures, and additional paperwork to complete the application and additional costs necessary to mail the completed application. The average print, copy, and postage costs necessary for compliance could vary slightly for each plan depending on the number of pages necessary to print, copy, and mail per application.

 The estimated cost to comply with the new sections represents an estimate for an insurer with average existing and proposed service areas in Texas, as compared to service areas the department has seen in past HMO and preferred provider benefit plan filings. The department estimates that costs will vary for insurers opting for smaller or larger service areas. Additionally, the department estimates insurers may incur additional costs necessary to print, copy, and mail the completed application. The department estimates that print, copy, and mail costs could vary slightly for each plan depending upon the number of pages necessary to print, copy, and file per application.

 ***Proposed §3.3723: Examinations.*** New §3.3723(c) requires that insurers make their books and records relating to their operations available to the department to facilitate an examination. New §3.3723(d) further requires insurers to provide a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider on request by the commissioner. Finally, new §3.3723(f) requires insurers to make available seven additional categories of documents for review, as set forth in new §3.3723(f)(1) – (7). Pursuant to §3.3723(a), examinations will occur at least once every five years.

 The department estimates that §3.3723(c), (d), and (f) could result in costs to comply for insurers and has determined that the total estimated cost for compliance could vary based upon certain components. The department considered: (i) the cost of identifying, collecting, producing, and printing or copying the required documents for each examination; (ii) the cost of facilitating an examination in compliance with §3.3723(c); (iii) the cost of auto-mapping software (for example, Geo-Access) to make the required maps available for review in compliance with §3.3723(f)(5); and (iv) the cost of information technology staff necessary to use the auto-mapping software.

 The department estimates that it would be reasonably necessary for an insurer to employ a general operations manager, an administrative assistant, and a functional division director from each of the insurer’s functional divisions to make the required documents available to the department during a subsequent examination. The department estimates that it would be reasonably necessary for a general operations manager to spend an average of three hours identifying and collecting the applicable documents per examination and to spend an average of two to 10 hours reviewing deficiencies and generating corrected responses. This estimate could vary, depending on the accuracy and completeness of the documents produced from each functional division and number of functional divisions an insurer opts to include within its organizational structure. The department additionally estimates that it would be reasonably necessary for an administrative assistant to spend an average of two hours copying or printing and combining the required documents per examination. The department further estimates that it would be reasonably necessary for a functional division director to spend an average of two hours of time gathering, reviewing, and producing required documents and to spend an average of one hour correcting any deficiencies per examination.

 In addition, the department estimates that it would be reasonably necessary for an insurer to employ a general operations manager and a functional division director from each of the insurer’s functional divisions to facilitate an examination in compliance with §3.3723(c). The department estimates that it would be reasonably necessary for a general operations manager and each functional division director to spend an average of six hours each per examination facilitating the examination by attending meetings with staff from the department. The total time necessary for an insurer’s functional division director to facilitate an examination will vary from plan to plan, depending on the number of functional divisions the insurer opts to include within its organizational structure and the complexity of the issues that arise during the examination.

 The department estimates that it would be reasonably necessary for an insurer to procure auto-mapping software, like Geo-Access or ArcGIS, to make the required maps available for review in compliance with §3.3723(f)(5) and to employ information technology staff to use the auto-mapping software. The department estimates that the initial cost of procuring ArcGIS software is $3,000 to $5,000. This is based on the cost estimates received from web-based searches conducted by department staff for software availability and price quotes. The department also estimates that it would be reasonably necessary for an insurer’s computer programmer to spend an average of five to 15 hours operating the auto-mapping software, determining service areas, and printing the required maps. It is likely that insurers with dense, limited service areas would be able to provide the necessary information with lower costs because of the decreased time needed to generate the necessary information.

 Additionally, the department estimates that the average printing and copying costs necessary for compliance could vary slightly for each plan depending on the number of pages necessary to print or copy per examination. Though the department has identified factors attributable to the cost of compliance with new §3.3723, it is not possible for the department to estimate the absolute total amount of compliance costs that an insurer could incur because there are numerous factors involved that limit reliable quantification by the department, including plan size and the number of relevant documents that might be requested by the department during any given examination. If an insurer has a larger than average plan and the department determines that additional relevant documents are necessary during an examination, the cost for making the required documents available for a qualifying examination will be accordingly higher. The estimated cost to comply with the new subsection represents an estimate for an insurer with an average plan size, with documents stored in electronic format, and with a simple subsequent examination that does not require the department to request numerous additional documents. If it is necessary for the department to perform additional exams during the five-year period, the costs will be accordingly higher.

 ***Section 3.3724: Quality improvement program.*** New §3.3724(a) requires that an insurer develop and maintain an ongoing quality improvement program. The quality improvement program must include: (i) a written description of the program outlining organizational structure, functional responsibilities, and meeting frequency; (ii) an annual work plan that includes objective and measurable goals, planned activities, timeframes, responsible individuals, and evaluation methodologies for 13 program areas as set forth in new §3.3724(a)(2)(B); (iii) an annual written report on the quality improvement program that includes information regarding completed activities, trending of clinical and service goals, program performance, and general conclusions; (iv) a credentialing process for the selection and retention of contracted physicians and providers; and (v) a peer review procedure for physicians and providers to obtain recommendations regarding credentialing decisions.

 New §3.3724(b) requires an insurer’s governing body to appoint a quality improvement committee, approve the quality improvement program, approve an annual quality improvement plan, meet at least once a year to review the quality improvement committee report, and to review the annual written report of the quality improvement program. Finally, new §3.3724(c) requires the quality improvement committee to meet regularly and provide an ongoing evaluation of the overall effectiveness of the quality improvement program.

 The department estimates that new §3.3724 could result in compliance costs for insurers. The department has determined that the total estimated cost for an insurer to comply with the new subsections could vary based upon certain components. The department considered the cost of: (i) hiring staff necessary to develop and maintain an ongoing quality improvement program in compliance with new §3.3724(a); (ii) hiring a qualified credentialing organization or an in-house credentialing body to comply with the credentialing function requirements in new §3.3724(a)(4); (iii) compensating members of the required credentialing committee to comply with new §3.3724(a)(5); (iv) conducting annual meetings in compliance with new §3.3724(b); (v) compensating members of the quality improvement committee for its ongoing evaluation of quality improvement activities to comply with new §3.3724(c); and (vi) copying, printing, and mailing.

 The department estimates that it would be reasonably necessary for an insurer to employ a medical director or registered nurse to serve as clinical director for the required quality improvement program, to employ administrative staff to assist the clinical director, and to employ information technology personnel to assist with the compilation of data necessary for drafting the required work plan and written report.

 The department estimates that an insurer’s clinical director might provide most of the labor necessary to develop and maintain an ongoing quality improvement program, including providing the required written description, drafting an annual work plan, drafting an annual written report, implementing the required credentialing process, and overseeing the peer review process. The department estimates that it would be reasonably necessary for a medical director or a registered nurse to spend between 10 and 40 hours per week developing and maintaining the quality improvement program. The department estimates that the total average labor cost for an insurer’s clinical director to develop and maintain the quality improvement program in compliance with new §3.3724(a) could vary depending on the size of the network and whether the insurer hires a medical director or registered nurse to develop and maintain the quality improvement program.

 The department estimates that an insurer’s administrative staff will provide some of the labor necessary to develop and maintain an ongoing quality improvement program in compliance with new §3.3724(a), including drafting, copying, printing, combining, and mailing the required work plan described in §3.3724(a)(2) and the required written report described in §3.3724(a)(3). The department estimates that it would be reasonably necessary for an administrative assistant to spend an average of six hours per week assisting the clinical director with the work plan and written report.

 The department further estimates that it would be reasonably necessary for an insurer to employ a computer programmer to assist with the compilation of data necessary to track the requirements in §3.3724(a)(2), regarding the annual work plan, and in §3.3724(a)(3), regarding the annual written report. The department estimates that the number of hours necessary to compile data for the required work plan and written report will vary from plan to plan with an average range from five to 15 hours of computer programmer labor per year to assist the clinical director with the required submissions.

 The department estimates that it would be reasonably necessary for an insurer to delegate credentialing functions to a qualified credentialing organization for a per-provider fee or employ an in-house credentialing body, including a peer review committee to review and approve credentialed providers. The department estimates that an insurer may incur costs for staff time spent researching credentials and for fees for accessing credentialing databases as a result of compliance with §3.3724(a)(4). The department has determined that an insurer may spend up to one hour per provider researching physician and provider credentials with an additional estimated access cost of $10 per physician to access the various credentialing databases. The department estimates that an insurer may opt to have an administrative assistant perform these tasks. The department estimates that this monthly cost component will vary for each insurer depending on how many providers are researched for credentialing and that each insurer has the information necessary to determine its approximate estimated cost.

 It may be reasonably necessary for an insurer to provide compensation to members of the credentialing committee for the time necessary to review and make recommendations regarding credentialing decisions. It is not feasible for the department to estimate the total cost attributable to compliance with new §3.3724(a)(5) because there are numerous factors involved that are not suitable to reliable quantification by the department, including the size of the insurer’s service area(s), the number of physicians and providers requesting a peer review of a credentialing decision, variation in the negotiated fees of physicians and providers to participate in the committee, and the number of physicians and providers designated to the committee by the insurer. The department estimates that each insurer has the information necessary to determine its individual labor costs necessary to meet the requirements of new §3.3724(a)(5).

 It may be reasonably necessary for an insurer to provide additional compensation to members of the governing body for the time necessary to plan and conduct the required annual meetings of the governing body. However, it is not feasible for the department to estimate the total cost attributable to compliance with new §3.3724(b), because there are numerous factors involved that are not suitable for reliable quantification by the department, including the size of the insurer’s service area(s) and the current salaries of the insurer’s governing body members. The department estimates that each insurer has the information necessary to determine its individual labor costs necessary to meet the requirements of new §3.3724(b).

 The department estimates that it may be reasonably necessary for an insurer to provide compensation to members of the appointed quality improvement committee for time necessary to meet regularly and to provide an ongoing evaluation of the overall effectiveness of the quality improvement program. However, it is not feasible for the department to estimate the total cost attributable to compliance with new §3.3724(c) because there are numerous factors involved that are not suitable for reliable quantification by the department, including the size of the insurer’s service area, the variation in the negotiated fees of physicians and providers agreeing to participate in the committee, and the number of physicians and providers appointed to the committee by the insurer’s governing body. The department estimates that each insurer has the information necessary to determine its individual labor costs necessary to meet the requirements of new §3.3724(c).

 Additionally, the department estimates that insurers may incur cost to print or copy the required written description, annual work plan, annual written report, required committee reports, procedures, and additional paperwork necessary to comply with new §3.3724. The average print, copy, and postage costs necessary for compliance could vary for each plan depending upon the number of pages necessary to print and copy per year.

 ***Section 3.3725: Nonpreferred provider claims.*** New §3.3725(d) requires insurers reimbursing a nonpreferred provider under §3.3725(a), (b), or (c)(2) to ensure that an insured is held harmless for any amounts beyond the copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider. New §3.3725(e) provides that, upon finding that a claim from a nonpreferred provider under §3.3725(a), (b), or (c)(2) is payable, an insurer must issue payment at a usual and customary rate or at an agreed rate when the medically necessary covered services are not available through a preferred provider and have been requested by a preferred provider.

 The department estimates that §3.3725 could result in costs to comply for insurers. The department has determined that the total estimated cost for an insurer to comply with the new section could vary based upon the following components: (i) the cost of information technology staff necessary to program the insurer’s computer software system to pay claims as required under §3.3725 and (ii) the cost of acquiring additional data concerning usual and customary rates.

 The department estimates that an insurer’s information technology staff will provide most if not all of the labor necessary to program the insurer’s computer software system to pay claims. The department estimates that it would be reasonably necessary for a computer programmer to spend an average of 10 to 100 hours making necessary programming changes to the insurer’s software, depending on the complexity of the insurer’s current computer software system.

 The department estimates that it may be reasonably necessary for an insurer to incur an additional annual cost to acquire additional data for determining usual and customary rates for claims payment. It is not feasible for the department to estimate the total amount of cost attributable to compliance with new §3.3725 regarding the determination of usual and customary rates, because there are numerous factors involved that are not suitable to reliable quantification by the department, including the insurer’s current reimbursement methodologies, the market share of the insurer, the service areas the data will be required to cover, and other facts specific to each insurer. The department estimates that each insurer has the information necessary to determine its individual costs necessary to determine usual and customary rates for its service areas.

**4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.** As required by the Government Code §2006.002(c), the department has determined that the proposed amendments may have an adverse economic effect on 10 to 40 small or micro businesses that must comply with the proposed rules. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses on the basis that a business is a large, small, or micro business, and the department’s cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note portion of this proposal is equally applicable to small or micro businesses. The total cost to large businesses and small or micro businesses to comply with the updated requirements for preferred provider benefit plans or the new requirements applicable to exclusive provider benefit plans is not dependent on the size of the insurer, but rather is dependent upon the individual insurer’s particular cost for each component. The department estimates that an individual insurer’s particular cost for each component will vary based on multiple factors as described in the Public Benefit/Cost Note portion of this proposal.

 In accord with the Government Code §2006.002(c-1), the department has considered other regulatory methods to accomplish the objectives of the proposal that will also minimize any adverse impact on small and micro businesses.

 The primary objective of the proposal is to provide health insurers offering health plan coverage in Texas with additional options to offer lower cost health plans to employers and individual consumers in a way that is consistent with HB 1772 by authorizing and providing the regulatory requirements for exclusive benefit provider plans.

 The other regulatory methods considered by the department to accomplish the objectives of the proposal and to minimize any adverse impact on small and micro businesses include: (i) not proposing the amendments; (ii) proposing different requirements for small and micro businesses; and (iii) excluding small and micro businesses from applicability under the amendments and new sections included in this proposal.

 **Not proposing the amendments.** As previously noted, the purpose of this rule proposal is to provide the regulatory requirements for exclusive benefit provider plans and to align the regulations applicable to preferred and exclusive provider benefit plans. If the rule were not proposed, no rules could be adopted that provide regulatory requirements for exclusive benefit provider plans. Current rules are in place that address preferred provider benefit plans. If the department does not create exceptions to those rules, some of them might be applicable to an insurer attempting to implement an exclusive provider benefit plan.

 Uncertainty regarding which rules apply to exclusive provider benefit plans and which rules do not apply to them would hamper the creation of exclusive provider benefit plans, and the result would be the delay or lack of creation of exclusive provider benefit plans. This, in turn, would frustrate the intent of HB 1772 to allow insurers to offer lower cost health plans to employers and individual consumers by permitting plans with closed networks where only services provided by network providers are covered.

 For this reason, the department has rejected this option.

 **Proposing different requirements for small and micro businesses.** The department has worked with stakeholders since the passage of HB 1772 to develop amendments to the current rules applicable to preferred provider benefit plans and new rules applicable to exclusive provider benefit plans that best achieve the goals of HB 1772. Many changes have been made to earlier drafts of the proposed amendments and new sections based on input from stakeholders and stakeholder groups, including groups that have among their membership small businesses. The department believes that proposing different standards than those included in this proposal would not provide a better option for small or micro businesses. Additionally, the department anticipates that many costs of compliance will be lower for insurers that have small service areas and networks, including small and micro businesses, which may have smaller service areas and networks than larger insurers. For example, in these instances this would reduce the impact of requirements for credentialing and quality improvement for small and micro businesses.

 Also, the department believes that the potential harm of lessened regulatory requirements to consumers and providers would outweigh the potential benefit to small or micro businesses. The proposed requirements include provisions addressing notice, claim payment, and network access and quality. Since many of the regulatory requirements are not reflected in policy documents, consumers and providers would not know what different regulations a small or micro business insurer would be following.

 In addition, exempting small and micro businesses from these requirements or reducing these requirements for those insurers within their service areas could result in additional costs and potentially less access to care or quality of care for the insureds of small or micro business insurers. Consumers would also be generally unable to make adequate comparisons and informed decisions in shopping for health insurance if different insurers were treated differently under the proposed rules, because consumers generally would not know what types of care the consumers would require in the future and because it would be difficult to recognize which insurers are large and small or to recognize the differences in the regulatory requirements applicable to the small versus large insurers.

 For these reasons, the department has rejected this option.

 **Excluding small and micro businesses from applicability under the new sections included in this proposal.** As addressed in the Public Benefit/Cost Note portion of this proposal, anticipated costs under the proposal are the result of the new requirements applicable to exclusive provider benefit plans. If small and micro businesses were excluded from applicability under the new sections applicable to exclusive provider benefit plans, they would not face the economic impacts. However, if small and micro businesses were excluded from applicability under the new sections applicable to exclusive provider benefit plans, they would not be subject to the credentialing or quality of care requirements, network adequacy standards, or other consumer protections included in the proposed rules. The department believes that the lack of these consumer protections would create potential harm for insureds that would outweigh the potential benefit to small or micro businesses.

 Additionally, failure to adopt rules applicable to small and micro businesses would be contrary to the Insurance Code. For example, failure to adopt network adequacy standards applicable to small and micro businesses would conflict with the Insurance Code §1301.055, which requires the commissioner to adopt network adequacy standards adapted to local markets in which an insurer offering a preferred provider benefit plan operates.

 For these reasons, the department has rejected this option.

**5. TAKINGS IMPACT ASSESSMENT.** The department has determined that this proposal affects no private real property interests, nor does it restrict or limit an owner's right to property that would otherwise exist in the absence of government action. Therefore, this proposal does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

**6. REQUEST FOR PUBLIC COMMENT.** To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on December 3, 2012, to Sara Waitt, general counsel, by email at: chiefclerk@tdi.state.tx.us or by mail at: Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments must be simultaneously submitted to Doug Danzeiser by email at: LHLcomments@tdi.state.tx.us or by mail at: Regulatory Matters, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

 The commissioner will consider the proposed amendments to §§3.3701 – 3.3710 and new §§3.3720 – 3.3725 in a public hearing under Docket No. 2745 scheduled for November 14, 2012, at 9:30 a.m. in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. The department will consider written and oral comments presented at the hearing.

**7. STATUTORY AUTHORITY.** The amendments and new sections are proposed under the Insurance Code §§1301.003, 1301.0042, 1301.007, and 36.001.

 The Insurance Code §1301.003 provides that an exclusive provider benefit plan that meets the requirements of Chapter 1301, relating to Preferred Provider Benefit Plans, is permitted.

 The Insurance Code §1301.0042 provides that, except for dental care benefits, a provision of the Insurance Code or other insurance law that applies to a preferred provider benefit plan also applies to an exclusive provider benefit plan unless the provision is determined to be inconsistent with the function and purpose of an exclusive provider benefit plan. The Insurance Code §1301.0042 also authorizes the commissioner to determine whether a provision is inconsistent with the function and purpose of an exclusive provider benefit plan.

 The Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Chapter 1301, relating to Preferred Provider Benefit Plans, and to ensure reasonable accessibility and availability of preferred provider services to residents of this state.

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

**8. CROSS REFERENCE TO STATUTE.** The following statutes are affected by this proposal:

 Rule Statute

 §3.3701 Insurance Code §1301.0041 and

 §1301.0042(a)

 §3.3702 Insurance Code §1301.001 and

 §1301.0042

 §3.3703 Insurance Code §§1251.006; 1301.003;

 1301.005; 1301.0041; 1301.0042;

 1301.134; 1301.136; 1301.152 –

 1301.154; 1301.160; 1301.161; Chapter

 1301, Subchapters B and C; and

 Chapters 1451 and 1460

 §3.3704 Insurance Code §§1301.0042,

 1301.005, 1301.0055, 1301.006, and

 1301.066

 §3.3705 Insurance Code §§541.003; 541.051;

 1301.0042; 1301.0045; 1301.005;

 1301.0055; 1301.0056; 1301.006;

 1301.055; 1456.003; 1456.006;

 1661.002; 1701.055; 1701.057;

 1701.060; and Chapter 1301,

 Subchapter D

 §3.3706 Insurance Code §§1301.0042,

 1301.005, 1301.0055, 1301.006,

 1301.051, 1301.053, 1301.054,

 1301.057, 1301.058, 1301.160, and

 Chapters 544 and 1451

 §3.3707 Insurance Code §1301.0055

 1301.005, 1301.0052, 1301.0055,

 1301.0056, and 1301.006

 §3.3708 Insurance Code §§1301.0042,

 1301.0052, and 1301.0053

 §3.3709 Insurance Code §§1301.0042,

 1301.005, 1301.0052, 1301.0055,

 1301.0056, and 1301.006

 §3.3710 Insurance Code §§1301.0042,

 1301.0056, and Chapters 82 and 83

 §3.3720 Insurance Code §§1301.0041,

 1301.0042, and 1301.0055

 §3.3721 Insurance Code §§301.0042,

 1301.0051, 1301.0055, 1301.0056

 §3.3722 Insurance Code §§1301.0042(a),

 1301.0051, 1301.0053, 1301.0055,

 1301.0056, and 1301.007

 §3.3723 Insurance Code §§401.054, 751.303,

 1301.0042, and 1301.0056

 §3.3724 Insurance Code §1301.0042 and

 §1301.0051

 §3.3725 Insurance Code §§1301.0042,

 1301.0052, and 1301.0053

**9. TEXT.**

**SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS**

**Division 1. General Requirements**

**28 TAC §§3.3701 – 3.3710**

**§3.3701. Applicability and Scope [~~Application~~].**

 (a) Except as otherwise specified in this subchapter, [~~the sections of~~] this subchapter applies [~~apply~~] to any preferred provider benefit plan or exclusive provider benefit plan as specified in this subsection.

 (1) This subchapter applies to any preferred or exclusive provider benefit plan policy that is offered, delivered, issued for delivery, or renewed on or after 150 days from the effective date of this section [~~May 19, 2012~~]. Any preferred or exclusive provider benefit plan policy delivered, issued for delivery, or renewed prior to this applicability date [~~May 19, 2012,~~] is subject to the statutes and provisions of this subchapter in effect at the time the policy was delivered, issued for delivery, or renewed.

 (2) This [~~The sections of this~~] subchapter does [~~do~~] not apply to:

 (A) provisions for dental care benefits in any health insurance policy; or

 (B) an exclusive provider benefit plan regulated under Subchapter KK of this chapter (relating to Exclusive Provider Benefit Plan) written by an insurer pursuant to a contract with the Texas Health and Human Services Commission to provide services under the Texas Children’s Health Insurance Program, Medicaid, or with the Statewide Rural Health Care System.

 (b) – (e) (No change.)

 (f) A provision of this title applicable to a preferred provider benefit plan is applicable to an exclusive provider benefit plan unless specified otherwise.

**§3.3702. Definitions**.

 (a) Words and terms defined in the Insurance Code Chapter 1301 have the same meaning when used in this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

 (1) Adverse determination--As defined in the Insurance Code §4201.002(1).

 (2) Allowed amount--The amount of a billed charge that an insurer determines to be covered for services provided by a nonpreferred provider. The allowed amount includes both the insurer’s payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) [~~(1)~~] 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) [~~(2)~~] Contract holder--An individual who holds an individual health insurance policy, or an organization that [~~which~~] holds a group health insurance policy.

 [~~(3) Emergency care--As defined in the Insurance Code §1301.155.~~]

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

 (8) [~~(4)~~] Facility--

 (A) an ambulatory surgical center licensed under the Health and Safety Code Chapter 243;

 (B) a birthing center licensed under the Health and Safety Code Chapter 244; or

 (C) a hospital licensed under the Health and Safety Code Chapter 241.

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

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

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

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

 [~~(7) Health insurance policy--As defined in the Insurance Code §1301.001(2).~~]

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

 [~~(9) Hospital--As defined in the Insurance Code §1301.001(3), a licensed public or private institution as defined by the Health & Safety Code Chapter 241 or the Health & Safety Code Title 7, Subtitle C.~~]

 [~~(10) Institutional provider--As defined in the Insurance Code §1301.001(4).~~]

 [~~(11) Insurer--As defined in the Insurance Code §1301.001(5).~~]

 (12) In-network--Medical or health care treatment, services, or supplies furnished by a preferred provider, or a claim filed by a preferred provider for the treatment, services, or supplies.

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

 (14) [~~(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.

 (15) Out-of-network--Medical or health care treatment services, or supplies furnished by a nonpreferred provider, or a claim filed by a nonpreferred provider for the treatment, services, or supplies.

 (16) [~~(14)~~] Pediatric practitioner--A physician with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults.

 [~~(15) Physician--As defined in the Insurance Code §1301.001(6).~~]

 [~~(16) Practitioner--As defined in the Insurance Code §1301.001(7).~~]

 [~~(17) Preferred provider--As defined in the Insurance Code §1301.001(8).~~]

 [~~(18) Preferred provider benefit plan--As defined in the Insurance Code §1301.001(9).~~]

 [~~(19) Prospective insured--As defined in the Insurance Code §1301.158(a).~~]

 [~~(20) Quality assessment--As defined in the Insurance Code §1301.059(a).~~]

 (17) [~~(21)~~] Rural area--

 (A) a county with a population of 50,000 or less as determined by the United States Census Bureau in the most recent decennial census report;

 (B) an area that is not designated as an urbanized area by the United States Census Bureau in the most recent decennial census report; or

 (C) any other area designated as rural under rules adopted by the commissioner, notwithstanding subparagraphs (A) and (B) of this paragraph.

 [~~(22) Service area--As defined in the Insurance Code §1301.001(10).~~]

 (18) [~~(23)~~] Urgent care--Medical or health [~~Health~~] care services provided in a situation other than an emergency that [~~which~~] 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 [~~his or her~~] 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 [~~his or her~~] health.

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

**§3.3703. Contracting Requirements.**

 (a) An insurer marketing a preferred provider benefit plan must [~~is required to~~] contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must [~~is required to~~] 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) – (7) (No change.)

 (8) An insurer’s contract with a physician, physician group, or practitioner must [~~is required to~~] have a mechanism for the resolution of complaints that are 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 of §3.3706(b)(2) of this title [~~subchapter~~] (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

 (9) – (10) (No change.)

 (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[~~, including the Insurance Code Chapter 1301, Subchapter C and §§21.2801 – 21.2820 of this title (relating to Submission of Clean Claims)~~] with respect to payment to the provider for covered services that are rendered to insureds.

 (12) – (18) (No change.)

 (19) A contract between a preferred provider and an insurer must require written notice to the provider on [~~upon~~] 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 [~~subchapter~~].

 (20) – (25) (No change.)

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

 (27) A contract between an insurer and a preferred provider must require 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 to coordinate the insured’s care;

 (B) notify the insurer that surgery has been recommended so that the insurer has the opportunity to coordinate the insured’s care, 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 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 to coordinate the insured’s care, and;

 (B) notify the insurer that surgery has been scheduled so that the insurer has the opportunity to coordinate the insured’s care.

 (29) This subsection does not prohibit other contractual provisions not prohibited by law.

 (b) (No change.)

 (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 the Insurance Code Chapter 1301 and this subchapter; [~~or~~]

 (2) ensure that the requirements of the 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 [~~Requirements~~]. A preferred provider benefit plan is not considered unjust under the Insurance Code §§1701.002 – 1701.005; [~~§§~~]1701.051 – 1701.060; [~~§§~~]1701.101 – 1701.103; and [~~§~~]1701.151, or to unfairly discriminate under the Insurance Code Chapter 542, Subchapter A, or §§544.051 – 544.054, or to violate §§1451.001, 1451.053, 1451.054, or [~~§§~~]1451.101 – 1451.127 of the Insurance Code provided that:

 (1) pursuant to the Insurance Code §§1251.005, 1251.006, 1301.003, 1301.006, 1301.051, 1301.053, 1301.054, 1301.055, 1301.057 – 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner, except that an exclusive provider benefit plan may utilize an exclusive network as permitted under the Insurance Code Chapter 1301;

 (2) – (4) (No change.)

 (5) insureds have the right to emergency care services as set forth in the Insurance Code §1301.0053 and §1301.155, and §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims);

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

 (7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider, or in the selection of a preferred provider under an exclusive provider benefit plan, are not restricted by the insurer;

 (8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the basic level of coverage of a plan that is not an exclusive provider benefit plan is reasonably consistent with [~~such~~] 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) (No change.)

 (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 [~~subchapter~~] (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations); [~~and~~]

 (11) both preferred provider benefits and, except to the extent permitted by the Insurance Code Chapter 1301 in an exclusive provider benefit plan, basic level benefits are reasonably available to all insureds within a designated service area; and[~~.~~]

 (12) if medically necessary covered services are not available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accord with the Insurance Code §1301.005 and §1301.0052, and §3.3708 and §3.3725 of this title, as applicable.

 (b) Payment of nonpreferred providers [~~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.

 (c) Retaliatory action prohibited [~~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 against the insurer or a preferred provider or has appealed a decision of the insurer.

 (d) Access to certain institutional providers [~~Certain Institutional Providers~~]. In addition to the requirements for availability of preferred providers set forth in the Insurance Code §1301.005, any insurer offering a preferred provider benefit plan must [~~is required to~~] make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the service area to afford all insureds under the [~~such~~] plan freedom of choice in the selection of institutional providers at which they will receive care, unless the [~~such a~~] mix is [~~proves to be~~] not feasible due to geographic, economic, or other operational factors. An insurer must [~~is required to~~] give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

 (e) Network requirements [~~Requirements~~]. Each preferred provider benefit plan must [~~is required to~~] include a health care service delivery network that complies with the Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements described in this section. An adequate network must [~~is required to~~]:

 (1) – (11) (No change.)

 (f) Network monitoring and corrective action [~~Monitoring and Corrective Action~~]. Insurers must [~~are required to~~] monitor compliance with subsection (e) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate.

 (g) Service areas [~~Areas~~]. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but any service areas that are smaller than statewide must [~~are required to~~] be defined in terms of one of the following:

 (1) one or more of the 11 Texas geographic regions designated in §3.3711 of this title [~~subchapter~~] (relating to Geographic Regions);

 (2) – (3) (No change.)

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

 (a) (No change.)

 (b) Disclosure of terms and conditions of the policy [~~Terms and Conditions of the Policy~~]. The insurer is required, on [~~upon~~] request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. The written description must [~~is required to~~] be in a readable and understandable format, by category, and must [~~is required to~~] include a clear, complete, and accurate description of these items in the following order:

 (1) a statement that the entity providing the coverage is an insurance company;[~~,~~] the name of the insurance company;[~~, and~~] 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;

 (2) – (8) (No change.)

 (9) any authorization requirements [~~prior authorizations~~], including preauthorization review, concurrent review, post-service review, and post-payment review; and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

 (10) – (11) (No change.)

 (12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients. Both [~~, both~~] of these items [~~which~~] may be provided electronically, if notice is also provided in the disclosure required by this subsection regarding how a nonelectronic copy may be obtained free of charge [~~with the agreement of the insured provided that information about how to obtain a nonelectronic provider listing free of charge is also provided~~];

 (13) (No change.)

 (14) information that is updated at least annually regarding whether any waivers or local market access plans approved pursuant to §3.3707 of this title (relating to Waiver Due to Failure to Contract Local Markets) apply to the plan and that complies with the following [~~network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this subchapter (relating to Geographic Regions), if the plan is offered on a statewide service area basis~~]:

 (A) if a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

 (B) the information may be categorized by service area or county if the preferred provider benefit plan is not offered on a statewide service area basis, and, if by county, the aggregate of counties is not more than those within a region; or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis; and

 (C) the information must identify how the local market access plan may be obtained or viewed.

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

 [~~(B) for each provider area of practice, including at a minimum internal medicine, family/general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of preferred providers, as well as an indication of whether an active access plan pursuant to §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan) applies to the services furnished by that class of provider in the service area or region and how such access plan may be obtained or viewed, if applicable; and~~]

 [~~(C) for hospitals, the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 of this subchapter applies to hospital services in that service area or region and how the access plan may be obtained or viewed.~~]

 (c) Filing required [~~Required~~]. A copy of the written description required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if applicable, must be submitted to the following email [~~e-mail~~] address: LifeHealth@tdi.state.tx.us [~~hwcn@tdi.state.tx.us~~]. Nonelectronic filings must [~~are required to~~] be submitted to the department at: Life/Health and HMO Intake Team [~~Filings Intake Division~~], Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas[~~,~~] 78714-9104.

 (d) Promotional disclosures required [~~Disclosures Required~~]. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must [~~are required to~~] clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must [~~is required to~~] be in close proximity to an equally prominent description of basic benefits, except in the case of an exclusive provider benefit plan.

 (e) Internet website disclosures [~~Website Disclosures~~]. Insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must [~~are required to~~] provide:

 (1) – (3) (No change.)

 (f) Notice of rights [~~Rights~~] under a network plan required [~~Network Plan Required~~]. An insurer must [~~is required to~~] include the notice specified in Figure: 28 TAC §3.3705(f)(1), for a preferred provider benefit plan that is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2), for an exclusive provider benefit plan, [~~§3.3705)(f)~~] in all policies, certificates, disclosures of policy terms and conditions provided pursuant to subsection (b) of this section, and outlines of coverage in at least 12 point font:

 **(1) Preferred provider benefit plan notice.**

**Figure: 28 TAC §3.3705(f)(1) [~~FIGURE: 28 TAC §3.3705(f)~~]:**

*Texas Department of Insurance Notice*

* *You have the right to an adequate network of preferred providers (also known as “network providers”).*
	+ *If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.*
	+ *If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network [~~in-network coinsurance~~] rate and your out-of-pocket expenses counted toward your in-network deductible and* [*~~, out-of-network, or general~~*] *out-of-pocket maximum*[*~~, as appropriate~~*]*.*
* *You have the right to obtain advance estimates:*
	+ *of the amounts that the providers may bill for projected services, from your out-of-network provider; and*
	+ *of the amounts that the insurer may pay for the projected services, from your insurer.*
* *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.*
* *If you are treated by a provider or hospital that is not a preferred provider* [*~~contracted with your insurer~~*]*, you may be billed for anything not paid by the insurer.*
* *If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html* [*~~www.tdi.state.tx.us/consumer/cpmmediation.html~~*].

**(2) Exclusive provider benefit plan notice.**

**FIGURE: 28 TAC §3.3705(f)(2):**

*Texas Department of Insurance Notice*

* *An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.*
* *You have the right to an adequate network of preferred providers (known as “network providers”).*
	+ *If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.*
* *If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider’s bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.*
* *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.*

 (g) Untrue or misleading information prohibited [~~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 [~~Concerning Access to Preferred Provider Listing~~]. The insurer must [~~is required to~~] 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 a nonelectronic copy of the listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

 (i) Required updates of available provider listings [~~Updates of Available Provider Listings~~]. The insurer must [~~is required to~~] ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months.

 (j) Annual provision of provider listing required in certain cases [~~Provision of Provider Listing Required in Certain Cases~~]. If no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must [~~is required to~~] distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if an [~~such~~] alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

 (k) Reliance upon provider listing in certain cases [~~Upon Provider Listing in Certain Cases~~]. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(b) – (d) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725(d) – (f) of this title (relating to Payment of Certain Out-of-Network Claims), as applicable, [~~at the applicable preferred benefit coinsurance percentage~~] if an insured demonstrates that:

 (1) – (4) (No change.)

 (l) Additional listing-specific disclosure requirements [~~Listing-Specific Disclosure Requirements~~]. In all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, the insurer must [~~is required to~~] comply with the requirements in paragraphs (1) – (7) [~~(10)~~] of this subsection.

 (1) (No change.)

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

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

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

 [~~(5) The provider information must designate those preferred providers that have notified the insurer of the preferred provider’s participation in a regional quality of care peer review program.~~]

 (3) [~~(6)~~] The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

 (A) information about the provider's contract status; and

 (B) whether the provider is accepting new patients.

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

 (5) [~~(8)~~] The provider information must be provided in at least 10 point font [~~fonts of not less than 10-point type~~].

 (6) [~~(9)~~] The provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable provider class.

 (7) [~~(10)~~] The provider information must be dated.

 (m) Annual policyholder notice concerning use of a local market access plan [~~Policyholder Notice Concerning Use of Access Plan~~]. An insurer operating a preferred provider benefit plan that relies on a local market [~~upon an~~] access plan as specified in §3.3707 [~~§3.3709~~] of this title relating to Waiver Due to Failure to Contract Local Markets must [~~subchapter is required to~~] provide notice of this fact to each individual and group policyholder participating in the [~~such~~] plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include a link to any webpage listing of regions, counties, or ZIP codes [~~Codes~~] made available pursuant to subsection (e)(2) of this section.

 [~~(n) Disclosure of Substantial Decrease in the Availability of Certain Preferred Providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility.~~]

 [~~(1) A decrease is substantial if:~~]

 [~~(A) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or~~]

 [~~(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) of this subchapter (relating to Contracting Requirements).~~]

 [~~(2) Notwithstanding paragraph (1) of this subsection, no notice of a substantial decrease is required if the requirements specified in either subparagraph (A) or (B) of this paragraph are met:~~]

 [~~(A) alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility such that the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or~~]

 [~~(B) the insurer provides to the Department, by e-mail to hwcn@tdi.state.tx.us, a certification of the insurer’s determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers), as those standards apply to the applicable provider specialty.~~]

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

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

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

 [~~(B) six months from the date that the insurer initially posts the notice; or~~]

 [~~(C) the date on which the insurer provides to the Department, by e-mail to hwcn@tdi.state.tx.us, a certification as specified in paragraph (2)(B) of this subsection indicating the insurer’s determination that the termination of provider contract does not cause non-compliance with adequacy standards.~~]

 [~~(5) An insurer is required to post notice as specified in paragraph (3) of this subsection and to update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after:~~]

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

 [~~(B) the later of:~~]

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

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

 (n) [~~(o)~~] Disclosures concerning reimbursement of out-of-network services [~~Concerning Reimbursement of Basic Benefit Services~~]. An insurer must [~~is required to~~] make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network [~~basic benefit~~] services as specified in this subsection.

 (1) An insurer must [~~is required to~~] disclose how reimbursements of nonpreferred providers will be determined.

 (2) Except in an exclusive provider benefit plan, if [~~If~~] an insurer reimburses nonpreferred providers based directly or indirectly on [~~upon~~] data regarding usual, customary, or reasonable charges by providers, the insurer must [~~is required to~~] disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.

 (3) Except in an exclusive provider benefit plan, if [~~If~~] an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer must [~~is required to~~]:

 (A) disclose that the insurer’s reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

 (B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer;

 (C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

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

 [~~(p) Plan Designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this subchapter without reliance upon an access plan may be designated by the insurer as having an “Approved Hospital Care Network” (AHCN). If a preferred provider benefit plan utilizes a preferred provider service delivery network that does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this subchapter, the insurer is required to disclose that the plan has a “Limited Hospital Care Network:”~~]

 [~~(1) on the cover page of any insurance policy, certificate of coverage, or outline of coverage utilizing the network; and~~]

 [~~(2) on the cover page of any nonelectronic provider listing describing the network.~~]

 [~~(q) Loss of Status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this subchapter and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer is required to:~~]

 [~~(1) notify the department in writing concerning such change in status at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104;~~]

 [~~(2) cease marketing the plan as an AHCN; and~~]

 [~~(3) inform all insureds of such change of status at the time of renewal.~~]

**§3.3706. Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process.**

 (a) Access to designation as a preferred provider [~~Designation as a Preferred Provider~~]. Physicians, practitioners, institutional providers, and health care providers other than physicians, practitioners, and institutional providers, if [~~such~~] other health care providers are included by an insurer as preferred providers, that are licensed to treat injuries or illnesses or to provide services covered by the preferred provider benefit plan and that comply with the terms and conditions established by the insurer for designation as preferred providers, are eligible to apply for and must be afforded a fair, reasonable and equitable opportunity to become preferred providers, subject to subsection (b) of this section.

 (1) – (5) (No change.)

 (b) Withholding preferred provider designation [~~Preferred Provider Designation~~]. An insurer may not unreasonably withhold designation as a preferred provider except that, unless otherwise limited by the Insurance Code or rule promulgated by the department, an insurer may reject an application from a physician or health care provider on the basis that the preferred provider benefit plan has sufficient qualified providers.

 (1) (No change.)

 (2) An insurer must [~~is required to~~] provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel.

 (A) (No change.)

 (B) At least one of the three individuals on the advisory review panel must [~~is required to~~] be a physician or practitioner in the same or similar specialty as the physician or practitioner requesting review unless there is no physician or practitioner in the same or similar specialty contracting with the insurer [~~insured~~].

 (C) – (E) (No change.)

 (c) Credentialing of preferred providers [~~Preferred Providers~~]. Insurers must [~~are required to~~] have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. At a minimum, an insurer's credentialing standards must [~~are required to~~] meet the standards promulgated by the National Committee for Quality Assurance (NCQA) [~~NCQA]~~ or URAC to the extent that those standards do not conflict with other laws of this state. Insurers will [~~shall~~] be presumed to be in compliance with statutory and regulatory requirements regarding credentialing if they have received nonconditional accreditation or certification by the NCQA, the Joint Commission, [~~the American Accreditation HealthCare Commission, the~~] URAC, or the Accreditation Association for Ambulatory Health Care.

 (d) Notice of termination of a preferred provider contract [~~Termination of a Preferred Provider Contract~~]. Before terminating a contract with a preferred provider, the insurer must [~~is required to~~] provide written notice of termination, which includes:

 (1) – (2) (No change.)

 (e) Review of a decision to terminate [~~Decision to Terminate~~]. To obtain a standard review of an insurer's decision to terminate him or her, a physician or practitioner must:

 (1) – (2) (No change.)

 (f) Completion of the review process [~~Review Process~~]. The review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, must [~~is required to~~] be completed and the results provided to the physician or practitioner within 60 calendar days of the insurer's receipt of the request for review.

 (g) Expedited review process [~~Review Process~~]. To obtain an expedited review of an insurer's decision to terminate him or her, a physician or practitioner must:

 (1) – (2) (No change.)

 (h) Completion of the expedited review process [~~Expedited Review Process~~]. The expedited review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, must [~~shall~~] be completed and the results provided to the physician or practitioner within 30 calendar days of the insurer's receipt of the request for review.

 (i) Confidentiality of information concerning the insured [~~Information Concerning the Insured~~].

 (1) – (2) (No change.)

 (j) Notice to insureds [~~Insureds~~].

 (1) (No change.)

 (2) If a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, the insurer must [~~is required to~~] provide assistance to the physician or provider in assuring that the notice requirements are met as required by §3.3703(a)(18) of this title [~~subchapter~~] (relating to Contracting Requirements).

 (3) (No change.)

**§3.3707. Waiver Due to Failure to Contract; Local Market Access Plans [~~in Local Markets~~].**

(a) In accord [~~accordance~~] with the Insurance Code §1301.0055(3), where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a portion of the state that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(e) [~~§3.3704~~] of this title [~~subchapter (relating to Freedom of Choice; Availability of Preferred Providers)~~]. The commissioner may grant the waiver if there is good cause based on [~~upon~~] one or more of the criteria specified in this subsection and may impose reasonable conditions on the grant of the [~~such~~] waiver. The commissioner may find good cause to grant the waiver if the insurer demonstrates that providers or physicians necessary for an adequate local market network:

 (1) – (2) (No change.)

(b) At a minimum, each waiver an insurer requests must include either the information specified by paragraph (1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.

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

 (A) a list of the providers or physicians within the relevant service area that the insurer attempted to contract with, identified by name and specialty or facility type;

 (B) a description of how and when the insurer last contacted each provider or physician;

 (C) a description of any reason each provider or physician gave for refusing to contract with the insurer;

 (D) an estimate of total claims cost savings per year the insurer anticipates will result from using a local market access plan instead of contracting with providers located within the service area, and its impact on premium; and

 (E) steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary.

 (2) If no providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer’s request for waiver must state this fact.

 (c) At the same time an insurer files a request for waiver, it must file a local market access plan, as specified in subsection (i) of this section, to be taken into consideration by the commissioner in deciding whether to grant or deny a waiver request.

 (d) [~~b~~] An insurer seeking a waiver under subsection (a) of this section must electronically [~~is required to~~] file the request with the department at the Office of the Chief Clerk through the following email address: chiefclerk@tdi.state.tx.us [~~, MC 113-2A, P.O. Box 149104, Austin, TX 78714-9104~~]. The insurer is also required to submit a copy of the request to any provider or physician named in the request for waiver at the same time that the request is filed with the department, but is permitted to redact information from the copy where provision of the information to the provider or physician would violate state or federal law. The insurer may use any reasonable means to submit the copy of the request to the provider or physician. The insurer must [~~and is required to~~] maintain proof of the [~~such~~] submission and include a copy of the redacted version with the waiver request submitted to the department.

 (e) [~~(c)~~] Any provider or physician may elect to provide a response to an insurer’s request for waiver by filing such response within 30 days after the insurer files the request with the department. Such response, if filed, shall be filed at the same address specified in subsection (d) [~~(b)~~] of this section for filing the request for waiver.

 (f) [~~(d)~~] If the department grants a waiver under subsection (a) of this section, the department will [~~shall~~] post on the department’s website information relevant to the grant of a waiver, including:

 (1) the name of the preferred provider benefit plan for which the request is granted;[~~,~~]

 (2) the insurer offering the plan;[~~,~~] and

 (3) the affected service area.

(g) [~~(e)~~] An insurer may [~~is required to~~] apply for renewal of a waiver described in subsection (a) of this section annually.

 (1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section at least 30 days prior to the anniversary of the department’s grant of waiver.

 (2) At the same time the insurer files an application for renewal of a waiver, the insurer must file any applicable local market access plan the insurer uses pursuant to the waiver, in the manner specified by subsection (i)(2) of this section.

 (3) A waiver granted by the department will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver or the department denies the application for renewal. [~~and at the same time the insurer files the annual network adequacy report required under §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan).~~]

(h) A waiver will expire one year after the date the department granted it if an insurer fails to timely request a renewal under subsection (g) of this section or if the department denies the insurer’s request for renewal.

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

 (1) The local market access plan must contain all the information specified in subsection (j) of this section and must be made available to the department on request.

 (2) The insurer must file the local market access plan with the department by email at: hwcn@tdi.state.tx.us or through the National Association of Insurance Commissioner’s System for Electronic Rate and Form Filing.

 (j) A local market access plan required under subsection (i) of this section must specify for each service area that does not meet the network adequacy requirements:

 (1) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this title, including a specification of the class of provider that is not sufficiently available;

 (2) a map, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, or providers are not available;

 (3) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this title;

 (4) procedures that the insurer will utilize to assist insureds in obtaining medically necessary services when no preferred provider is reasonably available, including procedures to coordinate care to limit the likelihood of balance billing; and

 (5) procedures detailing how out-of-network benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims).

 (k) An insurer must establish and implement documented procedures, as specified in this subsection, for use in all service areas for which a local market access plan is submitted.

 (1) The insurer must utilize a documented procedure to:

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

 (B) furnish to insureds, prior to the services being rendered, an estimate of the amount the insurer will pay the physician or provider; and

 (C) except in the case of an exclusive provider benefit plan, notify insureds that they may be liable for any amounts charged by the physician or provider that are not paid in full by the insurer.

 (2) The insurer must utilize a documented procedure to:

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

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

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

 (m) An insurer must submit a local market access plan established pursuant to this section as a part of the annual report on network adequacy required under §3.3709 of this title (relating to Annual Network Adequacy Report).

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

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

 (a) An insurer must comply with the requirements of subsections (b) and (c) [~~(e)~~] of this section when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:

 (1) requiring emergency care;

 (2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and

 (3) when a nonpreferred provider’s services were pre-approved or preauthorized based upon the unavailability of a preferred provider.

 (b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer must [~~is required to~~]:

 (1) pay the claim, at a minimum, at the usual, or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;

 (2) [~~(1)~~] pay the [~~such~~] claim at the preferred benefit coinsurance level; and

 (3) [~~(2)~~] in addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services in excess of the allowed amount toward the insured’s deductible and annual out-of-pocket maximum applicable to in-network services.

 (c) – (d) (No change.)

 (e) When services are rendered to an insured by a nonpreferred facility-based physician and the difference between the allowed amount and the billed charge is at least $1000, the insurer is required to include a notice on the applicable explanation of benefits that the insured may have the right to request mediation of the claim of an uncontracted facility-based provider under the Insurance Code Chapter 1467 and may obtain more information at www.tdi.texas.gov/consumer/cpmmediation.html. An insurer is not in violation of this subsection if it provides the required notice in connection with claims that are not eligible for mediation. [~~When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer is required to include a notice on each explanation of benefits that the insured has the right to request information concerning negotiated rates for comparison purposes. Upon the request of an insured, the insurer must furnish the median per-service amount the insurer has negotiated with preferred providers for the service furnished, excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount.~~]

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

**§3.3709. Annual Network Adequacy Report[~~; Access Plan~~].**

 (a) Network adequacy report required [~~Adequacy Report Required~~]. An insurer must [~~is required to~~] file a network adequacy report with the department on or before April 1 [~~April 1st~~] of each year and prior to marketing any plan in a new service area.

 (b) General content of report [~~Content of Report~~]. The report required in subsection (a) of this section must specify:

 (1) – (2) (No change.)

 (3) whether the preferred provider service delivery network supporting each plan is adequate under the standards set forth in §3.3704 of this title [~~subchapter~~] (relating to Freedom of Choice; Availability of Preferred Providers).

 (c) Additional content applicable only to annual reports [~~Content Applicable Only to Annual Reports~~]. As a part of the annual report on network adequacy, each insurer must [~~is required to~~] provide additional demographic data as specified in paragraphs (1) – (6) of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title [~~subchapter~~] (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 [~~is required to~~] specify in the report that there is no applicable data for that region. The report must include the number of:

 (1) claims for out-of-network [~~basic~~] benefits, excluding claims paid at the preferred benefit coinsurance level;

 (2) claims for out-of-network [~~basic~~] benefits that were paid at the preferred benefit coinsurance level;

 (3) – (6) (No change.)

 [~~(d) Additional Content Applicable if Inadequate Networks are Utilized. As a part of the annual report on network adequacy, an insurer is required to submit a local market access plan as specified in subsection (e) of this section if any of the insurer’s preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements specified in §3.3704 of this subchapter.~~]

 [~~(e) Content of Local Market Access Plan.~~]

 [~~(1) A local market access plan required under subsection (d) of this section must specify for each service area that does not meet the network adequacy requirements:~~]

 [~~(A) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this [subchapter, including a specification of the class of provider that is not sufficiently available;~~]

 [~~(B) a map, with key and scale, that identifies the geographic areas within the service area in which such health care services and/or physicians and providers are not available;~~]

 [~~(C) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this subchapter;~~]

 [~~(D) procedures that the insurer will utilize to assist insureds to obtain medically necessary services when no preferred provider is reasonably available; and~~]

 [~~(E) procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this subchapter (relating to Payment of Certain Basic Benefit Claims and Related Disclosures; Waiver).~~]

 [~~(2) The department may request additional information necessary to assess the local market access plan.~~]

 [~~(f) Procedures to Supplement Local Market Access Plan]. An insurer is required to establish and implement documented procedures as specified in this subsection for use in all service areas for which a local market access plan is submitted as required in subsection (d) of this section.~~]

 [~~(1) The insurer must utilize a documented procedure to:~~]

 [~~(A) identify requests for preauthorization of services for insureds that are likely to require, directly or indirectly, the rendition of services by physicians or providers that do not have a contract with the insurer;~~]

 [~~(B) furnish to such insureds, prior to such services being rendered, an estimate of the amount the insurer will pay the physician or provider; and~~]

 [~~(C) notify the insured that the insured may be liable for any amounts charged by the physician or provider that are not paid in full by the insurer.~~]

 [~~(2) The insurer must utilize a documented procedure to:~~]

 [~~(A) identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and~~]

 [~~(B) make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level~~].

 [~~(g) Negotiation Procedure Permitted in Access Plan. A local market access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.~~]

 (d) [~~(h)~~] Filing the report [~~Report~~]. The annual report required under this section must be submitted electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following email [~~e-mail~~] address: LifeHealth@tdi.state.tx.us [~~hwcn@tdi.state.tx.us~~].

 [~~(i) Access Plan Required if Network Adequacy Status Changes. If the status of a preferred provider service delivery network utilized in any preferred provider benefit plan changes such that the plan no longer complies with the network adequacy requirements specified in §3.3704 of this subchapter for a specific service area, the insurer is required to establish an access plan within 30 days of the date on which the network becomes non-compliant. Such access plan must contain all of the information specified in subsection (e) of this section and must be made available to the department upon request.~~]

**§3.3710. Failure to Provide an Adequate Network.**

 (a) If the commissioner determines, after notice and opportunity for hearing, that the insurer’s [~~preferred provider service delivery~~] network and any local market access plan supporting the [~~such~~] network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions pursuant to the authority of the commissioner in the Insurance Code Chapters 82 and [~~Chapter~~] 83 to issue cease and desist orders:

 (1) – (3) (No change.)

 (b) (No change.)

**Division 2. Exclusive Provider Benefit Plan Requirements**

**28 TAC §§3.3720 – 3.3725**

**§3.3720. Exclusive Provider Benefit Plan Requirements.** The provisions of this division apply only to exclusive provider benefit plans offered pursuant to the Insurance Code Chapter 1301 in commercial markets.

**§3.3721. Exclusive Provider Benefit Plan Network Approval Required.**  An insurer may not offer, deliver, or issue for delivery an exclusive provider benefit plan in this state unless the commissioner has completed a qualifying examination to determine compliance with the Insurance Code Chapter 1301 and this subchapter and has approved the insurer’s exclusive provider network in the service area.

**§3.3722. Application for Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications.**

 (a) Where to file application. An insurer that seeks to offer an exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance at the following address: Texas Department of Insurance, Mail Code 106-1A, P.O. Box 149104, Austin, Texas 78714-9104. A form titled Application for Approval of Exclusive Provider Benefit Plan is available on the department’s website at www.tdi.texas.gov/forms. An insurer may use this form to prepare the application.

 (b) Filing requirements.

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

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

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

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

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

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

 (A) an application for approval; or

 (B) a modification to an approved application.

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

 (A) the full name of the applicant;

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

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

 (D) the applicant’s telephone number.

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

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

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

 (B) the network, including any requested or granted waiver and any access plan as applicable, is adequate for the services to be provided under the exclusive provider benefit plan.

 (5) The applicant must provide a description and a map of the service area, with key and scale, identifying the area to be served by geographic region(s), county(ies), or ZIP code(s*).* If the map is in color, the original and all copies must also be in color.

 (6) The applicant must provide a list of all plan documents and each document’s associated form filing ID number or the form number of each plan document that is pending the department’s approval or review.

 (7) The applicant must provide the form(s) of physician contract(s) and provider contract(s) that include the provisions required in §3.3703 of this title (relating to Contracting Requirements) or an attestation by the insurer’s corporate president, corporate secretary, or the president’s or secretary’s authorized representative that the physician and provider contracts applicable to services provided under the exclusive provider benefit plan comply with the requirements of the Insurance Code Chapter 1301 and this subchapter.

 (8) The applicant must provide a description of the quality improvement program and work plan that includes a process for medical peer review required by the Insurance Code §1301.0051 and that explains arrangements for sharing pertinent medical records between preferred providers and for ensuring the records' confidentiality.

 (9) The applicant must provide network configuration information, including:

 (A) maps for each specialty demonstrating the location and distribution of the physician and provider network within the proposed service area by geographic region(s), county(ies) or ZIP code(s); and

 (B) lists of:

 (i) physicians and individual providers who are preferred providers, including license type and specialization and an indication of whether they are accepting new patients; and

 (ii) institutional providers that are preferred providers.

 (10) The applicant must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3725(a) of this title (relating to Payment of Certain Out-of-Network Claims) and that the policy contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement to provide items or services to insureds, the provisions and procedures for coverage of emergency care services as set forth in §3.3725 of this title.

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

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

 (d) Qualifying examinations; documents to be available. The following documents must be available during the qualifying examination at the physical address designated by the insurer pursuant to subsection (c)(12) of this section:

 (1) quality improvement--program description and work plan as required by §3.3724 of this title (relating to Quality Improvement Program);

 (2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and independent review organization logs;

 (3) network configuration information demonstrating adequacy of the exclusive provider network, as outlined in subsection (c)(9) of this section, and all executed physician and provider contracts applicable to the network, which may be satisfied by contract forms and executed signature pages;

 (4) credentialing files;

 (5) all written materials to be presented to prospective insureds that discuss the exclusive provider network available to insureds under the plan and how preferred and nonpreferred physicians or providers will be paid under the plan;

 (6) the policy and certificate of insurance; and

 (7) a complaint log that is categorized and completed in accordance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions).

 (e) Network modifications.

 (1) An insurer must file an application for approval with the department before the insurer may make changes to network configuration that impact the adequacy of the network, expand an existing service area, reduce an existing service area, or add a new service area.

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

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

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

 (C) network configuration information, as required by subsection (c)(9) of this section.

 (3) Before the department grants approval of a service area expansion or reduction application, the insurer must be in compliance with the requirements of §3.3724 of this title in the existing service areas and in the proposed service areas.

 (4) An insurer must file with the department any information other than the information described in paragraph (2) of this subsection that amends, supplements, or replaces the items required under subsection (c) of this section no later than 30 days after the implementation of any change.

**§3.3723. Examinations.**

 (a) The commissioner may conduct an examination relating to an exclusive provider benefit plan as often as the commissioner considers necessary, but no less than once every five years.

 (b) On-site financial, market conduct, complaint, or quality of care exams will be conducted pursuant to the Insurance Code Chapter 401, Subchapter B; the Insurance Code Chapter 751; and §7.83 of this title (relating to Appeal of Examination Reports).

 (c) An insurer must make its books and records relating to its operations available to the department to facilitate an examination.

 (d) On request of the commissioner, an insurer must provide to the commissioner a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider. Documentation provided to the commissioner under this subsection will be maintained as confidential as specified in the Insurance Code §1301.0056.

 (e) The commissioner may examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, as necessary to implement the purposes of this subchapter, including commencement and prosecution of an enforcement action under the Insurance Code Title 2, Subtitle B, and §3.3710 of this title (relating to Failure to Provide an Adequate Network). Information obtained under this subsection will be maintained as confidential as specified in the Insurance Code §1301.0056. In this subsection, "medical peer review committee" has the meaning assigned by the Occupations Code §151.002.

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

 (1) quality improvement--program description, work plans, program evaluations, and committee and subcommittee meeting minutes;

 (2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

 (3) complaints--complaint files and complaint logs, including documentation and details of actions taken. All complaints must be categorized and completed in 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 §3.3722(c)(9) of this title demonstrating adequacy of the exclusive provider network;

 (6) credentialing--credentialing files; and

 (7) reports--any reports submitted by the insurer to a governmental entity.

**§3.3724.** **Quality Improvement Program.**

 (a) An insurer must develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided within an exclusive provider benefit plan and to pursue opportunities for improvement. The QI program must be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The insurer must dedicate adequate resources, like personnel and information systems, to the QI program.

 (1) Written description. The QI program must include a written description of the QI program that outlines program organizational structure, functional responsibilities, and meeting frequency.

 (2) Work plan. The QI program must include an annual QI work plan designed to reflect the type of services and the population served by the exclusive provider benefit plan in terms of age groups, disease categories, and special risk status. The work plan must:

 (A) include objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, responsible individuals, and evaluation methodology; and

 (B) address each program area, including:

 (i) network adequacy, which includes availability and accessibility of care, including assessment of open and closed physician and individual provider panels;

 (ii) continuity of medical and health care and related services;

 (iii) clinical studies;

 (iv) the adoption and periodic updating of clinical practice guidelines or clinical care standards that:

 (I) are approved by participating physicians and individual providers;

 (II) are communicated to physicians and individual providers; and

 (III) include preventive health services;

 (v) insured, physician, and individual provider satisfaction;

 (vi) the complaint process, complaint data, and identification and removal of barriers that may impede insureds, physicians, and providers from effectively making complaints against the insurer;

 (vii) preventive health care through health promotion and outreach activities;

 (viii) claims payment processes;

 (ix) contract monitoring, including oversight and compliance with filing requirements;

 (x) utilization review processes;

 (xi) credentialing;

 (xii) insured services; and

 (xiii) pharmacy services, including drug utilization.

 (3) Evaluation. The QI program must include an annual written report on the QI program, which includes completed activities, trending of clinical and service goals, analysis of program performance, and conclusions.

 (4) Credentialing. An insurer must implement a documented process for selection and retention of contracted preferred providers that complies with §3.3706(c) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

 (5) Peer review. The QI program must provide for a peer review procedure for physicians and individual providers, as required in the Medical Practice Act, Occupations Code Chapters 151 – 164. The insurer must designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

 (b) The insurer’s governing body is ultimately responsible for the QI program.

 (1) The governing body must appoint a quality improvement committee (QIC) that:

 (A) must include practicing physicians and individual providers;

 (B) may include one or more insured(s) from throughout the exclusive provider benefit plan’s service area; and

 (C) must ensure that any insured appointed to the QIC is not an employee of the insurer.

 (2) The governing body must approve the QI program.

 (3) The governing body must approve an annual QI plan.

 (4) The governing body must meet no less than annually to receive and review reports of the QIC or its subcommittees and take action when appropriate.

 (5) The governing body must review the annual written report on the QI program.

 (c) The QIC must evaluate the overall effectiveness of the QI program.

 (1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians, individual providers, and insureds from the service area.

 (A) All committees must collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services.

 (B) All committees must meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

 (C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

 (2) The QIC must use multidisciplinary teams, when indicated, to accomplish QI program goals.

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

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

 (a) If an insured cannot reasonably reach a preferred provider, the insurer must fully reimburse a nonpreferred provider for the following emergency care services at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider until the insured can reasonably be expected to transfer to a preferred provider:

 (1) a medical screening examination or other evaluation required by state or federal law to be provided in a hospital emergency facility of a hospital, freestanding emergency medical care facility, or comparable facility that is necessary to determine whether a medical emergency condition exists;

 (2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and

 (3) following treatment or stabilization of an emergency medical condition, services originating in a hospital emergency facility or freestanding emergency medical care facility or comparable emergency facility.

 (b) If medically necessary covered services, excluding emergency care, are not available through a preferred provider upon the request of a preferred provider, the insurer must:

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

 (2) provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested under paragraph (1) of this subsection before the insurer may deny the referral.

 (c) An insurer may facilitate an insured’s selection of a nonpreferred provider when medically necessary covered services, excluding emergency care, are not available through a preferred provider and an insured has received a referral from a preferred provider.

 (1) If an insurer chooses to facilitate an insured’s selection of a nonpreferred provider pursuant to this subsection, the insurer must offer an insured a list of at least three nonpreferred providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the insured.

 (2) If the insured selects a nonpreferred provider from the list provided by the insurer, subsections (d) – (f) of this section are applicable.

 (3) If the insured selects a nonpreferred provider that is not included in the list provided by the insurer, then:

 (A) subsections (d) – (f) of this section are not applicable; and

 (B) notwithstanding §3.3708(f) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures), the insurer must pay the claim in accordance with §3.3708 of this title.

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

 (e) Upon determining that a claim from a nonpreferred provider under subsection (a), (b), or (c)(2) of this section is payable, an insurer must issue payment to the nonpreferred provider at the usual and customary rate or at a rate agreed to by the insurer and the nonpreferred provider. When issuing payment, the insurer must provide an explanation of benefits to the insured along with a request that the insured notify the insurer if the nonpreferred provider bills the insured for amounts beyond the amount paid by the insurer.

 (1) The insurer must resolve any amounts that the nonpreferred provider bills the insured beyond the amount paid by the insurer in a manner consistent with subsection (d) of this section.

 (2) The insurer may require in its policy or certificate issued to an insured that, if a claim is eligible for mediation under the Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title (relating to Out-of-Network Claim Dispute Resolution), the insured must request mediation.

 (A) The insurer must notify the insured when mediation is available under the Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title, and inform the insured of how to request mediation.

 (i) The insurer may not require that the insured participate in a mediation requested under the Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title.

 (ii) The insurer may not penalize the insured for failing to request mediation.

 (iii) Notwithstanding clause (ii) of this subparagraph, after the insurer requests that the insured initiate mediation, the insurer is not responsible for any balance bill the insured receives from the provider, until the insured requests mediation.

 (B) For purposes of determining eligibility for mediation under the Insurance Code Chapter 1467 and Chapter 21, Subchapter PP of this title the entire unpaid amount of the amount the nonpreferred provider bills should be taken into consideration, less any applicable copayment, deductible, and coinsurance.

 (C) If the amount of a claim is changed as a result of mediation required by the insurer, the insurer’s payment must be based on the amount that results from the mediation process.

 (f) Any methodology utilized by an insurer to calculate reimbursements of nonpreferred providers for services that are covered under the health insurance policy must comply with the following:

 (1) if based on usual, reasonable, or customary charges, the methodology must be based on generally accepted industry standards and practices for determining the customary billed charge for a service and fairly and accurately reflect market rates, including geographic differences in costs;

 (2) if based on claims data, the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

 (3) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than three years old; and

 (4) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

**10. CERTIFICATION.** This agency certifies that the proposal has been reviewed by legal counsel and found to be within the agency’s legal authority to adopt.

Issued in Austin, Texas, on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2012.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sara Waitt

 General Counsel

 Texas Department of Insurance