

**Subchapter C. Approval, Disapproval, and Withdrawal of Approval of Certain
Participating Policy Forms
28 TAC §3.205**

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**Subchapter X. Preferred and Exclusive Provider Plans
Division 1. General Requirements
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**Subchapter KK. Exclusive Provider Benefit Plan
28 TAC §3.9208 and §3.9210**

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC §§3.205, 3.3403, 3.3703, 3.9208, and 3.9210, concerning certain participating policy forms, health coverage of newborn children, and preferred and exclusive provider benefit plans. The amendments implement House Bill 4611, 88th Legislature, 2023; House Bills 388, 1620, and 2221, 89th Legislature, 2025; and Senate Bills 493, 896, and 1236, 89th Legislature, 2025.

EXPLANATION. Amendments to §§3.205, 3.3403, 3.3703, 3.9208, and 3.9210 are necessary to implement the following legislation.

- HB 388 requires health benefit plans to use a uniform coordination of benefits questionnaire that is adopted by TDI.

- HB 1620 revises Government Code references throughout the Insurance Code to reflect statutory amendments relating to Medicaid enacted in HB 4611, which made nonsubstantive revisions to various health and human services laws.

- HB 2221 moves requirements concerning unlawful rebates and inducements to new Insurance Code Chapter 1702.

- SB 493 prohibits certain pharmacy benefit manager contract provisions.

- SB 896 extends the enrollment period for newborn children from 31 days to 60 days.

- SB 1236 expands requirements for pharmacy benefit network contracts.

In separate proposals also published in this issue of the *Texas Register*, TDI proposes amendments to 28 TAC Chapters 11 and 26 to implement the previously referenced legislation. In a separate proposal published October 24, 2025 (50 TexReg 6976), TDI proposed a uniform coordination of benefits questionnaire in 28 TAC Chapter 3, Subchapter V, to implement HB 388. At a later date, TDI also plans to propose amendments to 28 TAC Chapter 21 to implement provisions in HB 2221 and SB 1236.

Descriptions of the sections' proposed amendments follow.

Section 3.205. A proposed amendment to §3.205 replaces the reference to Insurance Code §541.056(c), which was repealed by HB 2221, with new Insurance Code §1702.102(c), which was added by HB 2221.

Section 3.3403. The proposed amendments to §3.3403 implement SB 896. Subsections (a), (b), and (d) are amended by striking general references to "a period of time" for newborn coverage and replacing them with the concrete time period of "before the 61st day after the child's birth." Subsection (e) is amended by replacing references to a 31-day initial coverage period with a 60-day initial coverage period.

Subsections (f) - (h), addressing the original implementation period of Insurance Code §1367.003, are deleted because they are no longer relevant. Subsection (i) is

redesignated as subsection (f), and a title is added to the statutory reference in the subsection to conform to agency style.

Section 3.3703. The proposed amendments to §3.3703 implement HB 388, HB 493, and SB 1236. Subsection (a)(21) is amended by adding a reference to Insurance Code §1203.153. Consistent with SB 1236, new subsection (a)(31) requires a contract between an insurer and a pharmacy or pharmacist to comply with Insurance Code Chapter 1369. New subsection (a)(32) prohibits certain contract provisions in a contract between an insurer and a pharmacy or pharmacist, consistent with Insurance Code §4151.155 as added by SB 493. Although §4151.155 affects contracts involving a pharmacy benefit manager, subsection (a)(32) applies to contracts involving an insurer to ensure requirements for insurers and their pharmacy benefit managers are consistent. New subsection (a)(33) is added to cross-reference 28 TAC §7.1613, which addresses requirements for a contract between an issuer and a third-party administrator (TPA), including a requirement for a TPA to be contractually obligated to comply with all statutory and regulatory requirements related to a function carried out by the TPA. This makes clear that the requirements of §3.3703 apply to health plan contracts with physicians or providers, whether the plan contracts directly or relies on a TPA such as a pharmacy benefit manager to contract.

Section 3.9208. The proposed amendment to §3.9208 replaces the reference to Government Code Chapter 533 with Government Code Chapter 540, as repealed and replaced by HB 4611, and consistent with HB 1620.

Section 3.9210. The proposed amendment to §3.9210(a) replaces the reference to Government Code Chapter 533 with Government Code Chapter 540, as repealed and replaced by HB 4611 and consistent with HB 1620.

In addition, proposed amendments include nonsubstantive editorial and formatting changes to conform the sections to TDI's current drafting style and plain language preferences, and to improve the rule's clarity. These changes appear throughout the amended sections and include adding titles to cited statutes; nonsubstantive text edits, including the addition of necessary words such as "to" and replacing the word "which" with "that"; and other grammatical, punctuational, and format changes.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of the Regulatory Initiatives Office in the Life and Health Division, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the proposed amendments, other than that imposed by statute. Ms. Bowden made this determination because the proposed amendments do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed amendments.

Ms. Bowden does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Bowden expects that administering and enforcing the proposed amendments will have the public benefit of ensuring that TDI's rules conform to House Bills 388, 1620, 2221, and 4611, and Senate Bills 493, 896, and 1236.

Ms. Bowden expects that the proposed amendments will not increase the cost of compliance. Any costs for those required to comply with the proposed amendments are attributable to House Bills 388, 1620, 2221, and 4611; and Senate Bills 493, 896, and 1236 because the proposed amendments do not impose requirements beyond those in statute.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses, or on rural communities. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. Even if it did, no additional rule amendments would be required under Government Code §2001.0045 because the proposed amendments are necessary to implement legislation. The proposed rule implements: HB 388, HB 1620, HB 2221, HB 4611, SB 493, SB 896, and SB 1236.

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

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;
- will not require an increase or decrease in fees paid to the agency;
- will not create a new regulation;
- will expand, limit, or repeal an existing regulation;
- will not increase or decrease the number of individuals subject to the rule's applicability; and
- will not positively or adversely affect the Texas economy.

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

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on June 8, 2026. Consistent with Government Code §2001.024(a)(8), TDI requests public comments on the proposal, including information related to the cost, benefit, or effect of the proposal and any applicable data, research, and analysis. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2864. This proposal will

be part of a rule hearing docket that will begin at 10:00 a.m., central time, on June 1, 2026. TDI will hold the public hearing both remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701 in Room 2.034. Visit www.tdi.texas.gov/alert/event/index.html for more info on the proposed rule, hearing, and comment submission.

**Subchapter C. Approval, Disapproval, and Withdrawal of Approval of Certain
Participating Policy Forms
28 TAC §3.205**

STATUTORY AUTHORITY. TDI proposes amendments to §3.205 under Insurance Code §1702.006 and §36.001.

Insurance Code §1702.006 authorizes the commissioner to adopt reasonable rules necessary to implement Insurance Code Chapter 1702.

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

CROSS-REFERENCE TO STATUTE. Section 3.205 implements Insurance Code §1702.102.

TEXT.

§3.205. Construction of rules.

This subchapter may not be construed to prohibit the use of any provision authorized by Insurance Code §1702.102(c), concerning Prohibited Rebates and Inducements, [§541.056(e)] or other applicable statute.

Subchapter U. Newborn Children Coverage
28 TAC §3.3403

STATUTORY AUTHORITY. TDI proposes amendments to §3.3403 under Insurance Code §1367.002 and §36.001.

Insurance Code §1367.002 states that certain provisions of Insurance Code Chapter 1201, including provisions relating to rulemaking under Insurance Code Chapter 1201, apply to Insurance Code Chapter 1367, Subchapter A.

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

CROSS-REFERENCE TO STATUTE. Section 3.3403 implements Insurance Code §1367.003.

TEXT.

§3.3403. General Rules of Application.

(a) No individual policy or group policy of accident and sickness insurance that ~~[which]~~ provides for accident and sickness coverage of additional newborn children may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant before the 61st day after the date of the child's birth, ~~[for a period of time,]~~ or limitations or exclusions for congenital defects of a newborn child.

(b) No individual policy or group policy of accident and sickness insurance that ~~[which]~~ provides for maternity benefits may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant before the 61st day after the date of the child's birth, ~~[for a period of time,]~~ or limitations or exclusions for congenital defects of a newborn child.

(c) If the policy provides accident and sickness coverage for newborn children, the ~~[such]~~ coverage must be at least as comprehensive as the coverage provided under the policy for other children for loss as a result of an accident or sickness.

(d) If the policy provides maternity benefits, and included in those ~~[such]~~ benefits are coverages for newborn infants, the ~~[such]~~ policy may not contain any provision excluding or limiting initial coverage of newborn infants before the 61st day after the date of the child's birth, ~~[for a period of time,]~~ or limit or exclude coverage for congenital defects of a newborn child.

(e) The initial coverage provided to newborn children must continue for a period of at least 60 ~~[31]~~ days. The insurer may require that before the coverage continues beyond this initial 60 ~~[31]~~-day period, the policyholder must notify the insurer of the birth of the newborn child and pay any additional premium required to maintain the coverage in force. Any additional premium required for the initial period of coverage may be charged.

~~[(f) Insurance Code §1367.003 applies to all accident and sickness policies issued or issued for delivery, renewed, extended, or amended in the State of Texas on and after January 1, 1974. The insurer, upon a renewal, extension, or amendment, may charge such additional premiums as are just and reasonable for the additional risk incurred by compliance with Insurance Code §1367.003. With respect to any policy forms approved by the Texas Department of Insurance prior to the effective date of §1367.003, an insurer is authorized to achieve compliance with §1367.003 by the use of endorsements or riders provided such endorsements or riders are approved by the Texas Department of Insurance as being in compliance with Insurance Code §1367.003 and other provisions of the Texas Insurance Code.]~~

~~[(g) Insurance Code §1367.003 applies to policies written before January 1, 1974, if and when such a policy is "renewed, extended or amended" after January 1, 1974. If the~~

~~provisions of a policy written before January 1, 1974, allow the insurer to renegotiate the terms of the policy after January 1, 1974, or allow the insurer to adjust the premiums charged under the policy after January 1, 1974, and if at the time such renegotiation or adjustment could be accomplished and is accomplished, the policy continues in force or a policy with substantially similar coverage is agreed to by the insured and insurer, then the policy will be said to have been "renewed, extended or amended" for purposes of Insurance Code §1367.003, and the requirements of §1367.003 will attach to the policy.]~~

~~[(h) Insurance Code §1367.003 applies to any policy except a "non-cancellable and guaranteed renewable" policy written before January 1, 1974, if such policy is "renewed, extended or amended" or a rate adjustment could be made after January 1, 1974. If a group policy is written in conjunction with a collective bargaining agreement, such policy will be considered "renewed, extended or amended" upon the expiration of any applicable collective bargaining agreement.]~~

~~(f) [(f)]~~ Nothing in this subchapter will be deemed to extend the provisions of Insurance Code §1367.003, concerning Certain Limitations on Coverage for Newborn Children Prohibited, to insurance contracts providing benefits only for specified diseases, pure accident policies, disability only policies, or loss of time only policies.

Subchapter X. Preferred and Exclusive Provider Plans 28 TAC §3.3703

STATUTORY AUTHORITY. TDI proposes amendments to §3.3703 under Insurance Code §§1203.152, 1301.007, 4151.006, and 36.001.

Insurance Code §1203.152 requires the commissioner to adopt rules establishing a uniform coordination of benefits questionnaire to be used by all health benefit plan issuers in Texas.

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

Insurance Code §4151.006 authorizes the commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Insurance Code Chapter 4151.

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

CROSS-REFERENCE TO STATUTE. Section 3.3703 implements Insurance Code §1203.153 and §4151.155, and Chapter 1369.

TEXT.

§3.3703. Contracting Requirements

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

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

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

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

(4) A contract between an insurer and a hospital or institutional provider must not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges.

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

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

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

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

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

(8) An insurer's contract with a physician, physician group, or practitioner must have a mechanism for the resolution of complaints initiated by an insured, a physician, physician group, or practitioner. The mechanism must provide for reasonable due process, including, in an advisory role only, a review panel selected as specified in §3.3706(b)(2) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

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

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

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment

of clean claims with respect to payment to the provider for covered services rendered to insureds.

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

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

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

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

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

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

(18) A contract between a preferred provider and an insurer must require a provider that voluntarily terminates the contract to provide reasonable notice to the

insured, and must require the insurer to provide assistance to the provider as set forth in Insurance Code §1301.160(b), concerning Notification of Termination of Participation of Preferred Provider.

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

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

(A) This information is required to include a preferred provider specific summary and explanation of all payment and reimbursement methods that will

be used to pay claims submitted by the preferred provider. At a minimum, the information is required to include:

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

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

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

(ii) all applicable coding methodologies;

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

(iv) all applicable downcoding policies;

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

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

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

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

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

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

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

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon receipt of a request, the insurer is required to provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

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

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

(I) the preferred provider's practice management;
(II) billing activities;
(III) other business operations; or
(IV) communications with a governmental agency involved in the regulation of health care or insurance;

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

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

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

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

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

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage, consistent with Insurance Code §1203.153, concerning Uniform Coordination of Benefits Questionnaire Required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(31) A contract between an insurer and a pharmacy or pharmacist must comply with Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services.

(32) A contract between an insurer and a pharmacy or pharmacist may not include a provision that is prohibited under Insurance Code §4151.155, concerning Certain Disclosures and Communications by Pharmacist of Pharmacy Protected.

(33) A contract between an insurer and a third-party administrator, including a pharmacy benefit manager, must comply with §7.1613 of this title (relating to Written Agreements Between Administrators and Insurers).

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

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

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

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

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

Subchapter KK. Exclusive Provider Benefit Plan
28 TAC §3.9208 and §3.9210

STATUTORY AUTHORITY. TDI proposes amendments to §3.9208 and §3.9210 under Insurance Code §36.001.

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

CROSS-REFERENCE TO STATUTE. Sections 3.9208 and 3.9210 implement HB 1620 and HB 4611.

TEXT.

§3.9208. Provider Network: Accessibility and Availability.

An issuer is subject to the same network accessibility and availability requirements as outlined in §11.1607 of this title (relating to Accessibility and Availability Requirements).

Issuers must comply with this section; any requirements under a Medicaid contract, subject to Government Code^[7] Chapter 540, concerning Medicaid Managed Care Program ~~[533]~~; and any other applicable law.

§3.9210. Complaints System.

(a) Complaints System. Issuers must comply with this section; any requirements under a Medicaid contract, subject to Government Code^[7] Chapter 540, concerning Medicaid Managed Care Program ~~[533]~~; and any other applicable law. The complaint system must provide reasonable procedures for the resolution of oral and written complaints initiated by insureds or providers concerning health care services, including a process for the notice and appeal of complaints.

(1) If a complainant notifies the issuer orally or in writing of a complaint, the issuer, not later than the fifth business day after the date of the receipt of the complaint, must ~~[shall]~~ send to the complainant a letter acknowledging the date of receipt of the complaint that includes a description of the organization's complaint procedures and time frames. If the complaint is received orally, the issuer must ~~[shall]~~ also enclose a one-page complaint form. The one-page complaint form must prominently and clearly state that the complaint form must be returned to the issuer for prompt resolution of the complaint.

(A) The issuer must ~~[shall]~~ investigate each oral and written complaint received in accordance with its policies and in compliance with this subchapter.

(B) Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization must ~~[shall]~~ be concluded in accordance with the medical or dental immediacy of the case and may not exceed one business day from receipt of the complaint.

(C) For all other complaints, the total time for acknowledgment, investigation, and resolution of the complaint by the issuer may not exceed 30 calendar

days after the date the issuer receives the written complaint or one-page complaint form from the complainant.

(D) After the issuer has investigated a complaint, the issuer must ~~[shall]~~ send a response letter to the complainant explaining the issuer's resolution of the complaint within the time frame as set forth in this section. The letter must include a statement of the specific medical and contractual reasons for the resolution and the specialization of any health care provider consulted. The response letter must contain a full description of the process for appeal, including the time frames for the appeal process and the time frames for the final decision on the appeal.

(2) If the complaint is not resolved to the satisfaction of the complainant, the issuer must ~~[shall]~~ provide an appeals process that includes the right of the complainant to either ~~[to]~~ appear in person before a complaint appeal panel at a location where the insured normally receives health care services, unless another site is agreed to by the complainant, or to address a written appeal to the complaint appeal panel. The issuer must ~~[shall]~~ complete the appeals process under this section not later than the 30th calendar day after the date of the receipt of the written request for appeal.

(A) The issuer must ~~[shall]~~ send an acknowledgment letter to the complainant not later than the fifth business day after the date of receipt of the written request for appeal.

(B) The issuer must ~~[shall]~~ appoint members to the complaint appeal panel, which must ~~[shall]~~ advise the issuer on the dispute's resolution ~~[of the dispute]~~. The complaint appeal panel must ~~[shall]~~ be composed of equal numbers of issuer staff, physicians or ~~[other]~~ providers, and insureds. Each member on the complaint appeal panel must not have been previously involved in the disputed decision. The health care providers must have experience in the area of care that is in dispute and must be independent of any health care provider that ~~[who]~~ made any prior determination. If

specialty care is in dispute, then the appeal panel must include a person who is a specialist in the field, or related field, of care ~~[to which]~~ the appeal relates to. Panel members who ~~[that]~~ are insureds may not be the issuer's employees ~~[of the issuer]~~.

(C) Not later than the fifth business day before the scheduled meeting of the panel, unless the complainant agrees otherwise, the issuer must ~~[shall]~~ provide to the complainant or the complainant's designated representative:

(i) any documentation to be presented to the panel by the issuer staff;

(ii) the specialization of any health care providers consulted during the investigation; and

(iii) the name and affiliation of each issuer representative on the panel.

(D) The complainant, or designated representative if the insured is a minor or disabled, is entitled to:

(i) appear in person before the complaint appeal panel;

(ii) present alternative expert testimony; and

(iii) request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

(b) Notice of the final decision of the issuer on the appeal must include a statement of the specific contractual and clinical criteria used to reach the final decision. The notice must also include the toll-free telephone number and the address of the Texas Department of Insurance.

(c) In compliance with Chapter 21, Subchapter Q, of this Title (relating to Complaint Records to be Maintained), the issuer shall maintain a record of each complaint and any complaint proceeding and any actions taken on a complaint for three years from the date of the receipt of the complaint. The record must include complaints relating to limited

provider networks. A complainant is entitled to a copy of the record on the applicable complaint and any complaint proceeding.

(1) Each issuer must [~~shall~~] maintain a complaint and appeal log regarding each complaint.

(2) Each issuer must [~~shall~~] maintain documentation on each complaint received and the action taken on each complaint until the third anniversary of the date of receipt of the complaint. The Texas Department of Insurance may review documentation maintained under this subsection, including original documentation, during any investigation of the issuer.

(d) The commissioner may examine the complaint system for compliance with this subchapter and may require the issuer to make necessary corrections.

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

Issued in Austin, Texas, on April 27, 2026.

Signed by:
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