Subchapter X. Preferred and Exclusive Provider Plans
Division 1. General Requirements
28 TAC §3.3704 and §3.3707

INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC §3.3704 and §3.3707, concerning network adequacy requirements and other requirements for preferred and exclusive provider benefit plans. The amendments implement House Bill 3359, 88th Legislature, 2023, and Senate Bill 926, 89th Legislature, 2025, and address issues raised in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-26-000178 (TAHP Lawsuit).

EXPLANATION. In April 2024, TDI adopted rules (2024 Rules) that implemented HB 3359 by amending multiple sections in Subchapter X of 28 TAC Chapter 3, including §3.3704 and §3.3707. HB 3359 provided extensive new network adequacy standards and expanded the requirements for waivers for a deviation from those standards. The 2024 Rules amended §3.3704 to align with HB 3359 and clarify that preferred provider plans must comply with the new standards, provide sufficient choice and number of providers, monitor compliance, report material deviations to TDI, and promptly take corrective action. Amendments also deleted the previous network adequacy standards, consistent with the changes to statute in HB 3359.

The 2024 Rules also amended §3.3707 to (1) update the requirements for granting a waiver from network adequacy standards, subject to statutory limits; (2) require that a waiver request include certain information, including information demonstrating a good faith effort to contract and describing any exclusivity arrangements or other external factors impacting the ability of the parties to contract; and (3) clarify the commissioner's consideration of an access plan for waiver requests.

On January 9, 2026, the Texas Association of Health Plans (TAHP) filed the TAHP Lawsuit, which alleges that TDI engaged in ad hoc rulemaking in its implementation of HB 3359's waiver and sufficient access requirements and that certain 2024 Rules are contrary to the bill. In its petition to the court, TAHP stated that its members require additional guidance from TDI to comply with applicable regulations. Based on TAHP's claims and TDI's experience with network filings and waiver requests submitted since the adoption of the 2024 Rules, TDI has determined that additional rule amendments are necessary to implement HB 3359 in order to provide further guidance to health plans and adjust certain network requirements.

Accordingly, TDI proposes to amend §3.3704 to adjust and clarify minimum access standards. Amendments to §3.3704 are also necessary to implement SB 926, which expands provisions related to health plans that use steering or tiering to encourage enrollees to use certain network physicians and providers. TDI also proposes to amend §3.3707 to add guidance on how plans may demonstrate "good faith efforts" and "good cause" in waiver requests. TDI declines to define "good faith efforts" because the term is already defined in Insurance Code §1301.00565(a). In addition, form updates are needed to align the forms for network filings with the proposed rule amendments.

Descriptions of the sections' proposed amendments follow.

Section 3.3704. A proposed amendment to subsection (b) of §3.3704 adds a catchline, to make the structure of the subsection consistent with the other subsections in the section. Proposed amendments to subsection (e) implement SB 926 and broaden the subsection to conform with both Insurance Code §1301.0047 and §1458.101(i). These include amendments to add a reference to new Insurance Code §1301.0047 and to apply the provisions in subsection (e) to an insurer that encourages an insured to obtain care from a particular "physician or health care provider," consistent with the terminology in

§1301.0047, rather than "provider, as defined under Insurance Code Chapter 1458." To avoid duplicating language in Insurance Code §1301.0047(d), paragraphs (1) - (3) of subsection (e) are deleted.

Proposed amendments in subsection (f) implement HB 3359 by updating network adequacy standards. An obsolete date reference in subsection (f)(1)(E) relating to maximum appointment wait time standards is deleted. Although the TAHP Lawsuit raised concerns about the applicability of such standards to all provider types, TDI does not assess appointment wait time standards for services other than routine and preventive services. As described in subsequent paragraphs, recent updates to the forms for waiver applications prevent insurers from continuing to input appointment wait time data for nonroutine or nonpreventive services. In subsections (f)(2) and (f)(4), the minimum standards for sufficient choice and access to preferred providers are changed to require that all insureds have access to at least one preferred provider of each type within time and distance standards and at least 90% of insureds have access to at least two preferred providers.

TDI's review of network filings in 2024 and 2025 indicate that the current minimum standards requiring all insureds to have access to at least two preferred providers may be overly burdensome, especially in counties with provider shortages. The proposed standards would still allow consumers "sufficient choice" as required under Insurance Code §1301.0055(b) because at least 90% of insureds would have a choice between multiple preferred providers within the time and distance standards while the remaining 10% of insureds may need to travel farther to reach an alternative provider. TDI has also amended §3.3707(m) to make clear that insureds in this circumstance will be able to gain access to a choice of providers at the preferred provider benefit level through the insurer's access plan. TDI declines to apply less restrictive federal standards as argued by TAHP in the TAHP Lawsuit; unlike HB 3359, federal standards do not include "sufficient choice"

requirements. The proposed amendments also confirm that the minimum standards require preferred providers within the network's service area, consistent with the express requirements of HB 3359.

Similarly, TDI proposes to amend subsection (f)(3) to require at least one preferred provider, instead of two preferred physicians, of each specialty and diagnostic type listed in Insurance Code §1301.0055(b)(4) at a preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility. Consistent with the proposed changes in subsection (f)(2), a network provides sufficient choice of preferred facilities if all insureds can access at least one preferred facility within the time and distance standards and at least 90% of insureds can access two or more preferred facilities. Clarifying that networks may include at least "one preferred provider" better aligns with Insurance Code §1301.0055(b)(4), which uses the term "preferred providers" and with longstanding TDI review standards. This change also reflects that in some cases licensure standards permit covered benefits to be delivered by a variety of provider types.

In addition to revised minimum standards for sufficient choice, subsection (f)(4) provides a 75-mile minimum distance standard for specialty care and specialty hospitals for which time and distance standards are not specified in statute. In the reporting forms under the current rule, TDI measures compliance with optometry and therapeutic optometry services, prescription drugs, durable medical equipment, and home health services. TDI will not assess network compliance with respect to optometrists and therapeutic optometrists for a plan that does not cover non-medical vision services. If a plan has a sufficient number of in-network ophthalmologists within network adequacy standards who can provide covered basic vision services, TDI will not consider the plan to be deficient based on an insufficient number of optometrists or therapeutic optometrists. Subsection (f)(4) implements Insurance Code §1301.0055(b)(3) to require that the network ensure sufficient access to covered services. The minimum distance standard is necessary

for specialty care and specialty hospital services that consumers may need to access within a reasonable distance. As described in subsequent paragraphs, TDI proposes to remove home health from the list of specialty services assessed in the forms submitted as part of the network configuration filing.

Section 3.3707. Proposed amendments to subsection (a) of §3.3707 add new paragraphs (1) - (5) listing nonexclusive factors that TDI will consider when determining whether there is good cause to grant a waiver. TDI will consider whether the waiver is needed due to an insufficient number of uncontracted physicians or provider or because the insurer has failed to contract with available providers. If providers are available, TDI will consider whether the insurer made good faith efforts to contract, and whether physicians and providers declined to contract. TDI will also consider whether granting a waiver will serve the public interest by maintaining health plan availability and competition or whether the waiver may harm the public interest by allowing a plan to be sold that does not provide reasonable access to covered services.

Proposed amendments reorganize and expand subsection (b) to address how TDI will evaluate whether an insurer has made a good faith effort to contract with available physicians or providers. Subsection (b)(1) expands the information that must be included in the attempt to contract form to describe the insurer's efforts to contract with available providers. Subsection (b)(1)(B) clarifies that the form should include all attempts to contract that the insurer made during the reporting period. Current subsection (b)(1)(C) is redesignated as (b)(1)(B)(iii) to align with the organization of the data within the attempt to contract form, and amended to remove the examples of reasons that may be given for declining to contract with an insurer since a longer list of examples is provided in new subsection (b)(5). New clauses (iv) and (v) are added to subsection (b)(1)(B) to align with new fields in the attempt to contract form and require the insurer to identify whether it

offered commercially reasonable rates and contractual terms, and offered a different rate or contractual term after an initial offer was rejected. New subparagraph (C) in subsection (b)(1) aligns with a new field added to the cover page of the attempt to contract form and requires the insurer to explain the methodology they use to ensure the rate and contractual terms offered are commercially reasonable.

The current text of subsection (b)(2), which requires the insurer's waiver request to state if there are no providers or physicians available to resolve a network gap, is removed because it duplicates a requirement for information that must be provided within the network compliance and waiver request form under 28 TAC §3.3712(c)(2)(C)(i). New text in subsection (b)(2) requires the insurer to maintain documentation that substantiates the information submitted in the attempt to contract form, and provide that documentation to TDI on request.

New subsection (b)(3) specifies that, to demonstrate a good faith effort to contract, an insurer must attempt to contract with each available physician or provider that would allow the insurer to meet the standard or increase the percentage of enrollees for whom the standard is met. Contract attempts must meet the statutory definition of a good faith effort. New subsection (b)(4) specifies nonexclusive factors that TDI will consider in evaluating whether an insurer has made a good faith effort to contract. New subsection (b)(5) provides examples of circumstances when the insurer may be considered to have demonstrated a good faith effort. New subsection (b)(6) explains how TDI determinations about good faith efforts to contract will impact the statutory limits on waivers under Insurance Code §1301.0055(a)(5). New subsection (b)(7) provides definitions for the terms "commercially reasonable" and "similarly situated." New subsection (b)(8) requires issuers to review determinations and notify TDI within 15 calendar days if a correction is needed based on a clear factual error made by TDI.

Proposed amendments to subsections (c) and (m) clarify the instruction to file the access plan within the network configuration filing, and provide a more general rule citation, since §3.3712 references access plan requirements in multiple locations. Subsection (m) is also amended to require the insurer's access plan to demonstrate how the plan will facilitate access to care and a choice of physicians or providers for any insured that does not have access to at least two preferred providers within the network's service area and the applicable time and distance requirements under §3.3704(f)(2) or (4). Such an insured can request a network gap exception and receive the protections under §.3707(j) and (k).

Nonsubstantive amendments in subsections (d), (j), and (k) respectively add a section symbol to a statute citation, correct punctuation, and update a reference to "physician or provider" for clarity.

The 2024 Rules require insurers to use electronic forms published on TDI's website at www.tdi.texas.gov to provide the information specified in the rules. The required forms include the attempt to contract (ATC), network compliance and waiver request (NCWR), annual network adequacy report (LHL706), and provider listing forms. TDI proposes updates to the forms to align them with the proposed rule amendments and to improve clarity and ease of use. Some changes have been implemented to improve the instructions, formatting, layout, and utility of the forms to insurers.

The ATC form documents an insurer's good faith efforts to contract and is used by TDI to evaluate whether good cause for a waiver is shown. TDI proposes the following changes to the ATC form:

- adding a field in the "Cover Page" tab for a description of the insurer's methodology for ensuring that offered reimbursement rates and other contractual terms are commercially reasonable, consistent with new §3.3707(b)(1)(C);

- renaming the "Providers Attempted to Contract" tab as "Attempts to Contract";

- adding a "Drop-down" reference tab to list the options in the drop-down menus for the columns for specialty types, counties, provider reasons for declining to contract, and contact methods; and

- updating the "Attempts to Contract" tab with the following changes:

- removing the "SERFF tracking No." column;

- removing the "Deficient county waiver is being requested for" column;

- removing "County type" column and associated County Designation tab;

- adding "Major Medical or FB Physician and Provider?" and "NCWR row number where deficiency is reported" columns to allow staff to identify the waiver request that the attempts to contract relate to and prevent overreporting of attempts to contract, such as attempts that are unrelated to a waiver request;

- renaming "Phone number" column as "Telephone";

- renaming the "Additional information demonstrating that the insurer made a good faith effort to contract, as defined in Insurance Code TIC 1301.00565(a)" column as "Comments";

- renaming the "The reason given for declining to contract" column as "Provider's reason for declining to contract" and changing the column to allow selection from a drop-down menu instead of free-text entry, consistent with the examples specified in new §3.3707(b)(5);

- adding a column for information on whether the offered rates and contractual terms were commercially reasonable, consistent with new §3.3707(b)(1)(B)(iv); and

- adding a column for information on whether the insurer offered different rates or contractual terms after its initial offer was rejected by the provider, consistent with new §3.3707(b)(1)(B)(v).

The NCWR form documents network compliance and summarizes network waiver requests and associated access plans. TDI proposes the following changes to the NCWR form:

- applying conditional formatting and macros automation functionalities throughout the form;

- adding interdependent "Facilities" tab to auto-populate certain fields in the "FB Physician & Provider" tab;

- removing the "County Designation" tab;

- adding the "Reference" tab that includes lists that populate drop-down options within the "Major Medical" and "FB Physician & Provider" tabs, such as county and county designations, specialty types, compliance statuses, deficiency reasons, and access plan summaries. Previously, open-ended responses were permitted in most columns, with drop-down options provided only for specialty types and compliance statuses;

- adding the "Help" tab to provide additional technical guidance for completing the NCWR form;

- updating the "Cover Page" tab with the following changes:

- Adding a field for the insurer to include a hyperlink to its access plan, consistent with §3.3705(d) and §3.3712(c)(2)(C)(iv); and

- Relabeling "Counties in Service Area" section to "Service area designation instructions" and adding instructions and checkboxes to the list of counties;

- updating the "Major Medical" tab with the following changes:

- restricting the "Compliant with appointment wait time" field to only the specialties providing routine and preventive care (e.g., diagnostic radiology, gastroenterology, gynecology and obstetrics, inpatient or residential behavioral health facility services, mammography, outpatient clinical behavioral health, adult or pediatric primary care, and psychiatry). The field defaults to "N/A" for all other specialty types.

Related to this update, a note is added to the "NA Standards" tab to clarify that specialty types subject to appointment wait time reporting are shown in green text. Since the applicable specialties are not relevant for vision plans, the "Compliant with appointment wait time" column is removed from the "Vision" tab of the NCWR form for vision care plans; and

- replacing "Percentage of insureds with sufficient choice (at least two)" column with two new columns: "Percentage of enrollees with access to at least 1 preferred provider" and "Percentage of enrollees with access to 2 or more preferred providers," consistent with proposed amended §3.3704(f)(2); and

- updating the "Major Medical" and "FB Physician & Provider" tabs with the following changes:

- expanding or renaming the agency-locked columns that display data that is auto-populated or added by TDI;

- removing the "Reason preferred providers not available" column and replacing it with a "Reason for deficiency" column; and

- removing "Is waiver needed because there are no physicians or providers available to contract within the service area and applicable time and distance standards?" and "Comments" columns; and

- updating the NCWR Instructions Guide with the following changes:

- add instructions to specify that for the purposes of measuring compliance with Insurance Code §1301.0055(b)(4), an insurer should report the number of individual physicians and providers, rather than the number of organizations or groups of physicians or providers; and

- add instructions to clarify that for the purposes of measuring compliance with the time and distance standards for the permitted licensure types specified in Insurance Code §1301.00553, an insurer should report the number of individual physicians

or providers as applicable, rather than the number of organizations or groups. For example, for the purposes of measuring compliance for the physician specialty for "Primary Care: Adults," an insurer should only report the number of physicians, even though many advanced practice registered nurses also provide primary care services.

The LHL706 form provides additional demographic and utilization data related to network adequacy. TDI proposes the following changes to the LHL706 form:

- updating the "Network Info and Checklist" tab with the following changes:

- removing the Life and Health Transmittal Form LAH310 from the list of filing requirements;

- adding a field to capture the number of counties within the service area; and

- adding a field to allow an insurer to indicate if they are "Accredited per §3.3706(c)," because §3.3706(c) allows an insurer to be presumed to be in compliance with credentialing requirements; and

- updating the "Claims Data" tab by adding rows for the following additional specialty types: durable medical equipment, optometrists, pharmacy, and therapeutic optometrists.

The provider listing form lists the physicians and health care providers in the plan's network. TDI proposes the following changes to the provider listings form:

- replacing the "Individual" tab with a "Physician" tab and a "Non-Physician" tab to provide separate lists of physicians and non-physician providers;

- adding drop-down options to list each applicable specialty type, including 27 physician specialty types, 11 non-physician specialty types, 12 facility types, and 10 facility-based physician and provider types;

- adding an "Additional Providers" tab to allow reporting of other provider types that are in the network but are not subject to specific network adequacy standards or constrained to a drop-down listing of specialty types;

- adding an "Instructions" section within the "Cover Page" tab to provide instructions explaining which providers should be reported on each tab.

TDI also proposes the following changes to the specialty type lists and "NA Standards" tab in the ATC, NCWR, and provider listing forms:

- reorganizing the specialty type lists and NA standards to separate physicians, non-physicians, and facilities;

- removing "Home Health;" and

- modifying the list of "Facility types for evaluating facility-based providers" by removing "Critical Care Services - Intensive Care Units (ICU)" and adding "Hospitals (other)," since facility-based providers would be evaluated across the facility as a whole.

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 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 the proposed amendments will have the public benefit of ensuring that TDI's rules conform to Insurance Code §§1301.0047, 1301.0055, 1301.00553, 1301.00554, 1301.00555, 1301.0056, 1301.00565, and 1301.00566. The proposed rules will also help regulated entities understand the criteria that TDI will use to evaluate waiver requests for health plan networks, including good cause and good faith efforts, and how statutory limits on the ability to renew a waiver may apply if the insurer does not demonstrate good faith efforts.

Ms. Bowden expects that the proposed amendments will not increase the cost of compliance with Insurance Code Chapter 1301 because they do not impose requirements beyond those in statute. Insurance Code §1301.0055 requires TDI to adopt rules for network adequacy that ensure enrollees can access all covered services from preferred providers within the service area, allow waivers for good cause, and limit renewal of waivers if an insurer does not make good faith efforts to contract. Insurance Code §1301.0056 requires TDI to adopt a process for evaluating network adequacy before a plan can be offered, and for insurers to submit all information necessary for TDI to evaluate compliance. Insurance Code §1301.00565 provides a definition of "good faith effort" and requires TDI to hold a hearing before granting a waiver and to consider all pertinent information submitted by the insurer and the public. As a result, the cost associated with the additional information required within the waiver request filings that supports evaluation of good faith efforts does not result from the enforcement or administration of the proposed amendments.

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. However, even if the proposal did impose a cost on regulated persons, no additional rule amendments are required under Government Code §2001.0045 because the proposed amendments are necessary to implement legislation. The proposed rule implements Insurance Code §1301.0047 as added by SB 926, and §§1301.0055 - 1301.00565 as added and amended by HB 3359.

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 limit 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 29, 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. 2868. This proposal will be part of a rule hearing docket that will begin at 1:00 p.m., central time, on June 15, 2026. TDI will hold the public hearing remotely using online resources and in person at the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin Texas 78701 in Room 2.029. Visit www.tdi.texas.gov/alert/event/index.html for more information on the proposed rule, hearing, and comment submission.

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STATUTORY AUTHORITY. TDI proposes amendments to §3.3704 and §3.3707 under Insurance Code §§1301.0055, 1301.0056, 1301.007, and 36.001.

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

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

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

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

CROSS-REFERENCE TO STATUTE. The proposed amendments to §3.3704 and §3.3707 implement HB 3359 and SB 926.

TEXT.

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

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

(1) in accordance with Insurance Code §§1251.005, concerning Payment of Benefits; 1251.006, concerning Policy May Not Specify Service Provider; 1301.003, concerning Preferred Provider Benefit Plans and Exclusive Provider Benefit Plans Permitted, 1301.006, concerning Availability of and Accessibility to Health Care Services; 1301.051, concerning Designation as Preferred Provider; 1301.053, concerning Appeal Relating to Designation as Preferred Provider; 1301.054, concerning Notice to Practitioners of Preferred Provider Benefit Plan; 1301.055, concerning Complaint Resolution; 1301.057 - 1301.062, concerning Termination of Participation; Expedited Review Process, Economic Profiling, Quality Assessment, Compensation on Discounted Fee Basis, Preferred Provider Networks, and Preferred Provider Contracts Between Insurers and Podiatrists; 1301.064, concerning Contract Provisions Relating to Payment of Claims; 1301.065, concerning Shifting of Insurer's Tort Liability Prohibited; 1301.151, concerning Insured's Right to Treatment; 1301.156, concerning Payment of Claims to Insured; and 1301.201, concerning Contracts with and Reimbursement for Nurse First Assistants, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner;

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

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

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

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

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

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

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

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

(10) a preferred provider benefit plan that is not an exclusive provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider only if full disclosure of the

difference is included in the plan and the written description as required by §3.3705(b) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

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

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

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

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

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

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

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

the department or the insurer against the insurer or a preferred provider or has appealed a decision of the insurer.

(e) Steering and tiering. An insurer that encourages [~~uses steering or a tiered network to encourage~~] an insured to obtain a health care service from a particular physician or health care provider[~~, as defined under Insurance Code Chapter 1458, concerning Provider Network Contract Arrangements,~~] must comply [~~do so in a manner that complies~~] with the requirements of the Insurance Code, including the fiduciary duty imposed by Insurance Code §1301.0047, concerning Incentives to Use Certain Physicians or Health Care Providers, and §1458.101(i), concerning Contract Requirements, to act only for the primary benefit of the insured or policyholder. [~~For the purposes of this section:~~]

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

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

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

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

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

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

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

(f) Network requirements.

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

(A) Insurance Code §1301.005;

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

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

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

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

(F) Insurance Code §1301.006.

(2) An adequate network must, for each insured residing in the service area, ensure that all insureds can access <u>at least one preferred provider and 90% of insureds can access</u> a choice of at least two preferred providers for each physician specialty and each class of health care provider<u>, in both cases within the network's service area and</u>

within the time and distance standards specified in Insurance Code §1301.00553 and §1301.00554 and this section.

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

(4) For specialty care and specialty hospitals for which time and distance standards are not otherwise specified in Insurance Code §1301.00553, an adequate network must ensure that all insureds residing in the service area can access at least one preferred provider and 90% of insureds can access a choice of at least two preferred providers, in both cases within the network's service area and within a distance not greater than 75 miles.

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

(h) Service areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas[,] but may not divide a county. Any service areas that are smaller than statewide must be defined in terms of one or more Texas counties.

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

(a) Consistent with Insurance Code §1301.0055(a)(3), concerning Network Adequacy Standards, where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a county that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. After considering all pertinent evidence in a public hearing under Insurance Code §1301.00565, concerning Public Hearing on Network Adequacy Standards Waivers, the commissioner may grant the waiver if the requestor shows good cause, subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5). The commissioner may deny a waiver request if good cause is not shown and may impose reasonable conditions on the grant of the waiver. In determining whether there is good cause to grant the waiver, the commissioner will consider the factors specified in Insurance Code §1301.00565(d) and all pertinent information, including whether:

(1) there is an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area;

(2) the insurer has made a good faith effort to contract with physicians and health care providers that could fill any network gaps, as determined under subsection (b) of this section;

(3) physicians or health care providers necessary for an adequate network have declined to contract with the insurer;

(4) the waiver would serve the public interest by maintaining health plan availability and competition in a local market; and

(5) the waiver would harm the public interest by allowing a health plan to be sold that fails to ensure enrollees reasonable access to covered services.

(b) An insurer seeking a waiver under subsection (a) of this section must submit waiver and access plan information required under §3.3712(c) of this title (related to Network Configuration Filings) and information justifying the waiver request as specified in this subsection using the attempt to contract form available at www.tdi.texas.gov. An insurer must submit the network compliance and waiver request form and the attempt to contract form to the department using SERFF or another electronic method that is acceptable to the department.

(1) For each waiver requested with respect to a type of physician or provider in a given service area where there are uncontracted physicians or providers available that could help fill a network gap, as reported in the network compliance and waiver request form [~~county~~], the insurer must provide [~~either~~] the information specified by this paragraph [~~(1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.~~][~~(1) If providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must include,~~] within the attempt to contract form:

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

(B) a description, including the date and contact method, of all attempts to contract that the insurer made during the reporting period with [~~how and~~

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

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

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

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

(iv) whether the insurer offered commercially reasonable rates and contractual terms; and

(v) whether the insurer offered a different rate or contractual term after an initial offer was rejected;

(C) the methodology the insurer uses to ensure the rate and contractual terms offered are commercially reasonable;

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

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

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

(2) The insurer must maintain documentation that substantiates the information submitted in the network configuration filing and make that documentation available to TDI upon request. [~~If there are no providers or physicians available within the relevant service area with whom a contract would allow the insurer to meet the specific standard for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.~~]

(3) To demonstrate a good faith effort to contract, an insurer must attempt to contract with each available physician or provider that would allow the insurer to meet the specific standard or increase the percentage of enrollees for whom the time and distance standard is met. Contract attempts must meet the definition of "good faith effort" in Insurance Code §1301.00565(a).

(4) In evaluating whether an insurer has made a good faith effort to contract, TDI will consider all pertinent evidence, including evidence concerning:

(A) whether the insurer offered to contract at a commercially reasonable rate, taking into account how the offered rate compares with rates accepted by similarly situated physicians and providers;

(B) whether the insurer offered commercially reasonable contractual terms, taking into account how the terms compare with those accepted by similarly situated physicians and providers;

(C) whether the insurer agreed to change a rate or contractual term after an initial offer was rejected;

(D) the extent of the insurer's efforts to find and contact all available physicians and providers;

(E) the physician's or provider's reason for declining;

(F) whether the physician or provider has agreed to contract with other insurers and how the accepted rates and contractual terms compare with the rates and terms offered by the insurer;

(G) the physician's or provider's efforts to contact the insurer about contracting;

(H) whether the insurer timely responded to concerns raised by the physician or provider; and

(I) whether the lack of contract is related to any credentialing issues.

(5) The following list provides examples of circumstances when the insurer may be considered to have demonstrated a good faith effort to contract with a physician or provider during a particular waiver period.

(A) The insurer has documented confirmation that the physician or provider declined the insurer's initial offer to contract with a clear indication that the physician or provider was not interested in contracting on any terms. Examples of circumstances when an insurer is not expected to make a subsequent offer include:

(i) the physician or provider has stated to the insurer that the physician or provider does not intend to enter any new contract on any terms; or

(ii) the physician or provider was not able to contract because the physician or provider participates in an exclusivity arrangement.

(B) The insurer has documented confirmation that the insurer offered commercially reasonable rates and contractual terms, the physician or provider declined the insurer's initial offer to contract, and the insurer subsequently made at least one additional attempt to contract offering a different rate or term. Examples of circumstances when the insurer is expected to make at least two offers include when the physician or provider declined the initial offer because:

(i) the insurer and the physician or provider were unable to agree on rates;

(ii) the physician or provider were unable to agree on contractual terms; or

(iii) the insurer is too new or unknown.

(C) The insurer was unable to make contact with the physician or provider, despite making a reasonable search for contact information and using at least two different documented contact methods.

(D) The insurer's offer to contract was accepted but credentialing has not yet been completed, or the physician or provider failed to meet credentialing standards.

(6) A limit on the issuance of a waiver under Insurance Code §1301.0055(a)(5) may apply if, during the applicable waiver periods under review, considering all pertinent evidence, TDI determines that the insurer did not demonstrate a good faith effort to contract.

(A) A waiver that is requested more than twice consecutively will be granted only if the insurer demonstrates multiple good faith attempts to bring the plan into compliance with the network adequacy standard during each of the prior consecutive waiver periods.

(B) A waiver that is requested more than four times within a 21-year period will be granted only if the insurer demonstrates that it made good faith efforts to bring the plan into compliance with the network adequacy standard during the prior year and that the issue could not be remedied through good faith efforts.

(7) For the purposes of this section:

(A) "commercially reasonable" means that a rate or contractual term is at least as favorable as a rate or contractual term accepted by similarly situated physicians or providers; and

(B) "similarly situated" means that physicians or providers are similar across key factors that are relevant for the purposes of determining commercially reasonable rates and terms. Relevant factors include experience, credentials, performance standards, services provided, hours of operation, and geographic region. A comparable geographic region may be the same county or the same geographic rating area as defined in §3.504 of this title, concerning Geographic Regions, or a county or rating area with similar market conditions.

(8) An insurer must carefully review a determination issued under this section. If the determination is based on a clear factual error by TDI, the insurer must notify TDI that a correction is needed no later than 15 calendar days from the date the determination is issued.

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

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

(2) file the access plan within the network configuration filing as addressed in §3.3712 [~~as required in §3.3712(c)(2)(C)(iv)~~] of this title.

(d) If the insurer believes that the information provided under subsection (b) of this section in the attempt to contract form includes proprietary information that is confidential and not subject to disclosure as public information under Government Code

Chapter 552, concerning Public Information, the insurer must mark the document as confidential in SERFF. If the insurer marks the document as confidential, it must include in the filing an explanation of which information contained in the document is proprietary, and which information is not. However, consistent with Insurance Code §1301.00565(g), [~~1301.00565(g),~~] certain information is subject to release regardless of marking, and the department may publish or otherwise release such information. The insurer is not permitted to mark the entire filing as confidential. When scheduling a hearing related to a waiver request, the department will send a notice of the hearing to any provider or physician named in the waiver request.

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

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

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

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

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

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

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

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

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

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

(A) have expertise in the necessary specialty;

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

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

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

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

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

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

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

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

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

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

(m) As a contingency, and to protect insureds from any unforeseen circumstance in which an insured is unable to reasonably access covered health care services within the network adequacy standards provided in §3.3704 of this title, an insurer must submit an access plan that applies broadly to all counties within the service area and all types of physicians and providers, consistent with §3.3712 [~~and includes the information specified in §3.3712(c)(2)(C)(iv)~~] of this title. With respect to the requirements in §3.3704(f)(2) and (f)(4) of this title, the access plan must demonstrate how the plan will facilitate access to care and a choice of physicians or providers as required under subsections (j) and (k) of this section for any insured that does not have access at least two preferred providers within the network's service area and the applicable time and distance requirements.

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 May 15, 2026.

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