SUBCHAPTER X. Preferred Provider Plans
28 TAC §§3.3701 - 3.3711 and 3.3713

1. INTRODUCTION. The Commissioner of Insurance (Commissioner) adopts amendments to §§3.3701 – 3.3706, new §§3.3707 – 3.3711, and new §3.3713, concerning preferred provider benefit plans and network adequacy requirements. Sections 3.3701 – 3.3709, 3.3711 and 3.3713 are adopted with changes to the proposed text published in the January 28, 2011 issue of the *Texas Register* (36 TexReg 333). Section 3.3710 is adopted without changes. Section 3.3712 is not adopted.

2. REASONED JUSTIFICATION. These amendments and new sections are necessary to implement: (i) SECTION 2 of House Bill (HB) 2256, enacted by the 81st Legislature, Regular Session, effective June 19, 2009; (ii) SECTION 11 of Senate Bill (SB) 1731, enacted by the 80th Legislature, Regular Session, effective September 1, 2007; and (iii) HB 1030, enacted by the 79th Legislature, Regular Session, effective September 1, 2005. The amendments and new sections are also necessary as part of ongoing implementation of the Insurance Code Chapter 1301, concerning preferred provider benefit plans.

HB 2256 adds new §1301.0055 to the Insurance Code and requires the Commissioner to adopt by rule network adequacy standards that meet three requirements. The standards must be adapted to local markets where an insurer offers

a preferred provider benefit plan. The standards must also ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds. Additionally, on good cause shown, the standards may allow departure from local market network adequacy standards if the Commissioner posts on the Department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

SB 1731 added multiple provisions to the Insurance Code, the Health and Safety Code, and the Occupations Code requiring improved consumer access to health care information and consumer protection for services provided by or through entities including health benefit plans, hospitals, and other health care facilities. The new and amended sections require the provision of consumer information in a manner consistent with the requirements of SB 1731.

HB 1030 mandates that the insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services.

In addition, these new and amended sections are part of the ongoing implementation of the Insurance Code Chapter 1301. The amendments and new sections: (i) ensure reasonable accessibility and availability of both preferred and basic (out-of-network) provider services to Texas residents as provided in the Insurance Code §§1301.005, 1301.006, and 1301.007; and (ii) establish standards that support the use of preferred provider benefit plans that are not unjust under Chapter 1701, unfairly discriminatory under Chapter 544, Subchapters A and B, or in violation of Chapter 1451,

Subchapters B and C, concerning designation and selection of providers. The amendments also update statutory references resulting from the nonsubstantive revision of the Insurance Code and Occupations Code and amend existing text for clarification, nonsubstantive revisions to punctuation and grammar, and correct and update internal references.

As preparation for the proposal, the Department solicited extensive feedback from stakeholders. On April 23, 2010, the Department made an informal posting on its website of a concept paper and proposed revisions to the rules governing preferred provider benefit plans. The Department held a stakeholder meeting to discuss the drafts on May 5, 2010. After consideration of comments received, on September 13, 2010, the Department made a second informal posting on its website of proposed revisions to the rules and an estimate of anticipated costs to comply with the revised rules. In making the posting, the Department requested comments on the substance of the draft rules, the accuracy of the Department's estimates of costs to comply with the draft rules, and input on what costs certain draft provisions would entail. A second informal stakeholder meeting was held to discuss the draft rules and potential costs on September 21, 2010.

After further consideration of feedback, the Department next published the proposed amendments and new sections in the January 28, 2011 issue of the *Texas Register* (36 TexReg 333) and invited additional public comment. A separate and additional notice of the public hearing was submitted to the Office of the Secretary of State on January 14, 2011 for publication in the January 28, 2011 issue of the *Texas*

Register. The notice specified the availability of the Department's proposal on the Department's Internet website by means of Internet link effective January 14, 2011. A public hearing concerning the proposal was held on February 8, 2011, and oral and written comments were provided for the Department's consideration.

In response to written comments on the published proposal and oral comments made at the hearing, the Department has changed some of the proposed language in the text of the rule as adopted. The Department has also changed some of the proposed language for clarification and to correct internal references. The changes, however, do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Implementation related to network adequacy. Several existing provisions of the Insurance Code address network adequacy in addition to the new §1301.0055 added by HB 2256. The Insurance Code §1301.005 requires that an insurer offering a preferred provider benefit plan ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area. Section 1301.005 further mandates that if services are not available through a preferred provider within the service area, an insurer is required to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

Additionally, the Insurance Code §1301.006 requires that insurers contract with sufficient providers to ensure that all covered services will be provided in a manner

ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. Section 1301.007 authorizes the Commissioner to adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to Texas residents. Title 28 Texas Administrative Code (28 TAC) Chapter 3, Subchapter X, contains the existing adopted sections governing preferred provider benefit plans.

An important consideration in implementing changes to existing Subchapter X is the issue of balance billing. Directly addressing this issue, the bill analysis for HB 2256 includes the following statement of intent:

> *"Balance billing is the practice of physicians billing patients for the portion of medical expenses not covered by the patient's insurance. Most commonly, this occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice. An enrollee who is admitted into one of these facilities for a procedure or an emergency is ultimately responsible for an unexpected bill. Currently, there is no remedy for this bill other than the patient attempting to set up a payment plan with the facility-based physician."* TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, "Author's/Sponsor's Statement of Intent") HB 2256, 81st Leg., R.S. (May 22, 2009).

One of the remedies provided in HB 2256 for the problem of unexpected balance bills is the addition of §1301.0055 to the Insurance Code, mandating the Commissioner to adopt by rule network adequacy standards. The amended and new sections address the issues of network adequacy and unexpected balance billing in several ways: (i) the amendment and addition of network requirements; (ii) the amendment and addition of disclosure requirements; (iii) the amendment and addition of contracting requirements;

and (iv) the addition of requirements concerning payment of certain out-of-network (basic benefit) claims.

Network adequacy: network requirements. The Department has addressed network requirements as authorized by the Insurance Code §1301.0055 and §1301.007 and in a manner consistent with the sufficiency requirement of §1301.006. The new and amended network requirements are specified in: (i) §3.3704(e) and (f); (ii) §3.3706(a)(5) and (c); (iii) §3.3707; (iv) §3.3709; (v) §3.3710; (vi) §3.3711; and (vii) §3.3713. The new and amended provisions are necessary for the following reasons.

(i) §3.3704(e) and (f). New §3.3704(e) implements the respective requirements in the Insurance Code §1301.0055(1) and (2) for the Commissioner to adopt network adequacy standards that are adapted to local markets and that ensure availability of and accessibility to a full range of contracted physicians and health care providers to provide health care services to insureds. New §3.3704(e) imposes specific network requirements that each preferred provider benefit plan must include in the health care service delivery network that supports the plan. The Department has adapted the network requirements to reflect the rural or nonrural nature of the service area, the nature of the services as routine, urgent, or emergency care, and the class of physician or provider that furnishes the services consistent with the network sufficiency requirements in the Insurance Code §1301.006. The Department has revised §3.3704(e)(3) by changing the reference to “types” of physicians to “classes” of physicians in order to reduce ambiguity and for consistency with usage elsewhere in the subchapter. Because the need for an adequate network is ongoing, new §3.3704(f)

requires insurers to monitor compliance with these network requirements on an ongoing basis and to take any needed corrective action as required to ensure that the network is adequate.

(ii) §3.3706(a)(5) and (c). New §3.3706(a)(5) and (c) expand upon the network adequacy requirements of §3.3704. New §3.3706(a)(5) prohibits the selection standards used by an insurer from: (i) avoiding high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; or (ii) excluding a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses, or health services utilization. The prohibition is consistent with the requirement in the Insurance Code §1301.058 that any economic profiling of physicians and providers by insurers be adjusted to recognize the characteristics of a provider's practice that may account for variations from average costs.

Further, §3.3706(a)(5) is necessary to ensure that insurers afford all providers a fair, reasonable, and equivalent opportunity to apply to be and be designated as preferred providers, as required by the Insurance Code §1301.051. The prohibition is also necessary to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided are accessible and available as specified in the Insurance Code §1301.006.

Additionally, the prohibition ensures that the health insurance policy providing for the use of preferred providers is not unjust under the Insurance Code §1701.055(a)(2). It is the Department's position that a health insurance policy providing for different levels of benefits depending upon the use of preferred providers would not be just if selection criteria for preferred providers discriminated against the types of providers that are most particularly necessary for those insureds that present a risk of higher than average claims or health care services utilization.

Further, new §3.3706(c) requires insurers to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. The credentialing standards must, at a minimum, meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC to the extent that those standards do not conflict with other laws of this state. Additionally, there shall be a presumption of compliance with credentialing requirements if the insurer has received nonconditional accreditation or certification by the NCQA, the Joint Commission, the American Accreditation HealthCare Commission, URAC, or the Accreditation Association for Ambulatory Health Care.

New §3.3706(c) will ensure that the service delivery network of preferred providers is appropriately qualified to provide the benefit package required under the health insurance policy, a necessary requirement in a policy that provides for different levels of coverage depending upon the use of preferred providers. The Insurance Code §1301.006 requires insurers to contract with sufficient physicians and providers to

ensure “availability of and accessibility to adequate personnel, specialty care, and facilities.” It is the Department’s position that the use of a process for the selection and retention of physicians and providers that are appropriately credentialed is necessary to meet the adequacy requirement of §1301.006.

Section 3.3706(c) is also necessary to ensure that the policy is just, as contemplated in the Insurance Code §1701.055(a)(2). The Department’s position is that a policy that provides for different levels of benefits depending upon the use of preferred providers would be unjust if the insurer’s preferred provider network were inadequately credentialed.

(iii) §3.3707. New §3.3707 implements the requirement in the Insurance Code §1301.0055(3) for the Commissioner to adopt network adequacy rules that may allow departure from local market network adequacy standards on good cause shown if the Commissioner posts on the Department’s Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market. Section 3.3707 specifies the manner by which an insurer may request a waiver from one or more network adequacy requirements due to local market conditions. The Department has changed §3.3707(a) in response to comment to clarify the standard that applies to a waiver application. As specified in §1301.0055(3), the Commissioner may grant the waiver if there is good cause for such departure from the network adequacy standards. Under adopted §3.3704(a), the Commissioner may find good cause to grant the waiver if the insurer demonstrates that providers or physicians necessary for an adequate local market network: (i) are not available to contract; or (ii) have refused to contract with

the insurer on any terms or on terms that are reasonable. To limit the negative impact on insureds of plans operating without a supporting network that complies with network adequacy requirements, §3.3704(a) also specifies that the Commissioner may impose reasonable conditions upon the grant of a waiver.

Section 3.3707(b) further requires an insurer submitting a waiver request to submit a copy of the request to any provider or physician named in the request by any reasonable means and maintain evidence that such submission has been made. Section 3.3707(c) permits such provider or physician to electively submit a response to the waiver request. These provisions are necessary to permit the Department to fully consider the circumstances that the insurer asserts to support a waiver request.

As required by the Insurance Code §1301.0055(3), §3.3707(d) specifies that upon such waiver being granted, the Department shall post on the Department's Internet website the name of the preferred provider benefit plan for which the request is granted, the insurer offering the plan, and the affected service area. To ensure that such a waiver does not continue indefinitely despite potential changes in the circumstances that originally supported the waiver, §3.3707(e) requires that the insurer apply for renewal of the waiver annually. Physicians and providers will have an opportunity to furnish information in opposition to the request each year that the insurer applies for renewal of the waiver.

The Department has changed §3.3707(f) for clarification. Adopted §3.3707(f) specifies that an insurer that is granted a waiver for a plan under the section is still required to comply with adopted §3.3705(p), relating to designation as an "Approved

Hospital Care Network." The subsection further specifies that an insurer is required to designate such plan as having a "Limited Hospital Care Network" in accordance with the requirements of §3.3705(p).

Adopted §3.3707(f) does not address a situation in which an insurer is granted a waiver for compliance with network adequacy standards other than such standards for hospitals. This is because hospital-based services have been one of the main sources of unanticipated balance bills for insureds. *See* TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, "Author's/Sponsor's Statement of Intent") HB 2256, 81st Leg., R.S. (May 22, 2009) (stating that balance billing most often occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice).

Adopted §3.3707(f) is necessary to ensure that prospective and current insureds understand the limitations of the plan's ability to ensure the availability and accessibility of preferred hospital benefit services when considering the purchase or renewal of coverage that relies upon the network.

The disclosure requirement in §3.3707(f), applicable to an insurer operating under a waiver from network adequacy requirements, is consistent with the Insurance Code §1301.158. Section 1301.158(b) requires an insurer to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. Further, §1301.158(d) prohibits an insurer, agent, or representative of an insurer from using,

distributing, or permitting the use or distribution of information for prospective insureds that is untrue or misleading.

(iv) §3.3709. New §3.3709 establishes annual network adequacy report and access plan requirements in order to facilitate the Department's monitoring of compliance with network adequacy standards and to minimize the impact to insureds resulting from an insurer's use of an inadequate network. New §3.3709(a) requires insurers to file a network adequacy report with the Department on or before April 1 of each year and prior to marketing any plan in a new service area. Under new §3.3709(b), each report must specify the trade name of each plan in which insureds currently participate, the applicable service area of each plan, and whether the preferred provider service delivery network supporting each plan is adequate under the standards specified in §3.3704.

New §3.3709(c) specifies that annual reports must also include additional demographic information on the basis of specified geographic regions. This information includes the number of: (i) claims for basic benefits, excluding claims paid at the preferred benefit coinsurance level; (ii) claims for basic benefits paid at the preferred benefit coinsurance level; (iii) complaints by nonpreferred providers; (iv) complaints by insureds relating to the dollar amount of the insurer's payment for basic benefits or concerning balance billing; (v) complaints by insureds relating to the availability of preferred providers; and (vi) complaints by insureds relating to the accuracy of preferred provider listings.

Section 3.3709(c) is necessary because data collected by the Department indicates that insurers do not closely monitor some important network adequacy indicators. For example, a majority of health benefit plan issuers reported that they do not separately monitor balance billing complaints and inquiries. *See Report of the Health Network Adequacy Advisory Committee: Health Benefit Plan Provider Contracting Survey Results*, April 2009 (*April 2009 Network Report*) at 4, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork409b.doc. Further, less than half of the surveyed health benefit plan issuers reported that they have a process for monitoring the extent to which insureds receive treatment from out-of-network (nonpreferred) facility-based physicians at in-network (preferred provider) facilities. *April 2009 Network Report* at 4.

The information required to be reported under §3.3709 will encourage insurers to more closely monitor these important network adequacy indicators. In conjunction with TDI complaint data, the information will also facilitate the Department's oversight of compliance with network adequacy requirements on an ongoing basis in order to determine if additional examination of particular insurers is necessary.

Under §3.3709(d) and (e), if the insurer does not use a service delivery network that complies with the network adequacy requirements in §3.3704, the insurer is also required to submit an access plan as part of the annual report. The access plan must include for each service area that does not meet the network adequacy requirements: (i) the geographic area in which a sufficient number of preferred providers are not available, including a specification of the class of provider that is not sufficiently

available; (ii) a map identifying the geographic area in which such health care services and/or physicians and providers are not available; (iii) the reason(s) that the preferred provider network does not meet the adequacy requirements; (iv) the procedures that the insurer will use to assist insureds to obtain medically necessary services when no preferred provider is reasonably available; and (v) procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708.

The provision of information from insurers specifying the reasons for the network's inadequacy and the steps taken by the insurer to protect insureds faced with an inadequate network, as required under §3.3709(e), will facilitate the Department's determinations of what regulatory response is most appropriate to address an insurer's use of an inadequate network in support of its preferred provider benefit plan. The Department anticipates that the detailed submission of information as specified in §3.3709(e) will necessarily address the local market conditions within any area in which an insurer's preferred provider benefit plan does not comply with the network adequacy requirements of §3.3704. The Department has changed a reference to a "type of provider" to "class of provider" in §3.3709(e)(1)(A) to preclude ambiguity and for consistency with usage elsewhere in the subchapter.

In addition to the access plan, insurers are required under §3.3709(f) to establish and implement documented procedures for use in all service areas for which an access plan is submitted. Such procedures are required to 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, furnish to such insureds a pre-service estimate of the amount the insurer will pay the physician or provider, and notify the insured that the insured may be liable for balance bill amounts.

Section 3.3709(f) also requires such insurer to have a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured and to make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level. It is the Department's position that the Insurance Code §1301.005 and §1301.069 contemplate that there will be instances in which insureds are seen by nonpreferred physicians or providers due to the inadequacy of an insurer's network. Section 1301.005(b) requires that insurers pay such claims at the preferred benefit level of reimbursement, and §1301.069 requires that such claims be paid promptly. New §3.3704(f) ensures compliance with the Insurance Code §1301.005 by requiring insurers to proactively identify those areas in which networks are inadequate, and §3.3709(f) requires that insurers take steps to ensure that claims from nonpreferred providers under those circumstances are paid correctly.

Under §3.3709(g), access plans may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible. New §3.3709(h) specifies that the annual network adequacy report must be filed electronically in a format acceptable to the Department at a specified e-mail address. Additionally, new §3.3709(i) requires insurers to establish an access plan within 30 days of the date on

which a network no longer meets the adequacy requirements established in §3.3704. Such access plan is required to be made available to the Department upon request.

Collectively, the requirements specified in §3.3709 are necessary to permit ongoing monitoring of insurer compliance with network adequacy standards specified in the subchapter by the Department and to ensure that insurers are taking reasonable steps to reduce the potential scope of unanticipated balance bills that may result from the network's failure to comply with those network adequacy standards.

(v) §3.3710. New §3.3710 addresses an insurer's failure to provide an adequate network. Section 3.3710 provides that if the Commissioner determines, after notice and opportunity for hearing, that the insurer's preferred provider service delivery network and any access plan supporting such network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the Commissioner may order one or more specified sanctions.

Under the Commissioner's authority to issue cease and desist orders as specified in the Insurance Code Chapter 83, §3.3710(a) specifies that such sanctions may include an order to: (i) reduce the service area; (ii) cease marketing in parts of the state; and/or (iii) cease marketing entirely and withdraw from the preferred provider benefit plan market. Section 3.3710(b) clarifies that the section does not limit the Commissioner's authority to order additional or other authorized sanctions. Section

3.3710 is necessary to apprise insurers of potential sanctions that may result from the insurer's failure to provide an adequate network as is required under §§1301.005 and 1301.006.

(vi) §3.3711. New §3.3711 defines 11 geographic regions by ZIP Code designations. The designation of regions will facilitate the required disclosure of specified demographic information as required under §3.3705(b)(14) for those plans that are offered on a less than statewide basis to permit the comparison of information among plans for prospective and current policyholders. The designation of regions also facilitates the provision of demographic information submitted by insurers as part of the annual network adequacy report as required in §3.3709(c) and aids the Department's efforts to monitor network adequacy throughout the state. The designated regions correspond to public health regions established by the Department of Health and Human Services and are familiar to insurers. The regions also correspond to regions adopted separately by the Department in 28 TAC §21.4504 for use by insurers in providing health care rate reimbursement data to the Department pursuant to the addition of the Insurance Code §38.355 under SB 1731.

The Department has changed §3.3711 to correct an internal reference. Proposed §3.3711 included a reference to §3.3705(d)(1) that is corrected to refer to §3.3704(g)(1).

(vii) §3.3713. A final network requirement in adopted new §3.3713 concerns the requirement for an insurer to submit and implement a plan for the collection and analysis of information concerning the effects of undercompensated care. The

Department has changed §3.3713 in response to comments that: (i) the proposed language would require the disclosure of information that would be inappropriate for comparison by consumers due to the lack of a uniform standard; (ii) the proposed language would inappropriately place the burden for analysis of the broad issues concerning uncompensated care upon insurers; (iii) the proposed language did not define the term “uncompensated care” or clarify whether the term encompasses “undercompensated care;” (iv) the collection and analysis of information should be implemented earlier than proposed; and (v) the addition of required provisions in contracts between insurers and facilities would place additional strain upon negotiations between those parties concerning network participation.

In response to comments that proposed §3.3713 would require the annual report and disclosure of information that would be inappropriate for comparison by consumers due to the lack of a uniform standard, the Department has deleted the annual reporting requirement as proposed in §3.3713(a) and the disclosure requirement as proposed in §3.3713(c). The Department agrees that a lack of uniformity in the collection and analysis of such information does not facilitate appropriate comparison by consumers. In fact, such disclosure could lead to misleading comparisons.

However, it is the Department’s position that an insurer should collect and analyze information concerning the existence and effects of undercompensated care upon a facility’s contracted charges as part of the insurer’s responsibility to maintain an adequate and sufficient network, as required by the Insurance Code §§1301.005(a), 1301.0055(2), and 1301.006, and in order to be responsive to market forces that affect

what contracted rates are reasonable. It is further the Department's position that such information and analysis may be useful to an insurer's submission and the Department's consideration of an application for waiver from network adequacy requirements as permitted under §3.3707 and an access plan used in connection with an inadequate network pursuant to §3.3709(d) and (e).

Adopted new §3.3713(a), therefore, requires an insurer to submit to the Department a plan outlining how the insurer will collect information sufficient to determine: (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of undercompensated care; and (ii) a financial analysis of the monetary impact of undercompensated care on the contracted charges of each contracted facility.

The Department received comments that proposed §3.3713 would inappropriately place the burden for analysis of the broad issues concerning uncompensated care upon insurers that operate preferred provider benefit plans, as opposed to other consumers of health care services. In response to this comment, adopted §3.3713 does not impose detailed requirements concerning the scope of each insurer's collection and analysis of information concerning the existence and effects of undercompensated care. Instead, each insurer's plan may be tailored to the unique characteristics of the insurer's network utilization and contracting practices.

In response to comments that §3.3713 did not define the term "uncompensated care" or clarify whether the term encompasses "undercompensated care," adopted §3.3713(b) instead uses the term "undercompensated care" and clarifies that the term

means care that is not reimbursed through an agreement between an insurer and a facility and that is either uncompensated or is reimbursed at an amount less than the facility's billed charges.

In response to a comment that the collection and analysis of information should be implemented earlier than proposed, adopted §3.3713(a) requires the insurer to submit the plan to the Department on July 1, 2014, and adopted §3.3713(c) specifies the form and manner of such submission. Also in response to this comment, adopted §3.3713(d) requires the insurer to implement the plan concerning the collection and analysis of information concerning the effects of undercompensated care effective July 1, 2015. These timeframes are additionally appropriate because the plans may be uniquely tailored to the needs of the insurer and because there is no longer a requirement to plan and implement annual reporting and public disclosure of the information and analysis. For the same reasons, the Department has also deleted proposed §3.3713(e) – (g) concerning an application process for a six-month waiver of the requirements of §3.3713. The Department anticipates that such a waiver application process will be unnecessary due to the tailored nature of each insurer's plan and the reduced requirements of the section.

In response to comment that the addition of required provisions in contracts between insurers and facilities places additional strain upon negotiations between those parties concerning network participation, the Department has deleted the requirement in proposed §3.3713(d) that an insurer's contract with a facility must contain provisions permitting that insurer to obtain information from the facility necessary for the insurer's

completion of the financial analysis required in proposed §3.3713. Insurers, therefore, have greater flexibility to determine how best to obtain the information necessary for compliance with adopted §3.3713.

The Department has also changed the title of §3.3713 to "Submission of Plan; Collection and Analysis of Information Concerning the Effects of Undercompensated Care." The new title better reflects the revised content of the section.

Network adequacy: disclosure requirements. The amended and new sections also address the issues of network adequacy and unexpected balance billing through the amendment and addition of requirements concerning disclosures. The Department has addressed disclosures related to network adequacy pursuant to its authority to establish network adequacy requirements under the Insurance Code §1301.0055 and §1301.007. In addition, amended and new disclosure requirements ensure that prospective and current insureds and group contract holders considering the purchase or renewal of coverage that relies upon a network have access to information that conveys the scope and limitations of the plan's ability to ensure the availability and accessibility of preferred benefit services.

The new and amended disclosure requirements are specified in: (i) §3.3704(g); (ii) §3.3705(b)(12); (iii) §3.3705(b)(14); (iv) §3.3705(e); (v) §3.3705(f); (vi) §3.3705(h) – (j); (vii) §3.3705(k); (viii) §3.3705(l); (ix) §3.3705(m); (x) §3.3705(n); (xi) §3.3705(o); (xii) §3.3705(p); (xiii) §3.3705(q); (xiv) §3.3708(e). The new and amended provisions are necessary for the following reasons.

(i) §3.3704(g). New §3.3704(g) specifies the manner in which an insurer may define a preferred provider benefit plan's service area to provide for a clear delineation of a plan's boundaries for review by insureds. The Insurance Code §1301.005 requires insurers to ensure that benefits are reasonably available "within a designated service area."

New §3.3704(g) requires all insurers to use one of three different methods for defining service areas that are less than statewide. The use of common standards to define service areas will provide for greater consistency among the defined service areas used by insurers while still providing flexibility to insurers in designating such service areas. This delineation will facilitate an insured's ability to identify the service area in which preferred benefits are available and additionally permit comparison to the service areas of other plans. In conjunction with other disclosure requirements, information provided on the basis of permitted service area definitions will help prospective and current insureds and group contract holders to assess the network characteristics of a preferred provider benefit plan to determine if the plan is appropriate for the needs of the insured.

Such facilitation is consistent with the requirements of the Insurance Code §1301.158(b), which requires an insurer to provide to a current or prospective group contract holder or insured on request an accurate written description of the terms of the health insurance policy to allow the current or prospective group contract holder or insured to make comparisons and an informed decision before selecting among health

care plans. Section 1301.158(b) also authorizes the Commissioner to prescribe the format of such description.

(ii) §3.3705(b)(12). Existing §3.3705(b)(12) requires an insurer to provide to a prospective or current group contract holder or insured on request: (i) a current list of preferred providers and complete network descriptions; and (ii) a disclosure of which preferred providers are not accepting new patients. The adopted amendment to §3.3705(b)(12) specifies that this information may be provided electronically with the agreement of the insured provided that the insurer also furnishes the insured with information about how to obtain a nonelectronic provider listing free of charge. This amendment will provide insurers with a less costly alternative for complying with the requirement based upon the insured's ability to access the information electronically.

Further, §3.3705(b)(12) is consistent with the Insurance Code §1301.158(b) and §1301.159. Section 1301.158(b) requires insurers to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must include a current list of preferred providers. Section 1301.159 requires insurers to provide a current list of preferred providers at least annually.

(iii) §3.3705(b)(14). An additional disclosure requirement adopted in new §3.3705(b)(14) requires insurers to provide current and prospective group contract holders or insureds with information regarding network demographics for each service area, if the plan is not offered on a statewide service area basis, or for each of the 11

regions specified in §3.3711 of the subchapter if the plan is offered on a statewide service area basis.

The network demographic information must be updated at least annually and includes three general requirements. Under new §3.3705(b)(14)(A), the insurer must provide the number of insureds in the service area or region. Under adopted §3.3705(b)(14)(B), the insurer must provide the number of preferred providers, by area of practice, as well as an indication of whether an active access plan pursuant to §3.3709 applies to the services furnished by particular classes of provider in the service area or region and how such access plan may be obtained or viewed, if applicable. Under adopted §3.3705(b)(14)(C), the insurer must provide the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 applies to hospital services in the service area or region and how the access plan may be obtained or viewed.

Disclosure of this network demographic information will assist current and prospective insureds and group contract holders to compare plans and to make informed decisions concerning the selection or renewal of a plan, consistent with the requirements of the Insurance Code §1301.158. The Department also anticipates that additional transparency concerning this network demographic information will incentivize insurers to contract with adequate numbers of physicians and providers as a matter of competition. Further, such information will assist the insureds and group contract holders to more accurately assess the risk of unanticipated balance bills associated with reliance upon a particular plan and the network that supports such plan.

The Department has changed §3.3705(b)(14) in response to comments that some of the proposed network demographic disclosures: (i) are administratively burdensome; (ii) fail to provide substantially meaningful information to prospective and current insureds; and (iii) may be misleading to prospective and current insureds. The Department has also changed §3.3705(b)(14) for consistency in usage of terms.

In response to comment that some of the network demographic disclosures in proposed §3.3705(b)(14) are administratively burdensome, fail to provide substantially meaningful information, and may be misleading to prospective and current insureds, the Department has deleted the requirement in proposed §3.3705(b)(14)(B)(i) to disclose the ratio of insureds to providers in the plan. The ratio does not reveal the true scope of patient-to-provider accessibility because, although the ratio as proposed would require disclosure of the ratio for separate areas of practice, the ratio does not account for variation among providers within such practice areas. Further, the ratio does not account for the patient population in addition to those that are insured through the disclosing insurer's plan that are treated by the network providers.

The Department, therefore, has determined that this disclosure requirement does not provide substantially meaningful information sufficient to warrant the administrative burden of tracking, updating, and disclosing the ratio. The Department has also determined that, absent the additional information concerning the variation of accessibility within practice areas and the scope of the additional patient population, disclosure of this ratio could mislead a current or prospective insured by creating a false impression concerning provider accessibility.

In response to comment that some of the network demographic disclosures in proposed §3.3705(b)(14) are administratively burdensome, the Department has also deleted the requirement in proposed §3.3705(b)(14)(B)(ii) to disclose the percentage of preferred providers that are accepting new patients. Although this disclosure would provide a snapshot of accessibility within an area of practice, insurers are already required to provide a current list of preferred providers, including names and locations of physicians and health care providers and a disclosure of which preferred providers will not accept new patients, pursuant to §3.3705(b)(12). Also, insurers using very differently-sized networks could have comparable percentages of providers that are accepting new patients but with very different results. As such, disclosure of the percentage could be misleading. The Department has, therefore, deleted the requirement to reduce the burden associated with the duplicative disclosure requirements.

In response to comment that some of the network demographic disclosures in proposed §3.3705(b)(14) are administratively burdensome and fail to provide substantially meaningful information, the Department has also deleted the requirement in §3.3705(b)(14)(B)(iii) for disclosure of the percentage of preferred providers with board certifications in the applicable area of practice. This percentage may provide a snapshot concerning provider qualifications within an area of practice, but the more meaningful information for an individual insured is the scope of qualifications for a particular physician or provider. An insured may access this information from the particular physician or provider and may verify this information with the appropriate

certification board. Because the information is otherwise available in a more particularized fashion, the Department has deleted the disclosure requirement to reduce the administrative burden to insurers.

In response to comment that some of the network demographic disclosures in proposed §3.3705(b)(14) are administratively burdensome, fail to provide substantially meaningful information, and may be misleading to prospective and current insureds, the Department has deleted the requirement in proposed §3.3705(b)(14)(C)(i) to disclose the ratio of insureds to hospital beds. The ratio does not reveal the true scope of accessibility to hospital beds because the ratio does not account for the patient population in addition to those that are insured through the disclosing insurer's plan that also access the hospital's services, nor does the ratio account for daily variation in access to hospital beds or variation among hospitals within the service area or region.

The Department, therefore, has determined that this disclosure requirement does not provide substantially meaningful information sufficient to warrant the administrative burden of tracking, updating, and disclosing the ratio. The Department has also determined that, absent the additional information concerning the daily variation in access to hospital beds and the scope of the additional patient population, disclosure of this ratio could mislead a current or prospective insured by creating a false impression concerning such accessibility.

In response to comment that some of the network demographic disclosures in proposed §3.3705(b)(14) are administratively burdensome, fail to provide substantially meaningful information, and may be misleading to insureds, the Department has

deleted the requirement in proposed §3.3705(b)(14)(C)(ii) to disclose the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization. While the disclosure would provide a snapshot concerning the qualifications of hospitals within a network, the Department recognizes that an insured often has little choice in the selection of a hospital due to the lack of additional facilities in the insured's community or due to the emergent nature of the services required. Further, in geographic areas that lack competing facilities, this information will not likely vary among insurers and may, therefore, have less meaning in selecting a plan.

Additionally, although the proposal would require disclosure of accreditation information on no larger than a region-specific basis, the disclosure could nonetheless mislead insureds by presenting percentage information that is correct but that represents a disproportionate concentration of accredited hospitals within a small geographic area of the region. Finally, hospital accreditation information is separately available through the Texas Health Compare portion of the Department's website at http://www.texashealthoptions.com. For each of these reasons, the Department has determined that this disclosure requirement does not merit the administrative burden associated with tracking and disclosing the statistic.

In response to comments that some of the network demographic disclosures in proposed §3.3705(b)(14) are administratively burdensome, fail to provide substantially meaningful information, and may be misleading to insureds, the Department has deleted the requirement in proposed §3.3705(b)(14)(C)(iii) to disclose the average

surgical site infection rate at each specific preferred provider hospital in the service area or region. The Department recognizes that an insured often has little choice in the selection of a hospital due to the lack of additional facilities in the insured's community or due to the emergent nature of the services required. Further, in geographic areas that lack competing facilities, this information will not likely vary among insurers and may, therefore, have less meaning in selecting a plan.

The Department also received comments that surgical site infection rates may vary for many reasons, including the treatment of a higher-risk population. For this reason, disclosure of a raw surgical site infection rate without accompanying information to provide context for interpretation of the rate could be misleading for insureds that do have the opportunity to investigate and select among hospitals and facilities. Further, a much broader array of information about hospitals, including information on compliance with infection prevention measures, is available to the public through the Department's website at http://www.texashealthoptions.com. For all of these reasons, the Department has determined that this disclosure requirement does not merit the administrative burden associated with tracking and disclosing the statistic.

To accommodate the deletions of proposed §3.3705(b)(14)(B)(ii) and (iii), the Department has changed the subparagraph through reorganization. The requirement in proposed §3.3705(b)(14)(B)(i) is now included in Subparagraph (B), and no clauses in the subparagraph remain. The Department has also changed the reference in §3.3705(b)(14)(B) from a "pediatrics" practice to "pediatric practitioner practice" for consistency with the defined term in adopted §3.3702(14). The Department has also

made clarifying changes to §3.3705(b)(14)(B) to accommodate the deletion of the ratio disclosure requirement and to change the reference from “type of provider” to “class of provider” to reduce ambiguity and for consistency with usage elsewhere in the subchapter.

To accommodate the deletions of proposed §3.3705(b)(14)(C)(ii) and (iii), the Department has also changed this subparagraph through reorganization. The requirement in proposed §3.3705(b)(14)(C)(i) is now included in subparagraph (C), and no clauses in the subparagraph remain. The Department has also made clarifying changes to §3.3705(b)(14)(C) to accommodate the deletion of the ratio disclosure requirement.

(iv) §3.3705(e). Additional required disclosures are adopted at §3.3705(e) for insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective or current insureds or group contract holders. Such insurers are required to provide: (i) an Internet-based provider listing for use by current insureds and group contract holders, consistent with the requirements of the Insurance Code §1301.1591 and in furtherance of the requirements in the Insurance Code §1301.158(b); (ii) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer’s service area(s), indicating as appropriate for each region, county, or ZIP Code area the insurer’s determination that its network does or does not meet the network adequacy requirements of 28 TAC Chapter 3, Subchapter X; and (iii) an Internet-based listing of the information specified for disclosure in §3.3705(b). Section 3.3705(b) addresses the

insurer's required disclosure of terms and conditions of the policy to current and prospective insureds and group contract holders on request to permit comparison and informed decision-making concerning the selection or retention of a health care plan. The additional inclusion of that information on the insurer's website, in conjunction with the other specified disclosures, will facilitate such comparison and informed decision-making.

The Department has changed §3.3705(e) by revising a reference to "prospective consumers or current insureds" to "current or prospective insureds or group contract holders" to preclude ambiguity and for consistency with usage elsewhere in the subchapter and in the Insurance Code §1301.158(b).

The Department has also changed §3.3705(e)(1) to preclude ambiguity. As proposed, §3.3705(e)(1) required provision of an Internet-based provider listing for use by current insureds. However, §3.3705(e)(3) requires the provision of an Internet-based listing of the information specified for disclosure in §3.3705(b), which includes in §3.3705(b)(12) a list of current preferred providers for current or prospective insureds, as well as current or prospective group contract holders. The Department has therefore changed §3.3705(e)(1) by requiring provision of the Internet-based provider listing for use by current and prospective insureds and group contract holders to prevent confusion in application of the requirements of §3.3705(e)(1) and (3).

(v) §3.3705(f). Adopted new §3.3705(f) requires insurers to include a notice concerning rights of insured participants in preferred provider benefit plans in all policies, certificates, and outlines of coverage.

The content of the required notice is prescribed in Figure: 28 TAC §3.3705(f) and addresses eight rights that an insured has in connection with preferred provider benefit plans. First, the notice addresses the right to an adequate network of preferred providers, consistent with the Insurance Code §1301.005(a). Second, the notice addresses the right to file a complaint with the Department concerning an inadequate network, consistent with the Insurance Code §1301.161. Third, the notice addresses the right to reimbursement of claims at preferred benefit levels if services were received from a nonpreferred provider due to a lack of reasonably available preferred providers, consistent with the Insurance Code §1301.005(b). Fourth, the notice addresses the right to obtain a current listing of preferred providers and to obtain assistance in locating available preferred providers, consistent with the Insurance Code §1301.006 and §1301.159.

Fifth, the notice addresses the right to reimbursement of claims at preferred benefit levels if the listing of preferred providers relied upon by the individual in seeking preferred providers is inaccurate, consistent with §3.3705(k). Sixth, the figure addresses the right to notice about the potential for balance billing by nonpreferred providers, as required by the Insurance Code §1456.003(b)(1), added by SB 1731. Seventh, the notice addresses the right to advance estimates of bills from physicians and providers and of payment for services from insurers, consistent with the Health and Safety Code §324.101(d), the Occupations Code §101.352(c), and the Insurance Code §1301.158(d) and §1456.007. The Health and Safety Code §324.101(d), the

Occupations Code §101.352(c), and the Insurance Code §1301.158(d) and §1456.007 were each enacted under SB 1731.

Eighth, the notice addresses rights concerning mediation, consistent with the Insurance Code §1467.051(a) and §1467.053(d). The Insurance Code §1467.051(a) and §1467.053(d) were enacted under HB 2256.

Inclusion of the notice concerning each of these rights and facts is necessary to assist insureds and group contract holders to understand the several rights available to an insured both before and after the provision of services that affect, disclose, and potentially mitigate the scope of the insured's potential liability for balance bill amounts. Although not submitted by public counsel or specifically labeled as a "consumer bill of rights," this notice of rights is similar to the bill of rights contemplated in the Insurance Code §501.156 for each personal line of insurance regulated by the Department.

The Department has changed the content of Figure: 28 TAC §3.3705(f) in response to comment that the notice should be reorganized and further simplified for greater clarity. The Department has also changed the content of the figure in response to comment to address the fact that some policies may include a general out-of-pocket maximum rather than specific in-network and out-of-network maximums.

Specifically, in response to comment requesting reorganization and simplification, the language in the first bullet of the proposed figure has been simplified and reorganized as separately bulleted sentences. Also, adopted Figure: 28 TAC §3.3705(f) clarifies that an insured may be entitled to have out-of-pocket expenses counted toward the in-network, out-of-network, or general out-of-pocket maximum, as

appropriate, if the insured has obtained out-of-network services because no preferred provider was reasonably available. After reviewing comments concerning proper attribution of out-of-pocket expenses toward out-of-pocket maximums, the Department has determined that variation in plan design supports the provision of greater flexibility. The Department has therefore added language to the figure to address the possibility that a plan has a general out-of-pocket maximum rather than specific in-network and out-of-network maximums only.

Also in response to comment requesting reorganization and simplification of the figure, the language in the third bullet of the proposed figure has been simplified and reorganized into separately bulleted provisions, as well as being designated for earlier placement in the figure.

The Department has also changed instructional language in the third bullet of adopted Figure: 28 TAC §3.3705(f) that referenced “prospective consumers or current insureds” to refer to “current or prospective insureds or group contract holders” to preclude ambiguity and for consistency with usage elsewhere in the subchapter and in the Insurance Code §1301.158(b).

In response to comment requesting reorganization and simplification of the figure, the Department has moved the last sentence of the second bullet of the proposed figure into a separately bulleted sentence.

(vi) §3.3705(h) – (j). New §3.3705(h) - (j) address in greater detail an insurer’s obligations to provide information concerning preferred provider listings. Subsection (h) requires the insurer to notify all insureds at least annually of the manner in which the

insured may access a current listing of all preferred providers on a cost-free basis. Minimum requirements for the notice include information concerning how a nonelectronic copy of the listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers. Insurers are required to maintain a toll-free telephone number to receive complaints and provide information as specified in the Insurance Code §521.102.

New subsection (i) requires the insurer to ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months. New subsection (i) is consistent with the requirements in the Insurance Code §1301.159 and §1301.1591 concerning the annual provision of current preferred provider listings and the quarterly updating of preferred provider listings on the insurer's Internet website, respectively. New subsection (i) does not independently require distribution of preferred provider listings, but it does require that any preferred provider listings that are distributed be updated within the three months prior to distribution. New subsection (i) is also consistent with the prohibition in the Insurance Code §1301.158(c), which provides that an insurer, or an agent or representative of an insurer, may not use or distribute, or permit the use or distribution of, information for prospective insureds that is untrue or misleading.

Similarly, new subsection (i) is consistent with the Insurance Code §541.061. Pertinent provisions of §541.061 specify that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an

insurance policy by: (i) making an untrue statement of material fact; (ii) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made; (iii) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact; and (iv) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of the Insurance Code. It is the Department's position that quarterly updates of all provider listings as required under §3.3705(i) are necessary to prevent such violations of the Insurance Code.

New subsection (j) requires that if no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer is required to distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if such alternative method is agreed to by the insured, group policyholder on behalf of the group, or the certificate holder.

(vii) §3.3705(k). New §3.3705(k) clarifies the Department's position that an insured should be able to rely upon information recently obtained from an insurer or the insurer's designee concerning the status of preferred providers in accessing covered services at the preferred level of benefits.

Subsection (k) requires insurers to pay a claim for services rendered by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that: (i) in obtaining services, the insured reasonably relied upon

a statement that a physician or provider was a preferred provider as specified in a provider listing or provider information on the insurer's website; (ii) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds; (iii) the provider listing or website information was obtained not more than 30 days prior to the date of services; and (iv) the provider listing or website information obtained indicates that the provider of the services is a preferred provider within the insurer's network.

This requirement is necessary to ensure the reasonable accessibility and availability of preferred provider services as specified in the Insurance Code §1301.007. The Department has previously entered a consent order against one large insurer based on allegations that the insurer's listings of its contracted providers were not accurate. *See Commissioner's Order No. 08-0514*, June 13, 2008 at 3. It is the Department's position that if an insured reasonably relies on an insurer's representation that a physician or provider is available to insureds as a preferred provider, but the physician or provider is, in fact, not contracted with the insurer, then the insurer has failed to make preferred provider benefits reasonably available to the insured.

In such an instance, it is the Department's position that the insured is entitled to the protections of the Insurance Code §1301.005(b), which requires that the insurer reimburse a claim from a nonpreferred provider at the preferred benefit percentage level if services are not available through a preferred provider. Subsection (k) is also necessary to ensure that the underlying policy is not unjust in application, consistent

with the requirements of the Insurance Code §1701.055(a)(2). It is the Department's position that a health insurance policy providing for different levels of benefits depending upon the use of preferred providers is not just if the insured relies upon the representations of the insurer as specified in §3.3705(k) in order to access preferred benefits only to learn that the directory information is inaccurate. Payment of benefits by the insurer in such a case at the lower basic benefit level rather than the preferred benefit level would unjustly frustrate the purpose of differentiating between levels of benefits in the first place.

(viii) §3.3705(l). Additional listing-specific disclosure requirements are adopted in new §3.3705(l) for all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, as specified in paragraphs (1) – (10) of the subsection.

Collectively, the listing-specific disclosure requirements in §3.3705(l) will facilitate an insured's ability to proactively seek out preferred provider services in nonemergency situations and to assess for future purposes the risk that some services may not be accessible through the insurer's preferred provider network. Data collected by the Department has indicated that approximately 10 percent of aggregate facility-based provider claims are from nonpreferred providers. *See April 2009 Network Report* at 3. Because of the economic significance of the potential balance bills that an insured may receive for health care services of this nature, the information required to be provided in subsection (l) is necessary for insureds to make appropriate decisions about their care.

The Department has changed §3.3705(l)(1) to clarify the discrete nature of the contractual requirements specified in the paragraph. Adopted §3.3705(l)(1) requires the insurer to include in its provider listings a method by which insureds may identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in two discrete subparagraphs of the paragraph. Adopted §3.3705(l)(1)(A) specifies that one of the indicated contractual agreements is that the hospital will exercise good faith efforts to accommodate requests from insureds to use preferred providers.

Adopted §3.3705(l)(1)(B) specifies that the second of the indicated contractual agreements is that the hospital will provide insureds with information sufficient to enable the insured to identify a facility-based physician or physician group that is assigned to provide services to the insured with enough specificity that the insured may determine the status of the physician or physician group as preferred or nonpreferred. The latter disclosure requirement would only reflect contractual agreements that apply to instances in which the physician or physician group is assigned at least 48 hours prior to services being rendered and would require that the responsive information be furnished to the insured at least 24 hours prior to services being rendered.

Proposed §3.3705(l)(2) required the insurer to include in its listings a method by which the insured might identify those hospitals at which more than 10 percent of the dollar amount of total claims filed with the insurer by or on behalf of facility-based physicians, other than neonatologists and pathologists, are filed by or on behalf of a physician that is not under a contract with the insurer. The Department has changed

§3.3705(l)(2) in response to comments that: (i) the use of a 10 percent benchmark is inconsistent with findings of the committee established to study and report upon network adequacy issues (Health Network Adequacy Advisory Committee) as required under the Insurance Code §1456.0065, enacted in SB 1731; and (ii) the indicator should also reflect the network usage of neonatologists and pathologists.

The Department received a comment that the Health Network Adequacy Advisory Committee's findings are inconsistent with the use of a 10 percent benchmark for disclosure concerning out-of-network facility-based physician usage in provider listings because the benchmark appears to identify a "norm" for network usage and is not focused upon emergency department physicians as would be supported by such committee findings. The Department's determination to set the disclosure requirement at 10 percent of claims was not based upon a particularized finding from the Health Network Adequacy Advisory Committee but was rather a number that the Department determined to constitute a sufficient threshold to earn an insured's attention and signal the insured to investigate the status of facility-based physicians more closely.

However, the Department does agree that the Health Network Adequacy Advisory Committee findings indicate wide variation among classes of facility-based physician with respect to network provider usage. For example, the committee's final report indicates that nearly 30 percent of the billed dollar amount of claims included in the survey for emergency department physicians were out-of-network, as opposed to slightly more than five percent of the billed dollar amount of claims for pathologists. *See April 2009 Network Report* at 25, available at

http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork409b.doc. The committee's findings with respect to individual claim units was similar, finding that almost 28 percent of the claims surveyed for emergency department physicians were out-of-network, as opposed to slightly more than five percent of the claims for pathologists. *Id.*

In response to the comments concerning the inappropriateness of the 10 percent benchmark and the wide variation in network usage among classes of facility-based physician, adopted §3.3705(l)(2) requires insurers to include in all preferred provider listings a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. Adopted §3.3705(l)(2) further requires that the information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

The Department also received comments indicating that it would be both feasible and appropriate to include the claims of pathologists and neonatologists in disclosing indications of facility-based physician usage. In response to these comments, the Department has changed §3.3705(l)(2) to delete the exclusion for the claims of pathologists and neonatologists and to specifically include the classes of facility-based physician claims for which network usage is required to be available.

To accommodate the revised requirement in §3.3705(l)(2), the Department has also changed §3.3705(l)(3) to provide appropriate specificity concerning the requirement at subsection (l)(2). Adopted §3.3705(l)(3) clarifies that in determining the

percentages specified in that paragraph, the insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information is furnished to the insured.

Section 3.3705(l)(4) requires the insurer to indicate in each listing whether each preferred provider is accepting new patients, consistent with the requirement in the Insurance Code §1301.1591(a).

Section 3.3705(l)(5) requires the insurer to designate those preferred providers that have notified the insurer of the preferred provider's participation in a regional quality of care peer review program. It is the Department's position that a health insurance policy that provides for different levels of benefits depending upon the use of preferred versus nonpreferred providers should provide appropriate information to insureds for use in selecting a provider. If a preferred provider has notified the insurer of the physician or provider's participation in a regional quality of care peer review program, this factor may affect the insured's selection of provider and the determination to use preferred versus nonpreferred provider services. The information will, therefore, convey a characteristic of network adequacy to the insured and is adopted pursuant to the Insurance Code §1301.007.

Section 3.3705(l)(6) requires the insurer to provide a method by which insureds may notify the insurer of inaccurate information in the provider listing, with specific reference to information about the provider's contract status and whether the provider is accepting new patients. Section 3.3705(l)(6) is necessary to ensure that provider listings include accurate and current information concerning providers in compliance

with the requirements of the Insurance Code § 1301.158(b) and § 1301.1591(a). Section 3.3705(l)(6) is also necessary to ensure that the provider listing does not include misleading or untrue information as prohibited under the Insurance Code §1301.158(c) and §541.061 concerning the use of false or misleading representations concerning benefits under an insurance policy.

Section 3.3705(l)(7) requires insurers to provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities, if any. Section 3.3705(l)(7) is necessary to provide context for the listing of preferred providers so that an insured will understand the wider scope of the availability and adequacy of facility-based physicians at preferred provider facilities. The information will prevent a more general listing from being misleading as prohibited in the Insurance Code §1301.158(c). Section 3.3705(l)(8) requires the provider information to be furnished in fonts of not less than 10-point type.

Section 3.3705(l)(9) requires the insurer to furnish provider information that specifically identifies those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable class of provider. The Department has changed the references in proposed §3.3705(l)(9) from “type” of provider to “class” of provider to preclude ambiguity and for consistency with usage elsewhere in the subchapter. Adopted §3.3705(l)(9) addresses the requirement of the Insurance Code §1456.003(c) for clear identification of those network (preferred provider) facilities in which facility-based physicians do not participate in the health benefit plan’s provider

network by providing for clear delineation of those facilities at which there is a greater risk of unanticipated balance bills from facility-based physicians.

In response to a comment that a facility might have more than one exclusive contract with different physician groups within a single class of provider, but concerning the provision of different services by that class of provider, the Department has deleted proposed §3.3705(l)(10). Given the existence of dual "exclusive" contracts, the identification in preferred provider listings of those facilities at which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility could mislead an insured as to the possibility of receiving services from nonpreferred providers at a facility.

In response to comment that specification of "the date on which the [preferred provider listing] information was provided to the insured" is an impractical or infeasible requirement, the Department has changed §3.3705(l)(11), adopted as §3.3705(l)(10), due to the deletion of proposed §3.3705(l)(10). Adopted §3.3705(l)(10) requires all preferred provider listings to be dated. The Department anticipates that this revised requirement will afford greater flexibility to insurers in determining how to date such listings and will facilitate compliance with the requirement.

The Department has also changed the reference to numbered paragraphs in §3.3705(l) to reflect that the adopted subsection contains only 10 paragraphs.

Collectively, the listing-specific disclosure requirements in §3.3705(l) will facilitate an insured's ability to proactively seek out preferred provider services in nonemergency situations and to assess for future purposes the risk that some services may not be

accessible through the insurer's preferred provider network. Data collected by the Department has indicated that approximately 10 percent of aggregate facility-based provider claims are from nonpreferred providers. *See April 2009 Network Report* at 3. Because of the economic significance of the potential balance bills that an insured may receive for health care services of this nature, the information required to be provided in subsection (l) is necessary for insureds to make appropriate decisions about their care.

The collective provisions of adopted §3.3705(l) are necessary to provide sufficient information to an insured seeking to use preferred provider services under the health insurance policy for maximum benefit. Adopted §3.3705 is authorized pursuant to the Insurance Code §1301.0055(2) and §1301.007.

(ix) §3.3705(m). New §3.3705(m) requires an insurer operating a preferred provider benefit plan that relies upon an access plan as specified in §3.3709 to notify all policyholders of this fact at issuance and at least 30 days prior to renewal of a policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes illustrating the affected service area. This information is necessary to facilitate comparison and informed decision-making with respect to the purchase or renewal of a policy by current and prospective insureds and group contract holders.

This disclosure is also necessary to implement the Insurance Code §1701.055(a)(2) with respect to preferred provider benefit plan policies. It is the Department's position that a health insurance policy providing for different levels of benefits depending upon the use of preferred providers is not just if the insurer does not

provide the insured with advance notice of the limitations on the insured's ability to access preferred provider services.

Similarly, new subsection (i) is consistent with the Insurance Code §541.061. Pertinent provisions of §541.061 specify that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by: (i) making an untrue statement of material fact; (ii) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made; (iii) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact; and (iv) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of the Insurance Code. It is the Department's position that disclosure of limitations on an insured's ability to access preferred provider benefits under the health insurance policy as required under §3.3705(m) are necessary to prevent such violations of the Insurance Code.

(x) §3.3705(n). New subsection (n) requires an insurer to provide notice on the insurer's website of a substantial decrease in the availability of preferred facility-based physicians at preferred provider facilities. As specified in §3.3705(n)(1), a decrease is substantial if: (i) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at that facility terminates; or (ii) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that

specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26)(A).

The Department has reorganized the wording of adopted §3.3705(n) to clarify that an insurer is required to provide notice as specified in the subsection. The Department has also changed §3.3705(n)(1)(B) to clarify that it is an insurer's receipt of notice as required under §3.3703(a)(26) that affects whether a decrease is substantial as described in the subparagraph.

In response to comment that §3.3705(n) inappropriately results in existing levels of provider availability becoming the *de facto* standard for continuing adequacy, even if the existing levels exceed the level required for an insurer to have an adequate network, the Department has changed §3.3705(n)(2) by adding a second basis for exemption from the requirement to provide notice of a substantial increase in the availability of preferred providers. The Department has added text and reorganized the paragraph to create two subparagraphs to adopted §3.3705(n)(2) for accommodation of the additional exemption.

Adopted §3.3705(n)(2) specifies that notice of the substantial decrease is not required if the requirements specified in either subparagraph (A) or (B) are met. Under adopted subparagraph (A), the first basis for exemption is that alternative preferred providers of the same specialty as the physician group that terminates a contract are made available to insureds at the facility, provided the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease.

Under adopted subparagraph (B), the new second basis for exemption is that the insurer provides to the Department a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be non-compliant with the adequacy standards specified in §3.3704. The certification must be submitted to the Department by e-mail at a specified address.

The Department has changed §3.3705(n)(3) to clarify that either class of contract termination as specified in adopted §3.3705(n)(1) triggers the requirement for an insurer to prominently post notice of the contract termination and the resulting decrease in the availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

Similarly, the Department has changed §3.3705(n)(4) to clarify that either class of contract termination as specified in adopted §3.3705(n)(1) triggers the requirement for an insurer to maintain notice of the contract termination and of the decrease in availability providers in the manner specified in the paragraph. The Department has also changed §3.3705(n)(4) in response to the comment that the paragraph inappropriately results in existing levels of provider availability becoming the *de facto* standard for continuing adequacy, even if the existing levels exceed the level required for an insurer to have an adequate network.

Adopted §3.3705(n)(4), therefore, includes three bases for removal of an insurer's posted notice concerning the contract termination and of the decrease in availability providers. Under adopted §3.3705(n)(4)(A), an insurer may remove the

notice as of the date on which adequate levels of preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of the subsection. Under adopted §3.3705(n)(4)(B), an insurer may remove the notice six months from the date that the insurer posts the notice. Under adopted §3.3705(n)(4)(C), added in response to the comment concerning inappropriate *de facto* levels of adequacy, an insurer may remove the notice as of the date on which the insurer provides to the Department a certification indicating the insurer's determination that the termination of the provider contract does not cause non-compliance with adequacy standards. The certification must be submitted to the Department at a specified e-mail address.

In response to comment that some contracts include notice requirement provisions, the Department has changed §3.3705(n)(5). The Department has also changed the paragraph to clarify the proposed language. Adopted §3.3705(n)(5) specifies that an insurer is required to post notice as specified in paragraph (3) of the subsection and to update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after either of two events.

Under adopted §3.3705(n)(5)(A), the specified event is the effective date of the contract termination as specified in paragraph (1)(A) of the subsection. Under adopted §3.3705(n)(5)(B), the specified event is the later of: (i) the date on which the insurer receives notice of a contract termination as specified in paragraph (1)(B) of the subsection; or (ii) the effective date of the contract termination as specified in paragraph (1)(B) of the subsection. The Department has determined that adopted

§3.3705(n)(4) affords additional flexibility to hospitals, insurers, and facility-based physicians by permitting early communication between a facility and an insurer concerning pending terminations of contracts without requiring pre-termination disclosure by the insurer.

New §3.3705(n) is necessary because the notice implements the Insurance Code §§1301.158(a) and (c), 1301.1591(a) and (c), 1701.055(a)(2), 1301.0055(2), and 1301.007. The notice requirement in §3.3705(n) is necessary to place current and prospective insureds and group contract holders on notice of the increased potential that services received at the preferred provider facility in question may include services from nonpreferred provider facility-based physicians and therefore carry a greater risk of unanticipated balance bills.

The Insurance Code §1301.158(a) requires an insurer to provide to a current or prospective group contract holder or insured on request an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health care plans. The description must be in a format prescribed by the Commissioner and must include a current list of preferred providers. Section 1301.158(c) also specifies that an insurer may not use or distribute information for prospective insureds that is untrue or misleading. To the extent that an insurer uses its website to provide information concerning current preferred providers, §1301.158(a) and (c) authorizes the adoption of §3.3705(n).

Further, the Insurance Code §1301.1591(a) requires an insurer that maintains an Internet site to list on the site the preferred providers that insureds may use in

accordance with the terms of the insured's preferred provider benefit plan. The listing is required to identify those preferred providers who continue to be available to provide services to new patients, and under subsection (b) the site must be updated at least quarterly. Subsection (c) authorizes the Commissioner to adopt rules as necessary to implement the section and specifies that the rules may govern the form and content of the information required to be provided under subsection (a).

The Insurance Code §1701.055(a)(2) specifies that the Commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form: (i) violates the Insurance Code, a rule of the Commissioner, or any other law; or (ii) contains a provision that is unjust, encourages misrepresentation, or is deceptive. It is the Department's position that the use of a form that provides for the payment of benefits at a level of coverage that is different from the basic level of coverage if the insured uses a preferred provider would be unjust, encourage misrepresentation, and be deceptive if permitted to be used in conjunction with a listing of providers that the insurer has not updated in response to a substantial decrease in available preferred providers at a preferred provider facility. The inclusion of notice on the insurer's Internet website is necessary to prevent such a result.

The Insurance Code §1301.0055(2) requires the Commissioner to adopt network adequacy standards that ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health care services to insureds, and §1301.007 authorizes the Commissioner to adopt rules as necessary to: (i) implement Chapter 1301; and (ii) ensure reasonable accessibility and availability of

preferred provider services to residents of this state. Accurate communication concerning the accessibility and availability of preferred provider physicians at preferred provider facilities is crucial to implementing §1301.0055(2) and §1301.007 because the failure to communicate this information deprives the insured of the opportunity to investigate options that are less likely to result in the provision of nonpreferred provider services and the possibility of additional, unplanned balance billing expenses.

(xi) §3.3705(o). Section 3.3705(o) requires insurers to make certain disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services. Insurers must disclose how reimbursement of nonpreferred providers will be determined.

Further, if reimbursement is based upon data concerning usual, customary, or reasonable provider charges, the insurer must disclose: (i) the source of the data; (ii) how the data is used to determine reimbursements; and (iii) the existence of any applicable reductions. If reimbursement is based upon any amount other than full billed charges, the insurer must: (i) disclose that the insurer's reimbursement may be less than the billed charge; (ii) disclose that the insured may be liable to the nonpreferred provider for balance bill amounts; (iii) provide a description of the methodology used to determine the reimbursement amount; and (iv) provide a method for insureds to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

In addition to educating insureds both generally and specifically concerning the potential for unanticipated balance bills, the Department anticipates that the provision of

reimbursement methodology information may facilitate the insured's ability to mediate balance bill amounts owed to nonpreferred providers as contemplated in the Insurance Code §1467.054. Data collected by the Department indicates that insurers' allowable payment rates for nonpreferred providers varies significantly among insurers and by type of provider. *See Report of the Health Network Adequacy Advisory Committee, January 2009* at 19, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork09.doc.

Additionally, the Department has entered a disciplinary order against one large preferred provider benefit plan insurer based on allegations that: (i) the insurer's policy documents did not adequately define how it would determine out-of-network (nonpreferred provider) facility reimbursements; and (ii) those reimbursements were unreasonably low in context with representations made in advertising and policy documents. *See Commissioner's Order No. 08-0514*, June 13, 2008, at 2.

Based upon such information, the Department's position is that disclosure of the information required by §3.3705(o) is important to insureds' understanding of their coverage.

(xii) §3.3705(p). New §3.3705(p) authorizes insurers to designate preferred provider benefit plans using a network that complies with the network adequacy requirements for hospitals under §3.3704 without reliance upon an access plan as having an "Approved Hospital Care Network" (AHCN). A plan using a service delivery network that does not meet the requirements for hospitals under §3.3704 is required to disclose that the plan has a "Limited Hospital Care Network." The disclosure is

required: (i) on the cover page of any insurance policy, certificate of coverage, or outline of coverage using the network; and (ii) on the cover page of any nonelectronic provider directory describing the network.

The additional notice via the appropriate designation in new §3.3705(p) is necessary to implement the Insurance Code §§1301.158(a) and (c), 1701.055(a)(2), 1301.0055(2), and 1301.007. The designation requirement in §3.3705(p) is necessary to place current and prospective insureds and group contract holders on notice, as appropriate, of the increased potential that services received at hospitals under the preferred provider benefit plan may carry a greater risk of unanticipated balance bills due to the insurer's use of a preferred provider network that does not comply with network adequacy requirements for hospitals in the manner specified in §3.3704(e).

The Insurance Code §1301.158(a) requires an insurer to provide to a current or prospective group contract holder or insured on request an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health care plans. The description must be in a format prescribed by the Commissioner and must include a current list of preferred providers. Section 1301.158(c) also specifies that an insurer may not use or distribute information for prospective insureds that is untrue or misleading. It is the Department's position that disclosure by means of the designation specified in §3.3705(p) is necessary for compliance with §1301.158(a) and (c).

The Insurance Code §1701.055(a)(2) specifies that the Commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form: (i)

violates the Insurance Code, a rule of the Commissioner, or any other law; or (ii) contains a provision that is unjust, encourages misrepresentation, or is deceptive. It is the Department's position that the use of a form that provides for the payment of benefits at a level of coverage that is different from the basic level of coverage if the insured uses a preferred provider would be unjust, encourage misrepresentation, and be deceptive if permitted to be used without contemporaneous use of a designation as specified in §3.3705(p) to provide for additional notice to insureds and group contract holders concerning the scope of limitations on the plan's ability to provide accessible and available preferred provider hospital services in compliance with network adequacy standards for hospitals.

The Insurance Code §1301.0055(2) requires the Commissioner to adopt network adequacy standards that ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health care services to insureds, and §1301.007 authorizes the Commissioner to adopt rules as necessary to: (i) implement Chapter 1301; and (ii) ensure reasonable accessibility and availability of preferred provider services to residents of this state. Accurate communication concerning the accessibility and availability of preferred provider services in connection with hospital services is crucial to implementing §1301.0055(2) and §1301.007 because the failure to communicate this information deprives the insured of the opportunity to investigate options that are less likely to result in the provision of nonpreferred provider services and the possibility of additional, unplanned balance billing expenses.

The Department has changed §3.3705(p) to delete a duplicative section reference.

(xiii) §3.3705(q). New §3.3705(q) requires that a preferred provider benefit plan that is designated as an AHCN but loses its compliance status with the network adequacy requirements for hospitals notify the Department of such change if the noncompliant status is not corrected within 30 days of the insurer becoming noncompliant. Such insurer is additionally required to cease marketing the plan as an AHCN and to inform all insureds of such change of status at the time of renewal. The designation, notice, and marketing requirements in new §3.3705(q) will assist current and prospective insureds and group contract holders to assess the risk that a plan will not have available and accessible facility-based physicians at preferred provider hospitals as the insured compares plans in determining whether to select or renew a policy. The requirement will additionally assist the Department to monitor network adequacy status and help to prevent inappropriate, misleading, or deceptive marketing.

(xiv) §3.3708(e). Adopted §3.3708(e) requires an insurer to include a notice, along with each explanation of benefits, that the insured has the right to request information concerning negotiated rates for comparison purposes. The requirement applies when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured as specified in subsection (a) of the section. Upon the request of an insured, the insurer must furnish the median per-service amount the insurer has negotiated with preferred providers for the service

furnished, exclusive of cost sharing responsibilities of the insured, or notification that the claim was paid at this amount.

For an insured faced with unanticipated balance bills resulting from the need for emergency care or due to the failure of the insurer to provide an adequate network, §3.3708(e) is necessary to provide access to information to facilitate evaluation of the reimbursement made by the insurer. The information will also facilitate an insured in determining whether to request mediation as permitted under the Insurance Code §1467.054 for eligible claims. Even if mediation is not available, the information provided by the insurer could greatly assist an insured who wishes to contest an alleged unreasonable balance bill by a nonpreferred provider by allowing the insured to compare the physician or provider's charge to the average rate other providers have agreed with the insurer to use.

In response to comments that proposed §3.3708(e) requires the disclosure of inappropriate rate comparison standards and is administratively burdensome, the Department has changed §3.3708(e) and has deleted §3.3708(f) and (g). Proposed §3.3708(e) would have required the insurer to disclose on each explanation of benefits that the insured had the right to request three different categories of reimbursement data in relation to the claim for comparison purposes.

These comparison rates included: (i) the median per-service amount that the insurer has negotiated with preferred providers for the services furnished, or notification that the claim was paid at this amount; (ii) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits

provided by nonpreferred providers, or notification that the claim was paid at this amount; and (iii) the amount that would be paid under Medicare for the service.

The Department has deleted the requirements in proposed §3.3708(e)(2) and (3) in response to comments that such comparison rates were inappropriate and that the disclosure would be administratively burdensome. The comparison rate specified in proposed §3.3708(e)(2), the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers, is often going to be the rate at which the claim is actually paid. The Department also received comments indicating that this amount does not represent an appropriate comparison rate because the amount may be modified as a result of plan design rather than reflective of a market rate.

Similarly, the amount that would be paid under Medicare for the service, as required under proposed §3.3708(e)(3), is an inappropriate comparison rate according to the comments of some stakeholders because the amount is fixed pursuant to statute and does not represent the market rate. Based upon these comments, the Department has deleted proposed §3.3708(e)(2) and (3) to reduce the administrative burden associated with the disclosure of such comparison rates. As a result of these deletions, the Department has reorganized the content of proposed §3.3708(e) such that there are no longer any paragraphs to the subsection.

The Department has also changed proposed §3.3708(e) in response to the comment that there is limited space on an explanation of benefits form. Adopted §3.3708(e), therefore, requires that the insurer include the notice “along with,” rather

than “on” each explanation of benefits. Insurers will thus have greater flexibility in determining how to provide the notice as a result of this change.

The Department has also changed §3.3708(e) to delete the January 1, 2012 effective date proposed for the subsection. Pursuant to adopted §3.3701(a), the new and amended sections adopted by the Commissioner apply to any preferred provider benefit plan policy delivered, issued for delivery, or renewed on or after one year from the date of adoption. The Department has determined that it is reasonable to similarly extend the time for compliance with adopted §3.3708(e). Further, the Department has determined that it is no longer necessary to provide for an extended effective date for §3.3708(e) due to the reduced and more flexible requirements of the adopted subsection.

As a further result of the reduced and more flexible disclosure requirements, the Department has deleted §3.3708(f) and (g) and revised the section title to delete the reference to such waiver. The Department has determined that a waiver process to permit an additional six months for compliance is no longer necessary because the subsection no longer requires an insurer to make available on request comparison rate information based upon amounts paid by Medicare, a third-party payor. Instead, the insurer is only required to make available information concerning its own median negotiated rate. Further, the insurer is permitted to provide the underlying notice concerning availability of the information along with, rather than on, explanation of benefit forms. Because there is no longer a need to obtain third-party payment

information and to reconfigure explanation of benefit forms, there is a reduced need for a waiver process associated with the notice and disclosure requirement.

Network adequacy: contracting requirements. The Department has addressed contracting requirements necessary to support increased availability and accessibility of preferred benefit services and the network adequacy standards that are authorized by the Insurance Code §1301.0055 and §1301.007. The new and amended contracting requirements also support the network sufficiency requirement of the Insurance Code §1301.006. The new and amended contracting requirements are specified in: (i) §3.3703(a)(4); (ii) §3.3703(a)(23) and (24); (iii) §3.3703(a)(25); and (iv) §3.3703(a)(26). The new and amended provisions are necessary for the following reasons.

(i) §3.3703(a)(4). Adopted §3.3703(a)(4) retains the existing provision prohibiting a contract between an insurer and a hospital or institutional provider from requiring a physician or practitioner to enter into a preferred provider contract and clarifies that the prohibition does not apply to practice conditions other than conditions of membership or privileges.

The Department has changed proposed §3.3703(a)(4) in response to comments that proposed amendments to the paragraph would: (i) result in physicians and practitioners being forced into contracts with insurers at unreasonable rates; (ii) lead to economic credentialing of physicians at the expense of quality credentialing; (iii) place additional strain on both the contracting negotiations between insurers and hospitals and the negotiations concerning staff membership or hospital privileges between

hospitals and physicians; (iv) result in contract churning; (vi) impede efforts to attract new physicians and practitioners to Texas; and (vii) be impractical and administratively burdensome to implement.

Based upon all of these comments, the Department has determined that further consideration of the potential effects of amendments to the existing prohibition is appropriate and warranted and has, therefore, changed proposed §3.3703(a)(4). The Department is cognizant that individual and small group practices of physicians and practitioners may have little or no bargaining power in some situations. The Department has determined that it is possible that the proposed amendment to §3.3703(a)(4) could indirectly affect the staff membership or privileges of such individual and small group practices. The Department has, therefore, retained the existing prohibition but provided additional clarification as to the scope of the prohibition.

Adopted §3.3703(a)(4) clarifies that the prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges. For example, adopted §3.3703(a)(4) does not strictly prohibit that a contract between an insurer and a hospital include inducements designed to encourage network participation or good faith network negotiations by physicians. The prohibition also does not address the scope of permitted agreements between hospitals or institutional providers and physicians. During the public hearing on February 8, 2011, some commenters indicated that some hospitals do encourage or require physicians to participate in negotiations with insurers on a good faith basis. Adopted §3.3703(a)(4) does not address such requirements.

Adopted §3.3703(a)(4) is necessary to provide a basis from which insurers may improve accessibility and availability of preferred provider services to insureds under the plan while still affording a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners, institutional providers, and practitioners as required under the Insurance Code §1301.051(a).

(ii) §3.3703(a)(23) and (24). New §3.3703(a)(23) specifies that a contract between an insurer and a preferred provider may contain a provision requiring a referring physician or provider, or a designee, to disclose specified information to the insured concerning the referral as applicable. Under §3.3703(a)(23)(A), the referring physician or provider must disclose, as applicable, that the physician, provider, or facility to whom the insured is being referred is not a preferred provider. Under §3.3703(a)(23)(B), the referring physician or provider must disclose, as applicable, that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

New §3.3703(a)(23) is permissive in nature and does not apply to contracts between insurers and institutional providers. The provision clarifies the Department's position that such contract provisions are permitted. As a result, insureds may benefit from increased information concerning referrals. Such additional information will afford the insured an opportunity to consider whether to seek referral to a preferred provider and thereby reduce the potential for unanticipated balance bills from nonpreferred providers.

New §3.3703(a)(24) clarifies that, if used, a contract provision requiring disclosure of the nonpreferred status of the physician, provider, or facility to whom an insured is being referred is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care. The contract requirement also may not limit access to nonpreferred providers. New §3.3703(a)(24) is necessary to ensure that the benefits of the disclosures made pursuant to such a contractual provision do not result in delay of medically necessary care or interfere with the insured's freedom to elect to receive basic benefit care from nonpreferred providers should the insured desire to do so.

(iii) §3.3703(a)(25). New §3.3703(a)(25) requires that contracts between insurers and preferred providers include a requirement that the preferred provider comply with all applicable requirements of the Insurance Code §1661.005. Section 1661.005 requires physicians, hospitals, or other health care providers that receive an overpayment from an enrollee to refund the amount of the overpayment to the enrollee no later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made.

New §3.3703(a)(25) will reinforce this statutory requirement and help to ensure that overpayments are promptly refunded to insureds. Enforcement of an insured's rights under §1661.005 will reduce unnecessary negative financial consequences associated with receipt of care from within the insurer's network of preferred providers and provide an effective remedy for insureds alleging violations of §1661.005.

(iv) §3.3703(a)(26). Finally, adopted new §3.3703(a)(26) imposes new requirements for contracts between insurers and facilities. Under adopted §3.3703(a)(26), such contracts must require the facility to give notice to the insurer as soon as reasonably practicable but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer. This requirement is necessary to facilitate the insurer's ongoing responsibility to monitor the network(s) that support the insurer's preferred provider benefit plans for compliance with network adequacy requirements and take corrective action as needed. As such, adopted §3.3703(a)(26) is authorized under the Insurance Code §1301.0055 and §1301.007 and is consistent with the sufficiency requirement of the Insurance Code §1301.006.

As proposed, §3.3703(a)(26) specified additional requirements for contracts between insurers and facilities addressing requirements for the facility-based physicians providing services at the facility. Specifically, proposed §3.3703(a)(26) specified that such facility-based physicians must be required to: (i) make disclosure to the general public of the typical range of the physician's billed charges for professional services as specified in proposed §3.3712; and (ii) provide responsive information no more than annually to surveys of physician fees conducted by the Department or by an academic institution conducting the survey on behalf of the Department.

The Department has changed §3.3703(a)(26) in response to comments that the addition of new contracting requirements will: (i) place additional strain on both the contracting negotiations between insurers and hospitals and the negotiations

concerning staff membership or hospital privileges between hospitals and physicians; (ii) result in the unintended consequence of providers leaving an insurer's network; and (iii) create undue administrative burden for insurers, hospitals, physicians and practitioners.

A physician is required to provide an estimate of the charges for any health care service or supply on the request of a patient who is seeking services on an out-of-network basis or who does not have coverage under a government program, health insurance policy, or HMO evidence of coverage, pursuant to the Occupations Code §101.352(c). An insurer must provide comparable information, on request, for preferred provider charges under the Insurance Code §1301.158(d).

The Department has, therefore, determined that the benefits from the additional fee disclosure requirements specified in proposed §3.3703(a)(26)(B)(i) and (ii) do not, at this time, merit the strain upon provider negotiations and provider networks or the additional administrative burden that would possibly result from the requirements. As a result of these deletions, the Department has reorganized the content of adopted §3.3703(a)(26).

Also as a result of these deletions, the Department has deleted proposed new §3.3712. As proposed, §3.3712 specified professional services for which insurers must require public disclosure of billed charges under proposed §3.3703(a)(26)(B)(i). Because proposed §3.3703(a)(26)(B)(i) has not been adopted, proposed §3.3712 is no longer necessary.

Network adequacy: payment of certain basic benefit claims. The Department adopts new §3.3708 to establish minimum standards for certain basic benefit claims. Section 3.3708 applies to services provided by a nonpreferred provider when a preferred provider is not reasonably available to an insured, including circumstances: (i) requiring emergency care; (ii) when no preferred provider is reasonably available within the designated service area for which the policy is issued; and (iii) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider. In each of these circumstances, the insurer is required to pay the claim at the preferred benefit coinsurance level as required pursuant to the Insurance Code §1301.005(b) and §1301.155(b).

New §3.3708(b)(2) also requires the insurer to credit out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. This requirement is intended to protect the insured who does not voluntarily choose to obtain nonpreferred provider services by ensuring that the insured receives credit for actual out-of-pocket expenses in the same manner that the insured would receive such credit for services from a preferred provider. New §3.3708(b)(2) is consistent with the Insurance Code §1301.005 and §1301.069, which provide that, if an insured obtains out-of-network services from a nonpreferred provider due to an inadequate network or an emergency, the insured is entitled to the preferred level of benefits.

New §3.3708(c) requires that reimbursement of all nonpreferred providers be calculated pursuant to an appropriate methodology that meets specified criteria. The

methodology is required to: (i) be based on generally accepted industry standards and practices for determining customary billed charges for a service and to fairly and accurately reflect market rates, including geographic differences in costs, for those methods based upon usual, reasonable, or customary charges; (ii) be based on sufficient data to constitute a representative and statistically valid sample, if based on claims data; (iii) be updated at least annually; (iv) not use data that is more than three years old; and (v) be consistent with nationally recognized and generally accepted bundling edits and logic.

The reimbursement standards in §3.3708 are necessary to ensure that preferred provider benefit plan policies are offering meaningful and reasonably available basic benefits covered under the benefit package as specified in the Insurance Code §1301.005(a). It is the Department's position that the establishment of unreasonably low reimbursement rates for basic services that are based on inappropriate methodologies creates a barrier to the reasonable availability of basic services in a manner that is inconsistent with §1301.005(a) and that renders the underlying policy unjust under the Insurance Code §1701.055(a).

The standards established in §3.3708(c), while not setting reimbursement rates, will nevertheless help to ensure that reimbursement rates are based upon relevant, current, and statistically valid data and thus mitigate the potential unexpected balance billing to which insureds are subjected as a result of health care emergencies and inadequate networks. The standards will give physicians, providers, and insureds greater confidence that the methodologies underlying reimbursement determinations

are appropriate, and that terms used in preferred provider benefit plan documents will have consistent meanings as applied by different insurers. Further, the Department will benefit from clear standards to apply when reviewing the appropriateness of reimbursement methodologies used for nonpreferred providers.

New §3.3708(d) requires insurers to pay all covered basic benefits for services obtained from health care providers or physicians at the plan's basic level of coverage, regardless of whether the service is provided within the designated service area for the plan. This provision is necessary to ensure that health insurance policies do not restrict an insured's access to the basic health care services to which the insured is entitled as part of the benefit package as specified in the Insurance Code §1301.005 by limiting coverage to those services provided within the designated service area.

It is the Department's position that imposition of such a restriction by an insurer would reduce the insured's access to basic level services in a manner that would render the policy unjust as contemplated in the Insurance Code §1701.055(a)(2). Section 3.3708(d) reinforces the existing requirement specified in §3.3704(a)(1) that a preferred provider benefit plan is prohibited from requiring that a service be rendered by a particular hospital, physician, or practitioner in accordance with the Insurance Code §§1251.005, 1251.006, 1301.003, 1301.006, 1301.051, 1301.053 – 1301.055, 1301.057 – 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201.

New §3.3708(d) is also a necessary clarification to ensure that the adoption of §3.3704(g), which permits an insurer to define a service area on a smaller than

statewide basis, does not result in the improper reduction of an insured's access to basic level services.

Implementation related to HB 1030. In connection with HB 1030, §3.3704(a)(6) is amended. Existing §3.3704(a)(6) specifies that a preferred provider benefit plan is not considered unjust or unfairly discriminatory, and does not constitute a violation of specified provisions concerning access to practitioners and facilities, if: (i) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 30 percent less than the higher level of coverage; and (ii) a reasonable difference in deductibles is determined considering the benefits of each individual policy. HB 1030 amends the Insurance Code by adding §1301.0046 to mandate that the insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. Section 3.3704(a)(6) updates the specifications of the paragraph for greater consistency with this statutory requirement.

Changes to update and clarify. Additional amendments reflect and clarify the reorganized and updated content of the subchapter, including applicability.

Adopted §3.3701(a) is subdivided into two subsections to address the prospective application of the subchapter to policies delivered, issued for delivery, or renewed on or after May 19, 2012 and the remaining subsections are redesignated accordingly. Adopted §3.3701(a) also includes an exception clause to preclude ambiguity, confusion, or conflict between the general applicability date specified in the subsection and the more specific effective dates of provisions specified

elsewhere in the subchapter. The amendment to §3.3701(d), redesignated as §3.3701(e), updates the language concerning the severability of the subchapter's provisions and applications to clarify the scope of such severability.

The Department has changed §3.3701(a)(1) in response to comments concerning the administrative burdens associated with implementation of the new adopted requirements of the subchapter. As proposed, §3.3701(a)(1) specified that the subchapter would apply to a policy delivered, issued for delivery, or renewed on or after June 1, 2011. The Department has changed this date to May 19, 2012 to provide sufficient time for implementation.

Adopted amendments to §3.3702 add definitions for words and terms used in amendments to the subchapter to clarify the scope of such usage. These words and terms include: (i) *billed charges* at paragraph (1); (ii) *facility* at paragraph (4); (iii) *facility-based physician* at paragraph (5); (iv) *NCQA* at adopted paragraph (12); (v) *nonpreferred provider* at paragraph (13); (vi) *pediatric practitioner* at adopted paragraph (14); (vii) *rural area* at adopted paragraph (21); and (viii) *urgent care* at adopted paragraph (24).

The Department has changed proposed §3.3702 in response to comments that the terms *general practitioner* and *specialist* were no longer used in the subchapter. The Department has, therefore, deleted the proposed definitions for these terms at proposed paragraphs (6) and (24), respectively, and paragraphs throughout the section have been changed in accordance with reorganized content of the section.

The Department has changed proposed §3.3703(a)(20)(A)(i) to update the clause such that successor codes may be used in providing fee schedule information to preferred providers seeking information under the paragraph.

The adoption includes new catchlines in each subsection of §3.3704 to better reflect the organization and content of the section with respect to fairness requirements, payment of nonpreferred providers, prohibited retaliatory action, access to certain institutional providers, network requirements, network monitoring and corrective action, and service areas.

The Department deletes existing §3.3704(a)(10), which provides that if covered services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as preferred providers. Because the paragraph is largely duplicative of statutory language in the Insurance Code §1301.005(b) and (c), the Department has determined that retention of the paragraph in this subsection is unnecessary. The remaining paragraphs in §3.3704(a) are redesignated accordingly.

The Department has amended the title of §3.3705 to better reflect the content of the section. The amendment revises the title to “Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.”

Further, the Department has added catchlines to existing subsections (a) – (d) of §3.3705 to better reflect the content of those subsections concerning readability, disclosure of terms and conditions of the policy, filing requirements, and promotional disclosure requirements. Section 3.3705(b)(12) is amended by deleting the term “and”

at the end of the paragraph due to the addition of a paragraph to the subsection. An amendment to §3.3705(b)(13) recognizes that an insurer may have more than one service area and accommodates an additional paragraph in the subsection by substituting a semi-colon and the word “and” for the period at the end of the paragraph.

Filing requirements concerning preferred provider listings are addressed and updated in the amendment to §3.3705(c). This amendment permits the filing of such provider listings to be made electronically at a specified email address in a format acceptable to the Department or by submission of an Internet website address at which the Department may view the listing. For insurers choosing to file the listings nonelectronically, the amendment additionally specifies the address to which nonelectronic filings are required to be submitted.

As part of the reorganization of the content of §3.3705, existing subsection (e) is redesignated as subsection (g), and a catchline is added to the subsection to reflect that the subsection addresses the prohibition on the distribution of untrue or misleading information. The Department has also deleted existing §3.3705(f), concerning the distribution and filing of current lists of preferred providers. The distribution of such lists is addressed in new §3.3705(h) - (j).

The Department also has deleted existing §3.3705(g), which specifies that insurers must provide to each insured a toll-free number to be maintained 50 hours per week during business hours that the insured may call to obtain current listings of preferred providers, unless exempted by statute or rule. The provision of this information is addressed in new §3.3705(h).

To better reflect the organization and content of §3.3706, the Department has amended existing subsections (a) and (b) to add catchlines to emphasize that the subsections address access to designation as a preferred provider and withholding preferred provider designation, respectively. The Department has redesignated existing subsections (c) and (d) as subsections (d) and (e), respectively, to accommodate the addition of new subsection (c). The Department also has added catchlines to these subsections to emphasize that the subsections address notice of termination of a preferred provider contract and review of a decision to terminate.

The Department has redesignated existing §3.3706(d)(3) as subsection (f) and added a catchline to the subsection to emphasize that the subsection addresses completion of the review process. The Department has redesignated existing subsection (e) as subsection (g), accordingly, and added a catchline to the subsection to emphasize that the subsection addresses the expedited review process. Existing subsection (e)(3) is redesignated as subsection (h), and a catchline is added to the subsection to emphasize that the subsection addresses completion of the expedited review process. The Department has redesignated existing subsections (f) and (g) as subsections (i) and (j), respectively, to accommodate the addition of subsections to the section. The Department has also amended §3.3706(a) by adding the phrase “subject to subsection (b) of this section” to clarify the manner in which the two subsections are intended to work together.

Amendments throughout the rule update statutory references that have changed as a result of the Legislature’s nonsubstantive reorganization of the Insurance Code and

Occupations Code. These updates are made in adopted §§3.3701(c); 3.3702(3), (7) – (12), (15) – (20), (22) and (24); 3.3703(a)(11) - (15), (17), and (18), (b), and (c)(1) and (2); and 3.3704(a), (a)(1), (4), (5), and (9), and (d). A proposed update of a reference in §3.3704(a)(1) to the Insurance Code §1301.004 was not adopted because the section has been redesignated.

Amendments to update or provide greater specificity concerning internal references in the subchapter are adopted at §§3.3703(a)(8) and (19); 3.3704(a)(10); 3.3705(a); 3.3706(d)(2); and 3.3706(j)(2). The proposed update of the reference in §3.3706(j)(2) to §3.3703(a)(17) is not adopted because the update is no longer appropriate.

Additional amendments for clarity**,** ease of reading, and correction of punctuation, capitalization, and grammar are adopted throughout the rule, as well. These amendments appear in adopted §§3.3701(c) and (d); 3.3702(3), (6) – (11), (15 – 20), (22), and (24); 3.3703(a), (a)(1) - (3), (5) – (20), (20)(A), (20)(A)(i) and (iii), (20)(B) - (D), (F), (G)(i)(I) – (IV), and (H), and (22), (b), and (c)(1) and (2); 3.3704(a), (a)(1) – (6), (8) and (9), (b) - (d); 3.3705(a), (b), (b)(9), (c) and (d); and 3.3706(a), (a)(1) – (4), (b), (b)(1) and (2), (2)(A) – (E), (d), (d)(2), (e), (e)(1), (f), (g), (g)(2), (i), (i)(1) and (2), (j), and (j)(1) – (3).

3. HOW THE SECTIONS WILL FUNCTION.

Adopted §3.3701 specifies the applicability of the subchapter, including severability. Adopted §3.3702 specifies the meaning of words and terms when used in

the subchapter, unless the context clearly indicates otherwise. Adopted §3.3703 specifies requirements, prohibitions, and permitted provisions that apply to contracts between insurers and preferred providers as specified in the section.

Adopted §3.3704(a) specifies required conditions necessary for a preferred provider benefit plan to operate without being considered: (i) unjust under the Insurance Code §§1701.002 – 1701.005; §§1701.051 – 1701.060; §§1701.101 – 1701.103; and §1701.151; (ii) unfairly discriminatory under the Insurance Code Chapter 542, Subchapter A, or §§544.051 - 544.054; or (iii) in violation of §§1451.001, 1451.053, 1451.054 or §§1451.101 – 1451.127. Amended §3.3704(b) specifies a requirement concerning nondiscrimination in the prompt and efficient payment of nonpreferred providers.

Amended §3.3704(c) specifies a prohibition against retaliatory action by an insurer against an insured. Amended §3.3704(d) specifies accessibility requirements concerning certain institutional providers. Adopted §3.3704(e) specifies network requirements and local market adequacy requirements applicable to a preferred provider benefit plan. Amended §3.3704(f) specifies an insurer's responsibility for ongoing monitoring and corrective action necessary to ensure network adequacy. Amended §3.3704(g) specifies the manner in which an insurer may define the service area(s) applicable to a preferred provider benefit plan.

Adopted §3.3705 specifies requirements applicable to an insurer's communications with and required disclosures to current and prospective insureds and group contract holders. These requirements address: (i) readability; (ii) disclosure of

the terms and conditions of the policy; (iii) filing requirements; (iv) promotional disclosures; (v) Internet website disclosures; (vi) provision of a notice of rights; (vii) a prohibition concerning untrue or misleading information; (viii) access to and updates, content, and provision of preferred provider listings; (ix) reliance upon provider listings; (x) provision of notice concerning the use of an access plan; (xi) provision of notice concerning a substantial decrease in the availability of certain preferred providers; (xii) disclosures concerning the reimbursement of basic benefit services; (xiii) use of plan designations; and (xiv) communications regarding a plan that no longer complies with network adequacy requirements for hospitals.

Outline of coverage requirements applicable to individual accident and health insurance policies are set forth in 28 Tex. Admin. Code §3.3092. Outline of coverage requirements specific to preferred provider benefit plans such as new §3.3705(f) are in addition to existing requirements.

Adopted §3.3706 specifies requirements concerning access to designation as a preferred provider, decisions to withhold the designation, credentialing, and the notice and review process related to terminations of preferred provider contracts or participation rights.

Adopted §3.3707 specifies requirements and procedures related to a waiver from network adequacy requirements due to failure to contract in a local market. Adopted §3.3708 specifies requirements concerning the payment of certain basic benefit claims and related disclosures. Adopted §3.3709 specifies requirements related to an annual report concerning network adequacy and, as applicable, an access plan.

New §3.3710 specifies but does not limit the sanctions that the Commissioner may impose, after notice and opportunity for hearing, upon a determining that an insurer's preferred provider service delivery network and access plan, if any, are inadequate. Adopted §3.3711 specifies the geographic regions that an insurer is permitted to use in defining a smaller than statewide service area as described in §3.3704(g)(1). Adopted §3.3713 specifies requirements concerning an insurer's submission of a plan and collection and analysis of information concerning the effects of undercompensated care.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comments: Statutory Authority, Consistency with SB 1731 and HB 2256.

Comment: A commenter asserts that the Department's proposal far exceeds the statute and is contrary to the intent and design of SB 1731 and HB 2256. The commenter states that SB 1731 is the omnibus transparency bill and HB 2256 is the first real balance billing consumer relief legislation. The commenter opines that regulation affecting the breadth of the health care delivery system should not be done by a regulatory fiat but through the legislative process, and the commenter asserts that many sections of the rule are not directed by the Legislature.

The commenter further opines that whereas general rulemaking authority for the proposal can be debated and the citation of statutory authority included in the Department's proposal with respect to consumer protection is subject to interpretation, the proposal is not authorized by HB 2256. According to the commenter, HB 2256

contains a small section related to network adequacy that has resulted in expansive and incredibly broad rules.

Another commenter questions the statutory basis for a number of sections that do not relate to health plan network adequacy.

Agency Response: This response addresses the following points: (i) the Department does not agree that the proposal exceeds the statute; (ii) the Department disagrees that the proposal is contrary to SB 1731 and HB 2256; (iii) the Department does not agree that these rules have been done by regulatory fiat; and (iv) the Department agrees that statutory authority is subject to interpretation.

(i) *The Department does not agree that the proposal exceeds the statute.* While the Department disagrees that the proposal exceeds the statute, the Department does agree that the proposed amendments and new sections are not limited to those necessary to implement the Insurance Code §1301.0055, enacted under HB 2256 and requiring the Department to adopt network adequacy standards. The Department's position is that proposed §§3.3701 – 3.3713 are not limited in statutory basis to the provisions enacted under HB 2256 or SB 1731.

As explained in the Department's proposal, §§3.3701 – 3.3713 rely upon an extensive number of statutory provisions. These statutory provisions include: (i) the Insurance Code §§521.102, 544.002(a)(2), 544.052, 1301.0046, 1301.005, 1301.0055, 1301.006, 1301.007, 1301.051, 1301.058, 1301.069, 1301.155(b), 1301.158(b) and (d), 1301.159, 1301.1591, 1301.161, 1451.053, 1451.054(a), 1451.104(a) and (b), 1456.003(c), 1456.007, 1467.051(a), 1467.053(d), 1467.054(a), 1661.005,

1701.055(a)(2), and 36.001; (ii) the Health and Safety Code §324.101(d); and (iii) the Occupations Code §101.352(c).

Due to the general nature of this comment concerning statutory authority, this response will provide analysis concerning four of the provisions included in the Department's proposal for which the Department relied upon more extensive authority than the single provision in the Insurance Code §1301.0055. These provisions are: (a) §3.3703(a)(26); (b) §3.3705(b)(14); (c) §3.3705(k); and (d) §3.3706(c).

(a) §3.3703(a)(26). Proposed §3.3703(a)(26) would impose new requirements for contracts between insurers and facilities. Under proposed §3.3703(a)(26)(A), such contracts must require the facility to give notice to the insurer as soon as reasonably practicable, but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer.

Section 3.3703(a)(26)(A) was proposed in implementation of the Insurance Code §§1301.005(a), 1301.0055(2), 1301.006, 1301.007, and 36.001. The Insurance Code §1301.005(a) requires that an insurer offering a preferred provider benefit plan ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area. The Insurance Code §1301.0055(2) requires the Commissioner to adopt by rule network adequacy standards that ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds.

The Insurance Code §1301.006 requires that an insurer that markets a preferred provider benefit plan 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 health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

The Insurance Code §1301.007 authorizes the Commissioner to adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to Texas residents. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

As stated in the Department's proposal, §3.3703(a)(26)(A) was proposed to facilitate an insurer's ongoing responsibility to monitor the network(s) that support the insurer's preferred provider benefit plans for compliance with network adequacy requirements and take corrective action as needed, as necessary for an insurer's compliance with §1301.005(a) and §1301.006. As such, §3.3703(a)(26)(A) was proposed in direct furtherance of network accessibility and availability standards and therefore proper pursuant to the Insurance Code §§1301.0055(2), 1301.007, and 36.001.

Proposed §3.3703(a)(26)(A) is also necessary to facilitate an insurer's ability to provide notice to current and prospective insureds and group contract holders in

compliance with adopted §3.3705(n) concerning substantial decreases in the availability of preferred providers.

The Department has changed §3.3703(a)(26) in response to other comments as explained in the response to comments concerning §3.3703(a)(26) of this adoption order. Proposed §3.3703(a)(26)(A) is adopted as §3.3703(a)(26). Requirements proposed under §3.3703(a)(26)(B) are not adopted and are not, therefore, addressed in this response.

(b) §3.3705(b)(14). The Department proposed §3.3705(b)(14) to require insurers to provide current and prospective insureds and group contract holders with information regarding network demographics for each service area, for plans not offered on a statewide basis, or for each of the 11 regions specified in §3.3711 of the subchapter, for plans offered on a statewide basis.

Proposed §3.3705(b)(14) specifies that the network demographic information must be updated at least annually Proposed §3.3705(b)(14)(A) requires an insurer to disclose the number of insureds in the service area or region. Proposed §3.3705(b)(14)(B) further requires that an insurer make certain disclosures of demographic information by provider area of practice. These disclosures include the number of preferred providers, as well as an indication of whether an active access plan pursuant to §3.3709 of the subchapter applies to the services furnished by particular classes of provider in the service area or region and how such access plan may be obtained or viewed, if applicable.

Proposed §3.3705(b)(14)(C) specifies required disclosures of demographic information concerning hospitals. This information includes the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 applies to hospital services in the service area or region and how the access plan may be obtained or viewed.

Section 3.3705(b)(14) was proposed in implementation of the Insurance Code §§ 1301.158, 1301.005(a), 1301.055(2), 1301.006, 1301.007, and 36.001. Section 1301.158(b) requires an insurer to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must be in a readable and understandable format as prescribed by the Commissioner and must include a current list of preferred providers. Each of the other statutory provisions is explained in the previous section of this response concerning the statutory basis for §3.3703(a)(26) and is not repeated here.

As stated in the Department's proposal, disclosure of network demographic information is necessary to assist current and prospective insureds and group contract holders to compare plans and make informed decisions concerning the selection or renewal of a plan and is consistent with the requirements of the Insurance Code §1301.158(b). Such information is also necessary to assist the insureds and group contract holders to more accurately assess the risk of unanticipated balance bills associated with reliance upon a particular plan and the network that supports such plan.

Further, the Department also anticipates that additional transparency concerning this network demographic information will incentivize insurers to contract with adequate numbers of physicians and providers as a matter of competition. As such, §3.3705(b)(14) is adopted in furtherance of network accessibility and availability standards and therefore proper pursuant to the Insurance Code §§ 1301.005(a), 1301.0055(2), 1301.006, 1301.007, and 36.001.

The Department has changed §3.3705(b)(14) in response to other comments as explained in the response to comments concerning §3.3705(b)(14) of this adoption order. However, changes to adopted §3.3705(b)(14) will address the same purposes as those explained previously with respect to the provision and do not alter the basis of the underlying statutory authority.

(c) §3.3705(k). The Department proposed new §3.3705(k) to clarify the Department's position that an insured should be able to rely upon information recently obtained from an insurer or the insurer's designee concerning the status of preferred providers in accessing covered services at the preferred level of benefits.

Subsection (k) requires insurers to pay a claim for services rendered by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that: (i) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in a provider listing or provider information on the insurer's website; (ii) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by

its insureds; (iii) the provider listing or website information was obtained not more than 30 days prior to the date of services; and (iv) the provider listing or website information obtained indicates that the provider of the services is a preferred provider within the insurer's network.

Section 3.3705(k) implements the Insurance Code §§1301.005(a) and (b), 1301.0055(2), 1301.006, 1301.007, 1701.055(a)(2), and 36.001. The Insurance Code §1301.005(b) provides that if services are not available through a preferred provider within the service area, an insurer is required to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

The Insurance Code §1701.055(a)(2) authorizes the Commissioner to disapprove or, after notice and hearing, withdraw approval of a form if the form contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive, subject to the exception specified in subsection (d) of the section. Each of the other statutory provisions is explained in the previous section of this response concerning the statutory basis for §3.3703(a)(26) and is not repeated here.

Section 3.3705(k) is necessary to ensure the reasonable accessibility and availability of preferred provider services as required pursuant to the Insurance Code §1301.005(a) and (b) and §1301.006 and is authorized pursuant to and in furtherance of the Insurance Code §§1301.0055(2), 1301.007 and 36.001. As explained in the proposal, the Department has previously entered a consent order against one large

insurer based on allegations that the insurer's listings of its contracted providers were not accurate. *See Commissioner's Order No. 08-0514*, June 13, 2008 at 3.

It is the Department's position that if an insured reasonably relies on an insurer's representation that a physician or provider is available to insureds as a preferred provider, but the physician or provider is, in fact, not contracted with the insurer, then the insurer has failed to make preferred provider benefits reasonably available to the insured. In such an instance, it is the Department's position that the insured is entitled to the protections of the Insurance Code §1301.005(b).

Subsection (k) is also necessary to ensure that the underlying policy is not unjust in application, consistent with the requirements of the Insurance Code §1701.055(a)(2). It is the Department's position that a health insurance policy providing for different levels of benefits depending upon the use of preferred providers is not just if the insured relies upon the representations of the insurer as specified in §3.3705(k) in order to access preferred benefits only to learn that the directory information is inaccurate. Payment of benefits by the insurer in such a case at the lower basic benefit level rather than the preferred benefit level would unjustly frustrate the purpose of differentiating between levels of benefits in the first place and place the cost of inaccurate information on the insured who is in no way responsible for the inaccuracy.

(d) §3.3706(c). The Department proposed new §3.3706(c) to require insurers to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. The credentialing standards must, at a minimum, meet the standards promulgated by the National

Committee for Quality Assurance (NCQA) or URAC to the extent that those standards do not conflict with other laws of this state. Additionally, there shall be a presumption of compliance with credentialing requirements if the insurer has received nonconditional accreditation or certification by the NCQA, the Joint Commission, the American Accreditation HealthCare Commission, the URAC, or the Accreditation Association for Ambulatory Health Care.

Section 3.3706(c) is adopted in implementation of the Insurance Code §§1301.006, 1301.007, 1701.055(a)(2), and 36.001. Section 1701.055(a)(2) is explained in the previous section of this response concerning the statutory basis for §3.3705(k). The remaining statutory provisions are explained in the previous section of this response concerning the statutory basis for §3.3703(a)(26). None of these explanations are repeated here.

New §3.3706(c) will ensure that the service delivery network of preferred providers is appropriately qualified to provide the benefit package required under the health insurance policy, a necessary requirement in a policy that provides for different levels of coverage depending upon the use of preferred providers. It is the Department's position that the use of a process for the selection and retention of physicians and providers that are appropriately credentialed is necessary to meet the "adequate personnel" requirement of §1301.006. As such, §3.3706(c) is authorized pursuant to the Insurance Code §1301.007 and §36.001.

Section 3.3706(c) is also necessary to ensure that the policy is just as contemplated in the Insurance Code §1701.055(a)(2). The Department's position is that

a policy that provides for different levels of benefits depending upon the use of preferred providers would be unjust if the insurer's preferred provider network were inadequately credentialed. For example, the policy would be unjust if the insurer's preferred provider network included only preferred providers selected on the basis of economic considerations without regard to provider credentials.

(ii) The Department disagrees that the proposal is contrary to the intent and design of SB 1731 and HB 2256. The Department does not agree that the proposal is contrary to the intent and design of SB 1731 and HB 2256. The commenter does not specify the manner in which the commenter finds the proposed rules to be inconsistent with the intent and design of the two bills. This response, therefore, includes a brief analysis of the intent and design of the bills and the Department's response concerning why four of the provisions included in the Department's proposal are not inconsistent with HB 2256 and SB 1731. For consistency with the previous portion of this response, the provisions thus addressed are: (a) §3.3703(a)(26); (b) §3.3705(b)(14); (c) §3.3705(k); and (d) §3.3706(c).

Bill analyses for both SB 1731 and HB 2256 contain information addressing the intent and design of the bills. The House Research Organization's Bill Analysis of May 21, 2007 provides the following background to SB 1731:

> "Supporters say: SB 1731 would help promote transparency in the health care system. The bill represents a beneficial step in providing information to improve patient care and the patient-physician relationship. It would better educate consumers of health care about the actual costs and payment obligations for health care. Patients need accurate, current, and honest information on co-pays, deductibles, and health plan networks to make decisions in today's health care market, especially as health savings

> accounts become more prevalent. In addition, the bill would help employers by providing information to help their covered employees more responsibly utilize their health care options." TEXAS HOUSE RESEARCH ORGANIZATION, BILL ANALYSIS, SB 1731, 80th Leg., R.S. (May 21, 2007).

Further, as previously stated in the reasoned justification section of this adoption order, the bill analysis for HB 2256 includes the following statement of intent:

> *"Balance billing is the practice of physicians billing patients for the portion of medical expenses not covered by the patient's insurance. Most commonly, this occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice. An enrollee who is admitted into one of these facilities for a procedure or an emergency is ultimately responsible for an unexpected bill. Currently, there is no remedy for this bill other than the patient attempting to set up a payment plan with the facility-based physician."* TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, "Author's/Sponsor's Statement of Intent") HB 2256, 81st Leg., R.S. (May 22, 2009).

Collectively, the provisions of SB 1731 and HB 2256 establish a framework for a new level of transparency concerning insurers, facilities, and physicians with respect to medical and health care service billing, reimbursement, and the insured's potential personal liability for medical and health care services provided by nonpreferred providers.

The provisions also establish a greater level of transparency concerning the adequacy of networks used by preferred provider benefit plans and the status of facilities and facility-based physicians as either preferred or nonpreferred providers. HB 2256 further establishes a process for mediation of certain out-of-network claims as an additional possible remedy for insureds that receive a medical care service or supply

from a facility-based physician in a hospital that is a preferred provider under the insured's preferred provider benefit plan.

Consistency between the provisions of HB 2256 and SB 1731 concerning transparency and network adequacy requirements and the Department's proposal is as follows.

(a) §3.3703(a)(26). Adopted §3.3703(a)(26) imposes new requirements for contracts between insurers and facilities. Such contracts must require the facility to give notice to the insurer as soon as reasonably practicable, but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer.

As stated previously in this response, the Department has changed §3.3703(a)(26) in response to other comments, but the purpose of the paragraph, to facilitate an insurer's ongoing responsibility to monitor its network(s) for compliance with network adequacy requirements, take corrective action as needed, and provide notice to current and prospective insureds and group contract holders concerning a substantial decrease in the availability of preferred providers, remains unchanged. Adopted §3.3703(a)(26) is not inconsistent with SB 1731 and HB 2256 because it directly facilitates improved communications between an insurer and a preferred provider facility concerning the availability and accessibility of preferred facility-based physicians, as well as related communications from the insured to current and prospective group contract holders.

Similarly, SB 1731, SECTION 11, established disclosure requirements for insurers concerning the status of facility-based physicians as preferred or nonpreferred providers of a health benefit plan. See, e.g., TEX. INS. CODE §1456.003(a) (requiring a preferred provider health benefit plan to provide notice to enrollees that a facility-based physician may not be included in the plan's provider network), and TEX. INS. CODE §1456.003(c) (requiring a preferred provider benefit plan to clearly identify, in a separate and conspicuous manner in any provider network directory or website directory, any health care facilities within the provider network in which facility-based physicians do not participate in the health benefit plan's provider network).

Likewise, HB 2256, SECTION 4, imposed disclosure requirements upon facilities concerning the status of facility-based physicians as participants with an enrollee's health benefit plan. See TEX. HEALTH & SAFETY CODE §324.101(a)(6)(B). Adopted §3.3703(a)(26) directly facilitates compliance with these disclosure requirements of SB 1731 and HB 2256.

(b) §3.3705(b)(14). Adopted §3.3705(b)(14) requires insurers to provide current and prospective insureds and group contract holders with information regarding network demographics for each service area, for plans not offered on a statewide basis, or for each of the 11 regions specified in §3.3711 of the subchapter, for plans offered on a statewide basis. The requirement includes disclosure of the existence of an access plan with respect to specified preferred provider services, including hospital services, as applicable, as well as an indication of how such access plan may be obtained or viewed.

As stated previously in this response, the Department has changed §3.3705(b)(14) in response to other comments, but the purpose of the paragraph remains unchanged. Adopted §3.3705(b)(14) will assist current and prospective insureds and group contract holders to compare plans, make informed decisions concerning the selection and renewal of a plan, and more accurately assess the risk of unanticipated balance bills associated with reliance upon a particular plan and its network(s). The increased transparency among plans will also be an incentive for plans to improve and maintain adequate networks. Adopted §3.3705(b)(14) is not inconsistent with SB 1731 and HB 2256 because it provides for enhanced transparency concerning the adequacy of a preferred provider network and facilitates the comparison of information among and between plans.

SB 1731, SECTIONS 8 and 9, respectively, add reporting and disclosure requirements for insurers to facilitate the comparison of information among and between plans. *See,* e.g., TEX. INS. CODE §38.355(b) (mandating the Department to collect health care reimbursement rate data from an insurer in a uniform format to permit comparison of reimbursement rate data). *See* also TEX. INS. CODE §1301.009(c) (requiring the Department to make annual report information submitted by an insurer publicly available on the Department's Internet website in a user-friendly format to permit direct comparison of the financial and other data submitted by the insurers under the section).

HB 2256, SECTION 4, addressed enhanced transparency concerning the adequacy of a preferred provider network by imposing disclosure requirements upon

facilities concerning the status of facility-based physicians as participants with an enrollee's health benefit plan. See TEX. HEALTH & SAFETY CODE §324.101(a)(6)(B).

Adopted §3.3705(b)(14) will further the transparency requirements of SB 1731 and HB 2256 by providing additional network demographic information for comparison by current and prospective insureds and group contract holders.

(c) §3.3705(k). Section 3.3705(k) requires insurers to pay a claim for services rendered by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that the insured reasonably relied upon a recently obtained preferred provider listing or preferred provider information on the insurer's website. The purpose of the subsection is to ensure the availability and accessibility of preferred provider services and to ensure that the underlying health insurance policy of a preferred provider benefit plan is not unjust in application based upon the inaccurate representations of the insurer concerning the status of a physician or provider. New §3.3705(k) is not inconsistent with SB 1731 and HB 2256 because it supports accurate transparency concerning the status of a physician or provider as a preferred or nonpreferred provider with an insurer's network.

Similarly, SB 1731, SECTION 14, requires an insurer to provide to an insured, on request, information concerning whether a physician or health care provider participates in the insurer's network. *See* TEX. INS. CODE §1301.158(d). Likewise, HB 2256, SECTION 4, addresses enhanced transparency concerning status as a participant in an insurer's network by imposing disclosure requirements upon facilities concerning the

status of facility-based physicians as participants with an enrollee's health benefit plan. See TEX. HEALTH & SAFETY CODE §324.101(a)(6)(B).

New §3.3705(k) will support the transparency requirements in SB 1731 and HB 2256 concerning network participant status by ensuring that an insured's reasonable reliance upon recently obtained information concerning a physician or provider's status as a preferred or nonpreferred provider with the insurer's network is not frustrated via the provision of inaccurate information.

(d) §3.3706(c). New §3.3706(c) requires an insurer to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. The credentialing standards must, at a minimum, meet the standards promulgated by the NCQA or URAC to the extent that those standards do not conflict with other laws of this state.

The purpose of new §3.3706(c) is to ensure that the service delivery network of preferred providers is appropriately qualified to provide the benefit package required under the health insurance policy. This credentialing requirement further ensures that the underlying health insurance policy is not unjust due to the use of inadequately credentialed providers on the preferred provider panel that must be used by the insured in order to access the higher level of coverage. New §3.3706(c) is not inconsistent with SB 1731 or HB 2256 because the subsection will result in greater transparency concerning selection and retention of preferred providers due to the minimum standards with which the insurer will be required to comply.

Similarly, SB 1731, SECTION 1, addresses transparency requirements concerning quality of care information. *See*, e.g., TEX. HEALTH & SAFETY CODE §324.051(c)(1) (requiring the inclusion of an Internet link for consumers to access quality of care data in the consumer guide to health care to be made available on the Department of State Health Services Internet website).

HB 2256, SECTION 2, requires the Commissioner to adopt network adequacy standards that ensure availability of, and accessibility to, a full range of contracted physicians and health care providers. *See* TEX. INS. CODE §1301.0055(2).

New §3.3706(c) supports SB 1731's transparency measures concerning quality of health care information by ensuring that insurers use a documented process for the selection and retention of preferred providers that complies with minimum standards of credentialing. New §3.3706(c) supports HB 2256 by including this quality of health care credentialing requirement in the network adequacy standards with which an insurer must comply in selecting and retaining the providers that comprise the insurer's network.

(iii) The Department does not agree that these rules have been done by regulatory fiat because the rules are a product of both the legislative and agency rulemaking process. The Department disagrees that the proposed amendments to §§3.3701 – 3.3706 and proposed new §§3.3707- 3.3713 constitute a regulatory fiat. *Black's Law Dictionary* defines a *fiat* as "an order or decree, esp. an arbitrary one relating to a routine matter such as scheduling." *Black's Law Dictionary*, *copyright 2009, page 700.*

By contrast, as already explained in this response, the Department's proposal implements and supports broad legislative requirements by establishing a framework for intelligent decision-making by current and prospective insureds and group contract holders concerning: (i) the selection and renewal of a preferred provider benefit plan; (ii) the selection of physicians and providers; and (iii) the treatment of unanticipated balance bills. *See*, e.g., §3.3705(b)(14) (requiring an insurer to provide network demographic information for use by current and prospective insureds and group contract holders); and §3.3705(k) (requiring an insurer to pay a claim for services rendered by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates reasonable reliance upon a recently obtained preferred provider listing or preferred provider information on the insurer's website).

It is the Department's position that the proposed amendments and new sections are as broad as necessary to accomplish the overall objectives of the statutes relied upon by Department in making the proposal, including but not limited to SB 1731 and HB 2256, as well as the objectives of the agency in making the proposal.

Further, the Department disagrees that the proposal represents an arbitrary fiat because the Department solicited extensive feedback from stakeholders prior to publishing the proposal. To obtain comments, the Department made an informal posting on its website of a concept paper and proposed revisions to the rules governing preferred provider benefit plans on April 23, 2010. The Department held a meeting to discuss the drafts on May 5, 2010. After consideration of comments received, the Department made a second informal posting on its website of proposed revisions to the

rules and an estimate of anticipated costs to comply with the revised rules on September 13, 2010. In making the posting, the Department requested comments on the substance of the draft rules, the accuracy of the Department's estimates of costs to comply with the draft rules, and input on what costs certain draft provisions would entail.

A second informal stakeholder meeting was held to discuss the draft rules and potential costs on September 21, 2010. The Department next published the proposed amendments and new sections in the January 28, 2011 issue of the *Texas Register* (36 TexReg 333) and invited additional public comment. A separate and additional notice of the public hearing was submitted to the Office of the Secretary of State on January 14, 2011 for publication in the January 28, 2011 issue of the *Texas Register*. The notice specified the availability of the Department's proposal on the Department's Internet website by means of Internet link effective January 14, 2011. A public hearing concerning the proposal was held on February 8, 2011, and both oral and written comments were provided for the Department's consideration. At every stage of this process, the Department made changes to improve the rule in response to stakeholder input. For all of these reasons, the Department disagrees that the proposed rules represent a regulatory fiat.

(iv) *The Department agrees that statutory authority is subject to interpretation.* The Department does agree that statutory authority is subject to interpretation. One of the roles of a regulatory agency is to interpret statutes. Specifically, the Administrative Procedure Act defines the term *rule* by reference to a state agency as follows:

(A) means a **state agency statement** of general applicability that:

(i) implements, interprets, or prescribes law or policy; or
(ii) describes the procedures or practice requirements of a state agency;
(B) includes the amendment or repeal of a prior rule; and
(C) does not include a statement regarding only the internal management or organization of a state agency and not affecting private rights or procedures. TEX. GOV'T CODE §2001.003(6)(A) – (C)(emphasis added).

Further, an interpretation of a statute by the agency charged with enforcement of the statute is entitled to deference if the construction is reasonable and does not contravene the plain language of the statute. *See First American Title Ins. Co. v. Combs.*, 258 S.W.3d 627, 632 (2008); *Mid-Century Ins. Co. of Texas v. Ademaj*, 243 S.W.3d 618, 623 (2007).

General Comments: Legislative Intent, Scope of Remedy.

Comment: A commenter states that the issue of balance billing has been debated in several legislative sessions. According to the commenter, HB 2256 embodies a carefully negotiated compromise among health plans, hospitals, and physicians that is consistent with the bill author's requirement that consumer interests remain paramount.

The commenter asserts that several ideas were considered and rejected in the process of developing HB 2256, including: (i) regulation of health plan reimbursement rates; (ii) requiring providers to contract with all health plans that a facility contracts with; and (iii) requiring hospitals to ensure that health plan enrollees see only in-network physicians. The commenter argues that such concepts were rejected because stakeholders successfully convinced legislators that the requirements would have

significant, detrimental effects on the marketplace and were inconsistent with the reality of health care service delivery, as well as due to a lack of consensus among parties.

The commenter asserts that remedies established in HB 2256 and the transparency measures enacted in SB 1731 should be given a chance to work in lieu of adopting the proposed rules. The commenter states support for the mediation requirements of HB 2256, asserting that the requirements represent the most consumer-friendly approach to addressing balance billing by facility-based providers, and requests that the Department limit its adoption to those rules addressing network adequacy standards.

Another commenter states that the rules are sweeping, comprehensive, and will make substantial progress in improving transparency for patients regarding the benefits provided by their insurance plans.

Agency Response: This response addresses the following points: (i) the Department disagrees that recent legislative activity renders rulemaking activity by the Department inappropriate; (ii) the Department disagrees that §§3.3701 – 3.3713 implement the regulatory solutions that the commenter cites as examples of solutions rejected by the Legislature; (iii) the Department disagrees that recent legislative activity justifies the delayed implementation of the Department's rules; (iv) the Department disagrees that stakeholder participation in the legislative process justifies the delay or exclusion of the consumer protection measures included in proposed §§3.3701 – 3.3713; and (v) the Department appreciates the statements of support. The basis for the Department's position is as follows.

(i) The Department disagrees that recent legislative activity renders rulemaking activity by the Department inappropriate. The Department does not agree that discussion by the Legislature of particular requirements or remedies without subsequent proposal or enactment of provisions incorporating those requirements or remedies constitutes legislative intent that such requirements or remedies are prohibited or inappropriate. See *Robinson v. Budget Rent-A-Car Systems, Inc.,* 51 S.W.3d 425, 429 (Tex.App.-Hous. (1 Dist.) 2001), quoting the Texas Supreme Court in *El Chico Corp. v. Poole,* 732 S.W.2d 306, 314 (Tex.1987) ("[w]hile failure to enact a bill may arguably be some evidence of intent, other reasons are equably inferable. Lack of time for consideration, opposition by a particular member or committee chair, efforts of special interest groups, or any other unidentified extraneous factor may, standing alone or combined together, act to defeat a legislative proposal regardless of the legislature's collective view of the bill's merits.")

(ii) The Department disagrees that §§3.3701 – 3.3713 implement the regulatory solutions that the commenter cites as examples of solutions rejected by the Legislature. The Department further disagrees that the proposed amendments to §§3.3701 – 3.3713 implement the regulatory solutions that the commenter has cited as examples of inappropriate regulatory solutions considered and rejected in the development of HB 2256 as inconsistent with the reality of health care delivery or likely to have significant detrimental effects upon the marketplace. The commenter has cited as such examples: (a) regulation of health plan reimbursement rates; (b) requiring providers to contract with all health plans that are contracted with the facility; and (c) requiring hospitals to

ensure that health plan enrollees see only in-network physicians. The Department disagrees that §§3.3701 – 3.3713 implement the cited regulatory solutions for the following reasons.

(a) Regulation of health plan reimbursement rates. Two sections of the Department's proposal are related to reimbursement. These sections are §3.3705(k) and §3.3708. Neither promulgates reimbursement rates. Instead, the provisions implement and clarify existing requirements.

New §3.3705(k) requires an insurer to pay a claim for services rendered by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that the insured reasonably relied upon a recently obtained preferred provider listing or preferred provider information on the insurer's website. The purpose of the subsection is to ensure the availability and accessibility of preferred provider services and to ensure that the underlying health insurance policy of a preferred provider benefit plan is not unjust in application based upon the inaccurate representations of the insurer concerning the status of a physician or provider.

New §3.3705(k) does not promulgate reimbursement rates. Rather, the subsection provides a clear statement of the Department's position that an insured who reasonably relies upon an insurer's recent representations concerning the preferred provider status of a physician or provider in obtaining health care services is entitled to the protections of the Insurance Code §1301.005.

The Insurance Code §1301.005(a) requires an insurer to ensure that both preferred and basic level benefits are reasonably available within a designated service

area. If services are not available through a preferred provider, the insurer is required under the Insurance Code §1301.005(b) to reimburse a nonpreferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider. The Department's position is that preferred benefit services are not reasonably available if the insurer's preferred provider listing is not reasonably reliable, making reimbursement in accordance with the Insurance Code §1301.005(b) appropriate in such a case.

Further, §3.3705(k) is not inconsistent with the reality of health care delivery. Section 3.3705(k) requires in paragraph (1) that the insured's reliance upon the preferred provider listing or information be reasonable, and it further requires in paragraph (3) that the listing or information have been obtained not more than 30 days prior to the date of services. As such, the subsection will not apply to claims that lack a reasonable basis for reliance or that are based upon information obtained more than 30 days prior to the date of services.

Likewise, the Department disagrees that §3.3705(k) will have significant detrimental effects on the marketplace. This is because: (i) insurers are required to update preferred provider listings at least every three months pursuant to §3.3705(i); (ii) the Department anticipates that insurers will have incentive to better communicate with insureds concerning the nature and frequency of changes in preferred provider listings, reducing the number of claims made under §3.3705(k); (iii) claims under §3.3705(k) are limited to those that are based upon information obtained within 30 days of the date of services; (iv) insureds will have to make a showing of reliance on an inaccurate

directory to the insurer before the insurer is required to pay at the higher coinsurance rate; and (v) the Department anticipates that insurers will be able to negotiate contractual requirements with physicians and providers to reduce the occurrence and adverse consequences of inaccurate directories.

The Department has also addressed reimbursement in §3.3708. Section 3.3708(b) requires that when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available as specified in the section, the insurer is required to pay the claim at the preferred benefit coinsurance level and credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum.

Section 3.3708(b) provides a clear statement of the Department's position of what actions are required in order for an insurer to fully comply with the protection requirements of the Insurance Code §1301.005(b). Further, because §3.3708(b) represents the Department's position concerning the scope of the protection requirements with which an insurer must comply pursuant to the Insurance Code §1301.005(b), the Department disagrees that the subsection is inconsistent with the reality of health care delivery.

Section 3.3708(c) requires that reimbursement of all nonpreferred providers be calculated pursuant to an appropriate methodology that meets specified criteria to ensure that reimbursement rates are based upon relevant, current, and statistically valid data, as appropriate. The subsection does not promulgate a rate or specify the

methodology that an insurer must use. Section 3.3708(c) will ensure that preferred provider benefit plans are offering meaningful and reasonably available basic benefits covered under the benefit package as specified in the Insurance Code §1301.005(a) and §1301.006.

The Department is aware of no reasonable basis for an assertion that the required use of relevant, current, and statistically valid data, as appropriate to the insurer's reimbursement methodology, is inconsistent with the reality of health care delivery. Likewise, the Department is aware of no reasonable basis for an assertion that the required use of relevant, current, and statistically valid data, as appropriate to the insurer's reimbursement methodology, will have significant detrimental effects upon the marketplace.

Section 3.3708(d) requires an insurer to pay all covered basic benefits for services obtained from health care providers or physicians at least at the plan's basic benefit level of coverage, regardless of whether the service is provided within the designated service area. Section 3.3708(d) does not promulgate a reimbursement rate. Rather, it clarifies applicability of the insurer's own reimbursement rate for basic benefits to ensure that the insured's access to the basic health care services to which the insured is entitled under the benefit package are not unjustly restricted.

Section 3.3708(d) also reinforces the existing requirement specified in §3.3704(a)(1) that a preferred provider benefit plan is prohibited from requiring that a service be rendered by a particular hospital, physician, or practitioner in accordance with the Insurance Code §§1251.005, 1251.006, 1301.003, 1301.006, 1301.051,

1301.053 – 1301.055, 1301.057 – 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201. The subsection further is a necessary clarification to ensure that the adoption of §3.3704(g), which permits an insurer to define a service area on a smaller than statewide basis, does not result in the improper reduction of an insured's access to basic level services.

The Department is aware of no reasonable basis for an assertion that the requirement for an insurer to pay all covered basic benefits for services obtained from health care providers or physicians, at least at the plan's basic benefit level of coverage, is inconsistent with the reality of health care delivery. Rather, the requirement is consistent with the expectations of an insured and a group contract holder that the insured has reasonable access under the plan to basic benefits and is not under an obligation to use preferred providers.

Likewise, the Department is aware of no reasonable basis for an assertion that the requirement for an insurer to pay all covered basic benefits for services obtained from health care providers or physicians at least at the plan's basic benefit level of coverage will have significant detrimental effects upon the marketplace. This is because an insurer must ensure reasonable availability of and access to not only preferred but basic benefit services and may not discriminate by limiting the amount, extent, or kind of coverage available to an individual based on the individual's geographic location.

(b) Requiring providers to contract with all health plans that are contracted with the facility. The Department disagrees that its proposed or adopted rule imposes a

requirement for providers to contract with all health plans that are contracted with the facility. However, existing §3.3703(a)(4) does provide that a contract between an insurer and a hospital or institutional provider shall not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. Proposed §3.3703(a)(4) would have permitted, but not required, the use of such otherwise prohibited contract provisions by limiting the scope of the prohibition by means of a phase-out with respect to certain groups of physicians or practitioners over a five-year period. The contracting prohibition would have remained effective with respect to all practice groups of physicians or practitioners that were new to a hospital or institutional provider for the first three years of staff membership or privileges.

The Department has changed §3.3703(a)(4) in response to other comments. Adopted §3.3703(a)(4) retains the existing provision prohibiting a contract between an insurer and a hospital or institutional provider from requiring a physician or practitioner to enter into a preferred provider contract and clarifies that the prohibition does not apply to practice conditions other than conditions of membership or privileges. The paragraph does not impose requirements upon facility-based physicians to contract with all, or any, of the health plans that are contracted with a facility.

Adopted §3.3703(a)(4) is consistent with the reality of health care delivery because it retains an existing prohibition against insurers coercing physician participation in a plan by means of leveraging contracts with hospitals or institutional providers. The adopted amendment to §3.3703(a)(4) is consistent with the reality of

health care delivery because it limits the scope of the prohibition in order to balance its protective features with the need for insurers to have an enhanced basis for improving and maintaining adequate networks of physicians and practitioners at preferred hospitals and institutional providers.

The Department did receive comments that proposed §3.3703(a)(4) might have significant detrimental effects upon the marketplace. Based upon this and other comments, the Department has determined that further consideration of the potential effects of more substantive amendments to the existing prohibition is appropriate and warranted. Adopted §3.3703(a)(4), therefore, retains the existing prohibition but provides additional clarification as to the scope of the prohibition.

(c) Requiring hospitals to ensure that health plan enrollees see only in-network physicians. The Department disagrees that its proposed or adopted rule imposes a requirement for hospitals to ensure that health plan enrollees see only physicians that are preferred providers with an enrollee's health plan. However, the Department does agree that §3.3705(l)(1) requires increased disclosure concerning the scope of a hospital's contractual requirements with an insurer to facilitate the usage of preferred providers.

Section 3.3705(l)(1) requires that an insurer include in all preferred provider listings a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers in two ways. First, the hospital must have agreed to exercise good faith efforts to accommodate requests from insureds to use preferred providers.

Second, the hospital must have agreed to provide insureds with information sufficient to enable the identification of a facility-based physician or physician group that is assigned to provide services to the insured with enough specificity that the insured may determine the status of the physician or group as preferred or nonpreferred. The latter disclosure requirement would only reflect contractual agreements that apply to instances in which the physician or group is assigned at least 48 hours prior to services being rendered and would require that the responsive information be furnished to the insured at least 24 hours prior to the services being rendered.

The Department disagrees, however, that the disclosure requirement in §3.3705(l)(1) restricts an insured's option to seek basic level benefit services from a nonpreferred provider by imposing requirement on hospitals to ensure that enrollees see only preferred provider facility-based physicians.

Further, the Department disagrees that §3.3705(l)(1) is inconsistent with the reality of health care delivery. The paragraph directly reflects the reality that an insured may receive services from a facility-based physician who is a nonpreferred provider even when seeking services at a preferred provider hospital. The paragraph also reflects the reality of health care delivery by recognizing that good faith efforts to facilitate preferred provider usage is reasonable and by recognizing that a reasonable period of time, in this case 48 hours, is a reasonable condition precedent to requirements to furnish additional information to an insured in today's health care delivery system.

Section 3.3705(l)(1) is also consistent with the reality of health care delivery because the section only requires identification in the provider listings of those facilities that are able to agree to the specified contractual provisions. If no facilities are able to do so, then none will be identified. The Department anticipates that competitive facilities will be interested in making the changes necessary to obtain this favorable identification.

The Department is not aware of a reasonable basis for an assertion that the provision of information to current and prospective insureds and group contract holders concerning which hospitals have contractually agreed to facilitate preferred provider usage will have significant detrimental effects upon the marketplace.

(iii) The Department disagrees that recent legislative activity justifies the delayed implementation of the Department's rules. The Department strongly disagrees that the recent enactment of provisions to establish new transparency measures and to establish the mandatory mediation process as provided in SB 1731 and HB 2256, respectively, justify the delay or exclusion of additional regulatory protection measures as included in the Department's proposed amendments and new sections. The basis for the Department's disagreement is as follows.

While SB 1731 and HB 2256 add important consumer protection measures, the Department's proposal implements and supports these and other broad legislative requirements as cited in the Department's proposal by establishing a larger framework for intelligent decision-making by insureds and group policyholders concerning: (i) the selection and retention of a preferred provider benefit plan; (ii) the selection of

physicians and providers; and (iii) the treatment of unanticipated balance bills. *See, e.g.*, §3.3705(e)(2) (requiring Internet-based provider listing for use by prospective or current insureds to disclose the insurer's determination that its network does or does not meet the network adequacy requirements established by the Department); §3.3705(l)(1) (requiring provider listings to include method for identification of hospitals that will facilitate usage of preferred providers); and §3.3705(k) (requiring reimbursement at the preferred benefit coinsurance percentage in cases of reasonable reliance by the insured upon the insured's provider listing).

The enactment of SB 1731 and HB 2256 have not absolved the Department of the responsibility to continue ongoing implementation of the Insurance Code Chapter 1301 as required in the Insurance Code §1301.007 or of the powers and duties of the Department under the Insurance Code and other laws of this state as specified in the Insurance Code §36.001(a).

Additionally, the Insurance Code §1467.004, enacted under HB 2256, specifies that the remedies provided under Chapter 1467 are in addition to any other defense, remedy, or procedure provided by law, including the common law. It is the Department's position that inclusion of this provision in HB 2256 evidences that the Legislature did not envision the mediation process established under the bill to constitute a limit upon any other law, including the Insurance Code §1301.007 and §36.001.

(iv) The Department disagrees that stakeholder participation in the legislative process justifies the delay or exclusion of the consumer protection measures included in

proposed §§3.3701 – 3.3713. The Department does not agree that stakeholder participation in the legislative process is a justifiable basis for the delay or exclusion of the consumer protection measures proposed by the Department. While the participation of stakeholders permits the provision of valuable feedback and resource information to both legislators and regulatory agencies, it is also true that various stakeholders have differing perspectives and do not always agree. It is also true that many members of the public lack the resources to participate in the legislative or rulemaking process as fully as others but are nonetheless deserving of consideration as the Department undertakes implementation of an issue that has the potential for such significant impact upon insureds.

(v) The Department appreciates the statements of support. The Department appreciates the supportive comment concerning improved transparency for patients, as well as the statement of support for the mediation process established under the Insurance Code Chapter 1467.

General Comments: Justification and Policy.

Comment: A commenter asserts that the proposal is not justified under SB 1731 and HB 2256 and does not constitute good policy.

Agency Response: The Department disagrees that the proposal is not justified and is not good policy. The proposal serves multiple, often overlapping, implementation purposes, including but not limited to implementation of SB 1731 and HB 2256. For example, the Department's proposal implements transparency and disclosure

requirements to facilitate the comparison of plans by current and prospective insureds who are making decisions concerning the selection or renewal of a plan. *See*, e.g., §3.3705(e)(2) (requiring Internet-based provider listing for use by prospective or current insureds to disclose the insurer's determination that its network does or does not meet the network adequacy requirements established by the Department); and §3.3705(l)(1) (requiring provider listings to include method for identification of hospitals that will facilitate usage of preferred providers).

It is the Department's position that the policy of establishing a basis for intelligent decision-making by insureds with respect to the selection, renewal and use of preferred provider benefit plans represents good policy.

General Comments: Administrative Burden, Inconsistent with Reality of Health Care Service Delivery, Lack of Consumer Benefit and Participation - §§3.3705(b)(12), 3.3703(a)(26)(A), 3.3705(n), 3.3709(e)(1)(E) and (f), 3.3705(b)(14)(B)(ii), and 3.3705(b)(14)(C)(i).

Comment: A commenter asserts that the rule poses multiple serious administrative burdens that will not provide value to consumers, who the commenter opines do not obsessively pour over health plan websites and directories. The commenter states that many insurers have raised concerns about their ability to provide the data the proposal would require.

As an example of this concern, the commenter cites: (i) disclosure requirements concerning acceptance of new patients; (ii) notice and disclosure requirements concerning the substantial decrease of providers; (iii) determination requirements

concerning whether an enrollee has access to a network provider at any one point in time; and (iv) disclosure requirements concerning available hospital beds. The commenter argues that it is not certain whether health plans will realistically be able to collect some of the information required to be collected from hospitals under the proposal.

The commenter further strongly opines that the proposal is inconsistent with how health care is actually delivered and some of the dynamics that occur when multiple parties are trying to contract with one another. The commenter states based upon practical experience that it is not realistic to anticipate that consumers will study their directories and choose their providers as envisioned under the rule.

Agency Response: The Department's response addresses the following points: (i) the Department strongly disagrees that administrative burden, the reality of health care delivery, and a lack of benefit to consumers are sufficient or valid bases for the deletion of §§3.3705(b)(12), 3.3703(a)(26)(A), 3.3705(n), and 3.3709(e)(1)(E) and (f); (ii) the Department has not adopted §3.3705(b)(14)(B)(ii) and §3.3705(b)(14)(C)(i); and (iii) the Department disagrees that consumers will not look at preferred provider listings in selecting physicians and providers.

(i) The Department strongly disagrees that administrative burden, the reality of health care delivery, and a lack of benefit to consumers are sufficient or valid bases for the deletion of §§3.3705(b)(12), 3.3703(a)(26)(A), 3.3705(n), and 3.3709(e)(1)(E) and (f). The basis for the Department's position is as follows.

(a) §3.3705(b)(12). The Department strongly disagrees that administrative burden, the reality of health care delivery, and a lack of benefit to consumers are consumers are sufficient or valid bases for the deletion of the existing requirement in §3.3705(b)(12) for an insurer to provide to an insured a current list of preferred providers and a disclosure of which preferred providers will not accept new patients. This is because: (i) the disclosure is consistent with the Insurance Code §1301.158(b) and §1301.1591; (ii) disclosure of which preferred providers will not accept new patients is crucial information for a current or prospective group contract holder or insured; and (iii) insurers should not be experiencing new administrative burdens in response to an existing requirement. The Department also disagrees that §3.3705(b)(12) is inconsistent with the reality of health care delivery.

The Insurance Code §1301.158(b) requires an insurer to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must be in a readable and understandable format as prescribed by the Commissioner and must include a current list of preferred providers. *Id.* Further, §1301.158(b) specifies that the insurer may satisfy this requirement by providing its handbook if: (i) the handbook's content is substantively similar to and achieves the same level of disclosure as the written description prescribed by the Commissioner; and (ii) the current list of preferred providers is provided.

It is the Department's position that provision of a current list of preferred providers absent a disclosure of which preferred providers are accepting new patients is not a sufficient disclosure of the scope of the insurer's network to permit an individual to make comparisons and an informed decision before selecting among health plans. It is the Department's position that individuals and group contract holders desire and need information concerning both whether an individual's general physician is a preferred provider under the plan and the larger scope of physicians and preferred providers that are in the plan's network to address the need for specialty or hospital care services. Absent such a disclosure, the use or distribution of a listing of preferred providers could constitute untrue and misleading information in direct violation of §1301.158(c). Section 3.3705(b)(12), therefore, provides a clear benefit to consumers.

Further, the Insurance Code §1301.1591(a) reiterates the importance of this information by requiring an insurer that maintains an Internet site to include on the site a listing of its preferred providers that identifies those preferred providers who continue to be available to provide services to new patients or clients.

Additionally, this existing disclosure requirement in §3.3705(b)(12) was adopted by the Department in July 1999. *See* 24 *TexReg* 5212. The Department's amendment to the paragraph merely specifies that the information may be provided electronically with the agreement of the insured provided that the insurer also furnishes the insured with information about how to obtain a nonelectronic provider listing free of charge. Because insurers are already required to make the disclosure, any new administrative burden associated with this requirement should be minimal. The Department therefore

declines to delete the existing requirement concerning the disclosure of preferred providers that will not accept new patients in §3.3705(b)(12).

The Department also disagrees that §3.3705(b)(12) is inconsistent with the reality of health care delivery or contracting dynamics because the section is consistent with current statutory obligations specified in the Insurance Code §1301.1591(a). Because Code §1301.1591(a) requires an insurer that maintains an Internet site to include on the site a listing of its preferred providers that identifies those preferred providers who continue to be available to provide services to new patients or clients, insurers are required to take necessary steps to comply with this requirement.

(b) §3.3703(a)(26)(A). The Department strongly disagrees that administrative burden, the reality of health care delivery, and a lack of benefit to consumers are sufficient or valid bases for the deletion of the requirements concerning notice and disclosure of substantial terminations of facility-based physicians at preferred provider facilities. Section 3.3703(a)(26)(A), adopted as §3.3703(a)(26), specifies that a contract between an insurer and a facility must require the facility to give notice to the insurer as soon as reasonably practicable but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer.

It is the Department's position that such a process of notification is necessary to the insurer's capability to ensure that facility-based physician services are available and accessible to its insureds at the facilities that are preferred providers in the insurer's network. Early notice of changes in the composition of facility-based providers at the

facility will enable the insurer to take more immediate steps to assess its network adequacy status and take necessary corrective action as required under §3.3704(f). Insureds will, therefore, benefit from earlier assessment and corrective action by insurers with respect to the network relied upon by such insureds.

The Department also disagrees that §3.3703(a)(26) is inconsistent with the reality of health care delivery. The Department acknowledges that many facilities have not made it a practice to provide notice to insurers when the composition of the facility-based provider panel at the hospital has changed, but it is the Department's position that preferred provider facilities will provide such notice if required to do so pursuant to contract. The Department's position is that facilities are aware of the need for insurers to comply with statutory and regulatory requirements concerning preferred provider contracts.

The Department, therefore, declines to delete §3.3703(a)(26).

(c) §3.3705(n). The Department also strongly disagrees that administrative burden, inconsistency with the reality of health care delivery, and a lack of consumer benefit are sufficient or valid bases for the deletion of the requirements concerning notice and disclosure of substantial terminations of facility-based physicians at preferred provider facilities as specified in §3.3705(n). Section 3.3705(n) specifies that an insurer is required to provide notice of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility by prominently posting notice on the portion of the insurer's website where its provider listing is available to insureds.

The Department has changed §3.3705(n) in response to other comments as explained later in this adoption order in the response to comments concerning that subsection.

Under §3.3705(n), not all decreases in provider availability are substantial. Adopted §3.3705(n)(1) specifies that a decrease is substantial if the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates. A decrease is also substantial if the contract between the facility and facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required in adopted §3.3703(a)(26).

Further, the insurer need not post notice of the substantial decrease if the insurer meets one of two requirements. No posting is required under adopted §3.3705(n)(2) if alternative preferred providers of the same specialty as the physician group that terminates a contract are made available to insureds at the facility such that the percentage level of preferred providers for that specialty at the facility is returned to an equivalent level. Also, no notice is required if the insurer provides to the Department by e-mail a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be non-compliant with the adequacy standards of §3.3704.

Adopted §3.3705(n) requires the notice to be maintained on the insurer's website until the earlier of three dates. These dates are: (i) the date on which adequate preferred providers of the same specialty become available to insureds at the facility; (ii) six months from the date that the insurer initially posts the notice; and (iii) the date on

which the insurer provides to the Department by e-mail a certification indicating the insurer's determination that the termination of a provider contract does not cause non-compliance with adequacy standards.

Further, the insurer is required to update its Internet-based preferred provider listing as soon as practicable and in no case later than two days after: (i) the effective date of the termination of a contract between the insurer and a physician or physician group resulting in the substantial decrease of providers; or (ii) the later of the date on which the insurer receives notice of the termination of a contract between a physician or physician group and a preferred provider facility, or the effective date of such contract termination.

It is the Department's position that individuals receiving medical and health care services at a preferred provider facility expect access to and availability of preferred benefits for facility-based physician services. Because of this expectation, it is vital that an insurer provide notice to its insureds when there has been a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility. It is the Department's position that an insured in need of nonemergency facility-based services should be able to determine the scope of potential liability associated with the insured's decision concerning which facility to use. In requiring notice, §3.3705(n) meets this need and therefore provides a clear consumer benefit.

The Department also disagrees that §3.3705(n) is inconsistent with the reality of health care delivery. While the Department acknowledges that many facilities have not historically made it a practice to provide notice to insurers concerning substantial

decreases in the availability of facility-based physicians at the facility, the Department has addressed this concern by adopting §3.3703(a)(26) to require such notice pursuant to contracts between the insurer and preferred provider facilities.

The Department, therefore, declines to delete §3.3705(n).

(*d) §3.3709(e)(1)(E) and (f).* The Department strongly disagrees that administrative burden, the reality of health care delivery, and a lack of consumer benefit are sufficient or valid bases for the deletion of determination requirements concerning whether an enrollee has access to a network provider. This is because it is the Department's position that an insurer should already have procedures in place to determine whether accessibility was at issue in order to comply with the requirements of the Insurance Code §1301.005(b) and §1301.155(b).

When an insurer submits a local market access plan to the Department as part of its annual report on network adequacy for any of the insurer's preferred provider service delivery networks that do not comply with the network adequacy requirements established under the subchapter, §3.3709(e)(1)(E) specifies that the access plan is required to include procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available.

Further, §3.3709(f) specifies that an insurer is required to establish and implement documented procedures for use in all service areas for which a local market access plan is submitted. Under §3.3709(f)(1), the insurer must use a documented procedure to 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. The insurer must further furnish to such insureds a pre-service estimate of the amount that the insurer will pay the physician or provider and notice that the insured may be liable for amounts charged by the physician or provider that are not paid by the insurer.

Under §3.3709(f)(2), the insurer is required to use a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured. For those claims, the insurer is required to make initial and, if required, subsequent payment of such claims at the preferred benefit level.

The Insurance Code §1301.005(b) requires an insurer to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed, had the insured been treated by a preferred provider if services are not available through a preferred provider within the service area. This statutory requirement was originally enacted in former art. 3.70-3C as part of SB 383 and became effective June 19, 1997. SB 383, 75th Leg., R.S. (June 19, 1997). The provision was relocated to current Chapter 1301 as part of the recodification of the Insurance Code as part of the enactment of HB 2922 in 2003, effective April 1, 2005. HB 2922, 78th Leg., R.S. (June 21, 2003).

The Insurance Code §1301.155(b) specifies that if an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider: (i) a medical screening

examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists; (ii) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and (iii) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition.

The requirements of §1301.155(b) were originally enacted and subsequently recodified as part of the same bills as those enacting §1301.005(b), SB 383 and HB 2922, respectively.

Because there is an increased likelihood that services will not be available through a preferred provider when an insurer's preferred provider service delivery networks do not comply with the network adequacy requirements established under the subchapter, it is critical that an insurer specify in its access plan how the insurer will comply with the Insurance Code §1301.005(b) and §1301.155(b) in reimbursing claims. It is the Department's position that the burden for proper identification and reimbursement of out-of-network claims incurred when preferred provider services are not available rests more appropriately with an insurer marketing a preferred provider benefit plan with an inadequate network than with the insured.

It is further the Department's position that a requirement for the proper identification and reimbursement of nonpreferred provider claims incurred when preferred provider services are not available, particularly in a designated service area for which the insurer has already identified network deficiencies, should not be

inconsistent with the reality of health care delivery due to the existence of ongoing statutory requirements in the Insurance Code §1301.005(b) and §1301.155(b). Prompt and correct payment of claims at the appropriate benefit level will provide a clear benefit to an insured who is subject to less potential balance billing amounts as a result.

For all of these reasons, the Department declines to delete §3.3709(e)(1)(E) and (f).

(ii) Provisions not adopted – §3.3705(b)(14)(B)(ii) and §3.3705(b)(14)(C)(i). To the extent that the comments apply to the requirements concerning the disclosure of the percentage of preferred providers that are accepting new patients in proposed §3.3705(b)(14)(B)(ii) and the disclosure of the ratio of insureds to hospital beds in proposed §3.3705(b)(14)(C)(i), this response does not address the comment. Those provisions have been deleted in response to comments as addressed later in this adoption order, including but not limited to the comment that the requirement is administratively burdensome.

(iii) The Department disagrees that consumers will not look at preferred provider listings in selecting physicians and providers. A witness at the March 24, 2009 hearing before the House Insurance Committee concerning HB 2256 testified that his employees had become better consumers by becoming more informed through their health savings account plans. Hearing on Tex. H.B. 2256 before the House Committee on Insurance, 81st. Leg., R.S. (March 24, 2009) (testimony of Jerry Stamps) (materials on file with House Audio Services). The witness stated that even though his employees did their homework to make sure that their health coverage would pay for care, they

continued to be frustrated with charges for out-of-network services and desired assurances concerning what the plans actually cover. *Id.*

Consistent with this testimony, it is the Department's position that both current and prospective insureds and group contract holders want and need sufficient information to make informed decisions concerning the selection and renewal of plans and the selection of physicians and providers.

General Comments: Consumer Access to Care; Inconsistent with Findings of SB 1731 Advisory Committee, Focus on Emergency Care - §3.3704(e) and §3.3705(l)(2).

Comment: A commenter agrees that the Department is required to adopt rules related to network adequacy and states a belief that rules should ensure consumer access to care. The commenter states that an advisory committee was established under SB 1731 to examine network adequacy. The commenter asserts that the committee collected much data from larger health plans and issued two reports despite a failure to achieve consensus regarding recommendations.

The commenter argues that the reports reflect a lack of evidence that networks are inadequate that has been ignored by the Department in its rulemaking. The commenter further asserts that basic data was averaged by the Department for use in the reports and that such data appears to have been adopted in the proposal as a norm for concern regarding the level of out-of-network provider usage and possible violations of adequacy requirements.

The commenter strongly disagrees that the data collected under the interim study accurately evidences such a standard. Instead, the commenter asserts that the marketplace is working well in most places and urges that the rule should focus on emergency care, which the commenter states is the most consistent problem area, in conjunction with a standard of whether consumers have access to network providers.

Agency Response: The Department's response addresses the following points: (i) the Department agrees that rules concerning network adequacy that ensure access to care are required; (ii) the Department disagrees that data from the SB 1731 advisory committee reports serves as a basis for the Department's determination of a network adequacy "norm;" and (iii) the Department disagrees that further focus upon emergency care is necessary at this time. The basis for the Department's position is as follows.

(i) The Department agrees that rules concerning network adequacy that ensure access to care are required. *See, e.g.* the Insurance Code §1301.0055 and §1301.007. The Department's position is that §3.3704(e) addresses that requirement. *See*, e.g. §3.3704(e)(1) (requiring an adequate network to be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract, taking into account the number of insureds and their characteristics, medical and health care needs); and §3.3704(e)(2) (requiring an adequate network to include an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a week).

(ii) The Department disagrees that data from the SB 1731 advisory committee reports serves as a basis for the Department's determination of any specific "norm" for

disclosure requirements as required under §3.3705(l)(2). The commenter is correct that one of the reports included a finding as follows:

> Ninety percent of the total facility-based provider claims/visits reported by five of the largest preferred provider benefit plans (PPBPs) . . . indicate services were delivered by in-network facility-based physicians. *Report of the Health Network Adequacy Advisory Committee*, January 2009 (*Jan. 2009 Network Report*) at 3, available at http://www.tdi.state.tx.us/reports/report5.html.

The Department also acknowledges that proposed §3.3705(l)(2) includes a provision requiring provider information to include a method for insureds to identify those hospitals at which more than 10 percent of the dollar amount of specified facility-based physician claims filed with the insurer are filed by or on behalf of a physician that is not under contract with the insurer.

However, the determination to set the disclosure requirement at 10 percent of claims was not based upon a particularized finding from the *January 2009 Network Report* but was rather a number that the Department determined to constitute a sufficient threshold to earn an insured's attention and signal the insured to investigate the status of facility-based physicians more closely. The Department does take the position, however, that the *January 2009 Network Report*, including the finding cited previously in this response, serves as a basis for the general proposition that an insured may face a significant unanticipated balance bill from a facility-based physician despite exercising diligence in choosing a preferred provider hospital.

It is the Department's position that there is not a single magic number or dollar amount of claims that are "the" appropriate number sufficient to require particular

disclosure to an insured or group contract holder looking at a provider directory to evaluate the insurer's network or to make an informed choice concerning the hospital at which to receive services. To an insured, a relatively low percentage of out-of-network claims for a plan in general will likely offer little comfort when it is that insured's claim that falls within such low percentage.

It is also the Department's position that there is not a single magic number or dollar amount of claims that will determine whether an insurer has violated adequacy standards. The Department's determination of whether such a violation has occurred will be made on a case-by-case basis considering local market characteristics within the designated service area and an analysis that includes but is not limited to each of the factors identified in §3.3704(e) as necessary to an adequate network.

The Department has, however, changed the disclosure requirement in §3.3705(l)(2) based upon comments received, including but not limited to the comment that use of the 10 percent threshold is inappropriate, as explained later in this adoption order in responses to comments on §3.3705(l)(2).

(iii) The Department also disagrees that further focus upon emergency care is necessary at this time. Section 3.3704(e)(1)(7) requires an adequate network to provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers. The Department will, however, monitor to determine whether future rulemaking to address the accessibility and availability of emergency department physicians is necessary.

General Comments: Support for §§3.3704(e), 3.3708(b), 3.3703.(a)(24), 3.3702(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii).

Comment: A commenter states support for the Department's efforts to set standards for the availability of providers in preferred provider benefit plan networks and to address the payment of out-of-network claims, proposed at §3.3704(e) and §3.3708(b), respectively. Another commenter expresses general appreciation for the Department's efforts to enhance the health care experience for Texas patients. A commenter states support for the changes in the Department's regulatory approach made since informal publication to §§3.3703(a)(24), 3.3702(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii).

Agency Response: The Department appreciates the supportive comments.

General Comments: Alternative Solutions.

Comment: A commenter states that while there is an appropriate role for balance billing, the commenter, too, is concerned with situations in which consumers are balance billed by out-of-network providers when they receive services at a network facility. The commenter states that during the last legislative session, the commenter proposed a solution to protect consumers by establishing an out-of-network dispute resolution process.

Under this proposal, the commenter states that consumers utilizing network facilities would be protected from balance billing and health plans and facility-based providers would be required to allow an independent third party to resolve billing disputes. The commenter states that this proposal was recently signed into law in

Illinois and would incentivize health plans and physicians to agree to contractual terms while still allowing those parties the right to abstain from entering into contracts they deem unacceptable. Further, the commenter states that its proposal would avoid having the state dictate reimbursement terms, instead relying on a neutral third party to review claims and make a determination.

The commenter states that its member plans are willing to live with the determinations of an independent third party to ensure that consumers are protected. While this commenter's proposal did not become law, the commenter continues to support dispute resolution and believes it to be the most consumer-centric and fair proposal available.

Agency Response: The Department declines to adopt a mandatory dispute resolution process in the manner proposed by the commenter. The Department appreciates the commenter's statement of support for establishing a solution that protects insureds from unanticipated balance billing expenses. It is the Department's position that the use of alternative dispute resolution to determine a mandatory settlement of a claim is not currently within the scope of the Department's rulemaking authority, except to the extent that the Insurance Code Chapter 1467 already applies to such claim. Such a requirement beyond the scope of Chapter 1467 would necessitate legislative action.

Comment: A commenter states that there is merit to the sections of the rule establishing standards for availability of preferred providers (§3.3704), some modified form of reporting requirement for plans (§3.3709), and enforcement authority for the

Department in cases where health plans fail to address ongoing issues with availability of providers. The commenter states that a revised rule that limits itself to these sections would be consistent both with the legislative intent of HB 2256 and the language of the bill.

Additionally, while the commenter opines that the current sections of the rule related to directory requirements are not feasible or well designed, the commenter offers that there may be merit to working with the Department and other stakeholders to study what additional information would be useful to consumers.

Agency Response: The Department appreciates the statement of support for some provisions of the rule. The Department agrees that requirements concerning standards for availability of preferred providers and reporting requirements concerning network adequacy, as well as the provision addressing the Department's enforcement options, are consistent with the legislative intent and language of HB 2256, and in particular with respect to the Insurance Code §1301.0055.

However, the Department does not agree that a stakeholder study concerning what information would be useful to a consumer in a preferred provider listing is a necessary prerequisite to adopting requirements for such listings at this time. This is because the Department has solicited feedback from stakeholders on multiple occasions for the entire proposal, including proposed requirements concerning preferred provider listings.

To obtain comments, the Department made an informal posting on its website of a concept paper and proposed revisions to the rules governing preferred provider

benefit plans on April 23, 2010. The Department held a meeting to discuss the drafts on May 5, 2010. After consideration of comments received, the Department made a second informal posting on its website of proposed revisions to the rules and an estimate of anticipated costs to comply with the revised rules on September 13, 2010.

A second informal stakeholder meeting was held to discuss the draft rules on September 21, 2010. During this process, the Department made changes to the provider listing requirements in response to stakeholder input.

The Department next published the proposed amendments and new sections in the January 28, 2011 issue of the *Texas Register* (36 TexReg 333) and invited additional public comment. A public hearing concerning the proposal was held on February 8, 2011, and both oral and written comments were provided for the Department's consideration.

The Department has, however, changed some provisions concerning preferred provider listing requirements in response to other comments. These changes are addressed in the section of this adoption order concerning comments and responses that are specific to §3.3705(l).

Because the Department has solicited extensive comment concerning the proposed listing requirements and has made changes in response to comments, the Department disagrees that further stakeholder study of the issue is necessary at this time.

The commenter has provided additional, more specific comments concerning the feasibility and design of listing requirements. These comments are, therefore,

addressed in those portions of this adoption order concerning comments and responses regarding §3.3705(l) and are therefore not addressed in this response.

§3.3702 and §3.3704(e)(1) – Definitions: "Exclusive Privileges," "Local Market" and Network Requirements; "General Practitioner," and "Specialist."

Comment: A commenter requests that the Department add a definition for "exclusive privileges" in §3.3702.

Agency Response: The Department disagrees that a definition for "exclusive privileges" is necessary because the term is not used in the rule. Section 3.3705(l)(10) as proposed required that preferred provider listings include specific identification of facilities at which the insurer has a contract with facility-based providers that have an exclusive contract with the facility. However, the Department has deleted this requirement in response to other comments as described in the portion of this adoption order concerning comments and responses to §3.3705(l).

Comment: A commenter states that the proposed network adequacy regulations do not contain a definition of "local market." The commenter states that the regulations should add such a definition as new §3.3702(13) because the commenter asserts that HB 2256 specifically directs the Department to evaluate networks based on the adequacy of a network in "local markets."

The commenter opines that local markets are smaller than most carrier-designated service areas, which can be statewide and span several counties, as permitted in §3.3704(g). The commenter also asserts that local markets are much more

refined than the distinction between urban areas and rural areas outlined by the proposed regulations with the distance requirements imposed under §3.3704(e)(8). The commenter, therefore, suggests that the Department consider a definition that will be understood by the enrollees and policyholders seeking health care in their communities. The commenter states that most Texans would not expect to have to travel to cities outside their community for basic health care services. The commenter opines that the words “local market,” as they appear in HB 2256, are intended to refocus carriers, the Department, and insureds on the everyday expectation that a physician whom patients know and can easily reach will likely be available under the network benefit. Further, the commenter says, if the Legislature had intended for network adequacy to be determined based upon “designated service areas,” the language would have been utilized in the bill.

The commenter recommends that the Department replace the multiple references to “designated service area” in proposed §3.3704(e)(1) - (6) and (8) - (9) with “local market” and that the Department promulgate a consumer expectation-driven definition of “local market.”

Agency Response: The Department agrees that the Insurance Code §1301.0055(1) requires the Commissioner to adopt network adequacy standards that are “adapted to local markets.” The Department, however, disagrees that inclusion of a definition for “local market” is necessary or that the network adequacy requirements established in §3.3704(e)(8) are inconsistent with HB 2256 or the general expectation of insureds or policyholders.

This response explains the basis for the Department's position by addressing the following points: (i) the network adequacy and reporting requirements adopted by the Department are sufficiently detailed that a definition of "local market" is not necessary; (ii) an insurer's use of a statewide or multi-county region as a designated service does not obviate or dilute the network adequacy requirements specified in §3.3704(e); (iii) the legislative history for HB 2256 does not indicate that local market network adequacy standards must be stringently prescribed based upon a narrower concept of "local market"; (iv) it is commonly understood that many geographic areas simply lack particular physician or provider services; (v) the adequacy requirements established in §3.3704(e)(8) are generally consistent with existing and longstanding network adequacy requirements concerning HMOs and workers' compensation healthcare networks; and (vi) the Insurance Code §1301.005(c) provides that an insurer need not reimburse services at the preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience. The basis for the Department's responses is as follows.

(i) The network adequacy and reporting requirements adopted by the Department are sufficiently detailed that a definition of "local market" is not necessary. It is the Department's position that the network adequacy and reporting requirements adopted by the Department are sufficiently detailed that a definition of "local market" is not necessary. Section 3.3704(e)(8) addresses the adequacy standard, specifying that an adequate network is required to provide for preferred benefit services sufficiently

accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area (including an insured's residence within the service area) to a point of service is not greater than: (i) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and (ii) 75 miles for specialty care and specialty hospitals. Section 3.3704(e)(8) therefore establishes network adequacy standards specific to a limited geographic scale that address the availability of basic and specialty care within an area that the Department considers to be a local market.

In addition to network adequacy standards, §3.3709 addresses network adequacy reporting requirements. Section 3.3709(b)(3) requires an insurer to specify in its annual network adequacy report whether the preferred provider service delivery network supporting each plan is adequate under §3.3704. Section 3.3709(d) requires an insurer to submit a local market access plan as part of the insurer's annual report on network adequacy if any of the insurer's preferred provider benefit plans use a preferred provider delivery network that does not comply with the network adequacy requirements specified in §3.3704. Local market access plan requirements specified in §3.3709(e) include specification of the geographic area within the service area in which a sufficient number of preferred providers are not available, including a specification of the class of provider that is not sufficiently available, the reason for the lack of compliance with §3.3704, and the procedures that the insurer will use to assist insureds in obtaining services due to lack of availability. It is the Department's position that the required content of the access plan will result in a detailed analysis of the "local market" if

accessibility is at issue without the need for further definition of the actual term “local market.”

For these reasons, the Department’s position is that §3.3704(e)(8) is sufficiently detailed. Further refinement of the network adequacy standards to address the many “local markets” within the state in a more individualized manner would entail the devotion of substantial additional resources and unnecessary delay of the rule. However, the Department will monitor to determine whether additional rulemaking concerning “local markets” is necessary in the future.

(ii) An insurer’s use of a statewide or multi-county region as a designated service does not obviate or dilute the network adequacy requirements specified in §3.3704(e). Additionally, the Department disagrees that a definition for the term “local market” is necessary to safeguard the network adequacy requirements based upon the existence of statewide or multi-county designated service areas. The clear language of the network adequacy standard established in §3.3704(e)(8) requires sufficiently available and accessible preferred provider services such that the distance from any point in the insurer’s designated service area to a point of service is not greater than specified service-specific distances.

Further, §3.3704(e)(3) requires that an adequate network include sufficient numbers and types of preferred providers to ensure choice, access, and quality of care across the insurer’s designated service area. The standards in §3.3704(e) simply do not permit an insurer to dilute or obviate its network adequacy obligations based upon the insurer’s use of a large designated service area. For example, an insurer with a

statewide service area would not satisfy the network adequacy standards in §3.3704(e) for general practitioners in a North Texas community by inclusion of general practitioners that provide services in a South Texas community well beyond the geographic specifications set forth in §3.3704(e)(8).

(iii) The legislative history for HB 2256 does not indicate that local market network adequacy standards must be stringently prescribed based upon a narrower concept of "local market." The Department also disagrees that §3.3704(e)(8) is inconsistent with HB 2256 because the legislative history for HB 2256 does not indicate that local market network adequacy standards must be stringently prescribed based upon a narrower concept of "local market" than results under the Department's rules.

The filed version of HB 2256 proposes two new provisions that are particularly pertinent to this issue: (i) §1461.003, which would require a health benefit plan to make available in its network at least one physician for each medical specialty; and (ii) §1461.005, which would require that the Commissioner adopt network adequacy standards that are adapted to local markets and ensure availability of and accessibility to a full range of health care practitioners. HB 2256, filed version, 81st Leg., R.S. (March 3, 2009). The inclusion of both provisions in the same filed bill indicates the initial legislative concept that, in some markets, and subject to standards adopted by the Commissioner, a single physician per medical specialty per provider network might be adequate.

A committee substitute for HB 2256 (CSHB 2256) was considered subsequent to consideration of the filed version. *See*

http://www.capitol.state.tx.us/BillLookup/Actions.aspx?LegSess=81R&Bill=HB2256.

The proposed amendments to add new Chapter 1461 to the Insurance Code, including §1461.003 and §1461.005, are not present in the substitute version, which instead emphasizes out-of-network dispute resolution. CSHB 2256 (March 24, 2009). However, CSHB 2256 does include a comparable provision that would add new §1301.0055 to the Insurance Code, requiring the Commissioner to adopt network adequacy standards that are adapted to local markets and that ensure availability of and accessibility to a full range of health care practitioners. *Id*. The bill analysis for the CSHB 2256 addresses the issue of local markets by summarizing the view of bill supporters as follows:

> The [network adequacy] standards would be adapted to the unique local health care market so insurers would not be required to meet unreasonable standards for participating providers if they were in a smaller market. TEXAS HOUSE RESEARCH ORGANIZATION, BILL ANALYSIS, CSHB 2256, 81st Leg., R.S. (May 8, 2009).

This portion of the legislative history, therefore, indicates that adaptation of network adequacy standards to local markets under §1301.0055 is meant to protect insurers from the application of unreasonable standards in smaller markets rather than to provide for more stringent requirements on a smaller geographic basis.

Section 1301.0055 as added by CSHB 2256 was again revised via a Senate committee substitute on May 23, 2009 (SCSHB 2256). Under SCSHB 2256, the Commissioner is required to consider situations in which no provider in a field of practice in a local market agrees to contract with a plan at a reasonable rate of

reimbursement in adopting network adequacy standards (Subdivision 3). SCSHB 2256 (May 23, 2009).

On May 27, 2009, Floor Amendment No. 1 concerning SCSHB 2256 was adopted. TEXAS SENATE JOURNAL, page 4009 (May 27, 2009). Under the amendment, §1301.0055 is further revised to strike Subdivision 3 and to add substitute language. The amendment specifies that the Commissioner may allow departure from local market network adequacy standards on good cause shown if the Commissioner posts on the Department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market. *Id.* The amendment mirrors the provision as it exists in the enrolled bill. *Id; see also* HB 2256, enrolled version (May 30, 2009).

It is the Department's position that the collective legislative history concerning local market network adequacy standards as referenced in §1301.0055 does not support the position that such standards must be stringently prescribed based upon a narrower concept of "local market." Instead, the history indicates legislative intent that the Commissioner exercise discretion in establishing standards that are adapted to local markets while allowing for departure from the standards for good cause. As previously explained in this response, an insurer's failure to comply with the network adequacy requirements will result in the development of an access plan under §3.3709 that is tailored to the local market. As such, it is further the Department's position that the collective network adequacy standards and network adequacy reporting requirements previously addressed in this response are not inconsistent with HB 2256.

(iv) It is commonly understood that many geographic areas simply lack particular physician or provider services. The Department disagrees that §3.3704(e)(8) is inconsistent with HB 2256 and the general expectations of insureds and group policyholders because the Department believes it is commonly understood that many geographic areas simply lack particular physician or provider services. The bill analysis for a committee substitute to HB 2154, concerning a physician education loan repayment program under consideration by the Texas Legislature at the same time as HB 2256, states that "Texas has a shortage of health care providers, effectively denying access to health care for Texans living in a rural, border, and inner-city communities." SENATE RESEARCH CENTER, BILL ANALYSIS, 81st Leg., R.S. (May 25, 2009). More recently, a newspaper article addressed this shortage as follows:

> Across Texas' rural counties, recruiting doctors is the single biggest health care challenge. Twenty-seven Texas counties have no primary care physicians; 16 have just one. An elderly doctor's retirement is enough to shutter a rural hospital; a nurse practitioner's relocation can send a community into crisis." *Tough to Recruit Doctors in Rural Texas*, Texas Tribune, Emily Ramshaw, (Jan. 7, 2010).

Given the unavailability of certain providers in Texas, the Department believes flexibility in network standards is necessary for compliance by insurers in order to avoid the necessity for large numbers of requests by insurers for waivers of network adequacy requirements.

(v) The adequacy requirements established in §3.3704(e)(8) are generally consistent with existing and longstanding network adequacy requirements concerning HMOs and workers' compensation healthcare networks. The Department further

disagrees that §3.3704(e)(8) is inconsistent with HB 2256 and the general expectations of insureds and group policyholders because the adequacy requirements established in §3.3704(e)(8) are generally consistent with existing and longstanding network adequacy requirements concerning HMOs and workers' compensation healthcare networks. *See* 28 TEX. ADMIN. CODE §11.1607(h) (an HMO is required to provide an adequate network for its entire service areas and that covered services must be accessible and available so that travel distances from any point in the service areas to a point of service is no greater than 30 miles for primary care and general hospital care, and 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers). See also 28 TEX. ADMIN. CODE §10.80(d) (workers' compensation healthcare networks (WCHCNs) are required to provide network services sufficiently accessible and available to ensure that the distance from any point in the network's service area to a point of service by a treating doctor or general hospital is not greater than 30 miles in nonrural areas and 60 miles in rural areas.) For specialist services and specialty hospitals, the standard for WCHCNs is increased to 75 miles. 28 TEX. ADMIN. CODE §10.80(e).

HMO network adequacy standards based on equivalent mileage specifications have been used, albeit with slightly different formats, since 1998. *See* 23 TexReg 11394 (November 6, 1998). The standards for WCHCNs were adopted to be effective December 5, 2005. *See* 30 TexReg 8099 (Dec. 2, 2005). Standards comparable to the standards specified in §3.3704(e)(8) are therefore common and longstanding in the Texas health care market.

(*vi) The Insurance Code §1301.005(c) provides that an insurer need not reimburse services at the preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience.* The Department disagrees that §3.3704(e)(8) is inconsistent with HB 2256 and the general expectations of insureds and group policyholders because the Insurance Code §1301.005(c) provides that an insurer need not reimburse services at the preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience. Not all insureds or group policyholders reside in the service area that corresponds to the preferred provider benefit plan under which coverage is provided. For example, the designated service area may correspond to a particular employment location rather than individual residences. For this reason, not all policyholders and group policyholders would necessarily have the same concept of a provider that "they know and can easily reach."

For all of these reasons, the Department declines to add a definition for "local market" or to modify the network requirements in §3.3704(e) as requested by the commenter. The Department will continue to monitor to determine whether future rulemaking concerning local markets is necessary in the future.

Comment: A commenter notes that the terms “general practitioner” and “specialist” are no longer used in the body of the proposed rules. Thus, the commenter recommends the deletion of these definitions in §3.3702(6) and (24).

Agency Response: The Department agrees that the terms “general practitioner” and “specialist” are no longer used in the body of rules. The Department has, therefore, deleted these definitions in §3.3702(6) and (24) as unnecessary and redesignated §3.3702(7) – (26) accordingly.

Section 3.3703(a)(4).

Comment: A total of thirteen commenters raise a variety of concerns about proposed §3.3703(a)(4).

Five of the commenters raise issues related to the administrative burden and impact of proposed §3.3703(a)(4) on hospital contracting with physicians.

One commenter expresses concerns that the proposed rules would unnecessarily complicate hospital contracting for services provided by facility-based physicians. The commenter asserts that the proposed amendment to §3.3703(a)(4) would allow insurers to request that hospitals require physicians within a group practice to enter into the same preferred provider contracts as the hospital as a condition of medical staff membership or privileges. The commenter adds that some insurers have sufficient market presence to impose such a requirement, forcing physicians to contract with particular insurers even if the insurer is offering unreasonably low reimbursement rates.

A second commenter agrees with this concern, saying that it would remove an important safeguard for hospital-based physicians' practice independence. The commenters recommend that the proposed amendment be deleted.

A third commenter asserts that the proposed amendments affect all physicians who care for hospital patients, not just facility-based physicians, and that the proposed rule may not even truly achieve the goal of increased in-network encounters. The commenter notes that there are a large number of health insurers in Texas, and that many hospital contracts with insurers and physician contracts with insurers have 90-day termination provisions. The commenter says that these factors will require physicians to use very complex administrative systems in an attempt to comply with the contracting requirements contemplated.

A fourth commenter asserts that the proposed text for §3.3703(a)(4) is infeasible, if even possible, due to the significant administrative cost and burden of managing contracts with hospitals based on the size of the various group practices that contract with the hospital. The commenter asserts that there is neither a justifiable policy reason for the provision nor statutory authorization for the requirement and reiterates support for deleting the existing provision altogether. However, the commenter states that absent deletion of §3.3703(a)(4), many of the provisions throughout the proposed rules will not be achievable. The commenter also asserts that as proposed, §3.3703(a)(4) applies different standards to different provider groups by size, and that such stratification would involve insurers having to undertake much manual analysis of claims to determine compliance and that it would be incredibly difficult for insurers to

differentiate claims by downstream contractual terms based on the size of the provider group. The commenter recommends deletion of §3.3703(a)(4) altogether.

A fifth commenter asserts that in the commenter's experience most physician group contracts with hospitals have a requirement for the group to negotiate with insurers. The commenter says that such provisions typically require good-faith negotiations with all insurers with which the hospital is in-network. The commenter adds that hospitals have, over time, pushed for more stringent language, requiring metrics about how many claims are in and out-of-network, but that physician groups are very opposed to such requirements because they leave physician groups with no negotiating room with the managed care companies. The commenter says that physician groups oppose such stringent provisions when renegotiating with hospitals, and as a result contracts more generally require a good-faith negotiating effort.

Nine of the commenters express opposition to proposed §3.3703(a)(4) because they say that it would lead to economic credentialing.

One commenter asserts that proposed §3.3703(a)(4) would allow insurers to interject physician participation in an insurer's network into the medical staff credentialing process, and suggests deleting the proposed amendment.

A second commenter states that patient quality is paramount for physicians, credentials committees, and hospital system participants, and says that for this reason credentialing decisions should be made based on the competency of a physician. The commenter says that if other factors are considered, it might force the credentialing of lesser quality physicians simply to meet the demands of an in-network provider.

A third commenter notes that credentialing committees are already tasked with reviewing physician credentials, including the credentials of new physicians joining a hospital's staff; the competency, training, and expertise of physicians; and the continuing medical education credits and procedures of the physicians as part of re-credentialing. The commenter says that the extra burden of economic credentialing would be inconsistent with the function of those committees to ensure patient safety. The commenter also notes that such committees are not designed to review economic factors, but rather to determine whether doctors are qualified to render high quality care.

A fourth commenter asserts that the proposed rule transfers the responsibility of network development from the insurer to the hospital privileging committee, and that under the provision peer review committees will have to constantly monitor the contract status of all of physicians on staff, resulting in monthly or quarterly reviews. The commenter says that such a focus may displace the traditional review of patient safety and quality care, transforming the patient safety function into more of a financial examination and causing review committees to evaluate a physician's negotiating skills in addition to or in lieu of clinical skills. The commenter observes that the credentialing process has not traditionally addressed the contract status of physicians, and hospitals have not pressured physicians to bring in business. The commenter also notes that facility-based physicians typically join a firm that has existing contracts with insurers in place.

A fifth commenter states that, in the commenter's experience, a hospital will exert pressure for a physician group to contract with parallel payors if the hospital does not

perceive that the physicians are sufficiently contracted with payors. The commenter says that contract provisions sometimes require physician groups to participate in all third-party contracts entered into by the hospital, unless otherwise agreed to in writing by both parties, and that such a contract sometimes provides that the hospital will notify the physician group of changes in the hospital's contract status. The commenter notes that such contracts may also require that a physician group's negotiations with payors be undertaken in good faith.

A sixth commenter says that allowing economic credentialing would overrule the safeguards and processes in place for years. The commenter asserts that allowing facilities to financially de-credential doctors who have been specially trained, educated, and selected to provide a safe experience for the patient is to violate the vulnerable patient's sacred trust, and that economic credentialing sends an undesirable message to patients that having the best trained, best educated, and most qualified doctor is no longer the most important thing. The commenter also observes that medical credentialing and medical quality is typically a separate function from exclusive contracts and that medical and quality issues are addressed by a medical staff committee apart from contractual negotiations.

A seventh commenter states that elimination of the prohibition in §3.3703(a)(4) would dramatically change the dynamics of the marketplace because many insurance companies would aggressively pursue this approach as it would give them tremendous leverage to force physicians to accept below market fees. The commenter says that hospital membership and credentialing has always been and should continue to be

based solely on the physicians' demonstrated ongoing competence at performing the privileges requested, but that hospital credentialing would become an economic matter and patients would suffer as a result. The commenter asserts that, were insurance companies to interject such language in contracts with hospitals, any single insurance company could force a physician to relinquish hospital privileges, thereby depriving all patients in the hospital of his/her services. The commenter also says that keeping an accurate record of which physicians are providers for which network is a formidable task and asks whether it would be a hospital's responsibility to keep such records should a contract between an insurer and a hospital require the members of the hospital's medical staff to be providers for the insurer. The commenter says that the additional expenses a hospital would incur in tracking physician provider status would be substantial and would likely be passed on to patients.

The seventh commenter, along with the fourth and an eighth commenter, asserts that if the rule were adopted the image of Texas would shift from being a state focused on quality to one primarily concerned about whether health care providers meet arbitrary economic profiles and that Texas would become a hostile environment for physicians that practice medicine in hospitals. They warn that the ultimate result could be insufficient hospital-based physician resources for the growing Texas patient base.

The eighth commenter mentioned in the preceding paragraph also states that proposed §3.3703(a)(4) would likely cause changes adversely affecting patient safety, patient/physician relationships and the privileging process. The commenter says that it is not necessarily a physician's fault, as a plan may choose to not contract with the

physician for a variety of reasons. The commenter notes that credentialing of physicians and other health care providers is a medical staff function that is taken very seriously, and that credentials are granted based on a variety of fitness and quality factors, but that adding economic fitness would subvert the entire process to a business decision. The commenter says that facility credentialing committees serve primarily so that the quality of education, training and experience are the criteria for admittance to the medical staff, and that patient safety and treatment standards would not be advanced if the facility's focus shifts to evaluating healthcare providers based on arbitrary economic profiles.

The eighth commenter describes proposed §3.3703(a)(4) as a blunt instrument impacting a complex and dynamic market force and asserts that it will cause significant unanticipated consequences. The commenter says that the current prohibition was adopted in order to prevent economic factors from influencing the credentialing process and allow committees to focus on what protects patients. The commenter notes that the current system of competitive market-based medical services segregates physicians into several quality groups and that credentialing committees play a role in this selection process. The commenter says it is important to examine how changing the selection process would change the distribution of those groups. The commenter asserts that economic credentialing would create barriers for quality physicians, due to arbitrary decisions by insurers to deny in-network status. The commenter says that denials of network participation contracts are often arbitrary; thus access of quality physicians to medical staff privileges would also become arbitrary.

The eighth commenter further argues that economic credentialing would only be partially effective between facilities in urban areas. The commenter asserts that such facilities compete heavily in attracting quality physicians and predicts that many will be able to turn away restrictive contracts with insurers and would therefore continue to recruit quality physicians. The commenter says that larger systems are better able to situate themselves in certain demographic areas and are better able to negotiate with insurers to resist restrictive contracts. Based on this, the commenter opines, demographic areas served by those hospital systems would recruit quality physicians, while other systems would be handicapped, resulting in segregation of the market. Further, the commenter asserts, most ambulatory surgical centers (ASCs) are partially owned by surgeons and would also resist restrictive contracts; providers seeking to avoid price controls would shift their practices to such ASCs; and hospital systems would suffer due to the shift, negatively impacting patient access for the sickest populations.

The eighth commenter also asserts that the proposed provision would give the power to exclude a physician from medical staff to the four major insurers in Texas, because most facilities are contracted with the major plans and every facility is on at least one of the four major plans. The commenter expresses concern that the insurers could use such power to leverage threats against practices and put physicians at risk of losing their livelihood.

The eighth commenter also questions whether credentialing committees will continue to be a fail-safe mechanism preventing low quality physicians from obtaining

staff privileges if the current prohibition is phased out. The commenter points out that if a facility is forced into a restrictive insurance contract requiring economic credentialing, it would find itself short of physicians of targeted specialties, which would force its credentialing committee to grant privileges to physicians of marginal quality. The commenter warns that if insurers become de facto members of credentialing committees, other members could be instructed to approve a sub-par doctor or risk being black-balled themselves. The commenter also said that facilities will be forced to pay stipends in order to fill out their medical staffs.

The eighth commenter also points out that even when a group has a contract, it is frequently difficult to get it renewed, and the commenter says that a physician credentialed at a facility and in good standing could have hospital privileges terminated if the physician loses or cannot negotiate or re-negotiate a contract with a plan. Such a termination of privileges, says the commenter, would taint any future application for privileges. The commenter warns that the preference for physicians who are best qualified to provide care on the hospital campus could be replaced with a preference for physicians most able to negotiate deals with insurance plans.

The eighth commenter says that it is also not sound policy for hospitals and health plans to unite to coerce physicians into signing a contract, because there will also be a need for constant monitoring of the contract status of physicians in the hospital due to the constant change of contracting status, which would distract from the issues of safety and patient care. Additionally, the commenter expresses concern for patients seeking care in a local emergency room who require hospital admission, but learn that

their personal physician may not have hospital privileges because the physician's contract with another carrier, unrelated to the patient, is still being negotiated, and the physician does not have current privileges.

A ninth commenter says that as part of a credentialing process the commenter participated in when joining a practice, the commenter was required to show competency in the area to be performed as part of the practice. The commenter says this competency consideration was the basis for the commenter's credentialing, and ensured the safety of the patients that came into that hospital. The commenter also discusses past experiences in contracting, noting one instance when a hospital contract required the hospital to tell physician groups the hospital was negotiating with a plan so that the physician group could begin negotiations if it did not participate in the plan. The commenter also describes a situation in which an insurer decided not to pay for services, so the physician group dropped out of its plan. The commenter says that in that instance the group provided notice to the hospital, which intervened. Additionally, the commenter describes another contract which requires the physician group to participate in the plans with which the hospital is in or else the physician group will be in breach of contract. The commenter says that this contract also requires communication with the hospital. For these reasons, the commenter suggests that many facility-based physician safeguards are already in place. The commenter opines that privileging is a process designed to focus solely on patient safety and the competency of the physicians that are providing the care in hospitals, and economic credentialing as a

result of proposed §3.3703(a)(4) would distract from safety, the more important concern.

Another commenter asks that the Department carefully weigh the impact economic credentialing would have in the insurance market, as well as the physician-patient relationship.

One of the commenter raises several general concerns about proposed §3.3703(a)(4). The commenter asserts that SB 1731 did not authorize the Department to regulate physicians on staff at hospitals, that proposed §3.3703(a)(4) is not necessary in order for the remainder of the proposed rule to be successful and is a bad idea, and that under proposed §3.3703(a)(4) it would be administratively burdensome for hospitals to monitor the contracting lists of physicians on its staff.

Additionally, the commenter warns that adoption of proposed §3.3703(a)(4) would result in pressure for a legislative fix because a provision of this nature was not intended by legislation, resulting in new laws sufficiently different as to require the Department to reproduce the work it has done on the subject of network adequacy.

Last, the commenter asserts that proposed §3.3703(a)(4) is contrary to Texan-valued freedom of contract, independence of physicians, and excellence in medical care and insurance companies that provide a vehicle for payment of medical care rather than control of the health care system; and that it would permit insurer dictation of terms adverse to non-contracted physicians applying to staff hospitals, contrary to the American idea that third parties should not dictate contract terms to unrelated parties.

Seven of the commenters address concerns related to patient access and quality of care.

One commenter asserts that proposed §3.3703(a)(4) may incentivize physicians to change groups and establish new groups in order to offer better financial terms to hospitals, leading to disruption for patients, staff, and hospitals; discourage competition by forcing physicians off of medical staffs, limiting patient choice and access; undermine the principle of encouraging strong, independent hospital medical staff; and result in the prioritization of hospital income over quality in patient care, resulting in worsening patient care.

A second commenter says that surgeons post multiple cases on the same day, all of which may be insured under different plans. Because of this, asserts the commenter, a requirement for every patient to have an in-network provider could result in a different anesthesiologist being assigned for every case. The commenter says that surgeons and anesthesiologists work as a team and are familiar with each other's routines, so such a requirement would disrupt the flow of service provision, leading to unnecessary delays for patients and a decrease in quality of care.

A third commenter asserts that on a practical level, there may never be a circumstance where physicians are contracted with all plans. The commenter expresses concern that staff privileges, and thus patient access, may always be in jeopardy. The commenter adds that if an insurer refuses to contract or communicate with a physician, there would still be patients exposed to the possibility of out-of-network

levels of financial responsibility, and also notes that the biggest impact of amending §3.3703(a)(4) would be its effect on patient access, safety, and the privileges process.

A fourth commenter describes the commenter's experience with the current dynamics of the marketplace, noting that it is in the best interest of patients for physicians to be contracted with payors because physicians do not want patients to worry about whether there will be huge bills from the hospital and physician. The commenter notes that current market dynamics for contracting involve good-faith negotiations, and expresses concern that if current marketplace dynamics change, hospital and payors may potentially align themselves against physicians to require contracts, which would lead to a disruption in care for patients in the hospital setting. The commenter says that under the proposed rule if a group contracted with a hospital cannot come to terms with an insurer, the insurer might exercise its rights under the contract with the hospital to require that the group be de-credentialed. In such a situation, the commenter says, the hospital would have to replace a group of very highly qualified, highly trained physicians in order to care for its patients. The commenter predicts that adoption of proposed §3.3703(a)(4) would eventually cause disruption in patient care and the quality of care, for hospitals and, eventually, the state.

A fifth commenter expresses concern that proposed §3.3703(a)(4) would create substantial access problems in Texas for facility-based physicians. The commenter says that while the provision would be permissive, an insurer would likely seek the provision with each negotiated hospital contract, giving it veto power over physician privileges at the hospital. In such a case, the commenter argues, all patients, including

those not insured by that plan, would lose access to vetoed physicians. The commenter also notes that some groups would not be likely to split up their practice in order to achieve the safe harbor under proposed §3.3703(a)(4) because it would limit their ability to add physicians that have subspecialty training. The commenter says this could result in loss of specialization that would be bad for patients. Additionally, the commenter notes that most often doctors are not participants in 100 percent of the large plans in an area and expresses concern that doctors that do participate in every plan may be so broadly contracted because of a lack of work based upon the comparative quality of that physician.

A sixth commenter remarks that if §3.3703(a)(4) is amended as proposed and if the insurers in this state require physicians to contract with every plan for hospital privileges, it would result in one of the largest provider groups in a major Texas city not having any hospital staff privileges or being included in any medical staff, because the group has been out of contract with a major insurer and has been for two years. The commenter opines that this would create an access issue.

A seventh commenter observes that while most of the rules are extraordinarily fair and are representative of the law's intent to ensure adequate networks, the commenter has significant concerns about the effects of proposed §3.3703(a)(4) on patient safety and patient access to health care. The commenter bases this concern on experience with a group’s attempt to become a provider for a health plan. The commenter describes a situation where the group left a network due to a unilateral change in contract made by the plan and, over a period of years, made attempts to re-

enter the plan's network out of concern for patients' best interests, but was unable to due to refusal of the plan to communicate. The commenter says that there is a perception that it is easy for a large physician group to become a provider for a large health plan, as well as a perception that a failure to enter a network implies that the physician group is negotiating in bad faith. However, the commenter says, this is not always the case. The commenter says that if §3.3703(a)(4) is adopted as proposed, a health plan could delay contracting until physicians lose their privileges and thus be positioned to determine the composition of the medical staff of every hospital with which it contracts. The commenter expresses concern that this will have a very negative impact on both patient safety and access to care.

Finally, one of the commenters says that a provision such as proposed §3.3703(a)(4) is necessary for addressing the exclusive privileges issue, given some of the other requirements within the rule proposal, and the commenter also acknowledges physician concerns with downstream contractual obligations and whether the appropriate way to address the behavioral issues of physicians and hospitals is to specify contractual obligations required for inclusion in contracts with insurers. The commenter suggests that some areas are best regulated by means of a statute that directly governs the behavior of the person or entity in question, and the commenter questions how the Department will enforce downstream contracting obligations when the Department regulates only the health plans. The commenter says that if a plan has a contractual requirement but the provider decides not to comply with it, the Department would be left with taking disciplinary action against the plan to try to enforce the

underlying requirement or, as an alternative, requiring the insurer to use its clout to exercise the rights stated in the contract. The commenter expresses concern about requiring insurers to take such actions and warns that there is a cost to exercising clout at every point. The commenter says that at some point a reasonable exchange and some matter of trust between providers and plans is necessary in undertaking contract negotiations, as well as a recognition by all parties of what circumstances the other parties are operating under.

Agency Response: The Department acknowledges the multitude of comments on a variety of issues made in regard to the proposed amendment. Based upon these comments, the Department has determined that further consideration of the potential effects of amendments to the existing prohibition is appropriate and warranted and has, therefore, changed proposed §3.3703(a)(4). The Department is cognizant that individual and small group practices of physicians and practitioners may have little or no bargaining power in some situations. The Department has determined that it is possible that the proposed amendment to §3.3703(a)(4) could indirectly affect the staff membership or privileges of such individual and small group practices. The Department has, therefore, retained the existing prohibition but provided additional clarification as to the scope of the prohibition.

The Department declines to delete §3.3703(a)(4) altogether. The Department has received numerous comments regarding this section and has determined that the issue warrants additional study. Accordingly, the Department has revised the language in §3.3703(a)(4) to delete the language that was added in the proposed rule, leaving

intact the prohibition on contractual conditions but clarifying the scope of the prohibition by adding a statement that “this prohibition does not apply to practice conditions other than conditions of membership or privileges.”

The Department does not believe that the deletion of the proposed language will make other provisions of the rule unachievable for insurers. The deleted language would only have assisted insurers with the requirements in the rule relating to network adequacy in terms of facility-based physicians. Specifically, §3.3704(e) of the adopted rule requires that an adequate number of preferred providers be available and accessible to insureds. As noted herein, prior study by the Department indicates that “ninety percent of the total facility-based provider claims/visits reported by five of the largest preferred provider benefit plans (PPBPs) . . . indicate services were delivered by in-network facility-based physicians.” Report of the Health Network Adequacy Advisory Committee, January 2009 (Jan. 2009 Network Report) at 3, available at http://www.tdi.state.tx.us/reports/report5.html. Thus, deletion of the proposed language could have only potentially helped insurers reduce the 10 percent average of out-of-network claims by facility-based physicians.

However, it is also worth noting the comment by the Texas Association of Health Plans attached to the Jan. 2009 Network Report, that the occurrence of out-of-network claims is often due to provider groups with exclusive contracts that are unwilling to contract at reasonable rates. Under the portion of the adopted rule regarding the waiver of network requirements in §3.3707, an insurer could potentially receive a waiver if a provider group refused to contract at reasonable rates. Thus, the Department disagrees

that deletion of the language in §3.3703(a)(4) will make compliance with the rule unachievable. Nevertheless, the Department will continue to study the issue.

Comment: Four commenters address support for the text in proposed §3.3703(a)(4), but express disappointment in and opposition to the fact that the prohibition continued from prior law in proposed §3.3703(a)(4) expires after June 1,2014, for groups of 15 or more providers and after June 1, 2016, for groups of seven to 14 providers.

One of the commenters asserts that allowing the requirement to expire does nothing to address the overall concerns and will put hospitals in the position of granting privileges first on contracting status rather than clinical competence. In addition, that commenter says, removal of the prohibition will create an environment where hospitals will be required to force physicians into contracting arrangements.

A second commenter observes that the proposed rule provides that when a new group obtains privileges at a hospital, the prohibition will temporarily apply for three years, but states that this change will not address patient safety concerns. The second commenter also asserts that including a date on which the provision ends effectively negates the provision because, due to the difficulties insurers and providers have in contracting, hospitals will insist that any new contracted groups be preferred providers, as if the three-year grace period never existed. The commenter anticipates that the provision will insert into the hospital decision-making process an economic factor to the detriment of patient safety, and the commenter predicts that hospitals will be forced to choose physician groups first based on the preferred provider status of the groups, then, secondarily, on such important measures of safety, competence, and efficiency.

The second commenter says that the issue of preferred provider status of facility-based physicians is more properly addressed at proposed §3.3705(l), which requires insurers to provide information to consumers so that they may determine if a hospital's facility-based physicians are preferred providers with the insurer. The commenter says that provision is the effective method to address the issue in accordance with the underlying purpose of the rules to create transparency and provide information to consumers so that they can make effective, informed choices, as opposed to creating a requirement that forces hospitals to coerce physicians into contracts with insurers, harming their own credentialing and patient safety efforts in the process.

A third commenter asserts that, as proposed, the provision may be very detrimental to emergency department care in Texas for many reasons, and that phasing out the prohibition will cause hospitals to capitulate to financial pressures to prioritize economic alignment over patient quality of care; give health plans an advantage over physician groups, allowing them to impose low and unfair rates and use a "take it or leave it" negotiating posture; cause hospital/physician conflicts at a time when unity is needed to address national health reform and budget issues; drive qualified physicians away from Texas and slow down the recruitment of new providers in the state; and cause significant confusion in the state-wide administration of payor network membership by hundreds of individual providers who work in multiple in- and out-of-network hospitals across the state. The commenter concludes by saying that phasing out the prohibition will cause a protracted, expensive, and unnecessary drain on both state and provider resources due to the inevitable legal challenges that will follow the

implementation of this policy, due to its dubious legality, and requests that the Department delete the proposed amendment to §3.3703(a)(4) and retain the current prohibitory language that has been in place for decades.

A fourth commenter urges the Department to review: (1) the foundation of the current regulatory prohibition; (2) whether there is a true need to depart from the current prohibition; and (3) the potential consequences of removing or modifying the prohibition, as related to patient care and patient access to care. The commenter says that the current prohibition should be retained, noting that it has a public policy basis that has been in existence for over 15 years and citing a Department adoption order from 1995 that it says addresses such basis. The commenter says that the public policy foundation for the prohibition is especially pressing now because of increasing attempts by lay persons to relegate quality of care to a secondary consideration status in favor of business concerns and the current physician shortage in Texas.

The fourth commenter argues that there is no demonstrated need or proper justification for removal or modification of the prohibition, and questions why the provision is proposed to be phased out, given the Department's historical stance on the issue. The commenter posits that there are only two possible reasons for phasing out the provision: either to aid insurers in satisfying network adequacy requirements under HB 2256 and the proposed rules or in an attempt to decrease the burden on patients related to unanticipated out-of-network charges from facility-based physicians. The fourth commenter says that the first reason is based on a flawed argument in that neither HB 2256 nor the proposed rules place too high of a burden on insurers and

because both the law and the proposed rules accommodate insurer compliance concerns through the creation of a waiver process. The commenter says that the waiver process addresses any concern regarding meeting the network adequacy requirements without disturbing or manipulating market forces, thus there is no need to phase out the prohibition.

The fourth commenter says that the second possible basis could be based on stakeholder argument that requiring hospitals that grant exclusive privileges to provider groups to also require that those groups contract with the same health plans as the hospital could provide a legislative solution to balance billing, but that instead of adopting that solution the legislature chose to address the issue through the adoption of HB 2256, which focuses on adequate networks in local markets, dispute resolution, and transparency. The commenter says that HB 2256 offers a clear remedy to patients who receive unanticipated out-of-network charges through its mediation process, thus there is no need to phase out, delete, or modify the provision, and that further, it would be improper for the prohibition to be deleted due to inconsistency with the framework established by the legislature. The commenter also asserts that removing the prohibition may negatively impact patient care and access to care.

The fourth commenter also questions why removal of the prohibition is so desired by insurers, noting that in informal draft rules the Department explained that the prohibition was to be deleted in order to promote contracting flexibility. The commenter questions this reason, asserting that removal of the prohibition would result in little flexibility remaining in contracting for hospitals or physicians. The commenter asserts

that insurers would routinely insert into their contracts with hospitals a requirement that medical staff privileges be conditioned on preferred provider status because removal of the provision would increase insurers leverage and bargaining power and allow them to force physicians to take whatever contract terms are offered.

The fourth commenter argues that if the prohibition is weakened or removed, there will be a shift in hospital credentialing so that staff privileges are based on a physician's contract status rather than clinical skills. The commenter argues that this break in tradition quality-driven credentialing criteria may fracture the system and result in a sacrifice of quality-of-care concerns for the sake of network status and patient access to care. The commenter explains that access to care could be compromised if an area has only one hospital and physicians choose to leave the area rather than submit to an onerous contract with it, something that would not further the goal of network adequacy.

The fourth commenter also suggests that departing from the prohibition might have additional unintended consequences, and asks the Department to consider the following questions: (i) If a physician is dropped from a plan, does that mean hospital staff privileges are also terminated? (ii) How do contracting provisions affect hospital staff bylaws that require due process before privileges can be removed? (iii) How do contracting provisions affect patient continuity of care? (iv) What happens when an insurer decides it has sufficient physicians in its network and does not want any additional physicians? (v) Does an insurer or hospital breach its agreement when the insurer closes its network? (vi) How does a limit placed upon physician members in the

network by an insurer affect a hospital staff development plan? (vii) If some physicians are required to be contracted and some are not, is the reason for deleting the rule terminally undermined? (viii) If multiple insurers have agreements with hospitals that tie medical staff privileges to preferred provider status, how can physicians obtain knowledge of all the various contracts? (ix) Will physicians lose medical staff privileges merely for failing to sign with one of the many insurers with whom a hospital has such contractual provisions?

The fourth commenter also argues that phasing out the prohibition will promote activity that may violate state and federal antitrust laws, suggesting that removal of the prohibition will start a process that will cause an already consolidated market to consolidate even further, thereby limiting competition by permitting and encouraging insurers and hospitals to work together to restrain free market activities of physicians by forcing them to accept discounted or reduced fees for the benefit of insurers. The commenter says that removal of the prohibition creates the appearance that the Department tacitly approves of contract clauses that allow an insurer to piggyback on a hospital's leverage to create contracts of adhesion and encourages insurers and hospitals to act in opposition of state and federal antitrust laws. The commenter explains that the Texas Free Enterprise and Antitrust Act of 1983 and the federal Sherman Act prohibit actions that restrain trade and commerce and suggests that the Department take such concerns into consideration.

The fourth commenter also states that the proposed phase-out is inadvisable because there is no compelling or demonstrated need for removal of the prohibition as applied to physicians in groups of any size.

The fourth commenter says that all the commenter's concerns exist regardless of the timeframe of any modification or removal of the prohibition. The commenter expresses appreciation for the Department's efforts to avoid market disruption by proposing a partial phase-out on a staggered time frame, but contends that there is no date in the future when it would be appropriate for economic matters to take precedence over quality in credentialing or patient access to care, meaning that it is imperative to retain the current regulatory prohibition in full effect and without modification.

Agency Response: The Department appreciates the supportive comment from the commenters. However, multiple comments were made in regard to proposed §3.3703(a)(4), raising a multitude of issues, as noted herein, and the Department has determined that these issue warrant additional study. Accordingly, the Department has revised §3.3703(a)(4) to delete the proposed amendment, retaining the existing prohibition on contractual conditions but clarifying the scope of the prohibition by adding a statement that "this prohibition does not apply to practice conditions other than conditions of membership or privileges."

Comment: A commenter addresses direct physician involvement in negotiating insurance contracts. The commenter notes that it is common for health plans to use secondary or rental networks for hospital-based physicians not otherwise in-network, which means that even if a physician is not in-network, a patient will not necessarily be

balance billed. The commenter says that it is necessary for physicians to negotiate, because some insurance companies try to pay well below market rates, but that physicians notify hospital CEOs of negotiations with insurance companies. The commenter also says that physician groups have an incentive to ensure that patients are not affected by the negotiation process and will work with patients if there is a balance bill. The commenter posits that the market already takes care of issues related to physician negotiations in that if physicians were to aggressively balance bill patients, then patients would complain to the surgeons and hospital CEOs, and physicians would be forced to work out terms more quickly.

The commenter says that the physician's ability to negotiate is important, because if parallel contracting requirements were imposed on physicians on the front end of the process as a matter of economic credentialing, parties would never have incentive to negotiate. As it is, the commenter asserts, physicians do negotiate to address complaints internally, using the mediation process available to patients as noted on balance bills pursuant to HB 2256.

Agency Response: The Department appreciates the supportive comment from the commenters. However, multiple comments were made in regard to proposed §3.3703(a)(4), raising a multitude of issues, as noted herein, and the Department has determined that these issue warrant additional study. Accordingly, the Department has revised §3.3703(a)(4) to delete the proposed amendment, retaining the existing prohibition on contractual conditions but clarifying the scope of the prohibition by adding

a statement that “this prohibition does not apply to practice conditions other than conditions of membership or privileges.”

Section 3.3703(a)(23), (24), and (26).

Comment: A commenter suggests that the term “physician’s customary fees” in §3.3703(a)(26)(B) should be changed to “billed charges” because there is no customary fee for any particular procedure. The commenter recommends that TDI use the definition supplied in the prompt pay section of the Insurance Code and change the language to require disclosure of the method of calculating fees for care.

Agency Response: The Department disagrees that this changes is necessary because the term “physician’s customary fees” is not used in §3.3703(a)(26)(B). However, based on other comments as described herein, the Department has deleted the proposed language in §3.3703(a)(26)(B) relating to required disclosure of billed charges and participation in surveys.

Comment: A commenter suggests that for anesthesia fees, the disclosure should include time and complexity components based on a patient’s condition and other factors.

Agency Response: Based on other comments as described herein, the Department has deleted the proposed language in §3.3703(a)(26)(B) relating to required disclosure of billed charges and participation in surveys. Changes to the coding of the requirements for disclosure of fees in §3.3703(a)(26)(B) are therefore unnecessary.

Comment: A commenter expresses his general impression that a contract between the hospital and the facility-based physician really is more focused on the services that are going to be provided by that physician group. The commenter says that a lot of hospital-based physicians have administrative responsibilities, such as making sure that service is covered, considering how many doctors will be available, and determining whether a service is anesthesiology or pathology. Depending on the type of services, contracts will deal with how doctors are compensated, particularly for uncompensated care patients, quality requirements, and other things. However, the commenter expresses a lack of knowledge regarding whether contracts address the relationship between doctors and the health plans. For this reason the commenter opines that indirect contracting requirements to require facility-based physicians to make certain disclosures to the public or to the Department would be a significant change in how hospitals traditionally contract. Hospitals would have to amend contracts in order to impose such requirements.

The commenter opines that the role of hospitals in contracting is: (i) to ensure equality in providing services; (ii) to ensure that different specialties are available 24 hours per day, seven days per week; (iii) to ensure that doctors provide high quality services to the patients that arrive; (iv) to ensure doctors provide uncompensated care; and (v) to ensure the provision of administrative oversight to make sure that department is running well within the hospital. The commenter states that while the contracting of physicians with health plans is an issue, it's probably lower in priority for the hospital than such concerns.

The commenter states a general impression that, while physicians may be subject to general requirements to report information concerned with health care service delivery and to comply with state or federal law, contracts between hospitals and physicians are generally unlikely to include requirements for responses to Department or hospital inquiries.

Agency Response: The Department appreciates the comments and has deleted proposed §3.3703(a)(26)(B) in response to this comment concerning the administrative burden associated with implementation of downstream contracting requirements and in response to other comments as described herein.

Comment: Four commenters raise concerns about the burdens §3.3703(a)(23) will impose on providers and patients and assert that it is unreasonable and unnecessary.

One commenter says that the proposed provision would require referring physicians to investigate the contractual arrangements of other health care providers to whom a patient is to be referred. The commenter says that this requirement is unnecessary and would be best left to the insurance carriers and their insureds. A second commenter echoes this sentiment, noting that it is difficult or impossible for a referring physician to know with certainty whether the provider to which a patient wishes to be referred is or is not a participant in a health plan's network. The second commenter says that this difficulty exists because an insurer typically has hundreds of providers in its network, but that the network status of those providers may change from one month to the next and may not be the same with respect to all of the insurer's product lines.

A second commenter also asserts that proposed §3.3703(a)(23) is unnecessary and questions the benefit it would provide to health plans or insureds, asserting that existing preferred provider agreements almost uniformly require preferred providers to make referrals within the network and because the Texas Occupations Code §102.001 and §102.006 already require notification to patients of a physician's financial interest in a facility to which the physician makes referrals. The commenter also says that proposed §3.3703(a)(23) is unduly burdensome in requiring practitioners to produce and deliver to patients an extra form unrelated to actual care when health care providers already face a tremendous daily regulatory and compliance burden. The commenter adds that a form concerning out-of-network referrals is already being used by one insurer. The commenter opines that use of the form would have a chilling effect on an insured's ability to access out-of-network benefits because it includes 13 items of information to be addressed or signed by the provider and patient and prominently provides the 800 number for the plan's "Special Investigations" hotline. The commenter says the overall effect of the form is to intimidate both the referring physician and the patient against the selection of an out-of-network provider.

The second commenter requests that, if adopted, §3.3703(a)(23)(A) clarify that a health plan may not require an actual written, signed consent from the patient or referring physician to evidence the disclosure because the additional recordkeeping would be onerous and burdensome, and such a requirement is being used by one health plan to intimidate and restrict the patient's freedom of choice of provider. The commenter also asserts that a requirement for signed consent would violate existing

§3.3704, which provides that "a preferred provider benefit plan shall not be considered unjust under the Insurance Code Article 3.42, or unfair discrimination under the Insurance Code Articles 21.21-6 or 21.21-8, or to violate Articles 3.70-2(B) or 21.52 of the Insurance Code… provided that … the rights of an insured to exercise full freedom of choice in the selection of a physician or provider are not restricted by the insurer."

A third commenter points out that the referring physician does not play a role in building a managed care plan's network, and says that the burden of educating patients about their network options would interfere with the physician's primary duty of practicing medicine. The commenter says it is unreasonable to assume that a physician would have the time necessary to keep up with the constantly changing networks of several different managed care plans.

A fourth commenter says that one carrier has already implemented a process similar to the requirement of proposed §3.3703(a)(23), and it negatively affected the delivery of care to patients due to incredibly burdensome administrative policies that delayed necessary medical care from the physician identified by the referring physician as to the best to provide the necessary care. The commenter said that an express grant of permission by the Department for such referral policies would cause such provisions to proliferate. The commenter also asserts that very stringent referral policies have the potential to restrict a patient's full freedom of choice under Texas Administrative Code §3.3704(7) and to run afoul Texas' gag clause prohibition in the Texas Insurance Code.

Additionally, the fourth commenter states that imposing a requirement on a physician to provide referral information may impair the insured's detrimental reliance claim and fails to acknowledge the role of the patient in the referral process. The commenter says that the physician is not in charge of the network and has no control over the network's composition and that the insurer, not the physician, is responsible for the accuracy and timeliness of the provider list. The commenter says the Department appears to implicitly acknowledge this fact by creating a remedy in §3.3705(k) for patients who detrimentally rely upon an insurer's representation in the insurer's provider directory or on the insurer's website regarding the preferred provider status of a physician. The commenter says that pursuant to this provision, a claim for services rendered by a nonpreferred provider must be paid by the insurer at the applicable preferred benefit coinsurance percentage if a patient detrimentally relies on the insurer's representation.

The fourth commenter argues that inserting the physician into the process as would be permitted under proposed §3.3703(a)(23)(A) may serve to defeat the remedy provided in §3.3705(k) by giving insurers the ability to argue that a patient relied on a physician's representation rather than the insurer's provider directory or website. The commenter argues that inserting a physician into a process that is really an insurer/insured issue merely increases the margin for error and narrows the circumstances for a patient to seek remedy under proposed §3.3705(k). Additionally, the commenter asserts, the role of consumer involvement in the referral process and in determining a physician's in or out-of-network status should not be overlooked or

downplayed. The commenter says that a patient should always be encouraged and required to be involved in his or her own health care and that §3.3703(a)(23) should impose a duty on the patient to review the insurer's provider directory or website, thereby imposing the duty on the person who is capable of utilizing the remedy of §3.3705(k), namely the patient.

The fourth commenter acknowledges that the physician can facilitate a patient in the pursuit of information regarding a referred physician's preferred provider status by directing the patient to the insurers online provider directory or website. The commenter states that such an approach properly recognizes the roles of all parties (patient, insurer, and physician) and requires appropriate action by each.

The fourth commenter expresses appreciation for the Department's incorporation of prior recommendations that emergency situations be excepted from the referral requirement of proposed §3.3703(a)(23). The commenter expresses concern, however, that the provision is broadly drafted and provides significant leeway to insurers seeking to impose referral disclosure requirements on physicians in general, without regard to whether the provider is facility-based. The commenter says that no clear parameters are provided and argues that with the permissive language of the rule, insurers may seek to impose very stringent requirements on physicians, thereby creating barriers to referral. The commenter asserts that any such provisions concerning notification should not be permitted to include a requirement for a physician to obtain patient signatures, make telephone notifications or introduce administrative burdens that would inhibit a patient's freedom of choice of provider or interrupt or delay care.

The fourth commenter asserts that the intent of the provision to offer patients proper notice can be better achieved without risking the addition of unnecessary administrative burdens. The commenter notes that the Department has attempted to address patient care and freedom of choice concerns by including exception language in §3.3703(a)(24). However, the commenter opines, the current exception provides little guidance to insurers or physicians regarding impermissible contract provisions and is, therefore, not sufficient to prevent insurer abuse or to safeguard patient care and patient choice. The commenter says that without additional guidance, very stringent and burdensome referral policies will likely be imposed to the detriment of patients. The commenter therefore recommends that the Department provide more prescriptive language to ensure that patient care and choice are paramount and that patients are actively involved in their referral selections. The commenter recommends that the Department delete proposed §3.3703(a)(23) and (a)(24) and replace the language with the following:

"(23) In the case of a referral by a physician or provider who is a preferred provider to another physician or provider, a contract between an insurer and a preferred provider other than an institutional provider may provide that a physician or provider direct an insured to the insurer's online provider directory, Internet portal or website as required under §3.3705 (e). The contract may not require the physician to obtain a patient signature, make telephone or Internet notifications to the carrier, or introduce other administrative burdens that, directly or indirectly, delay medically necessary care or limit access to non-network physicians or providers."

The fourth commenter says that use of this alternative language will enable a patient to assert detrimental reliance claims based on inaccuracies in an insurer's information that may occur if the insurer's provider listing is not current; thereby allowing the insured to receive the benefit of in network coverage as provided in §3.3705(k).

Agency Response: The Department declines to make the requested change. The Department believes that it is important to clarify the ability of insurers to negotiate contractual arrangements with providers relating to referrals. Consumers are sometimes not aware when they are referred outside of a network, and providers have complained to the Department that they disagree with methods insurers have utilized to advise consumers when they are referred outside of the network. The Department agrees that the patient has a role in determining the status of physicians and providers as preferred or nonpreferred providers, and it is the Department's position that permitting insurers to include contract provisions such as the notice requirement in §3.3703(a)(23) will aid the patient in making an informed choice.

The Department disagrees that §3.3703(a)(23) requires a referring physician to investigate contractual arrangements of other providers with the insurer. The adopted rule is permissive and permits the insurer and physician to reach agreement on whether, and how, to provide relevant information to insureds. The Department anticipates that an insurer electing to use such a contractual provision would additionally provide a means to its preferred providers for determining the status of other physicians or providers as a network participant.

Under the adopted rule, insurers will have a better understanding of the limitations they will be subject to. The Department clarifies that §3.3703(a)(23) does not authorize an insurer to use contract provisions concerning disclosures related to referrals that are designed to circumvent the requirements of the Insurance Code §1301.067 or any other requirement of the law.

The Department also clarifies that §3.3703(a)(23) does not require the production and delivery of a form by physicians or providers. Section 3.3703(a)(23) merely clarifies the Department's position concerning whether the existence of such contractual provisions is generally permitted. The Department acknowledges that some insurers that include provisions such as those described in §3.3703(a)(23) may require the use of a form as a means of determining compliance with such requirements.

Additionally, the Department anticipates that some physicians or providers may use forms to document such disclosures. Such decisions will be up to the market participants, and physicians and providers will have the ability to decline to contract with insurers whose demands are burdensome. The Department declines to adopt more prescriptive requirements concerning the scope of contract provisions as permitted under §3.3703(a) in order to permit flexibility for insurers, physicians, and providers in the contracting process. Notwithstanding §3.3703(a)(23), however, the Department will have the ability to review insurers' requirements to determine if they meet the limitations set forth in the rule or are being used in a manner inconsistent with any other provisions of the law.

The Department also clarifies that §3.3703(a)(23) states the Department's position that it is generally permitted for a preferred provider contract to require a referring physician or provider to disclose the status of a physician or provider to whom an insured is being referred as a preferred or nonpreferred provider. Such disclosures may be particularly important if there is a large difference in the preferred benefit payable for services provided within the network and the basic benefit payable for the same services provided out-of-network. The Department clarifies that §3.3703(a)(23) is not limited in application to facility-based physicians. However, §3.3703(a)(24) does specify that contracting provisions concerning referrals to nonpreferred providers are required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care.

The Department agrees that access to out-of-network benefits is an important feature of preferred provider benefit plans and clarifies that §3.3703(a)(23) is not intended to imply that referral to a nonpreferred provider is prohibited under the subchapter. The Department has addressed this concern in §3.3703(a)(24), which provides in part that a contract provision requiring notice as specified in paragraph(23)(A) may not limit access to nonpreferred providers.

The Department does not believe that the adopted rule will detrimentally impact an insureds' reliance on the insurer's provider listings. If a provider is actually out-of-network, contrary to the insurer's provider listing, then correct information regarding provider status from the referring provider is beneficial information to the insured. The Department believes that it will generally be more advantageous to the insured to have

accurate information on which to base a decision of whether to seek services out-of-network and be subject to potential balance billing. If both the provider listing and the referring provider incorrectly state that a provider is a preferred provider, then adopted §3.3705(k) would require that the insurer pay the claim at the in-network coinsurance percentage if all other requirements of the subsection were also met.

Section 3.3703(a)(23) does not permit an insurer to require the use of forms that are deceptive in nature or that may mislead an insured as to the insured's right to access basic level benefits. The Department will monitor to determine whether additional rulemaking concerning the use of such contract requirements is necessary.

Comment: Three commenters raise concerns about the impact proposed §3.3703(a)(23) could have on patient welfare.

One commenter asserts that proposed §3.3703 would require a referring physician to disclose to the insured when a physician, provider, or facility to which the insured is being referred is not a preferred provider. The commenter asserts that this provision could interfere with the physician's independent medical judgment, and says that the network status of a provider or facility should not stand in the way of a patient accessing the most suitable treatment options.

A second commenter says that the notification requirement described in §3.3703(a)(23) could interfere with the patient-physician relationship as prohibited under the Insurance Code §1301.067. The commenter argues that §1301.067 prohibits an insurer from imposing, as a condition in a preferred provider contract, any restriction on the ability of a physician to discuss or communicate with a patient information regarding

the patient's health care, including the patient's medical condition or treatment options, or regarding the provisions, terms, or requirements of the health insurance policy. The commenter says that health plans would implement the provision in a way that would discourage physicians from referring or patients from selecting an out-of-network provider. The commenter requests that, if adopted, §3.3703(a)(23) clarify that a contractual provision as described in §3.3703(a)(23) may not have the effect of violating existing provisions of the Insurance Code.

A third commenter says that a doctor's first concern in making a referral is the patient's medical welfare. The commenter agrees that undue financial burden on a patient should be avoided, but asserts that sometimes a medical condition will override that need. The commenter says that proposed §3.3703(a)(23)(A) expressly permits an insurer and a preferred provider (other than an institutional provider) to enter into a contract containing a provision that requires the referring physician or provider to disclose to the insured, if applicable, that the physician, provider, or facility to whom the insured is being referred is not a preferred provider. The commenter expresses opposition to the provision because requiring a physician to provide such information poses operational challenges that may delay medically necessary care and limit access to non-preferred providers. The commenter says that delays would be likely, despite the vague requirements in §3.3703(a)(24) that "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 non-preferred providers."

Agency Response: The Department declines to make the suggested change. The Department believes that it is possible for preferred providers and insurers to develop procedures that provide an insured with information about the network status of a provider they are referred to without interfering with the physician's independent medical judgment, treatment options, or the relationship between the physician and the insured. The Department intends to monitor complaints on these issues closely to insure that insurers do not violate the Insurance Code §1301.067. Section 3.3703(a)(23) does not authorize an insurer to use contract provisions concerning disclosures related to referrals that are designed to circumvent the requirements of the Insurance Code §1301.067 or any other requirement of the law.

Comment: A commenter asserts that it is an unfair practice under the Insurance Code §541.060 for an insurer to "misrepresent[ ] to a claimant a material fact or policy provision relating to coverage…" The commenter also argues that there are several examples of violations related to misrepresentation of a policy that arise under the Insurance Code §541.061 and cites them: "[i]t is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by: (1) making an untrue statement of material fact; (2) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made; (3) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact; and (4) making a material misstatement of law." The commenter urges that, if adopted, §3.3703(a)(23) should be revised such that insurers may not require

notification in such a format as to lead a reasonably prudent policyholder to conclude that referrals to out-of-network providers are illegal, fraudulent, or not covered.

Agency Response: The Department clarifies its position that §3.3703(a)(23) does not authorize an insurer to use contract provisions concerning disclosures related to referrals that are designed to circumvent the requirements of the Insurance Code §541.060, §541.061, or any other requirement of the law. The Department disagrees that revision to §3.3703(a)(23) is necessary because provisions such as the Insurance Code §541.060 and §541.061 already clearly prohibit unfair or deceptive acts or practices that would mislead an insured concerning rights to access care from nonpreferred providers.

Comment: A commenter expresses support for proposed §3.3703(a)(23), describing it as a permissive provision that affords a measure of protection for consumers.

Agency Response: The Department appreciates the statement of support.

Comment: A commenter expresses support for the goal of increased transparency for hospital-based providers, but asserts that requirements such as §3.3703(a)(25) and (a)(26) should stem from statutory requirements concerning providers rather than contractual obligations imposed upon health plans. The commenter expresses uncertainty as to how such a requirement can be enforced, as the Department's authority would only extend to disciplinary action against a health plan. The commenter further asserts that the requirement could have the unintended result of providers leaving networks. The commenter recommends that the Department delete this section and instead study the idea of a centralized database that facility□based physician

groups, hospitals, and health plans could all utilize to determine the contract status of parties.

Agency Response: The Department agrees that its authority for enforcement of §3.3703(a)(25) and (26) rests with regulation of the insurer. However, it is the Department's belief that a preferred provider will likely want to comply with contractual requirements concerning the refund of overpayments to an insured because it is a requirement of the Insurance Code §1661.005. Inclusion of such a requirement in preferred provider contracts will reinforce this existing obligation.

With respect to §3.3703(a)(26)(A), adopted as §3.3703(a)(26), it is the Department's position that insurers marketing a preferred provider benefit plan need to actively monitor the status of the network for compliance with the network adequacy requirements established in §3.3704(e) and that the contractual requirement in §3.3703(a)(26) is a necessary means of monitoring the network adequacy of facility-based physicians at preferred provider facilities. The Department therefore disagrees that §3.3703(a)(26) should be deleted. The Department will monitor implementation of this requirement and continue to assess whether different or additional means of identifying gaps in the network adequacy of facility-based physicians, including a centralized database, are necessary or appropriate.

The Department agrees that §3.3703(a)(26)(B) could place unnecessary strain on the contracting process between insurers and preferred providers. The Department has, therefore, deleted §3.3703(a)(26)(B) in response to this and other comments as described herein.

Section 3.3703(a)(26).

Comment: A commenter notes that proposed §3.3703(a)(26)(A) requires that a contract between an insurer and a facility must require the facility to notify the insurer if there is a termination of the contract between the hospital and facility-based physicians. The commenter says that the intent of the provisions appears to be to ensure notice to an insurer that there might be a change in the physician group that is providing service in that particular facility. However, the commenter says, health plans do not always know which hospitals the facility-based doctors are working at and hospitals do not always know which health plans those doctors are under contract with. The commenter notes that facility-based physicians are not employees of the facility.

The commenter says that, as a practical matter, a hospital likely would notify all the plans it is under contract with of any changes in contracts with facility-based physicians, regardless of whether the physicians were under contract with the health plan. The commenter says that such a result would help the health plan to understand that there has been a change, but the commenter states that such result may not be consistent with the rule language.

The commenter also says that in order to comply with this as a contractual requirement, a hospital would be required to constantly monitor the contractual relationships between facility-based physicians and insurers and create a process to assure that insurers are timely notified of any contract termination with facility-based physicians. The commenter asserts that such a monitoring and notification process

would increase administrative costs for the hospital. The commenter also notes that the requirement has only an indirect impact on an insurer's network adequacy and, thus, lacks statutory authority. The commenter recommends that §3.3703(a)(26)(A) be deleted from the proposed rules.

Agency Response: The Department declines to make the suggested change. The Department believes that it is important to an insurer's maintenance of an adequate network that it have knowledge when a facility-based physician group terminates its contract with a facility because this will in most cases mean that a new group will be contracting with the facility that the insurer will need to consider contracting with. As such, the requirement directly affects network adequacy and authorized under the Insurance Code §§1301.0055, 1301.006, 1301.007, and 36.001. The Department clarifies that a general notice from a facility to all contracted insurers of any changes in physician group contracts would satisfy the requirements of §3.3703(a)(26)(A), adopted as §3.3703(a)(26), though insurers and facilities could agree to greater disclosures. Such a general notice would not entail significant monitoring of contracts between physician groups and insurers and is not anticipated to impose significant administrative costs to the facility.

Comment: Regarding proposed §3.3703(a)(26)(B), a commenter says that requiring physician disclosure of fees and participation in surveys may ultimately put hospitals out-of-network if physicians refuse to agree to make such disclosures. The commenter further asserts that such a requirement is inconsistent with legislation that instead

requires physicians to provide information to the consumer, if they are out-of-network, concerning what the consumer's financial exposure may be.

Agency Response: The Department agrees that the administrative costs of compliance with proposed §3.3703(a)(26)(B) may potentially outweigh the potential benefits to consumers. Accordingly, the Department has eliminated this subparagraph from the adopted rule in response to this and other comments as described herein.

Comment: Regarding proposed §3.3703(a)(26)(B), a commenter expresses support for the required disclosure to patients of the typical range of professional charges for facility-based physicians. However, the commenter notes that the rule only requires the disclosure of certain charges by facility-based physicians. The commenter recommends that instead proposed §3.3703(a)(26)(B) be clarified to require the disclosure of all health care services and supplies and that proposed §3.3712 be deleted.

Agency Response: The Department appreciates the supportive comment. However, based on other comments as described herein, the Department has determined to delete the proposed §3.3703(a)(26)(B) because the administrative costs of the provision appear to outweigh the potential benefits. The commenter's suggestion to expand the required disclosures would appear to increase administrative costs, and the Department does not believe that the potential benefits would outweigh the costs at this time. Accordingly, the Department declines to make the suggested change.

Comment: A commenter recommends that the Department replace the reference to "physician fees" contained within the content of proposed §3.3703(a)(26)(B)(ii) with "physician billed charges," so that the section would read as follows:

"(ii) A provision of the contract must require facility-based physicians to provide responsive information no more than annually to surveys of physician billed charges conducted by the department or by an academic institution conducting the survey on behalf of the department."

The commenter says the recommended change is necessary to clarify that the Department is referring to the physician's billed charges, not contract rates. Additionally, the commenter asserts that the change is necessary for consistency purposes, given the Department's proposed adoption of a definition of "billed charges" under §3.3702(1) and the Department's use of the "billed charges" terminology in proposed §3.3703(a)(26)(B)(i).

Agency Response: Based on other comments as described herein, the Department has determined that it is most appropriate to delete the proposed §3.3703(a)(26)(B) because the administrative costs of the provision appear to outweigh the potential benefits. Accordingly, the Department does not make the suggested change.

§3.3704(e) - Network requirements.

Comment: A commenter states support of §3.3704, finding the criteria necessary for an adequate network to be reasonable and supported by the language of HB 2256. Another commenter agrees, stating that consumers should have access to an adequate

number of providers and that the Department should have authority to require corrective action plans when necessary.

Agency Response: The Department appreciates the statements of support. The Department concurs that the Department has the authority to require corrective actions as necessary to ensure an adequate provider network for consumers pursuant to the Insurance Code §§1301.005, 1301.0055, 1301.006, 1301.007, and 36.001.

Comment: A commenter observes that proposed §3.3704(e) establishes network adequacy standards for preferred provider benefit plans that are patterned after the standards established for HMOs and expresses support for the section. The commenter states that use of such similar standards is reasonable and appropriate for preferred provider networks.

However, the commenter recommends that the Department modify §3.3704(e)(2) to address the adequacy of the number of facility-based physicians who have privileges at preferred provider hospitals. The commenter states that it makes sense for the rules to require networks to have facility-based physicians reasonably available in all service areas because much of the legislative concern that prompted passage of HB 2256 related to balance billing of patients by facility-based physicians. Another commenter agrees that the rule should address adequate numbers of hospital-based physicians at preferred provider hospitals.

Agency Response: The Department appreciates the statement of support. The Department, however, declines to modify §3.3704(e)(2) to specifically address the adequacy of the number of facility-based physicians who have privileges at preferred

provider hospitals. Although the Department agrees that the legislature has looked at the issue of balance billing by facility-based physicians in passing legislation, the Department considers §3.3704(e)(2) to include a requirement that an adequate number of facility-based physicians be reasonably available in all service areas of the preferred provider network. While there might be occasions when an insurer has an adequate network while failing to have all facility-based physician classes contracted at all preferred provider hospitals in a service area, the Department will generally expect preferred providers to be available at preferred provider hospitals. The preferred provider listing information required in adopted §3.3705 of this rule will assist consumers to identify those facilities where there are gaps in the network.

Comment: A commenter observes that proposed §3.3704 requires an adequate network to "include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions." The commenter questions whether adequacy is determined based upon a specific facility or the overall service area, as well as whether there are any mitigating circumstances. The commenter opines that the measurement should be based on whether insureds actually have access, rather than on a predetermined number of providers.

The commenter also opines that the ability of insurers to meet the adequacy requirements is dependent upon adoption of some of the other provisions that have been proposed, such as whether insurers can get those physicians under contract to begin with, which the commenter asserts relates to the concern of exclusive privileges.

The commenter says that to the extent such issues are not addressed, it is challenging for insurers to get some of those physicians into the network.

The commenter states that with respect to HMO requirements, there is a different arrangement than for the preferred provider benefit plan side, because of the prepaid nature of services and the fact that an HMO limits out-of-network choices by definition. The commenter expresses comfort with existing network requirements for HMOs but is not sure how the requirements will work for preferred provider benefit plans.

Agency Response: The Department agrees that §3.3704(e)(4) requires an adequate network to "include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions." The Department also agrees that network adequacy measurements include consideration of whether or not the insureds actually have access to physicians and providers, a requirement specified in §3.3704(e)(2). While there might be occasions when an insurer has an adequate network while failing to have all facility-based physician classes contracted at all preferred provider hospitals in a service area, the Department will generally expect preferred providers to be available at preferred provider hospitals.

The Department has addressed the potential for mitigating circumstances in two ways. An insurer may apply for waiver from one or more network adequacy requirements if there is good cause based upon one or more of the criteria specified in §3.3707. Alternatively, an insurer may use an access plan as specified in §3.3709.

The Department acknowledges that the insurer's ability to meet adequacy requirements is dependent upon fair and reasonable contracts that incentivize physicians and providers to contract. Several of the contracting requirements that were proposed, such as facility-based physician disclosure of the typical range of the physician's billed charges in proposed §3.3703(a)(26)(B), have been removed in response to comments, including the comment that additional contracting requirements impede the contracting process.

The Department appreciates the support for the HMO requirements for HMO plans, and believes the current network requirements will also work for preferred provider benefit plans without restricting the ability of an insured to seek care from nonpreferred providers if they so choose.

Comment: Some commenters express disappointment that §3.3704(d) does not specifically address access to facility-based physicians that provide indigent care or care for uninsured individuals. The commenters assert that emergency department physicians, in particular, provide a tremendous amount of indigent and uninsured care by accepting all patients regardless of their ability to pay. The commenters opine that giving emergency physicians the same consideration as hospitals that provide indigent and uninsured care would provide a wide-ranging benefit to the "safety net" of care for the Texas public and better accomplish the purpose of the section to assist in the provision of indigent and uninsured care to the Texas public.

Agency Response: The Department appreciates the service of the emergency department physicians in providing a "safety net" of care for the Texas public but

declines to specifically address facility-based physicians in §3.3704(d). Section 3.3704(d) is a long-standing provision addressing the different types of hospitals with which preferred provider plans may contract, and the stated purpose of the subsection is to afford insureds freedom of choice in the selection of institutional providers. Other sections of the rule address the availability of facility-based physicians.

Specifically, new §3.3704(e)(2) requires preferred provider plans to have an adequate number of preferred providers available and accessible 24 hours a day, new §3.3704(e)(7) requires that emergency care be available and accessible 24 hours a day, and new §3.3706(a)(5) prohibits insurers from using selection standards that directly or indirectly exclude physicians or providers located where there is a population presenting a risk of greater than average claims or utilization or exclude physicians or providers because they treat populations with higher risks or utilization. The network adequacy standards, disclosures, and reporting adopted herein will permit much closer scrutiny of the types of issues raised by the commenter. The Department intends to continue to monitor network adequacy issues following the adoption of these rules in order to determine if standards concerning the accessibility and availability of emergency room physicians should be addressed with greater specificity in the rule at a later date.

Comment: Two commenters make separate comments on the individual provisions of the proposed rule but also jointly propose that the Department consider the adoption of a simpler version of the rules, agreed to by significant stakeholders, that would focus on the network requirements set out in §3.3704(e) of the proposed rules, along with the

sections that relate to the annual report on network adequacy (§3.3709) and the responsibility of an insurer to develop an access plan (§3.3710). The commenters include with their submitted comments a proposal containing these sections, and assert that such a proposal would meet the statutory requirement for the Department to adopt network adequacy rules. To the extent that other issues are not addressed in the commenters' proposal, the commenters express a willingness to have additional discussion on how those issues might be resolved.

Agency Response: The Department appreciates the commenters' proposal for network requirements and annual network adequacy reporting and their willingness to continue additional discussions. The Department has made a number of changes to the rule in response to comments, as discussed herein, and believes that it has substantially simplified the rule. Nevertheless, there are provisions of the adopted rule that the proposed substitute would delete that the Department believes are necessary for adequate regulation of preferred provider benefit plan networks, as discussed herein. Accordingly, the Department declines to adopt the substitute proposal as submitted. The Department intends to continue to monitor the market for additional changes that may be necessary to these rules, which, for the first time in Texas, provide detailed, substantive standards for network adequacy. The Department intends to continue to work with stakeholders to improve the rules over time.

§3.3704(e)(2) - (4) and §3.3705(l)(2).

Comment: A commenter states that the definition of an adequate network under proposed §3.3704(e)(2) – (4) is based on the words adequate and sufficient, stating that the section calls for an "adequate" number of preferred providers available 24/7 in a service area; a "sufficient" number/types of preferred providers to ensure choice, access, and quality; and an "adequate" number of preferred provider physicians with admitting privileges at preferred provider hospitals in designated area. The commenter expresses concern that the use of terms like "adequate" and "sufficient" are subjective measures of adequacy to be judged by some internal process only known to the Department, that there are high expectations being placed on the facility to achieve a 90 percent in-network designation for facility-based physicians, and that the use of the arbitrary 90 percent value anchors patients' expectations around this value.

The commenter also expresses concern that the difference in expectations between the insurer and facility-based provider places providers at a disadvantage when negotiating with insurers and that there is no disclosure on the insurance web-site to demonstrate the level of out-of-network benefits. The commenter recommends a change to the insurer web site disclosure concerning network adequacy that eliminates the required listing of facilities that achieve a 90 percent in network status and replaces it with specialty and facility in-network percentages, geographic in-network percentages, and geographic presentation of the out-of-network allowable. The commenter supports a requirement for disclosure, by facility and by specialty, on an insurer's website of the percent of claims by total dollars that were processed as in-network with no judgment by

the Department about what is or is not adequate, saying that the patient should make that determination.

The commenter also supports a geographic area by geographic area and specialty by specialty disclosure on the insurer website of the percent of claims by total dollars that were processed as in-network. Additionally, the commenter states its support for a web-based disclosure of the ratio of allowed charges to billed charges specialty by specialty for cases that are performed by out-of-network providers. The commenter states that the recommended alternative disclosures would empower patients to know which facilities have a high degree of in-network providers and which plans have a high degree of in-network providers in their geographic area, and that the alternative disclosures would also empower patients to know the value of those out-of-network benefits.

By way of example, the commenter cites the Department's Study of Network Adequacy from SB 1731. The commenter references one plan that processed 95 percent of its claims as in-network at 50 percent of billed charges, but paid out-of-network claims at 50 percent of billed charges, and another plan that processed only 78 percent of its claims as in-network, but paid out-of-network claims at about 94 percent of the billed charges. The commenter says that the first plan clearly has a much more adequate network of providers, but that the second plan pays out-of-network benefits at much higher levels to the benefit of the patient. The commenter says that such information would be valuable to a patient, as it would allow the patient to make informed decisions about how premium dollars are spent.

Agency Response: The Department appreciates the suggested language changes to subsections §3.3704(e)(2) – (4); however, the Department declines to make some of the requested changes. Much of the language used in §3.3704(e) regarding sufficiency and adequacy comes from the similar health maintenance organization (HMO) network adequacy rule, found in 28 TAC §11.1607, a rule which dates back to 1998. The Department has not encountered significant problems with implementation and enforcement of the similarly worded HMO rule to date. The Department believes that the use of a similar standard will be beneficial to regulation through consistency in positions taken by the Department and compliance by insurers, some of which participate in both markets. The Department intends to continue to monitor this issue in order to determine whether greater specificity is necessary.

The Department has changed the required disclosure in proposed §3.3705(l)(2) of facilities at which more than 10 percent of claims filed by facility-based physicians were out-of-network based upon comments received, including the comment that the 10 percent standard was establishing a norm for determination of adequacy that some commenters did not agree to be appropriate. Instead, adopted §3.3705(l)(2) requires a provider listing to include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by facility-based physicians that are not under contract with the insurer, by class of physician.

The Department does not agree that the additional disclosure requirements suggested by the commenter are necessary to permit informed decision-making by

insureds due to the number of substantial disclosure requirements adopted in this rule. Specifically, insurers are required to disclose: (1) pursuant to §3.3705(b)(14), network demographic information, including whether listed areas of practice are the subject of an access plan in each particular service area; (2) pursuant to §3.3705(e), a statement of whether the network is adequate; (3) pursuant to §3.3705(l)(1), a way to identify hospitals that will assist insureds in obtaining preferred provider services; (4) pursuant to §3.3705(l)(2), a way to identify, for each preferred provider hospital, the percentage of claims filed by nonpreferred provider facility-based physicians, by class; and (5) pursuant to §3.3705(l)(9), identification of those facilities at which the insurer has no contracts with a class of facility-based provider, by class of provider. The Department believes that this information is sufficient to permit insureds to know which facilities have a high or low degree of preferred providers.

Additionally, §3.3705(o) requires disclosures of how an insurer will pay out-of-network (basic) claims. Though this disclosure is not required to be made on the insurer's webpage, the Department believes that there is sufficient variation between different plans offered by the same insurer on how out-of-network claims are paid and sufficient complexity to warrant that such information only be disclosed in the plan documents issued to particular insureds.

§3.3704(e)(8).

Comment: A commenter observes that proposed §3.3704(e)(8) establishes a network adequacy requirement under which a network must provide for preferred benefit

services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care. The commenter notes that a similar requirement with a distance of 75 miles for specialty care and specialty hospitals is imposed. The commenter says that the distance parameters, as currently drafted, are too expansive to satisfy the requirements under HB 2256, asserting that HB 2256 requires rules that address "local markets."

The commenter asserts that as currently proposed, Dallas and Fort Worth or Austin and San Antonio could be combined into an insurer's "designated service area." The commenter recommends that in order to meet the "local market" parameters of the law, network adequacy should be measured by distances of not greater than 15 miles in nonrural areas and 30 miles in rural areas. Further, for specialty care and specialty hospitals, the commenter recommends that the distance be reduced to 45 miles, rather than 75 miles.

Agency Response: The Department appreciates the suggested language offered to limit the parameters of network adequacy to 15 miles in nonrural areas and 30 miles in rural areas to prevent the distance parameters from being too expansive. However, the Department declines to make this change. The Department held several stakeholder meetings to discuss potential network adequacy standards and various methodologies to measure network adequacy and encountered substantial disagreement as to the appropriate standards. The standards in §3.3704(e)(8) were suggested by some

stakeholders as the standard most acceptable. The adopted mileage standards are the same that have been required of HMOs since 1998, and the Department has not received significant complaints of denials of access to necessary care in the context of HMOs.

Also, the use of similar regulatory language will be beneficial to efficient regulation through consistency in network requirements for both HMOs and insurers, both because some carriers participate in both markets, often using the same providers, and because the same area of the Department will likely be monitoring compliance with both the HMO and the preferred provider network requirements. Nevertheless, the Department intends to monitor implementation of this rule in order to determine whether the mileage requirements are appropriate in practice. Specifically, the Department will monitor the data received pursuant to new §3.3709(c), which requires insurers to file annual network adequacy reports with the Department, including information about the number of complaints by insureds relating to the availability of preferred providers.

Comment: A commenter opines that most physicians prefer to be in-network, for multiple reasons, but mainly because that is what is best for patients. The commenter says that it also creates a great deal of additional billing paperwork and back-end office work when a group is not in-network. The commenter states that when a physician group is contracted with 99 percent of carriers, it evidences that the group is incentivized to contract as preferred providers. The commenter states that if insurers and physicians enter into good-faith negotiations, it has been the commenter's experience that there is a resulting contract at the end of the process.

The commenter says that it is not clear from the rules how the Department of Insurance is going to determine whether a network is adequate, pointing out as an example that the proposed rules do not specify whether one neonatologist would suffice for purposes of the rule. As another example, the commenter says that the rule does not make it clear as to whether a busy neonatal intensive care unit that needs 10 physicians to staff would require 10 physicians for determining adequacy under the rule. Additionally, the commenter relates a situation from the commenter's experience where one group in a hospital provided the vast majority of care, while a second group had consulting privileges for two of its doctors. The commenter says that the insurer in the situation identified all doctors as providers for the hospital, and such an identification could create the appearance of adequate network coverage for that hospital, when, in fact, the second group did not actually deliver that type of care in that particular facility.

Based on the examples given and the situation described, the commenter opines that there is a need to more clearly define what constitutes network adequacy.

Agency Response: The Department appreciates the comment but declines to make a change to the network adequacy standards in §3.3704(e). The Department held several stakeholder meetings to discuss potential network adequacy standards and various methodologies to measure network adequacy and encountered substantial disagreement as to the appropriate standards. The adopted requirements of "the distance from any point in the insurer's designated service area to a point of service is not greater than 30 miles in non-rural areas and 60 miles in rural areas for primary care and general hospital care; and the similar requirement with a distance of 75 miles for

specialty care and specialty hospitals" were suggested by some stakeholders as the most acceptable standard. The adopted mileage standards track what have been required of HMOs and workers' compensation networks. Additionally, network adequacy is not easily broken down into very specific rules but instead depends upon a number of variables, such as how available preferred providers are to treat insureds given their other patients. The adopted rule approaches adequacy through general principles that the Department will apply in practice, with the key being whether an adequate number of preferred providers are available and accessible to insureds. The Department intends to work closely with insurers, as it has with HMOs, to address such issues as consumer availability complaints. The Department will also monitor the market for additional changes that may be needed for additional specificity in the future.

§3.3704(g) and §3.3705(b)(14) - Service areas.

Comment: A commenter recommends that the Department revisit the rules with regard to the use of "designated service areas" and "service areas," given the "local market" terminology and directives required by HB 2256. The commenter seeks clarification of proposed §3.3704(g), asking how the provision aids in the development of local market network adequacy regulations or gives effect to a standard on the local market level. Additionally, the commenter notes that the disclosure requirements of proposed §3.3705(b)(14) are tied to service areas.

Agency Response: The Department declines to make the suggested changes in regard to "designated service areas" and "service areas." Subsection §3.3705(g)

provides the needed flexibility for each preferred provider benefit plan to determine the size of their service area(s) by Texas geographic region, by Texas county, or by the first three digits of ZIP Codes in Texas, if they do not wish to have a statewide service area. The Department has required the disclosure requirements listed in §3.3705(b)(14) to be tied to service areas to facilitate consumers' ability to determine if the preferred provider benefit plan meets their individual needs and requirements. The adopted rule allows for the state to be divided into markets in various ways that will encompass the local markets as required by HB 2256.

At the same time, the network adequacy standards adopted in §3.3704 are inherently local market standards, tailored to the local market of the actual insured. Section 3.3704(e)(8) generally measures network adequacy for primary care, hospital care, and specialty care in terms of mileage from any point in the insurer's designated service area, including the location of an insured who resides within the designated service area, with standards that further vary depending on whether the insured's market is rural or nonrural. Additionally, §3.3707 permits waivers when an insurer fails to contract with providers in a particular local market, depending on issues such as the availability of providers in the particular market. The adopted rule thus does comply with the HB 2256 requirement that network adequacy standards be adapted to the local markets in which an insurer operates.

§3.3703 and §3.3705 - Contracting and Disclosure Requirements.

Comment: A commenter states agreement that network requirements are required by statute but expresses strong concern with respect to the proposed contracting and disclosure requirements. The commenter states that health plans are concerned with their ability to comply with the proposal and the realistic probability that health plans would be able to impose regulation on facility providers through the contracting process.

The commenter asserts that smaller and medium-sized companies are sometimes unable to directly contract to make their own network and typically contract with network providers. The commenter asserts that under the law, companies are required to either directly contract with the provider or to contract with a network provider organization that does have a contract. The commenter states that a network provider furnishing services to entities that are not regulated by the Department and subject to these rules would not have to comply with some of the requirements of the rule.

The commenter states that there are fewer small or medium-sized companies than there were 10 years ago and requests the Department to consider the likely overall impact of the proposed rules in a marketplace where less than 50 percent of the insured marketplace is covered through insurance companies or HMOs regulated by the Department. The commenter asserts that the vast majority of workplace insurance is provided through self-funded employer plans that the rules will not address, as well as Medicare and Medicaid. The commenter asserts that self-funded plans often have networks that may not be affected by these rules. The commenter questions whether the insured products of insurance companies that pay premium taxes and are regulated

by the Department will be more or less competitive with other products as a result of the proposed rules and some of the new requirements. The commenter opines that this factor merits particular consideration in making determinations to adopt the rules.

Agency Response: The Department appreciates the comment and notes that it has deleted the contracting requirement that was in proposed §3.3703(a)(26)(B). It has also deleted portions of the disclosure requirements that were found in proposed §§3.3705(b)(14), 3.3705(l), 3.3708(e), and 3.3713. Specifically, the Department has deleted the requirements in §3.3705(b)(14) requiring disclosures of the ratio of insureds to providers in the plan, the percentage of preferred providers accepting new patients, the percentage of preferred providers with board certifications, the percentage of accredited preferred provider hospitals, and the average surgical site infection rate at each preferred provider hospital.

The Department has also deleted the requirements in §3.3705(l) to disclose those facilities at which the insurer has a contract with facility-based providers that have an exclusive contract with the facility. The Department has also deleted the portion of the requirements in §3.3708(e) that the carrier provide on request the amount that the carrier normally pays out-of-network providers for a service and the amount that would be paid under Medicare for a service. The Department has also deleted the requirement of §3.3713 that the insurer make information concerning the effects of uncompensated care publicly available and provide notice of such availability to insureds.

Regarding the remaining contracting and disclosure requirements, the Department disagrees that insurers will not be able to comply with the requirements. The remaining facility contractual requirements are found in adopted §3.3703(a)(25) and (26). These provisions require insurers to include in their contracts with providers requirements that the provider refund overpayments from enrollees and that facilities give notice to the insurer of the termination of a contract between the facility and a facility-based physician group. The provision requiring refunds of overpayments simply places into contract what is already required under law in §1661.005 of the Insurance Code. The provision requiring notice of terminations may be easily accomplished through a notice by a facility to all its contracted insurers when a physician group terminates. Given the strong interest of insurers in providing preferred provider benefits and the low burden placed on the facility, the Department does not believe insurers will be unable to comply with these requirements.

Regarding insurers that utilize network provider organizations, the Department believes that the industry is familiar with the potential for insurance regulations that impact provider organization contracts with providers. For instance, the Insurance Code §1301.136 requires that certain provisions concerning coding guidelines be in a contract between an insurer and a preferred provider and §1301.138 applies that requirement to network provider organizations. Further §3.3703(c) of the Department's preferred provider benefit plan rules, which was not substantively amended in this rulemaking, has long required that insurers may contract with network provider organizations but are still responsible for compliance with all applicable statutes and regulations. The

Department has no reason to believe that insurers will be unable to obtain compliance with the new requirements contained in the adopted rule.

The Department agrees that the stability of the insured market is a factor to be considered in promulgating regulations, but notes that the commenter's argument would appear to apply equally to any statute or regulation of the business of health insurance in Texas. In light of the numerous existing statutes and regulations, the state has clearly determined that it is appropriate to regulate the business of health insurance in this state even if this results in different regulations being applied in the insured versus the self-funded markets. The Department believes that the adopted rule strikes an appropriate balance between placing burdens on the insured market and necessary consumer protections and does not believe that the adopted rules will result in reduced availability of insured health insurance products.

§3.3705(b).

Comment: In regard to proposed §3.3705(b), a commenter asserts that a large question exists regarding the purpose of the directory. The commenter asks whether directories are intended to be a source for measuring the quality, size and availability of providers or if they are intended to provide a universal understanding of coverage. The commenter suggests that directories should just say what providers are accessible under a plan. If the directory is to be used as a means of quality control or to provide additional information, the commenter states that it may merit consideration to standardize the form under which plans are going to offer that information or to

standardize the elements. The commenter says such a task might be appropriate for further consideration by a work group, because such an undertaking would require a level of expertise from people that are employed to compile directories to address how the directory would be set up and would look.

Agency Response: The Department believes that the provider listing should be used to inform consumers and potential enrollees with information regarding the availability of contracted providers and facilities, to include facility-based physicians. The Department anticipates consumers will utilize provider listings in selecting providers to meet their medical needs as well as a methodology of selecting providers that will meet their financial needs in determining provider contracted status and in determining out of pocket expenses for care for providers and facilities not listed within the provider listing.

Nevertheless, the Department has determined that some of the benefits of the proposed requirements for listings may be outweighed by the associated administrative costs. Thus, the Department has modified the requirements to delete some of the required provider listing information under §3.3705(b)(14) and 3.3705(l) in response to other comments as described herein. The remaining required provider information does not convey benefits and coverage information. Adopted §3.3705(b)(14) requires basic information about the network, including, for each service area, the number of insureds and the number of preferred providers available to service those insureds, and information on how to obtain any access plan created by the carrier to address network insufficiencies. Adopted §3.3705(l) requires basic information about the preferred providers in the network, including whether preferred provider hospitals have agreed to

assist insureds in obtaining preferred provider services, whether the preferred provider is accepting new patients, and whether the preferred provider has agreed to participate in quality of care peer review programs. The section also requires that provider listings enable an insured to find out the percentage of facility-based provider claims at preferred provider facilities that were out-of-network the prior year, which preferred facility-based physicians are available at preferred provider facilities, and those facilities where there are no preferred facility-based physicians. Because the above requirements do not deal with benefits and coverage, the Department declines to delete these requirements in response to this comment.

Additionally, while the Department does agree that standardization of the required elements may be beneficial to consumers, it disagrees with the idea that it is necessary for the Department to dictate standards at this date. The Department believes that it is likely that insurers will either be able to comply with the rule without consumer confusion or that the insurance industry will be able to jointly develop standards without excessive governmental oversight. The Department intends to monitor provider listing complaints to determine whether greater standardization may be necessary in the future.

§3.3705(b).

Comment: A commenter expresses concern about whether proposed §3.3705 is consistent with the work done by the Network Adequacy Advisory Committee. The commenter says the proposed section will require plans to provide an extraordinary

amount of detailed information and expresses concern as to whether plans will be able to provide it, especially in regard to the percentage of providers accepting new patients. The commenter asserts that physician offices generally make decisions about whether to accept new patients on a monthly or weekly basis, and that unless health plans are given the ability to require providers to accept new patients, it would be difficult for a plan to provide this information. The commenter notes that insurers can likely include contractual language requiring notice of whether a physician's office is accepting new patients, but points out that it is not always practical for a plan to exercise the full measure of its contractual authority over every issue.

The commenter also expresses concern that the present statutory requirement concerning identification of preferred providers that are accepting new patients will now carry new financial obligations concerning that representation under the proposed rule. The commenter says that there is doubt as to whether insurers can calculate percentages of providers accepting new patients, statute notwithstanding, and points out that as soon as something is printed, unless it is updated on a daily basis, it is probably not accurate.

Agency Response: The Department appreciates the comment. In response to this and other comments as described herein, the Department has revised §3.3705(b)(14) to remove the requirements of providing the percentage of providers accepting new patients, the ratio of providers to insureds, the percentage of providers with board certifications, the ratio of insureds to hospital beds, the percentage of accredited hospitals, and the average surgical site infection rate at hospitals. The Department

believes that the remaining adopted requirements are well within the capability of carriers to provide to insureds. The Department acknowledges that providers sometimes leave a network after a listing is printed, but has seen evidence that insurers have made insufficient efforts keep their listings up to date, resulting in an enforcement order being entered against one carrier. In order to mitigate the problems associated with printed listings, the Department has deleted the requirement previously found in §3.3705(f) of distributing a provider listing to all insureds annually. Instead, such listings may generally be made available electronically, which should allow them to be kept more up to date.

Further, the Department clarifies that an insurer is still required to comply with the Insurance Code §1301.1591(a), requiring an insurer that maintains an Internet site for use by insureds to list the preferred providers under the plan and to identify those preferred providers who continue to be available to provide services to new patients. This requirement is also specified in §3.3705(b)(12), concerning provider listings in written plan descriptions, and §3.3705(l)(4), concerning preferred provider listings generally.

§3.3705(b)(12).

Comment: A commenter recommends striking the phrase “with the agreement of the insured” as used in proposed §3.3705(b)(12).

Agency Response: The Department appreciates the comment but respectfully declines to strike the phrase “with the agreement of the insured.” The Department

notes that the section provides insurers an opportunity to do business electronically in a way that was not previously permitted under the rule. As a condition of only providing preferred provider listings electronically, however, the Department believes that certain requirements should be met by insurers. Specifically, as occurs in many business transactions, the insurer should obtain the agreement of the insured to conduct business electronically in this manner, and the insurer should offer an opportunity for the insured to decline to do business electronically, and thus receive a paper copy of the provider listing. The Department believes that the agreement of the insured could be obtained in a number of ways without significant burden on the insurer. For example, this could be a question that the insured answers when applying for coverage. Since not all Texas consumers have access to receive electronic documents, the Department believes that such agreement is necessary and a reasonable requirement of the rule.

§3.3705(b)(14)(A) - (C).

Comment: A commenter recommends that the Department delete proposed §3.3705(b)(14)(A) - (C). The commenter opines that the information required under this provision would be difficult and expensive to obtain and to include in web applications. In addition, the commenter argues that because the Department can only require information on fully insured and governmental plan members, the ratios would be misleading to consumers with respect to the total number of potential members.

Agency Response: The Department appreciates the comment but respectfully declines to delete §3.3705(b)(14)(A) - (C) in its entirety. The Department has, however, made changes to the required disclosures in §3.3705(b)(14)(A) - (C) by removing ratios and percentages from this subsection to allow for more meaningful information for Texas consumers, in response to this and other comments as described herein. Adopted §3.3705(b)(14) requires basic information about the network, including, for each service area, the number of insureds and the number of preferred providers available to service those insureds, and information on how to obtain any access plan created by the carrier to address network insufficiencies. This limited information is easily obtained from the insurer's own records.

§3.3705(b)(14)(B)(ii) - Administrative burden and infeasibility.

Comment: A commenter expresses concern that compliance with §3.3705(b)(14)(B)(ii) will be difficult or impossible because physicians ignore contract requirements to notify health plans before deciding to stop accepting particular preferred provider benefit plan products. The commenter asserts that physicians regularly manage their payor mix by simply telling their staff to no longer take a given payor's product, and says that while contracts between health plans and physicians may provide that the physician shall provide advance notice, the reality is often otherwise. The commenter asserts that such adjustments to a physician's payor mix are regular occurrences. The commenter states this is of particular concern given rule requirements linking listings of available providers

to a requirement to pay claims. The commenter says the requirement is infeasible absent the ability for a health plan to require physicians to accept and treat patients.

Agency Response: The Department appreciates the comment and has removed §3.3705(b)(14)(B)(ii) from the rule in response to this and other comments as described herein. However, the Department has retained §3.3705(l)(4), requiring an indication in a provider listing of whether each preferred provider is accepting new patients. The Department notes that there is a statutory requirement in the Insurance Code §1301.1591 that preferred provider listings identify those preferred providers who continue to be available to provide services to new patients. The Department also notes that, while §3.3705(k) requires insurers to pay additional amounts when insureds reasonably rely upon inaccurate directories, it is not anticipated that an inaccuracy regarding whether a provider is accepting new patients would result in additional payments because the insured would likely not receive services from such a provider.

§3.3705(b)(14)(C)(i).

Comment: In regard to proposed §3.3705(b)(14)(C)(i), a commenter notes that hospitals, rather than health plans, determine the number of available beds.

Agency Response: The Department appreciates the comment. The Department has changed §3.3705(b)(14)(C)(i), adopted as §3.3705(b)(14)(C), to delete the required disclosure of the ratio of insureds to hospital beds. The Department has made this change in response to other comments as described herein.

§3.3705(b)(14)(C).

Comment: A commenter observes that proposed §3.3705(b)(14)(C) requires insurers to disclose the number of contracted hospitals in a service area or region, the ratio of insureds to hospital beds, as well as whether an active access plan applies to hospital services in that service area or region, and to provide information on the percentage of preferred provider hospitals that are accredited by a nationally recognized accreditation organization and average surgical site infection rate of each preferred provider hospital. The commenter expresses support for greater transparency of provider cost and quality, but says that the proposed disclosure requirements do not relate to the adequacy of a health plan's provider network and likely will only increase plan administrative costs while providing only limited information on hospital quality.

The commenter suggests that discussions with stakeholders should continue so that appropriate processes may be developed and considered and asserts that should insurers be required to have any type of provider quality information system, the Department should review what has already been developed by the Centers for Medicare and Medicaid Services (CMS), including the Hospital Compare website and the Physician Compare website that is under development by CMS. The commenter states that to the extent that uniform reporting and public disclosure systems can be developed by both public and private payors, the public will be able to access information in a more consistent and more understandable fashion and the administrative costs associated with such systems will be less for both insurers and health care providers.

The commenter recommends that the provision be deleted.

Agency Response: The Department appreciates the comments and agrees that greater amounts of provider quality information are becoming available to the public. The Department has changed §3.3705(b)(14)(C) by deleting the required disclosures set forth in clauses (ii) and (iii) from the rule. The Department makes this change in response to this and other comments concerning the value of the proposed disclosures as described herein.

The Department has deleted the requirement in proposed §3.3705(b)(14)(C)(ii) to disclose the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization because the Department has determined that these disclosure requirements do not provide substantially meaningful information sufficient to warrant the administrative burden of tracking, updating, and disclosing the ratio.

The Department has deleted the requirement in proposed §3.3705(b)(14)(C)(iii) to disclose the average surgical site infection rate at each specific preferred provider hospital in the service area or region because the Department recognizes that an insured often has little choice in the selection of a hospital due to the lack of additional facilities in the insured's community or due to the emergent nature of the services required. Further, in geographic areas that lack competing facilities, this information will not likely vary among insurers and may, therefore, have less meaning in selecting a plan. Additionally, although the proposal would require disclosure of accreditation information on no larger than a region-specific basis, the disclosure could nonetheless

mislead insureds by presenting percentage information that is correct but that represents a disproportionate concentration of accredited hospitals within a small geographic area of the region. Finally, hospital accreditation information is separately available through the Texas Health Compare portion of the Department's website at http://www.texashealthoptions.com.

The Department has retained the required disclosure in §3.3705(b)(14)(C)(i), adopted as §3.3705(b)(14)(C), regarding the number of preferred provider hospitals in the service area, whether an access plan applies to hospital services in that area, and how the access plan may be obtained or viewed, because the Department has determined that this is relevant information to insureds that is not otherwise publicly available in a manner accessible to insureds.

***§3.3705(b)(14)(C)(ii)*.**

Comment: A commenter expresses lack of opposition to a requirement that hospital accreditation status be disclosed in plan directories. However, the commenter says that while such information may be useful, it will provide only limited assistance to insureds in determining whether there are an adequate number of quality hospitals within a particular service area. The commenter also notes that while health plans are familiar with the concept and often use accreditation as a basis for contracting, most consumers don't know what an accredited hospital is.

Agency Response: The Department appreciates the comment and recognizes that accreditation status is available through other means to insureds interested in this

information. It is even available through the Department's own Texas Health Options website: www.texashealthoptions.com/compare/hospitals.html. Accordingly, the Department has removed §3.3705(b)(14)(C)(ii) from the rule in response to this and other comments as described herein.

§3.3705(b)(14)(C)(ii) and (iii).

Comment: A commenter states that §3.3705(b)(14)(C)(ii) and (iii) is not supported by statute.

Agency Response: The Department disagrees that it lacks statutory authority to require the provision of the information required in proposed 3.3705(b)(14)(C)(ii) and (iii) and believes that it is relevant information that insurers should monitor in maintaining their networks and information that consumers may need to make choices about where to receive health care services. Nevertheless, the Department recognizes the burden that the requirement would put on insurers and that similar information is available from other sources, such as through the Department's own Texas Health Options website: www.texashealthoptions.com/compare/hospitals.html. Accordingly, the Department has removed §3.3705(b)(14)(C)(ii) and (iii) from the rule in response to this and other comments as described herein.

§3.3705(b)(14)(C)(iii).

Comment: Four commenters raise concerns about the requirement to provide information about average surgical site infection rates under §3.3705(b)(14)(C)(iii).

One commenter says that for many reasons requiring insurers to provide information on the average surgical site infection rate at each contracted hospitals is a great concern.

The first commenter notes past support for required public disclosure of hospital infection rates to the Department of State Health Services, but questions the necessity and appropriateness for requiring health plans to develop an independent system and expresses concern with how health plans will collect the information and calculate infection rates, since the occurrence of surgical infections is not reported on hospital claims submitted to insurers. The commenter says that such calculations are complicated, noting that the Department of State Health Services is currently working through a process to address them, and says that the rule proposal is not clear in defining a process. The commenter stresses the importance of such information and the impact it can have on hospitals, saying that safeguards must be in place to make sure correct data is used and that an accurate infection rate is calculated, and that hospitals must be given the opportunity to review, comment on, and suggest corrections if there are concerns about the validity of the data or calculation of the infection rate.

The first commenter also points out that surgical infection rates are just one of many important hospital process and outcome measures currently collected by state and federal governmental agencies and that disclosure of surgical site infection rates provide only a very limited portrayal of hospital quality. As an example, the commenter notes that the Medicare program collects information on whether a patient received an

antibiotic prior to surgery that might prevent an infection, and that it collects information concerning outcome measures, such as mortality, readmission, and infection rates.

The first commenter expresses no opposition to study and discussion of such a disclosure requirement, but recommends deletion of the provision.

A second commenter says that it is a good idea to emphasize quality measures for consumers, but recommends caution in using surgical site infection rates as a surrogate for a measurement of hospital quality. The commenter says that one has to be careful about what measures are chosen and how they are reported. Specifically, the commenter expresses concern based on experience as a member of infection control committees and as a medical director of a microbiology laboratory where pathologists are actually growing the organisms that are causing the infections. The commenter says it could be misleading to report a raw infection rate on a hospital-by-hospital basis because the infection rate in a pure, elective surgical hospital is going to be much different than the infection rate in an acute care hospital, or a hospital that's dealing with transplant patients or immune-suppressed patients. The commenter says that the concept of providing consumers with quality information is a good one, but refinement in terms of how quality metrics would be required to be reported are necessary. As one example, the commenter suggests that the Department consider whether there is some sort of risk stratification.

A third commenter postulates that the reason to require reporting of surgical site infection rates is to assist insureds in assessing the quality of a provider institution. The commenter says that this is a desirable endeavor, but expresses concern that a facility-

wide surgical site infection rate would provide little if any material information. The commenter says that surgical site infection rates are highly dependent on the type of surgery performed, whether or not there was pre-existing contamination of the area, risk factors inherent to the patient (such as diabetes, obesity, or immunosuppression) and many other factors. The commenter says that presentation of a facility-wide infection rate information to people who do not have knowledge of the subtleties of these statistics could be very misleading, and observes that a number of governmental and independent agencies offer aggregated data that attempts to gauge quality at a hospital. The commenter says that the current state of the art of such quality measures is far from perfect, but opines that they are arguably more meaningful than a gross surgical site infection rate.

A fourth commenter notes that the rule does not address the source of that information, the rationale for the source, or how the information is weighted for different types of facilities.

Agency Response: The Department appreciates the comments and has removed §3.3705(b)(14)(C)(iii) from the rule in response to these and other comments as described herein.

§3.3705(f).

Comment: A commenter states that the rules will require a determination about whether an insured has reasonable access to a network provider. The commenter asserts that this determination will be difficult given the circumstances, citing as an

example a situation where an area has four hospitals, and an insurer has wide coverage in three but only limited or no coverage in the fourth. The commenter says it would be difficult to determine whether, under such a situation, an insured has reasonable access to a provider. The commenter states that this requirement would entail a mandate that at every facility an insurer needs to have every physician or a given percentage of physicians.

Agency Response: The Department appreciates the comment. The Department notes that the Insurance Code §1301.005(b) and §1301.157(b) have long required insurers to make determinations of whether the insured has reasonable access to a network provider. Since this is a statutory requirement the Department declines to make a change to the proposed rule on this basis. However, the Department does acknowledge that network adequacy is difficult to reduce to requirements of exact numbers of each type of provider. Especially in urban areas, there will be a number of factors to consider in determining whether network providers are reasonably available, including factors such as the number of insureds and the availability of preferred providers in light of their entire patient loads. For this reason, the Department has found it necessary to state network adequacy requirements in terms of broad principles such as “an adequate number of preferred providers” that are “available and accessible.” This is not intended to create a mandate that every facility-based physician must be contracted at every preferred provider facility, but it does create a requirement that an insured be able to obtain treatment by preferred providers. The Department, therefore, declines to make a change to Figure: 28 TAC §3.3705(f).

§3.3705(f).

Comment: Three commenters suggest revisions to proposed Figure: 28 TAC §3.3705(f).

One commenter expresses support for the inclusion of an insurance notice to insurance consumers, but suggests the proposed notice is confusing and recommends revision of the figure to reflect all information a consumer is entitled to receive. The commenter says advance disclosure of all fees provides consumers more accurate information when they are estimating out-of-pocket health costs, but that not all consumers are aware of the right to request this information. The commenter also recommends revising the notice with respect to information concerning mediation to reflect a consumer's right to mediation when out-of-network costs for any facility-based physician is greater than $1,000. Finally, the commenter says that a consumer may desire hard copies of policies, certificates, and policy outlines, but not know how to obtain such documents; therefore, the commenter suggests including a statement in the notice explaining how a consumer may obtain hard copies of insurance documents.

Specifically, the commenter recommends revising proposed Figure: 28 TAC §3.3705(f) and offers text for an alternative version of Figure: 28 TAC §3.3705(f) that makes revisions to all but the second bullet of proposed Figure: 28 TAC §3.3705(f). The following text is included in the alternative Figure: 28 TAC §3.3705(f) provided by the commenter.

Beside the first bullet, the commenter recommends text that states “You have the right to an adequate network of preferred providers. If you believe that the network is inadequate, you may file a complaint with the Department of Insurance at http://www.tdi.state.tx.us or 1-800-252-3439.”

Beside the second bullet, the commenter recommends text that states “If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network coinsurance rate and your out-of-pocket expenses counted toward your in-network or out-of-network out-of-pocket maximum, as appropriate.”

Beside the third bullet, the commenter recommends text that states “You have the right to obtain advance estimates of the costs associated with health care services from your insurer, your provider, and the facility where you receive services. You may request:” followed by a series of indented bullets that list: (i) “an advance estimate from your insurer of your personal responsibility for copayments, deductibles, and coinsurance amounts based on your provider’s contracted rate for in-network services;” (ii) “an advance estimate from your insurer of the insurer’s usual and customary reimbursement rate for out-of-network services;” (iii) “an advance estimate from your provider of the charges for health care services when the services will be provided on an out-of-network basis; and”; and (iv) “an advance estimate from the facility where you receive services for any elective inpatient admission or nonemergency outpatient surgical procedure.”

Beside the fourth bullet, the commenter recommends text that states “You may obtain a current directory of preferred providers at the following website: [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds] or by calling [to be filled out by the insurer] for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.”

Beside the fifth bullet, the commenter recommends text that states “If you are treated by a provider or hospital that is not contracted with your insurer, you may be billed for anything not paid by the insurer.”

Beside the sixth bullet, the commenter recommends text that states “If the amount you owe an out-of-network radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist for services received in a network hospital is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities), you may be entitled to have the parties participate in a teleconference to settle your claim. If the result is not to your satisfaction, you may choose to mediate the claim at no cost to you. The physician and the insurer must participate if you choose mediation. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.state.tx.us/consumer/cpmmediation.html.”

Finally, beside the seventh bullet, the commenter recommends text that states “You may request a hard copy of your insurance policy, your certificate of coverage, or

an outline of your policy at the following website: [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds] or by calling [to be filled out by the insurer]."

Two other commenters suggest that the reference to "out-of-pocket" amounts in the first bullet of the figure be revised to state that the amount counts towards the "in-network out-of-pocket maximum" and that the language in the fourth bullet of the figure clarify whether the $1000 in question applies to a single or aggregate event.

One of the two commenters expresses the opinion that the intent of the bill was for application to a single event and suggests modification of the statement to that effect.

The second of the two commenters recommends that the text following the first bullet be revised to say: "You are entitled to an adequate network of preferred providers. If you believe that the network is inadequate, you may file a complaint with the Department of Insurance. If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network coinsurance rate and your out-of-pocket expenses counted toward your in-network or general out-of-pocket maximum, as appropriate."

Additionally, the second of the two commenters recommends that the text following the fourth bullet be revised to say: "If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency

department physician, or neonatologist for a health benefit claim is greater than $1,000 (after copayments, deductible, and coinsurance, including the amount unpaid by your administrator or insurer) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.state.tx.us/consumer/cpmmediation.htm."

Agency Response: The Department appreciates the comments and has made several of the suggested changes to Figure: 28 TAC §3.3705(f) in response to comments requesting that the notice be clarified for Texas consumers. The Department believes that the notice, as adopted, provides the most important information for consumers in a clear manner and has declined to make some non-substantive changes. The Department does not believe notice of how to obtain insurance documents is necessary, as it does not appear to the Department that insurers have had a practice in the past of refusing to provide such documents upon request.

The language in the first bullet of the proposed figure has been simplified and reorganized as separately bulleted sentences. Also, adopted Figure: 28 TAC §3.3705(f) clarifies that an insured may be entitled to have out-of-pocket expenses counted toward the in-network, out-of-network, or general out-of-pocket maximum, as appropriate, if the insured has obtained out-of-network services because no preferred provider was reasonably available. Additionally, the Department has determined that variation in plan design supports the provision of greater flexibility. The Department has

therefore added language to the figure to address the possibility that a plan has a general out-of-pocket maximum rather than specific in-network and out-of-network maximums only.

For reorganization and simplification of the figure, the Department has moved the last sentence of the second bullet of the proposed figure into a separately bulleted sentence.

The language in the third bullet of the proposed figure has been simplified and reorganized into separately bulleted provisions, as well as being designated for earlier placement in the figure. Additionally, The Department has also changed instructional language in the third bullet of adopted Figure: 28 TAC §3.3705(f) that referenced "prospective consumers or current insureds" to refer to "current or prospective insureds or group contract holders" to preclude ambiguity and for consistency with usage elsewhere in the subchapter and in the Insurance Code §1301.158(b).

§3.3705 - Estimate of service cost from pathologist.

Comment: A commenter discusses the commenter's experience regarding a provider's ability to estimate the cost of services, an insured's right that is referenced in the notice in §3.3705(f).

The commenter says that in a non-emergency case a provider can probably make some estimate. However, the commenter notes that it is not unlikely that in performing some procedures, services in addition to those originally requested will be performed. As an example, the commenter notes that if a condition turns out to be

more extensive than initially thought, additional tests or escalation to a higher, more expensive level of tests may be required. In such situations, the commenter says, it becomes very difficult to provide good advance information about the cost to the patient. The commenter says that on simple procedures, it would be possible to give a very good estimate, but that with more complicated procedures involving unforeseen issues and additional testing, it would be very difficult to give an estimate, though sometimes even simple procedures can have unforeseen complications.

The commenter notes that it would be possible to provide a patient with a laundry list of CPT codes, but does not know if the AMA would permit the doctor to state what those CPT codes mean. The commenter observes that, in reality, a patient will probably have no clue as to how many coded procedures a doctor is going to order, and the commenter also points out that different doctors will order different procedures. The commenter said that while the commenter has knowledge of what procedures in the commenter's specialty cost, the commenter may not have a good concept of what costs services in others specialties will have.

The commenter says that standard of care issues are factored in when providing services and determining appropriate tests. The commenter notes that, despite tort reform, tests may sometimes be ordered to cover a physician for litigation reasons, but that overall, decisions for tests are usually based on whether a physician has a sufficient confidence level in the diagnosis. The commenter also says that in the commenter's experience, some groups hold consensus conferences to collaborate on

the need for additional tests, but that such conferences would not themselves result in additional costs.

Agency Response: The Department notes that the right to an estimate is based on the Health and Safety Code §324.101(d) and the Occupations Code §101.352(c). The notice in the adopted rule merely reflects what is required of physicians and providers by law. Thus, the Department declines to make a change.

§3.3705(i) - Provider Listing Requirements.

Comment: A commenter recommends that there be separate requirements for updating electronic versus nonelectronic provider listings.

Agency Response: The Department notes that, in response to other comments as described herein, it has revised §3.3705(b)(14) to remove the requirements of providing the percentage of providers accepting new patients, the ratio of providers to insureds, the percentage of providers with board certifications, the ratio of insureds to hospital beds, the percentage of accredited hospitals, and the average surgical site infection rate at hospitals. Section 3.3705(b) specifies required content for inclusion in written descriptions of the policy and permits an insurer to use its handbook to satisfy the requirement provided the handbook complies with the requirements of the subsection. In light of the changes to the required content of handbook, used by many insurers in conjunction with the preferred provider listing, the Department disagrees that there should be separate requirements for updating electronic versus nonelectronic provider listings.

This is because: (i) the accuracy of information in the provider listing is crucial to deliberate decision-making by current and prospective insureds and group contract holders; (ii) an insurer's continued use of outdated information may violate several provisions of the Insurance Code; and (iii) in light of the changes to the requirements, it will not be difficult to provide the same information both on paper and electronically.

Current insureds would be hindered in attempting to use preferred provider services if choices of facilities and physicians were based upon outdated information. Current and prospective insureds and group policyholders attempting to assess the adequacy of a network for their own needs in determining whether to select or retain coverage under a preferred provider benefit plan would likewise be hindered.

Additionally, an insurer's long-term use of outdated information in a provider listing may constitute a violation of several provisions of the Insurance Code, including §§1301.158(b) and (c), 1301.159, 1301.1591, and 541.061. Section 1301.158(b) requires an insurer to provide on request an *accurate* written description of the terms of the policy, including the *current* list of preferred providers (emphasis added). Section 1301.158(c) prohibits an insurer or an agent or representative of an insurer from the use or distribution of information for prospective insureds that is untrue or misleading. Section 1301.159 requires an insurer to provide a current list of preferred providers to each insured at least annually. Section 1301.1591(a) requires an insurer that maintains an Internet site to list on the site the preferred providers that insureds may use, specifically identifying the preferred providers that continue to be available to provide

services to new patients. Section 1301.1591(b) requires the insurer to update the site at least quarterly.

Further, pertinent provisions of §541.061 specify that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by: (i) making an untrue statement of material fact; (ii) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made; (iii) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact; and (iv) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of the Insurance Code. It is the Department's position that quarterly updates of all provider listings as required under §3.3705(i) are necessary to prevent such violations of the Insurance Code.

§3.3705(k)(3) - Reliance upon inaccurate directory.

Comment: A commenter states that §3.3705(k)(3) specifies that obtaining a provider listing within 30 days prior to the date of service is a prerequisite to requiring an insurer to reimburse services at the preferred benefit level when the insured relied upon information provided by the insurer in seeking preferred provider services. The commenter states that the rule does not require the use of the most current listing.

Agency Response: The Department agrees that §3.3705(k)(3) does not require the use of the most current listing of providers as a prerequisite to reasonable reliance upon

a listing such that the insurer is required to reimburse services at the preferred benefit level. The Department disagrees that this is an inappropriate standard because: (i) there is not a universal date standard for the updating of provider listings; (ii) insurers may elect to take additional steps to communicate changes or impending changes to insureds.; and (iii) the rule requires reasonable reliance upon an inaccurate directory and thus permits the insurer to assert that the insured's reliance on an outdated directory was unreasonable under the circumstances.

Some portion of the myriad individual contracts between insurers and physicians or providers and between facilities and physicians are subject to change on a daily basis, and even provider contracts that cover one or more years may include opt-out provisions on a much shorter timeframe. *See, e.g. Transcript of Proceedings, Hearing to Consider the Adoption of Amendments to Sections 3.3701 through 3.3713 Concerning Preferred Provider Benefit Plans and Network Adequacy Requirements in the State of Texas, Docket No. 2726,* page 158 (Feb. 8, 2011). Given the reported state of flux concerning provider contracts, and because some insurers may be very proactive and update provider listings more frequently than is required by law, an insured will likely be unaware of the next date on which the listing will be updated.

Further, the Department clarifies that §3.3705(k) requires that the insured's reliance upon a provider listing as a basis for the preferred nature of benefits for services must be reasonable. The Department anticipates that each insurer will undertake independent analysis to determine whether there are ways in which to communicate possible or pending changes to listings in a manner that alerts insureds of

the need to confirm the continued participation of a physician or provider in less than 30 days. For example, an insurer might determine that it is appropriate to notify insureds in advance that a listing will be updated within the next 30 days. Whether and how to communicate to insureds that updates are pending or imminent will be a business decision made by the insurer.

Finally, there may be facts and circumstances in which it is unreasonable for an insured to rely upon an out of date provider listing. Because the rule requires reasonable reliance, the insurer will not be required to pay at the higher coinsurance percentage in those cases.

Comment: A commenter says that proposed §3.3705(k) provides that if an insured reasonably relied upon a directory of preferred providers maintained by the insurer then such claim for services shall be paid at the applicable preferred benefit coinsurance percentage. The commenter supports this proposed subsection, provided that the subsection does not and is not interpreted to restrict the ability of an out-of-network provider to balance bill the patient. However, the commenter recommends that the Department modify the language of proposed §3.3705(k) to more clearly reflect the rule's intent that the insurer is the party charged with paying the services at the applicable preferred benefit coinsurance percentage under this provision. The commenter states that the provision is clearly intended to compensate the insured for detrimentally relying on an insurer's inaccurate information. Thus, the commenter asserts, the remedy is directed at the insurer's responsibilities.

To provide clarification regarding this point, the commenter suggests that subsection (k) be revised to state “Reliance upon provider directory in certain cases. A claim for services rendered by a nonpreferred provider must be paid by the insurer or administrator at the applicable preferred benefit coinsurance percentage if an insured demonstrates that...”

Agency Response: The Department declines to make the suggested change because the change is not necessary. This is because §3.3701 of the rule states that the subchapter applies to preferred provider benefit plans. The rule does not impose direct requirements upon providers. Additionally, §3.3705(k) addresses the payment of claims by an insurer, and the Department believes that the context is sufficiently clear that it applies to an insurer’s payment responsibilities without making the suggested change.

§3.3705(l).

Comment: Two commenters address concerns regarding the requirement under proposed §3.3705(l) concerning disclosures relative to hospitals and facility-based physicians.

One of the commenters says that proposed §3.3705(l)(1) is not feasible, asserting that the use of prescriptive formats for provider listings as a roundabout method of regulating preferred provider contracts will undermine the ability of the insurer to provide meaningful, clear data to insureds, particularly in regard to the requirement to indicate hospitals that have agreed to make good faith efforts to assign preferred provider facility-based physicians to enrollees of the insurer and to assign provider

groups 48 hours in advance. The commenter also reminds the Department that requirements concerning directories should ensure that the listings are correct.

The second commenter opines that a number of the new disclosures are reasonable and helpful to insureds and that the subsection is generally consistent with the requirements imposed on hospitals by House Bill 2256, but that many of the disclosures should be modified or deleted from the rules.

The second commenter observes that “good faith effort” is not defined. The commenter also asserts that the requirement for insurers to provide information to insureds on how to identify hospitals that have agreed to make good faith efforts to accommodate requests to use contracted providers and to provide the insured with information about facility-based physicians is stated in very general terms, and the commenter notes that there may be a number of valid reasons why a contracted facility-based physician was not utilized in a particular case. The commenter expresses concern regarding how health plans will comply with the provisions, and suggests that such requirements might work better as a part of the insurer-facility contract rather than being included as required disclosures.

Additionally, the second commenter notes that the proposed rules require a disclosure of those facilities where the facility-based physicians at the facility do not have contracts with particular insurers. The commenter supports this provision and says inclusion of the disclosure in the directory or on the health plan website is important to consumers.

Agency Response: The Department appreciates the supportive comments but declines to make the suggested changes. The Department notes that §3.3705(l)(1) does not require insurers or hospitals to enter into specific contract agreements as described in the paragraph. Instead, it is anticipated that the rule will act as an incentive for hospitals that are able to voluntarily comply with the provisions regarding assisting insureds with obtaining services from preferred providers and thus obtain a competitive advantage over other hospitals listed in the provider listing by qualifying for the specified indicator.

The Department does not agree that it is not feasible to include an indication of the hospitals that meet the qualifications specified in §3.3705(l)(1). The Department has not provided a prescriptive means of complying with §3.3705(l)(1) and anticipates that insurers will develop efficient methods for including the indicator as required. The Department has chosen to not define “good faith effort,” but rather to leave it to the contracting process. The Department will monitor complaints for indications that hospitals are not exercising good faith efforts, and consider at that time whether more specificity is necessary.

The Department agrees that any listing information is required to be correct.

Comment: A commenter notes that the Health Network Adequacy Study involved the collection of claims from facility-based physicians and the identification of claims that were out-of-network, by dollar amount and percent. The commenter observes that there were a range of claims, with some percentage small, with a small dollar amount, and some claims with a high percentage and high dollar amounts. The commenter says

that the Department should concentrate its efforts in the areas that both were of a high percentage and had a high dollar amount.

The commenter opines that the Department had combined all the claims, rather than looking at them to identify the area of emergency services, which presents a problem both in terms of percentage of claims and dollar amounts. The commenter says that such claims arise under unique circumstances where, if it is an actual emergency, the consumer had no choice of provider. Because of this, the commenter says, the 10 percent standard, which is referenced in proposed §3.3705(l), is extrapolated into the rest of the standard and has no true meaning because it is an average, and a possibly flawed average at that.

Agency Response: The Department agrees that in the event of emergency services, consumers may not have their choice of providers available to render care. The Department notes that proposed §3.3705(l)(2) and its 10 percent threshold has been deleted from the adopted rule in response to comments, including the comment that the 10 percent threshold appears to establish an inappropriate norm for acceptable levels of preferred and basic benefit claims. In response to this comment, the Department has changed §3.3705(l)(2) to require that insurers instead make available a method for insureds to identify, for each preferred provider hospital, the percentage of claims filed by facility-based physicians that are not preferred providers, by class of physician, including emergency department physicians.

In this way, consumers will be able to make their own determinations of where to obtain services based upon relevant information. The Department believes that it will

be rare that an insurer will list a facility that is a preferred provider without having contracted with substantially all of the facility-based physicians. In those cases where it has not, however, such information will be important both to the insurer in its active monitoring of the adequacy of its network, and to consumers in deciding what facilities to utilize for medical services.

§3.3705(l)(2) – Exclusion of neonatologists and pathologists.

Comment: Four commenters observe that neonatologists and pathologists are not included in proposed §3.3705(l)(2), which requires notice concerning hospitals at which more than 10 percent of the total dollar amount of claims filed with the insurer by facility-based physicians are out-of-network. They raise concerns about this exclusion.

One commenter says that reviewing the place of service code and the use of the 26 modifier with a code on a bill for services should permit a determination of whether a pathology service was performed in connection with hospital services, which would encompass most claims that are submitted from pathologists in hospitals. Based on this, the commenter says it would be possible to make a reasonable estimate of what in-network versus out-of-network claims are for pathologists practicing in facility-based environments. The commenter therefore expresses opposition to the exclusion of pathology services from the services identified in §3.3705(l)(2).

A second commenter asserts that neonatologists are an integral part of hospital services and that neonatology services are often expensive and would represent a significant amount of dollars that are not accounted for in calculating whether notice is

required. The commenter explains that claims identify the location where a service is rendered, and also notes that, based on the commenter's knowledge, all but one private practice neonatologist groups are contracted with all the major payors. The commenter recommends that neonatology services should be represented in the rule.

A third commenter expresses uncertainty as to why neonatologists and pathologists were excluded from the rules' application.

Finally, a fourth commenter points out that the place of service is listed on claim forms; therefore, hospital patients that receive pathology services can be identified. The commenter also observes that at a recent hearing pathologists and neonatologists contended that they should not be excluded from reporting by insurers. The commenter urges the Department to carefully weigh such testimony.

Agency Response: The Department appreciates the comments and has changed §3.3705(l)(2) in response to these and other comments as described herein. To provide more specifically meaningful information to current and prospective insureds and group contract holders, adopted §3.3705(l)(2) now requires that insurers make available a method for insureds to identify, for each preferred provider hospital, the percentage of claims filed by facility-based physicians that are not preferred providers by class of physician, including pathologists and neonatologists.

§3.3705(l)(2).

Comment: A commenter says that the rule as proposed requires that the information on aggregate non-contracted claim amount statistics be provided to insureds. The

commenter states that this information is very valuable in assessing network adequacy for hospital-based providers and thus the insurers should also be required to disclose this information to the Department and to providers.

Agency Response: The Department declines to make the suggested change. Insurers are required under adopted §3.3705(l)(2) to include in their provider listings a method for insureds to obtain, for each network hospital, the percentage of the total dollar amount of claims filed by facility-based physicians that are not under contract with the insurer. Insurers are not required to file this information with the Department or providers. The Department has identified the information in §3.3709 that it wishes insurers to file with the Department each year with the annual network adequacy report. The Department may request additional information as necessary to review network adequacy issues. In light of this, the Department does not believe that the information must be explicitly required to be provided to the Department at this time.

Further, contracted providers will likely be able to obtain the same information from their contracted insurers or insureds upon request. Weighing administrative costs against the necessity of obtaining the information, the Department does not believe that it is necessary that insurers provide this information to all providers at this time, but will continue to monitor the issue.

§3.3705(l)(2) and (3).

Comment: Two commenters raise concerns regarding §3.3705(l)(2) and (3), which requires insurers to develop and provide information to insureds on how to identify

hospitals at which more than 10 percent of claims by certain facility-based physicians were out-of-network claims.

One commenter says it is unclear why the Department chose 10 percent and unclear whether the Department believes there is an appropriate amount of out-of-network usage. Additionally, the commenter expresses concern that the requirement suggests that health plans with out-of-network usage above 10 percent have violated a norm and that the figure is being used as a benchmark without consideration of whether the enrollee had access to a network provider.

This first commenter says that while the advisory committee established under SB 1731 issued a report finding that 10 percent of facility-based provider claims were out-of-network, there was wide variation in both area of practice and total dollar amount of claims. The commenter says that a 10 percent threshold is not consistent with the actual data collected by the Health Network Adequacy Advisory Committee and that it represents a flawed methodology. The commenter also says the provision sets an arbitrary standard about what an acceptable level of out-of-network claims is before the insurer is required to provide notice.

Finally, the first commenter states that the data arising from the committee's review supports the view that out-of-network usage of hospital-based physicians is a smaller problem than previously thought, and the commenter opines that the data evidenced a higher concentration of out-of-network claims for emergency services, and the commenter therefore asserts that such emergency services need separate rules.

A second commenter opines that proposed §3.3705(l)(2) - (3) is intended to reduce the potential for balance billing by identifying those hospitals in which there has been a higher percentage of out-of-network claims. The commenter expresses concern that the provision may not provide insureds with a good assessment, because it is based on a percentage of dollar amounts of total claims and does not reflect the cost or volume of particular facility-based physicians. The commenter recommends that the provisions be deleted.

Agency Response: The Department appreciates the comments but declines to delete the requirements because §3.3705(l)(1) provides a method by which insureds may identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in two discrete subparagraphs of the paragraph, and collectively, the listing-specific disclosure requirements in §3.3705(l) will facilitate an insured's ability to proactively seek out preferred provider services in nonemergency situations and to assess for future purposes the risk that some services may not be accessible through the insurer's preferred provider network.

The Department's initial decision to set the disclosure requirement at 10 percent of claims in the proposed rule was not based upon a particularized finding from the Health Network Adequacy Advisory Committee, but was rather a number that the Department determined to constitute a sufficient threshold to earn an insured's attention and signal the insured to investigate the status of facility-based physicians more closely. However, the Department does agree that the Health Network Adequacy Advisory

Committee findings indicate wide variation among classes of facility-based physician with respect to network provider usage.

In response to the concerns addressed by the commenters, adopted §3.3705(l)(2) requires insurers to include in all preferred provider listings a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer.

§3.3705(l)(4).

Comment: In regard to proposed §3.3705(l)(4), a commenter asserts that in the absence of a requirement for providers to accept and treat new patients, a health plan can only provide enrollees with the information available to the plan.

Agency Response: The Department appreciates the comment, but notes that the requirement for identification of whether a physician or provider is accepting new patients is statutorily required by the Insurance Code §1301.1591(a). The Department expects that the information regarding acceptance of new patients would be included in the provider credentialing and contracting process and updated with changes with each listing update performed. This information will also be more likely to be kept current through input by insureds pursuant to §3.3705(l)(6)(B), which requires notice to insureds of how to notify the insurer of inaccurate information in the preferred provider listing relating to whether the provider is accepting new patients.

§3.3705(l)(5).

Comment: A commenter asserts that there is no statutory basis for §3.3705(l)(5).

Agency Response: The Department disagrees with the commenter regarding statutory basis for §3.3705(l)(5). Section 3.3705(l)(5) is adopted pursuant to the Insurance Code §1301.007. It is the Department's position that a health insurance policy that provides for different levels of benefits depending upon the use of preferred versus nonpreferred providers should provide appropriate information to insureds for use in selecting a provider. If a preferred provider has notified the insurer of the physician or provider's participation in a regional quality of care peer review program, this factor may affect the insured's selection of provider and the determination to use preferred versus nonpreferred provider services. The information will, therefore, convey a characteristic of network adequacy to the insured. Section 3.3705(l)(5) is also adopted pursuant to the Insurance Code §1301.158(b), which requires an insurer to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must be in a readable and understandable format as prescribed by the Commissioner and must include a current list of preferred providers.

In addition, §3.3705(l)(5) is also adopted pursuant to the Insurance Code §1301.159, which requires insurers to provide a current list of preferred providers at least annually, and the Insurance Code §1301.1591, which: (i) requires an insurer subject to Chapter 1301 that maintains an Internet site to list on the Internet site the

preferred providers, including, if appropriate, mental health providers and substance abuse treatment providers, that insureds may use in accordance with the terms of the insured's preferred provider benefit plan.; (ii) requires that the listing identify those preferred providers who continue to be available to provide services to new patients or clients; (iii) requires the insurer to update such Internet sites at least quarterly; and (iv) authorizes the Commissioner to adopt rules as necessary to implement the section, specifying that the rules may govern the form and content of the information required to be provided. The Department notes that insurers are only required under the adopted rule to make special note of those providers who have notified the insurer of their participation in regional quality of care peer review programs. Thus, the Department anticipates that providers will be incentivized through competition to obtain such designations in preferred provider listings. The information is relevant and useful to consumers deciding on where to obtain health services. However, if no providers participate in such programs or notify insurers, then no action on the part of insurers is required.

§3.3705(l)(5).

Comment: In regard to proposed §3.3705(l)(5), a commenter asserts that health plans have no way of knowing whether a provider is participating in a regional quality of care peer review program. The commenter also says that absent some standards or a uniform definition of a “regional quality of care peer review program,” inclusion of such

information should not be a required disclosure as it will not give consumers any meaningful information.

Agency Response: The Department agrees but notes that the rule only requires this information be provided to insureds when the preferred provider notifies the insurer of their participation in a qualifying program. Absent such notification, no action on the part of the insurer is required. The Department therefore declines to change §3.3705(l)(5).

§3.3705(l)(5).

Comment: In regard to the additional listing-specific disclosure requirements under proposed §3.3705(l)(5), a commenter says that absent some standards or a uniform definition of a "regional quality of care peer review program," inclusion of such information should not be a required disclosure as it will not give consumers any meaningful information.

Agency Response: The Department appreciates the comment, but respectfully declines to modify the rule text at this time. The Department assumes that insurers and providers will be able to appropriately identify regional qualify of care peer review programs. As drafted, §3.3705(l)(5) providers for greater flexibility based upon the potential for variation in such programs regionally and based upon specialties. Should the Department receive complaints on this issue, additional specificity in the rule could be considered.

§3.3705(l)(9).

Comment: A commenter observes that §3.3705(l)(9) requires insurers to identify facilities in which the insurer has no contracts with a particular type of facility-based provider. The commenter opines that this disclosure directly relates to potential balance billing of insureds by facility-based physicians. The commenter supports inclusion of this disclosure requirement because the commenter opines that the provision is simple and will be understandable to insureds.

Agency Response: The Department appreciates the supportive comment.

§3.3705(l)(10).

Comment: In regard to proposed §3.3705(l)(10), a commenter asserts that hospitals, and not health plans, have access to information concerning whether exclusive privileges have been granted to physicians. Another commenter states that it is possible for "dual" exclusive contracts to be granted to different physician groups of the same class for the performance of different or specialized services at the same facility.

Agency Response: The Department appreciates the comments and has changed §3.3705(l) to delete proposed paragraph (10) in response. In a situation where an exclusive contract was granted but only for a subset of the services provided by a class of physician at a facility, a consumer reviewing a provider listing could be misled into believing that he or she could not receive services from a nonpreferred provider of that physician and thus not be balance billed, when in fact the services would be provided by

a different physician group of the same class that may or may not be preferred providers.

§3.3705(l)(10).

Comment: A commenter observes that proposed §3.3705(l)(10) requires plans to identify facilities that have exclusive contracts with facility-based providers, specifying the provider type. The commenter says that hospitals use exclusive contracts with facility-based physicians to assure physician coverage on a 24/7 basis and to improve the management and coordination of these physician services. The commenter agrees that such exclusive contracts may have some influence on the negotiation of insurer-physician contracts, but asserts that identification of those facilities that have exclusive contracts with facility-based physicians will in no way assist insureds in determining whether they may be balance billed by a facility-based physician. The commenter further argues that most insureds will not understand or care what an exclusive contract is in this context. Because of this, the commenter recommends that this provision be deleted.

Agency Response: The Department appreciates the comment and has changed §3.3705(l) to delete proposed paragraph (10) in response to other comments, as noted herein.

§3.3705(l)(11).

Comment: A commenter states that the requirement under proposed §3.3705(l)(11) that provider information specify the date on which the information was provided to the insured is unreasonable because often insureds may view multiple listings before deciding on a doctor, and there is no way to require an insured to enter such a date for tracking.

Agency Response: The Department appreciates the comment and has made changes to §3.3705(l)(11), adopted as §3.3705(10), to address the concern. Adopted §3.3705(10) now instead requires the provider information to be dated. The Department anticipates that this revised requirement will afford greater flexibility to insurers in determining how to date such listings and will facilitate compliance with the requirement. Additionally, the inclusion of such dating should assist consumers in using the most recent version of listings to locate a participating preferred provider while also giving insurers more flexibility in administration.

§3.3705(n) - Notice of substantial decrease in availability of hospital-based physicians.

Comment: A commenter states that, with respect to §3.3705(n) and the required notice concerning substantial decreases in the availability of in-network providers, there may be some notice requirement for term contracts. The commenter states that confusion may result from notices of substantial decreases in preferred provider physicians at preferred provider facilities because of the fact that there are plans in multiple areas all over the state that may work from one website, resulting in crowded information on the

insurer's Internet site. The commenter also opines that the preferred provider benefit plan model provides incentive on the front end for providers and plans to contract, while on the back end of the claim process there now exists the mediation process. The commenter further offers that throughout the health care selection process there are transparency elements. The commenter opines that this formula is fairly new and should be given time to work before significantly revamping the elements in the system such as the notice requirements in §3.3705(n).

Agency Response: The Department agrees that some term contracts include notice provisions and has revised §3.3705(n)(5) in response to this comment and to accommodate the possibility that pending contract terminations will be resolved prior to the effective date of the termination. Section 3.3705(n)(5) as adopted addresses deadlines for posting notice of substantial decreases in available preferred facility-based physicians at preferred provider facilities based upon two possible contract termination scenarios. If the substantial decrease results from the termination of a contract between the insurer and a facility-based physician group, §3.3705(n)(5)(A) requires that the insurer post notice of the substantial decrease and update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after the effective date of the contract termination. The Department has determined that §3.3705(n)(5)(A) does not require modification because the provision does not require posting of the notice and updating of the listing prior to the actual effective date of the termination.

If the substantial decrease results from the termination of a contract between a preferred provider facility and a preferred provider physician group, §3.3705(n)(5)(B) requires that the insurer post notice of the substantial decrease and update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after the later of: (i) the date on which the insurer receives notice of the contract termination; or (ii) the effective date of the contract termination. As adopted, §3.3705(n)(5)(B) will give greater flexibility to hospitals, insurers, and facility-based physicians by permitting early communication between a facility and an insurer concerning pending terminations of contracts without requiring pre-termination disclosure by the insurer. The Department disagrees that either potential confusion based upon additional notices or the existence of current contract incentives, mediation, and transparency measures justify deleting or delaying implementation of the requirement for insurers to provide notice of substantial decreases in the availability of preferred provider physicians at preferred provider facilities. The basis for the Department's position is as follows.

Potential confusion. The Department disagrees that potential confusion based upon the inclusion of a notice concerning substantial decreases in the availability of providers outweighs the confusion to a consumer that unsuccessfully seeks network services in reliance upon a provider listing that fails to include such a notice. While the inclusion of additional notice may result in the need for a consumer to review more information, it is the Department's position that such a notice will benefit insureds by permitting the selection of a facility based upon the risk of receiving services from a

nonpreferred facility-based physician. Due to the potential for balance billing from a nonpreferred physician, the Department's position is that the notice is important for both current insureds who are selecting a facility and for prospective insureds and group contract holders who are assessing the adequacy of a network.

Additionally, the notice is only required in the event of substantial decreases in preferred provider physician availability. The Department has defined "substantial decrease" in §3.3705(n)(1) based upon two possible terminations of a provider contract. Section 3.3705(n)(1)(A) specifies that a decrease is substantial if the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates. Section 3.3705(n)(1)(B) specifies that a decrease is substantial if the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26)(A). Thus, the Department has structured §3.3705(n) to require posted notice of a decrease only when the decrease is particularly significant.

Effect of existing framework. The Department disagrees that the combination of existing incentives to contract, the mediation process, and transparency measures justify deletion or delay of the requirement for insurers to provide notice to current and prospective insureds and group contract holders concerning substantial decreases in the availability of preferred provider physicians at preferred provider hospitals for three reasons as follows.

First, for those instances in which contracting incentives are a sufficient inducement for all parties involved, a substantial decrease in available preferred providers is less likely to occur in the first place. There are, however, several parties involved with the contracts that may affect network adequacy, including insurers, facilities, and physicians. Because of this complexity, there is an increased possibility that contracting incentives will not suffice to ensure sufficient and adequate networks.

Second, the Department disagrees that the existence of a mediation process as provided under the Insurance Code Chapter 1467 is a sufficient enough consumer protection that insureds should not have access to additional notice when there is a decrease in available preferred provider physicians. This is because an insured's recourse to mediation is subject to several limitations. A physician may avoid mandatory mediation by disclosing to the insured: (i) that the physician is not under contract with the insured's health benefit plan; (ii) the projected amount for which the insured may be responsible; and (iii) the circumstances under which the insured will be responsible for those amounts. TEX. INS. CODE §1467.051. The insured's recourse to mediation is also limited to claims that involve patient financial responsibility amounts greater than $1,000, not including copayments, deductibles, and coinsurance. TEX. INS. CODE §1467.051(a).

It is, therefore, possible that an insured could seek preferred provider services, only to learn at the last minute that some of the services provided in a preferred provider facility will be furnished by a nonpreferred provider. The nonpreferred provider may furnish disclosures to the insured as specified in §1467.051

in a manner that makes it impractical or unreasonable for the insured to seek an alternative physician that is a preferred provider. Existing protections under Chapter 1467 would not aid such an insured. Further, even if an insured qualifies to request mediation, the insured may still be subject to balance bill amounts that exceed the amount for which the insured would have been responsible had services been provided by a preferred provider.

Third, as explained in examining the disclosure requirements in the Insurance Code Chapter 1467, transparency measures do not always suffice to protect an insured from unanticipated balance bills. An insured can take all of the proper steps to seek preferred provider services, including requesting advance estimates of payments and charges from insurers, physicians, and facilities, only to learn that patient coverage issues at a facility have resulted in a change in the identity of the physician that actually furnishes ancillary services. Existing disclosure requirements will not protect an insured facing such a scenario from unanticipated balance bill amounts.

For each of these reasons, it is the Department's position that notice of substantial decreases in the availability of preferred provider facility-based physicians at preferred provider facilities is an important consumer protection in that it puts current and prospective insureds and group contract holders on notice that there is a greater risk that benefits furnished by facility-based physicians at the facility may be furnished by nonpreferred providers. Further, the notice requirement increases the possibility that the insured will realize this increased risk of higher balance billing potential at an earlier point in time and take steps to reduce that possibility.

Comment: A commenter states that §3.3705(n), as structured, creates a situation in which the current number of providers becomes the *de facto* standard of adequacy even if excessive. As such, if the group terminates, the commenter asserts that the only acceptable response for the insurer is the designation of this predetermined number of providers that arguably is not necessary to adequate access. The commenter questions whether it is possible to establish a set number of providers or a set methodology that determines what constitutes access and whether or not it is a better approach to determine access by whether or not patients can actually see providers in-network when they wish.

Agency Response: The Department agrees that: (i) proposed §3.3705(n) created a *de facto* standard of adequacy that may not be appropriate if the original number of providers exceeded that necessary to an adequate network; and (ii) flexibility concerning determination of adequacy is appropriate based upon the potential for wide variation in circumstances from market to market. The Department has, therefore, revised §3.3705(n) in response to this comment.

Section 3.3705(n) as adopted provides for additional flexibility to an insurer whose network of preferred provider physicians at a preferred provider facility has suffered a substantial decrease in two situations. First, the Department has modified subsection (n)(2) concerning initial network adequacy at the time of the substantial decrease. Subsection (n)(2) as proposed includes an exemption from the section's notice requirement for an insurer that makes available preferred provider physicians of the same specialty at an equivalent or greater percentage level as that prior to the

decrease. The Department has revised subsection (n)(2) to provide for an additional basis for exemption from the notice requirement. Subsection (n)(2) as adopted extends this exemption to an insurer that provides to the Department a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be non-compliant with the adequacy standards specified in §3.3704, as those standards apply to the applicable provider specialty. Subsection (n)(2) also specifies that the certification must be submitted to the Department by e-mail to hwcn@tdi.state.tx.us.

Second, the Department has modified subsection (n)(4) to address situations in which an insurer's network of preferred provider physicians at a preferred provider facility suffers a substantial decrease but nonetheless becomes adequate with a smaller level of physicians earlier than the six-month period of time for which notice would otherwise be required under §3.3705(n)(4)(B). Subsection (n)(4)(C) as adopted specifies that an insurer may remove notice concerning the substantial decrease if the insurer certifies to the Department that the termination of the provider contract has not caused the insurer's preferred provider service delivery network for any plan supported by the network to be non-compliant with the adequacy standards specified in §3.3704. The provision also specifies that the certification must be submitted to the Department by e-mail to hwcn@tdi.state.tx.us.

The Department has determined that §3.3705(n)(2) and (4) as adopted afford additional flexibility to insurers by creating exemptions from the notice requirements of the section that are based upon specific adequacy requirements rather than solely upon

existing levels of preferred providers that may exceed the level required to maintain an adequate network. Further, the Department anticipates that an insured's ability to receive services from a preferred provider physician at the facility on request will be included in an insurer's analysis of network adequacy in determining whether to seek an exemption under §3.3705(n)(2) or (4).

Comment: A commenter asserts that there is no statutory basis for §3.3705(n).

Agency Response: The Department disagrees that there is no statutory basis for §3.3705(n) because the notice is necessary to implement the Insurance Code §§1301.158(a) and (c), 1301.1591(a) and (c), 1701.055(a)(2), 1301.0055(2), 1301.007, and 1456.003(c). The notice requirement in §3.3705(n) is necessary to place current and prospective policyholders on notice of the increased potential that services received at the preferred provider facility in question may include services from nonpreferred provider facility-based physicians and therefore carry a greater risk of unanticipated balance bills. The Insurance Code §1301.158(a) requires an insurer to provide to a current or prospective group contract holder or insured on request an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health care plans. The description must be in a format prescribed by the Commissioner and must include a current list of preferred providers. Section 1301.158(c) also specifies that an insurer may not use or distribute information for prospective insureds that is untrue or misleading. To the extent that an insurer uses its website to provide information

concerning current preferred providers, §1301.158(a) and (c) authorizes the adoption of §3.3705(n).

Further, the Insurance Code §1301.1591(a) requires an insurer that maintains an Internet site to list on the site the preferred providers that insureds may use in accordance with the terms of the insured's preferred provider benefit plan. The listing is required to identify those preferred providers who continue to be available to provide services to new patients, and under Subsection (b) the site must be updated at least quarterly. Subsection (c) authorizes the Commissioner to adopt rules as necessary to implement the section and specifies that the rules may govern the form and content of the information required to be provided under Subsection (a).

The Insurance Code §1701.055(a)(2) specifies that the Commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form: (i) violates the Insurance Code, a rule of the Commissioner, or any other law; or (ii) contains a provision that is unjust, encourages misrepresentation, or is deceptive. It is the Department's position that the use of a form that provides for the payment of benefits at a level of coverage that is different from the basic level of coverage if the insured uses a preferred provider would be unjust, encourage misrepresentation, and be deceptive if permitted to be used in conjunction with a listing of providers that the insurer has not updated in response to a substantial decrease in available preferred providers at a preferred provider facility. The inclusion of notice on the insurer's Internet website is necessary to prevent such a result.

The Insurance Code §1301.0055(2) requires the Commissioner to adopt network adequacy standards that ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health care services to insureds, and §1301.007 authorizes the Commissioner to adopt rules as necessary to: (i) implement Chapter 1301; and (ii) ensure reasonable accessibility and availability of preferred provider services to residents of this state. Accurate communication concerning the accessibility and availability of preferred provider physicians at preferred provider facilities is crucial to implementing §1301.0055(2) and §1301.007 because the failure to communicate this information deprives the insured of the opportunity to investigate options that are less likely to result in the provision of nonpreferred provider services and the possibility of additional, unplanned balance billing expenses.

Finally, §1456.003(c) requires that an insurer clearly identify any facilities within its provider network in which facility-based physicians do not participate in the network. Such facilities must be identified in a separate and conspicuous manner in any provider directory or website directory. Consistent with the statute, the adopted rule requires a separate, conspicuous identification of such facilities in the location on the insurer's website where its provider listing is available. In the limited situations where the insurer has represented to insureds that the provider group is in its network and then suffered a substantial change in its ability to provide in-network services at that facility, the Department has added additional consumer protections by specifying that such notice must be given promptly and for a specified period of time. Such consumer protections are supported by the statutory provisions cited.

Comment: Two commenters state concerning §3.3705(n) that health plans have no idea what percentage of any specialty a group may represent at a facility because health plans do not grant hospital privileges to physicians.

Agency Response: The Department disagrees that an insurer's knowledge of the total percentage of a specialty a group represents at the facility is necessary for compliance with §3.3705(n). Section 3.3705(n)(1) addresses only the decreased availability of facility-based physicians that comprise 75 percent or more of the *preferred providers* at the facility. Based upon the Department's experience in reviewing contract provisions and credentialing materials, it is the Department's position that insurers do monitor the hospital privilege status of the physicians that are part of the insurer's network. The Department therefore declines to change §3.3705(n) in response to this comment.

§3.3705(n)(5)(B).

Comment: A commenter states that proposed §3.3705(n)(5)(B) also presumes that the current level of providers is the acceptable figure and therefore a return to that figure is required in order for there to be adequate access. The commenter says the proposed section should be deleted, as a health plan may not remove a provider from the listing until the effective date of termination of the contract.

Agency Response: The Department agrees with the comment, but declines to delete the section and has instead modified it. Section 3.3705(n) as adopted provides for additional flexibility to an insurer whose network of preferred provider physicians at a preferred provider facility has suffered a substantial decrease in two situations. First,

the Department has modified subsection (n)(2) concerning initial network adequacy at the time of the substantial decrease. Subsection (n)(2) as proposed includes an exemption from the section's notice requirement for an insurer that makes available preferred providers physicians of the same specialty at an equivalent or greater percentage level as that prior to the decrease. The Department has revised subsection (n)(2) to provide for an additional basis for exemption from the notice requirement. Subsection (n)(2) as adopted extends this exemption to an insurer that provides to the Department a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be non-compliant with the adequacy standards specified in §3.3704, as those standards apply to the applicable provider specialty. Subsection (n)(2) also specifies that the certification must be submitted to the Department by e-mail to hwcn@tdi.state.tx.us.

Second, the Department has modified subsection (n)(4) to address situations in which an insurer's network of preferred provider physicians at a preferred provider facility suffers a substantial decrease but nonetheless becomes adequate with a smaller level of physicians earlier than the six-month period of time for which notice would otherwise be required under §3.3705(n)(4)(B). Subsection (n)(4)(C) as adopted specifies that an insurer may remove notice concerning the substantial decrease if the insurer certifies to the Department that the termination of the provider contract has not caused the insurer's preferred provider service delivery network for any plan supported by the network to be non-compliant with the adequacy standards specified in §3.3704.

The provision also specifies that the certification must be submitted to the Department by e-mail to hwcn@tdi.state.tx.us.

§3.3705(o) - Disclosure Concerning Reimbursement of Basic Benefit Services.

Comment: A commenter states that §3.3705(o) establishes new member disclosure obligations regarding the basis of payment for out-of-network services and opines that this information is not likely to be helpful in a realistic way for consumers. The commenter states that the rules presuppose that a consumer will calculate the maximum allowable cost and decide which provider to choose and arrange before surgery, a scenario that the commenter asserts does not reflect reality. The commenter expresses concern that the provision places a tremendous burden on consumers. The commenter argues that one of the reasons products like insurance are regulated is that there is an asymmetry of knowledge in consumer – provider and consumer – plan dynamics.

The commenter opines that the model established under SB 1731 and HB 2256, while not perfect, accounts for the fact that there are multiple parties negotiating and that absent a requirement for all these parties to reach some agreement, there will be a level of brinksmanship that occurs in the system. The commenter questions whether the better way to deal with that is to have an incentive on the front end, some transparency in the middle, and then provision for the consumer to seek relief via mediation on the back end. The commenter opines that this is the system that the legislation provides.

Agency Response: The Department disagrees that disclosure requirements concerning reimbursement of basic benefit services are not realistically helpful or place too great a burden upon consumers. Section 1301.158 of the Insurance Code requires that insurers provide an accurate description of the terms of the policy, and the Department believes that it is a fundamental aspect of insurance regulation that an insured must be given some notice of what the insurer must pay if there is a claim.

However, the Department has entered an order against one large insurer based on allegations by the Department that the insurer's out-of-network reimbursements were unreasonably low in light of representations made in its policies. *See Commissioner's Order No. 08-0514*, June 13, 2008 at 2. The Department has concluded that some disclosure of out-of-network reimbursement methodologies must be made in order to allow consumers to enforce their insurance policies and to put them on notice of the potential for balance billing if a carrier does not intend to pay an out-of-network provider's full billed charge.

The Department disagrees that the requirements for disclosure concerning reimbursement of basic benefits are inconsistent with reality because the general purpose of transparency requirements concerning health insurance reimbursement amounts is to satisfy the need for a better, more accurate understanding of both the benefits to which an individual is entitled under a policy and the scope of potential personal liability that an individual may face after receipt of basic benefit services. Collectively, the disclosure requirements in §3.3705(o) permit an insured to better determine both how an insurer will calculate reimbursement of nonpreferred provider

services and whether the actual calculation is performed according to the stated methodology. Knowledge of how an insurer calculates reimbursement of nonpreferred provider services is crucial to an insured's understanding of the scope of actual benefits offered under a given preferred provider benefit plan. It is the Department's position that some current or prospective insureds or group contract holders will consider the scope of basic benefit reimbursement in conjunction with information concerning actual network adequacy when making decisions regarding the selection or retention of a plan. Further, it is the Department's position that disclosure concerning basic benefit reimbursement may facilitate an insured's inquiry into whether such reimbursement has been made appropriately.

§3.3705(o).

Comment: A commenter observes that proposed §3.3705(o)(2) would require insurers to identify a data source and explanation of how such data is used if reimbursement to nonpreferred providers is based indirectly upon data regarding usual, customary, or reasonable charges by providers. The commenter expresses support for transparency of information regarding determination of out-of-network rates and also asserts that patients, providers, and managed care plans would all benefit from the certainty that would be provided by a system in which "usual and customary" is defined by the Texas Department of Insurance.

Agency Response: The Department appreciates the commenter's statement of support. The Department agrees that transparency of information is important. Though

the adopted rule does not define usual and customary or require all insurers to base their claim payments on usual and customary, the rule does require insurers using usual and customary as a basis for determining reimbursement to disclose the source of their data, how it is used, and the existence of any reduction from usual and customary charges that will be applied. Because the Department is not requiring all insurers to use "usual and customary" charges in making reimbursement, it does not believe it is necessary to incorporate a definition for "usual and customary" in order to achieve transparency and declines to make the requested change.

§3.3705(p) - Plan Designations.

Comment: A commenter questions whether the network designations of a "PPO AHCN" or a "PPO LHCN" will be meaningful for consumers when there is an asymmetry of knowledge between consumer and provider, and consumer and plan. The commenter opines that the use of network designations places a great burden upon consumers. Another commenter asserts that proposed §3.3705(p) and (q) have no statutory basis. A final commenter states that additional designations such as "Approved Hospital Care Network" and "Limited Hospital Care Network" will confuse consumers.

Agency Response: The Department appreciates the comments but declines to make any changes to §3.3705(p) and (q) based upon these comments. The Department believes that Texas consumers will benefit from the shorthand ability to quickly compare health plans based on whether they comply with the network hospital requirements.

The Department adopts §3.3705(p) because the additional notice via the appropriate designation is necessary to implement the Insurance Code §§1301.158(a) and (c), 1701.055(a)(2), 1301.0055(2), and 1301.007. The designation requirement in §3.3705(p) is necessary to place current and prospective insureds and group contract holders on notice, as appropriate, of the increased potential that services received at hospitals under the preferred provider benefit plan may carry a greater risk of unanticipated balance bills due to the insurer's use of a preferred provider network that does not comply with network adequacy requirements for hospitals in the manner specified in §3.3704(e).

The Insurance Code §1301.158(a) requires an insurer to provide to a current or prospective group contract holder or insured on request an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health care plans. The description must be in a format prescribed by the Commissioner and must include a current list of preferred providers. Section 1301.158(c) also specifies that an insurer may not use or distribute information for prospective insureds that is untrue or misleading. It is the Department's position that disclosure by means of the designation specified in §3.3705(p) is necessary for compliance with §1301.158(a) and (c).

The Insurance Code §1701.055(a)(2) specifies that the Commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form: (i) violates the Insurance Code, a rule of the Commissioner, or any other law; or (ii) contains a provision that is unjust, encourages misrepresentation, or is deceptive. It is

the Department's position that the use of a form that provides for the payment of benefits at a level of coverage that is different from the basic level of coverage if the insured uses a preferred provider would be unjust, encourage misrepresentation, and be deceptive if permitted to be used without contemporaneous use of a designation as specified in §3.3705(p) to provide for additional notice to insureds and group contract holders concerning the scope of limitations on the plan's ability to provide accessible and available preferred provider hospital services in compliance with network adequacy standards for hospitals.

The Insurance Code §1301.0055(2) requires the Commissioner to adopt network adequacy standards that ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health care services to insureds, and §1301.007 authorizes the Commissioner to adopt rules as necessary to: (i) implement Chapter 1301; and (ii) ensure reasonable accessibility and availability of preferred provider services to residents of this state. Accurate communication concerning the accessibility and availability of preferred provider services in connection with hospital services is crucial to implementing §1301.0055(2) and §1301.007 because the failure to communicate this information deprives the insured of the opportunity to investigate options that are less likely to result in the provision of nonpreferred provider services and the possibility of additional, unplanned balance billing expenses.

§3.3706.

Comment: A commenter states that §3.3706(a)(5) will prohibit insurers from using selection standards for designation of preferred providers in a way that directly or indirectly avoid high risk populations through exclusion of physicians or other health care providers that are located in certain geographic areas or who treat high risk populations of insureds. The commenter expresses strong support for inclusion of this prohibition, asserting that from a public policy perspective it is essential that insurers provide reasonable access to all insureds, regardless of their socio-economic status or health condition, and that physicians, hospitals and other care providers who treat high risk patients not be denied participation in an insurer's provider network.

Agency Response: The Department appreciates the supportive comment.

Comment: A commenter expresses appreciation for the Department's recognition of accreditation as a quality indicator for provider credentialing programs and looks forward to new opportunities to work with the Department as it looks at network adequacy issues pertinent to §§3.3701 - 3.3713.

Agency Response: The Department appreciates the supportive comment.

Comment: A commenter observes that in proposed §3.3706, the Department has established a presumption of compliance with state credentialing requirements for insurers that have received non-conditional URAC Accreditation. The commenter encourages the Department to similarly consider how URAC Accreditation may complement the Department's network adequacy requirements and the goal of ensuring reasonable access and availability of preferred provider services to Texas residents.

Agency Response: The Department appreciates the supportive comment. The Department has reviewed the URAC Health Network Standards, Version 6.0 (URAC Standards). While the URAC Standards appear useful and reasonable, the Department declines to revise the proposed rule to require compliance with the URAC Standards at this time. The Department notes that the network adequacy standards in the proposed rule are the product of two prior rounds of informal drafts and stakeholder discussions and believes that it would be a substantial change to the rule to move to the URAC Standards at this time which would necessitate additional opportunity for input by stakeholders.

Additionally, the URAC Standards appear to have a different focus than the proposed rule. Specifically, the URAC Standards appear to have relatively brief requirements as to network access and availability and provider selection criteria, but many more requirements in the area of provider relations. The proposed rule goes into more depth on the issues of access and availability, as evidenced by §3.3704(e), and selection of preferred providers, as evidenced by §3.3706. The Department does not believe that additional rules on provider relations are necessary at this time in light of the existing statutory requirements concerning relations with providers in the Insurance Code Chapter 1301, Subchapters B, C, and C-1. The Department recognizes, however, that preferred provider network regulation is an emerging area nationally and intends to monitor this area on an ongoing basis to determine whether additional rulemaking is necessary. Consideration of the URAC Standards will likely be a part of any future rulemaking process.

Comment: A commenter appreciates the Department's attempt to prevent insurer "cherry-picking" among physicians and patient populations through the language in proposed §3.3706(a)(5). The commenter believes that it would also be appropriate in this section to prohibit an insurer from excluding a preferred provider based, in part, upon who owns and operates the preferred provider. The commenter recommends the following language be inserted into proposed §3.3706(a)(5): "(C) exclude a preferred provider based, in whole or in part, on who owns or operates the preferred provider."

Agency Response: The Department appreciates the supportive comment but declines to make the suggested change. The Department notes that the current language in §3.3706(a) requires that insurers must afford all licensed providers that comply with the terms and conditions of the insurer a "fair, reasonable, and equitable opportunity to become preferred providers." The Department believes that the current language is broad enough to prevent physicians and providers from being excluded based solely on who owns or operates a provider. The Department also believes that that there might be circumstances when the ownership of the provider might be relevant to the insurer's decision to contract. For instance, an insurer that has been unable to contract with the physicians that practice at a facility on reasonable terms might decide not to contract with the facility owned by those physicians if balance billing of insureds might result, and the ownership of the facility by those physicians might be relevant to that decision. Thus, the Department does not believe that a blanket prohibition is appropriate at this time.

Section 3.3707.

Comment: A commenter asserts that inclusion of specific reference to situations in which exclusive privileges are granted is necessary in §3.3707 as a basis for waiver due to failure to contract based on statements of legislative intent that can be found in the legislative history of HB 2256.

The commenter notes that for an insurer, the worst case scenario is when an in-network hospital considered to be crucial to a network in a given service area has granted exclusive privileges to certain providers. The commenter says that in some cases exclusive privileges are held by extremely large provider groups or by a group that is the one of few or only such provider groups in the area, and when that happens it affects the leverage and the ability of plans to approach the provider group and get them in-network at reasonable rates. The commenter says that in acting as an agent for employers an insurer tries to negotiate fair reimbursement rates, but that some groups exploit exclusive privileges as a negotiating tool and require insurers to pay the rates that will get them into the network.

The commenter points out that there are usually benefits for physicians to be in-network, though at times both parties can make a good-faith effort and nonetheless reach a different conclusion about what is fair reimbursement, and the commenter says it is important that both parties be allowed to walk away if they don't want to contract. The commenter notes that the process does not all happen on the front end, but that at times parties must have conversations, show-downs, and stare-downs before parties understand the impact of walking away from a contract.

Agency Response: The Department declines to make the requested changes to §3.3707. While a hospital's granting of exclusive privileges may provide support for the grant of a waiver of network adequacy requirements, the Department does not believe that HB 2256 requires the grant of a waiver based upon the existence of such an arrangement alone. For instance, the existence of a grant of exclusive privileges might not dictate the grant of a waiver in a case where the provider holding exclusive privileges offers to contract with an insurer at reimbursement rates that are below average in the market. Instead, the Department will consider the existence of exclusive privileges both in determining whether providers are available to contract with the insurer and whether those that are available have refused to contract on terms that are reasonable, as specified in §3.3707(a).

Comment: A commenter expresses appreciation for the Department's revision of §3.3707 based on feedback received during the informal draft period. The commenter observes that §3.3707 requires an insurer to demonstrate the efforts it has made to locate and contract with providers before applying for a waiver from network adequacy requirements, but says the rule as proposed is unclear and suggests that §3.3707(a) be revised to state the following:

"(a) In accordance with the Insurance Code §1301.0055(3), an insurer may make an application for a waiver from one or more network adequacy standards in a specific local market required by §3.3704 of this subchapter (relating to Freedom of Choice: Availability of Preferred Providers). The commissioner may grant the requested waiver and impose reasonable conditions on the waiver if the insurer proves:

"(1) the local market lacks providers or physicians necessary to establish an adequate network in the market under this subchapter; or

"(2) the insurer has made a good faith effort to contract with providers and physicians in the local market, but the providers and physicians in the local market have been unwilling to contract with the insurer."

Agency Response: The Department appreciates the statement of support, as well as the suggested language. The Department declines to make the specific suggested change as proposed; however, the Department has revised the language in response to this and other comments as described herein to clarify that the standards that apply to an application for a waiver include situations where there are a lack of providers or physicians available to contract or where providers or physicians have refused to contract with the insurer on any terms or on terms that are reasonable. The Department believes adopted §3.3707(a) addresses the situations addressed by the commenter's suggested revision as well as additional situations where a waiver would be appropriate.

Comment: A commenter says that many of the provisions in the proposed regulations will aid patients by providing them valuable information on network composition and introducing transparency, and the commenter expresses support for the inclusion of a physician's response to an insurer's request for waiver due to the insurer's failure to contract in local markets in §3.3707, because such information will be helpful in decision-making concerning waivers.

Agency Response: The Department appreciates the statement of support.

Comment: Two commenters express opposition to what they describe as an insurance-industry bias inherent in §3.3707. Additionally, one of the commenters recommends that the Department modify proposed §3.3707 to provide more specific parameters for the granting of waivers and to strengthen the physician notice provisions in the section.

One commenter states that the language of proposed §3.3707(a) implies that the physician is always the party not available for contracting, refusing to contract, or seeking contract terms that are unreasonable. The commenter asserts that two parties are necessary to enter into a contract, and either party may be responsible for "refusing to contract" or for "seeking unreasonable terms." The commenter urges that this is especially true because many insurance contracts are in reality contracts of adhesion, and asks how the Department will interpret and apply the "unreasonableness" waiver provision (i.e., by whose definition).

The commenter states that the implication that it is solely physicians who are unwilling "to come to the table" and negotiate when insurers fail to meet their duty to provide adequate networks is incorrect. According to the commenter, in a recent, statistically-valid survey 32 percent of respondents reported that within the past two years they had approached a plan they were not contracted with in an attempt to join the plan's network. According to the commenter, physicians in indirect access specialties were most likely to approach a plan. Among those physicians who attempted to join a network, 27 percent received no response from the network, 29 percent received an unacceptable offer, and 44 percent ultimately received a contract.

The commenter argues that the survey demonstrates both that there are many situations (i.e., 27 percent of the time) during which the insurer is the nonresponsive party and that, in many situations (i.e., 44 percent), the parties are eventually able to enter into an agreed contract. The commenter says that this is the natural result of the contract negotiation process and that §3.3707 should reflect this, but that instead the section disrupts the process and allows insurers to avoid establishment of an adequate network by allowing them to make unacceptable demands during contract negotiations.

The commenter also asserts that as the provision is drafted it seems possible an insurer could obtain a waiver applicable to the entire state, but that this would not be in accord with the local market requirements contained in HB 2256. The commenter suggests that the insurer identify the local market for which the waiver is sought.

Additionally, the commenter expresses appreciation for the Department's efforts to incorporate more physician input into the waiver process, but says that if the Department permits an insurer to notify physicians itself (rather than having the Department provide notice to the physician), then additional proof of notice requirements should be added to the rule. To address these concerns, the commenter recommends revising proposed §3.3707 to state:

"(a) An insurer may make application for a departure from local market network adequacy standards in a particular local market and the commissioner may permit such a departure upon good cause shown and appropriate proof, including:

"(1) that the insurer has made multiple offers at materially differing rates for the services sought from the physician or provider and a contract has not been executed:

"(2) that the network adequacy standards are impossible to meet in the given local market due to the absence of certain physicians and providers in the area: and

"(3) the submission of an access plan, acceptable to the commissioner, to address network access to physicians and providers in the particular local market.

"(b) An insurer seeking a waiver under subsection (a) of this section is required to file the request, a copy of the notice required under subsection (c), and a certificate of delivery of the notice required under subsection (c) with the department at the Office of the Chief Clerk, MC 11 3-2A, P.O. Box 149104, Austin, TX 78714-9104.

"(c) The insurer is required to notify any provider or physician named in the request for waiver of the filing by mailing a copy of the request to the provider or physician at the same time the request is filed with the department. This mailing must include a statement of the physician's right to respond to the request within 30 days after the insurer files the request with the department and the contact information for the department.

"(d) The insurer's request for waiver shall include submission of a description of the local market, acceptable to the commissioner, that is the subject of an application for waiver and provide contact information for the physician, physician-group, or

provider that is relevant to the waiver application, including the name of the person responsible for negotiating on behalf of the physician, physician group, or provider.

"(e) Before a waiver is granted, the commissioner shall solicit and consider input from the physician, physician group, or provider identified in the waiver application.

"(f) If the department grants a waiver under subsection (a) of this section, the commissioner shall post on the department's website the name of the preferred provider plan, the insurer offering the plan. and the affected local market.

"(g) An insurer shall apply for a waiver described in subsection (a) of this section annually, at the same time the insurer files the annual network adequacy report required under S3.3709 of this subchapter (relating to Annual Network Adequacy Report: Access Plan).

"(h) An insurer's receipt of a waiver under this section does not authorize the insurer to designate its plan as having an "Approved Hospital Care Network" (AHCN). The insurer is required to designate such plan as having a 'Limited Hospital Care Network" in accordance with the requirements of 3.3705(p) of this subchapter (relating to Nature of Communications with Insureds: Readability. Mandatory Disclosure Requirements, and Plan Designations)."

The other commenter states that even though the Department has explained that the phrase "providers who have refused to contract" is not intended to imply that providers are the guilty party in a contract failure, the proposed provision does imply fault of the physician. The commenter argues that more precise language can be used so that the next "interpreter" of the language does not draw such a conclusion. The

commenter suggests that it may be more accurate to say that the physician and the insurer have not agreed to the terms of an agreement, and suggests revising the provision to say:

"In accordance with the Insurance Code §1301.0055(3), upon a showing by an insurer that providers or physicians necessary for an adequate network under this subchapter are not available for contracting or the Insurer and the physician have failed to reach a mutual agreement..."

Agency Response: The Department declines to make the suggested changes as worded. The Department disagrees that the language of §3.3707(a) reflects a pro-insurance industry bias. The Department has revised the language of §3.3707(a) in response to this and other comments as described herein to more clearly describe the circumstances under which an insurer may request and could receive a waiver from one or more of the network adequacy requirements of this subchapter.

The Department has changed §3.3707(a) in response to comment to clarify the standard that applies to a waiver application. As specified in §1301.0055(3), the Commissioner may grant the waiver if there is good cause for such departure from the network adequacy standards. Under adopted §3.3704(a), the Commissioner may find good cause to grant the waiver if the insurer demonstrates that providers or physicians necessary for an adequate local market network: (i) are not available to contract; or (ii) have refused to contract with the insurer on any terms or on terms that are reasonable.

The language of §3.3707(a) is intended to permit a waiver of network adequacy requirements only in cases in which no providers are available or in those cases in

which the failure to contract can be attributed to the provider and the insurer is not also at fault. Pursuant to the provisions of §3.3707(c), named providers will have the opportunity to rebut an insurer's assertion that it should be granted a waiver. Thus, even if an insurer fails to accurately represent the provider's negotiating position, the provider will have the opportunity to do so.

The Department notes that the suggested language regarding a "failure to reach a mutual agreement" might permit a waiver to be granted when the insurer has taken an unreasonable negotiating position, even if the provider's/physician's position was reasonable. The Department does not believe that a grant of a waiver in that circumstance would be consistent with the intent of HB 2256.

The Department believes the provisions of §3.3707(c), coupled with the changes to §3.3707(a), adequately prevent insurers from making unreasonable contractual demands of providers and the establishment of inadequate networks and using the resulting failure to contract as a basis for receiving a waiver. Instead, these provisions will enable the Department to consider all of the circumstances that support a request for a waiver. Though the "reasonableness" standard is used in other areas of the Insurance and Administrative Codes, the Department intends to monitor the granting of waivers in order to determine whether additional specificity and clarity is warranted. The Department notes that it is unlikely that an insurer could obtain a waiver applicable for the entire state. The purpose of this section is to establish a process in which insurers can be excused from certain compliance in **local markets** (emphasis added),

and obtaining a waiver from compliance for the entire state would conflict with the spirit of the rule in its entirety, as well as the law.

The Department appreciates the statement of support for incorporating physician input into the waiver process, but respectfully declines the suggestion to require the Department – instead of insurers – to provide notice to providers of an insurer's request for a waiver, or to require additional proof of notice requirements.

The Department believes the requirement for insurers to maintain copies of the notice provided is sufficient for several reasons: insurers are required to demonstrate that providers are not available to contract or refuse to contract; the Department may ask an insurer to produce proof of notice required by §3.3707(b) sent to providers; and providers will have the opportunity to rebut an insurer's claims directly to the Department, in response to an insurer's request for a waiver. Additionally, even if a waiver is granted without provider input, the Department will post the waiver on its website, and the provider will have an opportunity to argue against the waiver the following year. The Department believes that the approach taken, when considered as a whole, outweighs the value of adding an administrative burden and cost to the Department or of requiring additional proof of notice requirements.

§3.3708(b)(2).

Comment: A commenter asserts that there is no statutory basis for proposed §3.3708(b)(2). The commenter also asserts that proposed §3.3708(b)(2) gives insufficient consideration to the role of a provider in balance billing. The commenter

states that providers have free reign to set billed charges, and that ample evidence exists that billed charges far exceed the market rate. The commenter asserts that proposed §3.3708(b)(2) will result in higher premium rates and that manual adjudication of claims will also require a significant administrative cost. The commenter points out that health plans are now required to meet certain loss ratio requirements and says that proposed §3.3708(b)(2) will severely impact a health plan's ability to determine rates.

Agency Response: The Department disagrees and declines to make a change. The Insurance Code §1301.007 requires the Commissioner to adopt rules as necessary to implement Chapter 1301, and §1301.0055 requires the Commissioner to adopt network adequacy standards. The language of §3.3708(b)(2) works to ensure that an insured receives credit for out-of-pocket expenses for services provided by a nonpreferred provider in the same manner as he or she would receive credit for services from a preferred provider, if one had been reasonably available. The requirement of §3.3708(b)(2) applies when no preferred provider is reasonably available, and not when an insured seeks services from a nonpreferred provider even though a preferred provider is reasonably available, which is consistent with the Insurance Code §1301.005 and §1301.069.

Further, §3.3708(b)(2) only applies when an insured is able to demonstrate that they have paid a balance bill out-of-pocket. At that point, an insurer is only required to credit those out-of-pocket amounts to the insureds' deductible and out-of-pocket maximum, not to pay any additional amounts on the claim. The Department is confident that the provisions of §3.3708(b)(2) will not result in higher premium rates because of

higher administrative costs because not all insureds will be balance billed by out-of-network providers under the requisite circumstances, not all of those insureds will actually pay the balance billed amount, not all of those insureds will submit evidence to insurers supporting requests that such out-of-pocket amounts be credited to their deductibles and out-of-pocket maximums, and not all of those insureds will then hit their deductible and out-of-pocket maximums.

It is also the Department's position that an insurance policy providing coverage under Chapter 1301 of the Insurance Code would be unjust and deceptive under Chapter 1701 if it did not provide credit for an insured's necessary and actual out-of-pocket expenses incurred as a result of an inadequate network or in a case of an emergency.

§3.3708(b)(2).

Comment: In regard to out-of-network payments and how those payments are calculated against the consumer's deductible, a commenter reminds the Department that a bill of charge is composed of multiple elements that include what the carrier pays and also what the provider bills. The commenter interprets the rule as requiring, if an insured is treated by an out-of-network provider, use of the billed charge in determining the application to the deductible. The commenter points out that in such a situation an insurer cannot control the billed charges, but that they have a significant impact on the cost, which is unfair. The commenter concedes that there needs to be transparency on the consumer side, making sure they have access to the insurer's maximum and

allowable or usual and customary amount, that it is clearly delineated, and that the consumer knows what it means. But the commenter says that a blanket solution where a market rate is assigned to a certain amount of billed charges, which usually do not have any connection to the actual market rate, and then applying that amount to the insured's deductible, could have serious negative consequences and rate impacts. A second commenter echoes the concerns of the first commenter.

Agency Response: The Department appreciates the commenter's comments and concerns about the burden this places on insurers in determining what constitutes a billed charge, as well as the commenter's appreciation for ensuring that consumers' expectations be met with transparency. However, the Department declines to make a change. The Department does not believe that it will be common that an insurer will have to credit an insured's out-of-pocket expenses to their out-of-pocket maximum. This is because not all insureds will be balance billed by out-of-network providers under the requisite circumstances, not all of those insureds will actually pay the balance billed amount, not all of those insureds will submit evidence to insurers supporting requests that such out-of-pocket amounts be credited to their deductibles and out-of-pocket maximums, and not all of those insureds will then hit their deductible and out-of-pocket maximums.

It is further the Department's understanding that many nonpreferred providers negotiate balance bill amounts with insureds, so in such cases there would be a further reduction to the out-of-pocket payments of the insured. Thus, the Department disagrees that there is no application of actual market rate to the amount that will be

required to be credited. This will be an amount that an insured has agreed to pay and has demonstrated to the insurer that they have actually paid to the nonpreferred provider. The Department believes that §3.3708(b)(2) represents a reasonable balancing of interests between the insured, who by definition has no choice in being seen by an out-of-network provider under the narrow circumstances specified in §3.3708(a), and the insurer, whose responsibility it is to have an adequate network.

The Department also notes that if an insurer has reason to believe that there is a substantial difference between a physician or provider's billed charges and a reasonable rate of reimbursement, the insurer is not precluded from negotiating a reduction in overall charges.

§3.3708(b)(2).

Comment: A commenter notes that proposed §3.3708(b) establishes requirements for insurers when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured. The commenter says that subsection (b) requires the insurer to pay the claim at the preferred benefit coinsurance level and to credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. The commenter expresses general support for the requirements of proposed §3.3708(b) and the Department's efforts to ensure that an insurer is held accountable for the lack of availability of a preferred

provider within the designated service area. The commenter, however, recommends that paragraph (2) of the subsection be revised to read as follows:

"(2) Credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's in-network deductible and annual in-network out-of-pocket maximum. If the insured has already met his annual in-network out-of-pocket maximum, such amounts shall be credited toward the insured's annual out-of-network deductible."

The commenter says that the purpose of the alternative language is to fully realize the stated intent of the Department to "protect insureds who do not voluntarily choose to obtain services from nonpreferred providers by giving the insureds credit for their actual out-of-pocket expenses in the same manner they would receive such credit if they had received services from a contracted preferred provider." The commenter says that to give insureds credit in the "same manner" as if they had received services from a contracted provider, the credit must be applied to the patient's in-network deductible and in-network out-of-pocket maximum.

Agency Response: The Department appreciates the commenter's statement of support relating to §3.3708(b), but declines to adopt the suggested language. The Department has deliberately left the language of the rule broad to allow insurers flexibility to draft their policy language to clarify whether such amounts will be credited to the insured's in- or out-of-network deductibles and out-of-pocket maximums. The Department believes that this represents a reasonable balancing of interests between

the insured, who by definition has no choice in being seen by an out-of-network provider under the narrow circumstances of the rule as specified in §3.3708(a), and the insurer, whose responsibility it is to have an adequate network but who is unable to determine in advance what amounts an insured will pay out-of-pocket.

§3.3708(c).

Comment: A commenter asserts that requirements concerning reimbursement methodologies have been considered and rejected during previous legislative processes and that there is no statutory basis for the Department to prescribe the methodology by which out-of-network reimbursement is calculated.

Agency Response: The Department disagrees. Initially, the Department disagrees that it has promulgated a mandatory reimbursement methodology by which out-of-network reimbursements are calculated. Section 3.3708(c) merely applies basic standards of fairness to whatever reimbursement methodology an insurer may choose to utilize. Thus, an insurer is permitted under the rule to base its reimbursements on usual and customary charges; but if it does so, it must use generally accepted industry standards for determining billed charges. An insurer is permitted to base its reimbursements on claims data; but if it does so, it must use data that is updated periodically. Further, an insurer is required to use generally accepted bundling edits and logic when determining how to pay its claims. The Department's position is that an insurer that does not comply with these fundamental requirements would be selling a product that is unjust, encourages misrepresentation, or is deceptive under Chapter

1701. If insurers are not required to comply with these requirements, an insured will be unable to have any confidence that their claims are paid correctly or fairly.

The Insurance Code §1301.007 requires the Commissioner to adopt rules as necessary to implement Chapter 1301. The failure to address the methodology by which out-of-network reimbursement is calculated could adversely affect insureds and providers, particularly if insurers use old data, statistically insignificant samples, or any other information described by §3.3708(c) to calculate out-of-network reimbursements.

§3.3708(d).

Comment: A commenter asserts that there is no statutory basis for §3.3708(d).

Agency Response: The Department disagrees and declines to make a change. This provision is necessary to ensure that health insurance policies do not restrict an insured's access to the basic health care services to which the insured is entitled as part of the benefit package as specified in the Insurance Code §1301.005 by limiting coverage to those services provided within the designated service area.

It is the Department's position that imposition of such a restriction by an insurer would reduce the insured's access to basic level services in a manner that would render the policy unjust as contemplated in the Insurance Code §1701.055(a)(2). Section 3.3708(d) reinforces the existing requirement specified in §3.3704(a)(1) that a preferred provider benefit is prohibited from requiring that a service be rendered by a particular hospital, physician, or practitioner in accordance with the Insurance Code §§1251.005,

1251.006, 1301.003, 1301.006, 1301.051, 1301.053 – 1301.055, 1301.057 – 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201.

New §3.3708(d) is also a necessary clarification to ensure that the adoption of §3.3704(g), which permits an insurer to define a service area on a smaller than statewide basis, does not result in the improper reduction of an insured's access to basic level services.

For each of these reasons, §3.3708(d) is authorized pursuant to the Insurance Code §1301.007 and §36.001.

§3.3708(e).

Comment: A commenter raises several concerns in regard to proposed §3.3708(e). The commenter asserts that proposed §3.3708(e) creates a new disclosure requirement on the explanations of benefits form, but that there is no statutory basis for it. The commenter also points out that there is limited space on an explanation of benefits form and that significant administrative cost will be necessary to incorporate the requirements of proposed §3.3708(e), if it is even possible to do so. Finally, the commenter asserts that proposed §3.3708(e) presumes that a health plan is aware of situations where an insured is unable to find a preferred provider.

Agency Response: The Department appreciates the commenter's comments, but disagrees. However, the Department has determined that the provisions of §3.3708(e) should be modified due to potential administrative costs as indicated in the comment. Adopted §3.3708(e) requires an insurer to include a notice, along with each explanation

of benefits, that the insured has the right to request information concerning negotiated rates for comparison purposes. The requirement applies when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured as specified in subsection (a) of the section. Upon the request of an insured, the insurer must furnish the median per-service amount the insurer has negotiated with preferred providers for the service furnished, exclusive of cost sharing responsibilities of the insured, or notification that the claim was paid at this amount.

For an insured faced with unanticipated balance bills resulting from the need for emergency care or due to the failure of the insurer to provide an adequate network, §3.3708(e) is necessary to provide access to information to facilitate evaluation of the reimbursement made by the insurer. The information will also facilitate an insured in determining whether to request mediation as permitted under the Insurance Code §1467.054 for eligible claims. Even if mediation is not available, the information provided by the insurer could greatly assist an insured who wishes to contest an alleged unreasonable balance bill by a nonpreferred provider by allowing the insured to compare the physician or provider's charge to the average rate other providers have agreed with the insurer to use.

The Department has changed §3.3708(e) in response to this and other comments as described herein to delete the requirements in proposed §3.3708(e)(2) and (3) because the Department has determined that such comparison rates may be inappropriate and that the disclosure could be administratively burdensome. The comparison rate specified in proposed §3.3708(e)(2), the amount for the service

calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers, is often going to be the rate at which the claim is actually paid, and this amount may be modified as a result of plan design rather than reflective of a market rate. Similarly, the amount that would be paid under Medicare for the service, as required under proposed §3.3708(e)(3), may be an inappropriate comparison rate because the amount is fixed pursuant to statute and does not represent the market rate.

The Department has also changed proposed §3.3708(e) in response to the comment that there is limited space on an explanation of benefits form. Adopted §3.3708(e), therefore, requires that the insurer include the notice “along with,” rather than “on” each explanation of benefits. Insurers will thus have greater flexibility in determining how to provide the notice as a result of this change.

The Department has also changed §3.3708(e) to delete the January 1, 2012 effective date proposed for the subsection. Pursuant to adopted §3.3701(a), the new and amended sections adopted by the Commissioner apply to any preferred provider benefit plan policy delivered, issued for delivery, or renewed on or after one year from the date of adoption. The Department has determined that it is reasonable to similarly extend the time for compliance with adopted §3.3708(e). Further, the Department has determined that it is no longer necessary to provide for an extended effective date for §3.3708(e) due to the reduced and more flexible requirements of the adopted subsection as changed in response to comments.

As a further result of the reduced and more flexible disclosure requirements of §3.3708(e) as changed in response to comments, the Department has deleted §3.3708(f) and (g) and revised the section title to delete the reference to a waiver. The Department has determined that a waiver process to permit an additional six months for compliance is no longer necessary because the subsection no longer requires an insurer to make available on request comparison rate information based upon amounts paid by Medicare, a third-party payor. Instead, the insurer is only required to make available information concerning its own median negotiated rate. Further, the insurer is permitted to provide the underlying notice concerning availability of the information along with, rather than on, explanation of benefit forms. Because there is no longer a need to obtain third-party payment information and to reconfigure explanation of benefit forms, there is a reduced need for a waiver process associated with the notice and disclosure requirement.

The Department declines to entirely delete §3.3708(e) because the Department believes that it is vital that an insured have information about what preferred providers have agreed to accept for the same services when negotiating with an nonpreferred provider, at least in the narrow circumstances when the insured had no choice in obtaining services out-of-network. It is the Department's position that an insurer does not make preferred provider services reasonably available to an insured, as required by the Insurance Code §1301.005, unless the insurer provides an insured at least this potential tool to demonstrate to a nonpreferred provider what a reasonable rate of reimbursement would be.

§3.3708(e).

Comment: A commenter says that proposed §3.3708 is inappropriate in that in specific situations it allows insureds to seek a comparison of the commercial insurance and Medicare rates. The commenter states that comparing a government set rate for Medicare that clearly shifts costs to the non-government insured is an unreasonable comparison for the commercial market and that a more appropriate approach would be to provide a panel comparison of rates of the commercial insurance products that could include products for the self-insured/individual market, the employer market, and for the ERISA/TPA products the commercial insurer manages. Alternatively the commenter suggests that ERISA/TPA information could be provided for state employee plans or the plans managed by county or city government for employees or teachers.

Agency Response: The Department appreciates the commenter's comments, and has changed §3.3708(e) to delete the provisions of 3.3708(e)(3) as a result of these and other comments as described herein. While provision of comparison Medicare rates would provide an insured with some basis of comparison, the Department agrees that it is not necessarily a market-based comparison. The Department disagrees that the benefit of providing additional third party payor information for comparison appears to justify the administrative burden of obtaining and providing the information at this time.

§3.3708(e).

Comment: Two commenters address the methodologies delineated for payment to a nonpreferred provider.

One commenter notes that in proposed §3.3708(e), the Department proposes a requirement that when services are rendered to an insured by a non-preferred provider because no preferred provider is reasonably available to the insured, an insurer must include a notice on each explanation of benefits that the insured has the right to request for comparison purposes: (1) the median per-service amount the insurer has negotiated with preferred providers for the service furnished, excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount; (2) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by non-preferred providers (such as usual, customary and reasonable amount), excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount; and (3) the amount that would be paid under Medicare for the service, excluding any cost sharing imposed with respect to the insured.

The commenter references the Department's rational for proposed §3.3708(e) that is provided in the proposal preamble and says that, while the commenter supports transparency and provision of useful billing information to patients and insured, the commenter disagrees with the Department's stated rationale for this provision and strongly contends that the three amounts listed in the proposed rule do not reflect what is a "reasonable" billed charge.

First, the commenter notes that that the median per-service amount listed in §3.3708(e)(1) does not take into account the fact that some insurance companies negotiate fees with two fee schedules. In certain cases, commenter states, an insurer will establish separate fee schedules based upon place of service (e.g., inpatient, outpatient, ASC, or physician office). The commenter contends that the median referenced in §3.3708(e)(1) should not be calculated based upon a mixture of places of services. Rather, the commenter opines that the median should be specific to the applicable place of service in question. To that end, the commenter recommends that proposed §3.3708((e)(1) be modified to read as follows:

(A) The median per-service amount, <u>taking into account the applicable place of service,</u> the insurer has negotiated with preferred providers for the service furnished, excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount;

Next, it the commenter notes that two of the three rates contained within §3.3708(e) are largely within a plan's control and are, therefore, subject to plan data manipulation. The commenter argues that a plan makes the ultimate decision on what rates to accept in-network under the first methodology (i.e., proposed §3.3708(e)(1)). Additionally, the commenter says that the second methodology (i.e., use of the usual, customary, and reasonable (UCR) amount) is determined solely by the plan based upon internal or external data sources available to carriers. The commenter argues that recent events related to the use of one external data source wholly-owned by a payor illustrates the inherent conflicts that may characterize and the problems that may plague

insurer-determined out-of-network payment amounts. The commenter provides support for this position by relating a 2008 investigation by an attorney general in another state that the commenter says resulted in a determination that rates were unfairly set, an agreement by some insurers to use a new independent database, and a civil lawsuit by an organization that represents providers.

Based on the situation described by the commenter, the commenter argues that insurer-controlled measures have been demonstrated to lack reliability or objectivity as indicators of what is a “reasonable” amount for a plan to pay providers for out-of-network services. The commenter expresses appreciation for the Department’s efforts to reduce gaming of computations, but asserts that at the present time, due to the position taken by most carriers that their method of calculating payments (e.g., UCR) is proprietary data, plans still have ultimate control over methodologies and that there is little or no transparency associated with the numbers used. The commenter argues that based on this, payments cannot be properly reviewed by a consumer or a provider to determine the appropriateness of the methodology.

Concerning the third methodology contained in proposed §3.3708(e)(3), the commenter expresses support for the Department’s desire to include a method for calculating an out-of-network payment that is independent of insurers. The commenter contends that it is critical that the rule contain a method for calculating out-of-network payments that is easily quantifiable, publicly available, and independently formulated so that a true, transparent representation of out-of-network market rates may be established under the proposed rule for comparison purposes. However, says the

commenter, finding the appropriate methodology is difficult. The commenter argues that Medicare is not a reflection of prevailing market rates for out-of-network services, because Medicare rates fluctuate based upon political factors and other factors entirely unrelated to the commercial insurance market. As an example, the commenter cites the continuing and recurring threat of 20 to 30 percent cuts related to the Sustainable Growth Rate.

Additionally, the commenter argues that Medicare is a flawed methodology for the intended purpose of §3.3708(e) because Medicare rates have failed consistently to keep pace with physician practice operating costs. Because of this, the commenter opposes the inclusion of Medicare in the methodology under proposed §3.3708(e)(3) and recommends deletion of it. The commenter stresses the importance of the Department revisiting this issue as more information regarding out-of-network rates becomes publicly available and independent databases become operational.

A second commenter points out that under proposed §3.3708(e) there are three methods delineated for payment to a provider who is not in-network. The commenter asserts that two methods rely on metrics provided by the insurer and the third is Medicare and argues that all three methods are flawed and allow no input by the provider. The commenter requests that a fourth method be added that would require utilization of surveys performed by the state specialty society so long as they are statistically significant and consistent with the safety zones established in Policy Statement #6 of the “Statement of Department of Justice and Federal Trade

Commission Enforcement Policy on Provider Participation in Exchanges of Price and Cost Information."

Agency Response: The Department appreciates the comments related to §3.3708(e), and has determined that it the information required to be provided under proposed §3.3708(e)(2) and (3) should be deleted in response to these and other comments as described herein. However, the Department disagrees that the remaining required information, the median per-service amount negotiated with preferred providers is not useful, relevant information for insureds. The Department has not added additional language relating to taking into account the applicable place of service because the information intended to be conveyed is what the average provider has agreed to accept for the services to be provided, regardless of location. Thus, the Department declines at this time to impose the additional administrative expense that accounting for the place of service would add.

The Department acknowledges that there have been issues with the methods insurers have used to determine usual and customary amounts, but believes that the average reimbursement contracted rate is an amount readily available within the insurers own records which will be subject to verification by the Department should complaints arise. Though surveys of state specialty societies might also be a useful method to develop this information, the Department does not regulate those societies and cannot require that they produce such data. Thus, the Department does not adopt that proposed alternative.

§3.3708(e)(1).

Comment: A commenter expresses agreement that the provision of information regarding median per-service amount for services furnished would be useful for consumers. However, the commenter says, the cost associated with providing such services varies widely depending on the place of service. The commenter explains that a high volume reference laboratory performing services on certain specimens obtained in a physician office setting may have a substantially different fee structure as compared to a hospital based pathologist, and that that median fee amounts calculated across the entire continuum may not accurately reflect the range of fees encountered in the hospital based setting.

The commenter suggests changing the language of proposed §3.3708(e)(1) to address: "the median per-service amount the insurer has negotiated with preferred providers for the service furnished under the same or similar circumstances, excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount."

The commenter states that place-of-service codes may be used to determine similarity of circumstance. The commenter also suggests the use of a metric to indicate the variation in fees encountered in the marketplace, such as listing the minimum to maximum range or fee levels at certain percentiles (tenth, fiftieth, and ninetieth), etc.

Agency Response: The Department appreciates the commenter's comments and believes that an insurer could utilize the methodology proposed in complying with adopted §3.3708(e). However, the Department does not adopt this methodology in the

rule, preferring instead to provide insurers maximum flexibility in determining these amounts in order to reduce potential administrative costs. The Department expects that a nonpreferred provider that negotiates balance billed amounts with an insured will have the opportunity to provide an explanation for their particular circumstances, if different from the average contracted provider from which the insurer's data is derived.

§3.3708(e)(3).

Comment: In regard to disclosure of the Medicare amount under proposed §3.3708(e)(3), a commenter points out that Medicare may not have an amount for every service or may use a local rate. Additionally, the commenter states that many Medicare amounts are adjusted retrospectively or depend on information that is not always available on a claim to a commercial payor due to billing requirements.

Agency Response: The Department appreciates the comments. The Department has deleted the requirement to make available to an insured comparison data from Medicare as proposed in §3.3708(e)(3) in response to this and other comments as described herein.

§3.3709.

Comment: A commenter says that any annual network adequacy report should primarily reflect consumer concerns. The commenter also opines that the reporting requirements under proposed §3.3709 are not justified by the reports of the advisory committee established under SB 1731 to consider network adequacy and may be

excessive given the findings of the committee. The commenter says the committee found balance billing issues to be concentrated in a single area. The commenter states that while the Department has latitude to require health plans to report certain information, this proposed report is not justified by HB 2256 or the work of the advisory committee.

Agency Response: The Department disagrees that consumer concerns should be the primary focus of an annual network adequacy report.

Even though it is unclear what type of limitations a consumer-oriented report as contemplated by the commenter would entail, the Department believes that a report that considers all aspects of a network would more accurately reflect whether it is truly adequate. Additionally, the Department respectfully disagrees with the commenter's assertion that the reporting requirements of §3.3709 are not justified by the findings of the advisory committee or may be excessive given the committee's findings.

The committee's findings showed great variations in insurer practices, including activities related to the development and oversight of networks. For example, a majority of health benefit plan issuers reported that they do not separately monitor balance billing complaints and inquiries. *See Report of the Health Network Adequacy Advisory Committee: Health Benefit Plan Provider Contracting Survey Results*, April 2009 (*April 2009 Network Report*) at 4, available at www.tdi.state.tx.us/reports/life/documents/hlthnetwork409b.doc.

Further, less than half of the surveyed health benefit plan issuers reported that they have a process for monitoring the extent to which insureds receive treatment from

nonpreferred facility-based physicians at preferred provider facilities. *April 2009 Network Report* at 4. It is the Department's opinion that these variations justify the reporting requirements of §3.3709, regardless of whether balance billing issues were concentrated in a single area. The Department believes that the requested data is essential to both an insurer's and the Department's assessment of the adequacy of a network.

The Department appreciates the commenter's recognition of its authority to require health plans to report certain information; however, the Department disagrees that the reporting requirements are not justified.

§3.3709(c).

Comment: A commenter requests that the Department clarify that the annual network adequacy reports concerning complaints by insureds on balance billing should not include complaints about payments for co-payments, co-insurance, or deductibles. The commenter opines that complaints concerning copayments and deductibles should not be included, for the sake of accuracy and fairness to all parties.

Agency Response: The Department appreciates the commenter's concerns for ensuring fair and accurate reporting. The Department shares these concerns and agrees that the required report should not include complaints about amounts attributable to co-payments, co-insurance, or deductibles because those apply to the covered amount of the claim and do not involve the practice of billing for amounts beyond what is covered, consistent with the approach taken in HB 2256 relating to

mediation. The Insurance Code §1467.051, addressing mediation, clarifies that it does not apply to amounts the enrollee is responsible for after consideration of copayments, deductibles, and coinsurance. The Department expects and understands that insurers will likely receive consumer complaints that fall outside of the categories required for reporting. However, the Department declines to make the suggested change because the Department is confident that insurers will be able to discern whether a consumer complaint qualifies as one of the enumerated categories of complaints and should be included in a report to the Department, or if a complaint does not relate to any of those enumerated categories at all. Thus, the Department has determined that the requested change is not necessary.

§3.3709(c)(4).

Comment: A commenter points out that the term “balance billing” appears in proposed §3.3709(c)(4), but is not defined in the rules. The commenter asks that the term be defined to exclude payment by the patient of deductible amounts or co-pays. The commenter states that given the increasing prevalence of high deductible plans, such amounts are reflected on statements to patients as “balances due,” but that complaints related to high balances resulting from such a plan design should not be labeled as “balance billing.”

Agency Response: The Department appreciates the comment but declines to define “balance billing” in the rule. The Department agrees that balance billing is the practice of billing for amounts in excess of what is covered under the health plan and that

deductibles and co-payments are the patient's responsibility within the context of covered amounts. The Department is confident that insurers are aware of their plan designs and will be able to discern whether an amount complained about is the result of the plan structure or the result of balance billing.

Section 3.3712.

Comment: Two commenters point out that proposed §3.3712(2), which addresses required disclosure of billed charges by physicians, includes a number of pathology codes that are simply listed by the global code. The commenters say that typically a facility-based provider would bill those codes with the "26 modifier" to indicate the professional component and that the section should be revised to include the 26 modifiers.

One of the commenters also states that some insurers refuse to pay pathologists for professional component services for clinical pathology, which has been a common cause for contractual disputes in the past and continues to result in hospital based pathologists being out-of-network.

The second commenter notes that CPT Code 88142 does not require a 26 modifier. The commenter explains that 88142 is its own code without a modifier, since there is no corresponding technical code.

The second commenter specifically suggests that proposed §3.3712(2) be revised to read as follows: "(2) Pathology- CPT Codes 80048, 80048*26, 80053, 80053*26, 80061, 80061*26, 81000, 81000*26, 81025, 81025*26, 82270, 82270*26,

82947, 82947*26, 82962, 82962*26, 84153, 84513*26, 84443, 84443*26, 85018, 85108*26, 85025, 85025*26. 85610, 85610*26, 87491, 87491*26, 87880, 87880*26, 88142, 88304, 88304*26, 88305, 88305*26, 88307, 88307*26, 88309, 88309*26, 88312, 88312*26, 88331, 88331*26, 88342, 88342*26;".

Agency Response: The Department appreciates the information provided by the commenter regarding the codes in §3.3712. However, the Department has deleted §3.3712 due to the corresponding deletion of the related contracting requirement proposed in §3.3703(a)(26)(B) in response to other comments as described herein. Due to the deletion of §3.3703(a)(26)(B), §3.3712 is no longer necessary, and thus does not require modification.

Section 3.3713.

Comment: A commenter asserts that there is no statutory basis for proposed §3.3713.

Agency Response: The Department disagrees with the assertion that there is no statutory basis for §3.3713. The Insurance Code §1301.007 requires the Commissioner to adopt rules as necessary to implement Chapter 1301, including the regulation of network adequacy and responding to requests for waivers submitted pursuant to §1301.0055 for good cause shown. The language of proposed §3.3713 addressed an insurer's obligation to maintain an adequate network by requiring the insurer to collect and analyze information that will impact its understanding of local markets. Nevertheless, the Department has determined that the purpose of the section may be achieved through a less burdensome approach and has accordingly made several

changes to the text of the rule in response to other comments concerning this administrative burden as described herein.

Adopted §3.3713 requires insurers to create and implement a plan for determining whether contracted rates reflect the cost of undercompensated care and to undertake a financial analysis of the monetary impact of undercompensated care on the contracted rates of each contracted facility. The plan is required to be submitted to the Department, but the results will only be submitted upon request of the Department. The Department clarifies that the focus of the section is on insurers' creation and management of their networks. It is the Department's position that a necessary part of the creation and maintenance of a network is an understanding of facilities' provision of undercompensated care to patients not covered by the insurer and the impact of that undercompensated care on the rates facilities negotiate with the insurer on an ongoing basis.

Additionally, the information will be relevant to any request for waiver of network adequacy requirements submitted by an insurer related to a facility pursuant to §3.3707 and to the Department's review of such a request. Finally, pursuant to §1301.007, the Commissioner is required to adopt rules to ensure reasonable accessibility and availability of preferred provider services. The Department has been made aware of allegations that part of the high cost of health insurance premiums and deductible and coinsurance payments by insureds is to compensate facilities for undercompensated care. Adopted §3.3713 is, therefore, also a necessary first step to obtaining information to determine whether this cost-shifting actually occurs so that the Department may

begin to work on potential future efforts by the Department to keep health care services available and accessible to insureds.

Comment: A commenter expresses support for proposed §3.3713, which the commenter notes requires insurers to provide an annual report disclosing the effects of uncompensated care. The commenter opines that such information will educate consumers about the effect of uncompensated care on the health care fees and premiums they pay. The commenter also notes, however, that the rule does not require insurers to disclose the information to the public for eight years from the effective date of the rule. The commenter instead requests the rule be revised to require insurers to disclose this information to consumers within two years of the effective date. The commenter asserts that the Department's proposal is necessary to protect consumers and serves as an important step to address balance-billing related issues.

Agency Response: The Department appreciates the statement of support. In addition, the Department has carefully considered the commenter's and others' comments and made several changes to the text of §3.3713 in response. The adopted rules have different time frames, but the nature and manner of disclosure of such information has also been revised. The Department respectfully declines to change the rule to require the disclosure of information to consumers within two years of the rule's adoption date. Instead, adopted §3.3713(d) requires the insurer to implement its plan effective July 1, 2015, a change made in response to a different comment. This timeframe is appropriate because the plans may be uniquely tailored to the needs of the

insurer and because there is no longer a requirement to plan and implement annual reporting and public disclosure of the information and analysis.

An insurer is not required to make information received pursuant to §3.3713, as adopted, publicly available. Instead, insurers will be required to create and implement a plan for determining whether contracted rates reflect the cost of undercompensated care and a financial analysis of the monetary impact of undercompensated care on the contracted rates of each contracted facility. The Department clarifies that the focus of the section is on insurers' creation and management of their networks. It is the Department's position that a necessary part of the creation and maintenance of a network is an understanding of a facility's provision of undercompensated care of patients not covered by the insurer and the impact of that undercompensated care on the rates the facility negotiates with the insurer. Adopted §3.3713 is also important to help insurers and the Department work on ways to reduce the cost of health insurance.

Section 3.3713 permits insurers to develop their own approach to the collection and analysis of information concerning the effects of undercompensated care rather than prescribing a uniform standard for use by all insurers, as pointed out by some commenters. The Department has, however, determined that this lack of uniformity does not render the resulting analytical product suitable for comparison by consumers. Accordingly, in weighing the costs and potential benefits of public disclosure, the Department has determined not to require public disclosure by insurers at this time.

Comment: A commenter asserts that issues concerning cost-shifting are widely debated among economists and that it would be difficult or impossible to determine the impact of such cost-shifting across the state for all plans, much less for individual plans at specific facilities. The commenter asserts that there is a serious debate about whether cost-shifting even exists, though many people suggest it can exist.

The commenter discusses two theories on cost-sharing in hospitals, noting that under a hospital revenue maximization model cost-shifting really does not exist, because hospitals get dollars where they can, but that some people suggest there is a pure dollar-for-dollar shift. The commenter says that reality is probably somewhere between these two concepts, and states uncertainty that insurers will ever be able to calculate or provide data concerning uncompensated care on a facility-level basis.

Agency Response: The Department appreciates the comments and understands the difficulties insurers face in determining how costs of undercompensated care impact insurers, providers and consumers. Adopted §3.3713 is deliberately drafted to provide insurers flexibility in designing a plan for the collection and analysis of the data related to the effects of undercompensated care. The Department acknowledges that there is no clear data on cost-shifting at the facility level at this time and believes that adopted §3.3713 will help foster a greater understanding of how costs may shift from one party to another.

Comment: A commenter asks why §3.3713 is proposed to take effect in seven years.

Agency Response: Section 3.3713 was proposed to include an effective date of seven years from adoption of the section for reporting requirements under the section, and on the following year the section would have required the insurer to make its findings publicly available. This was because the Department anticipated that greater amounts of time would be necessary to develop collection and analysis strategies compatible with regulatory reporting and public disclosure standards. However, because the Department has changed §3.3713 in response to other comments as described herein, the Department has determined that it is appropriate to change the proposed timeframes. Adopted §3.3713(a) requires an insurer to submit to the Department its plan for the collection of information concerning the effects of undercompensated care on July 1, 2014. Adopted §3.3713(d) requires the insurer to implement its plan effective July 1, 2015. These timeframes are appropriate because the plans may be uniquely tailored to the needs of the insurer and because there is no longer a requirement to plan and implement annual reporting and public disclosure of the information and analysis.

Comment: A commenter says that while a lot of people have worked on issues surrounding the proposal over an extended period of time, the commenter is not sure that the Department fully comprehends the level of operational impact on providers and health plans that would take place under the proposal. The commenter states that portions of the rule are good and will help the consumer and address some of the issues and concerns, but that some provisions of the rule will be difficult to implement for both health plans and providers.

The commenter opines that the proposal is addressing too many issues at once. For example, the commenter states that the issue of uncompensated care is a growing concern, especially with federal reform and concern as to whether: (i) uncompensated care amounts will go down; and (ii) how changes in uncompensated care will affect negotiation and rates by providers. However, the commenter questions whether the issue is appropriate to be addressed in these rules.

The commenter expresses concern that further development is still necessary because of remaining challenges at the operational level, noting that many stakeholders would willingly continue to work through such details to better develop some requirements. The commenter observes that there is a great challenge in determining what constitutes uncompensated care, such as whether it includes care not compensated by the insurer or care that is undercompensated because of underpayment by the Medicare or Medicaid programs, and the commenter says that the proposed rule fails to address the definition for the term.

The commenter notes that the Health and Human Services Commission (HHSC) has recently published a report on uncompensated care, and that it took the agency over a year to determine the uninsured levels, to determine cost for those services, to determine whether there were payments that a hospital might receive for services, and to determine what that amount is.

The commenter also opines that it is a challenge to figure out how uncompensated care impacts charges, noting that different providers have different funding sources. For example, the commenter states that a public hospital has a

revenue source of taxes that another hospital may not, and that some hospitals may receive supplemental payments.

The commenter says that the HHSC report indicates there was approximately $3.8 billion for hospital uncompensated care after adjusting everything down to cost and subtracting or netting out any additional payments received. The commenter states that this $3.8 billion does get passed on to the consumer, but in some cases is paid for by taxes or cost-shifted to the insurer.

Based on this, the commenter opines that it would therefore be possible to undertake such a study related to hospitals. The commenter explains that is was possible with respect to hospitals because hospitals publicly report a lot of financial information. However, the commenter states that if the study included uncompensated physician care, it would be much more challenging. The commenter agrees that hospitals look at their revenue sources and what they anticipate for future budget years. The commenter also agrees that hospitals look at their expenses. The commenter opines that hospitals can control revenue and expenses to a certain extent. As it relates to charges, however, the commenter opines that a hospital ultimately has to set its charges at a certain level in order to get the revenues at the necessary level.

Agency Response: The Department recognizes the potential difficulty in implementing the provisions of §3.3713 as proposed, and has accordingly made changes to §3.3713 that should mitigate these concerns in response to this and other comments as described herein. The Department believes it is appropriate to address uncompensated care issues in these rules but simultaneously has revised the proposed

rules to reflect concerns voiced by this commenter and others. In response to comments that the term “uncompensated care” is not sufficiently defined or clear as to whether the term includes undercompensated care, references to the term “uncompensated care” have been removed and replaced with the term “undercompensated care.” Also in response to these comments, the Department has added adopted §3.3713(b) to clarify that the term “undercompensated care” means care that is not reimbursed through an agreement between an insurer and a facility and that is either uncompensated or is reimbursed at an amount less than the facility’s billed charges.

The Department acknowledges that there may be wide variations in approaches to the study of undercompensated care and its effects. Section 3.3713 permits insurers to develop their own approach to the collection and analysis of information concerning the effects of undercompensated care rather than prescribing a uniform standard for use by all insurers. The Department has, however, determined that this lack of uniformity does not render the resulting analytical product suitable for comparison by consumers. Accordingly, in weighing the costs and potential benefits of public disclosure, the Department has determined not to require public disclosure by insurers at this time and has changed §3.3713 to delete this requirement. Further, to permit insurers to uniquely tailor their collection and analysis as appropriate to each insurer’s situation, adopted §3.3713 requires an insurer to submit its plan for the collection and analysis of data concerning uncompensated care but does not require submission of the analyzed results on a standardized basis.

Altogether, the flexibility provided by these changes should result in insurers obtaining information necessary to understand how undercompensated care impacts charges, especially in light of the concerns expressed by the commenter relating to differences in provider practices, various funding sources, tax implications, network participation and more. The Department declines to delete this requirement entirely.

Comment: A commenter agrees that uncompensated care results in increases in hospital and other facility charges, which in turn results in a cost-shift to the private health insurer market. The commenter opines that federal health care reform will help reduce the number of uninsureds in Texas and will lessen this cost-shift but will not eliminate it. The commenter states that hospitals and other providers also must shift the costs that are not adequately reimbursed by various governmental programs, including Medicare and Medicaid, and opines that the federal legislation did not address this problem.

The commenter says that it is understandable that the Department wishes to collect information on the effects of uncompensated care and how these uncompensated amounts impact hospital charges and payments by insurers. However, the commenter argues that this issue simply does not relate to the adequacy of insurer provider networks or balance billing of out-of-network services. The commenter argues that even if this issue were relevant to the network adequacy rules, insurers do not have the information to make a determination of the amount of uncompensated care provided by health care facilities or how uncompensated care impacts facility charges.

The commenter states that proposed §3.3713(d) will require health care facilities to compile and provide insurers with the information necessary to determine a facility's level of uncompensated care. The commenter opines that this requirement will impose new and unnecessary administrative costs on facilities. The commenter is further concerned that health care facilities could be required by insurers to provide information on how facility charges are established. Per the commenter, a hospital or health care facility that also periodically negotiates its reimbursement terms with an insurer could be required to provide the insurer with confidential, internal budgeting and pricing information. The commenter argues that such required disclosures to an insurer would be inappropriate for many legal and competitive reasons. The commenter therefore strongly opposes inclusion of this section in the rules.

Agency Response: The Department appreciates the comments. However, the Department disagrees that understanding how undercompensated care impacts costs does not relate to the adequacy of insurer provider networks, the accessibility of health care services under preferred provider plans, or balance billing of out-of-network services. The Department is adopting these rules in order to understand whether or how costs impact the ability of an insurer to contract with providers and develop an adequate network. The Department agrees that insurers currently do not collect sufficient information to make a determination about the amount of uncompensated care provided or how it impacts facility charges, which is another reason why the Department believes it is necessary to adopt these rules.

The Department has changed proposed §3.3713 by deleting subsection (d) of the section in order to address concerns that these requirements will generate new and unnecessary costs for facilities and in response to comments that each contracting requirement resulting from regulations places an additional strain upon the contracting process. The Department believes that deleting this provision will adequately address the commenter's concerns about confidential budgeting and pricing, periodic negotiations, and other legal or competition issues. This change should also provide greater flexibility for insurers in determining how best to obtain the information required by §3.3713, as adopted.

Comment: A commenter asserts that the proposed rule imposes more cost on insurers, including small and medium-sized businesses. The commenter notes, for example, that proposed §3.3713 requires insurer determinations concerning cost-shifting. The commenter asserts that whether or not there is cost-shifting, a facility's payor mix will include a workers' compensation system paying based upon a fee schedule for workers' compensation patients, emergency room patients for whom an auto liability policy may be paying for service, and Medicare and Medicaid patients for whom compensation is at different levels. The commenter questions whether it is reasonable to place the burden of gathering and reporting such data on the health insurance market that the Department regulates. The commenter suggests that it may be more reasonable to delete the requirement at this time and give further study to the issue.

The commenter agrees that it is a prudent business practice for a carrier to know what it is spending money on but opines that this practice is addressed in other ways. The commenter says that proposed §3.3713 requires evaluation of the unreimbursed costs of a facility. The commenter states that this would require a wealth of data collection from facilities, due to the variety of payors that exist in the United States health care system. The commenter states that under proposed §3.3713, a company representing a small piece of that equation would be required to evaluate the entire process and report on it to the Department, or be subject to fines or disciplinary action for failure to do so.

The commenter concedes that consumers want information, but also notes having viewed online information for one major hospital indicating that its amount uncompensated care was relatively low. The commenter points out that consideration of the impact of uncompensated care upon workers' compensation rates has been a contentious issue in the past, including lawsuits filed by hospitals and review of multiple charge masters that made understanding uncompensated care difficult, and questions whether such a study can be done without getting the legislature to establish a reporting requirement addressing the heart of the matter, which the commenter asserts to be facility-based providers.

The commenter states that he has heard the argument that government is underpaying Medicaid and Medicare services, causing a cost-shift to all other payors, including auto liability insurance, other liability insurance, health insurance, and workers' compensation. However, the commenter lacks data to that effect. Overall, the

commenter opines that it would be cumbersome to seek the data through the contracting process of only the health insurance market.

Agency Response: The Department notes that it has revised §3.3713 to address several of the issues raised by the commenter, but declines to delete the section altogether. The Department agrees that the proposed section carried some administrative burden for insurers, but believes the changes made to §3.3713 will substantially reduce those costs, including costs to small and medium-sized businesses. In response to these comments and other comments as described herein, the Department has made several revisions to §3.3713 as adopted to reduce the administrative burden it could create.

In response to comments that proposed §3.3713 would require the annual report and disclosure of information that would be inappropriate for comparison by consumers due to the lack of a uniform standard, the Department has deleted the annual reporting requirement as proposed in §3.3713(a) and the disclosure requirement as proposed in §3.3713(c). Additionally, in response to a comment that proposed §3.3713 would inappropriately place the burden for analysis of the broad issues concerning uncompensated care upon insurers that operate preferred provider benefit plans, §3.3713 as adopted does not impose detailed requirements concerning the scope of each insurer's collection and analysis of information concerning the existence and effects of undercompensated care. Instead, each insurer's plan may be tailored to the unique characteristics of the insurer's network utilization and contracting practices.

The Department believes that these changes will reduce concerns about the practical considerations of implementation, but also will provide greater flexibility for insurers in determining how to obtain the information required by §3.3713, as adopted, which in turn should lessen the likelihood that insurers will be faced with additional costs.

The Department appreciates the commenter's acknowledgment of the importance of an insurer knowing how it spends its money and believes the changes to §3.3713 will address the commenter's concerns about the data collection required for compliance with §3.3713. However, the Department continues to believe that such information is essential to insurers of all sizes in negotiating contracts with facilities. Further, the information may be important to an insurer's request for a waiver and the Department's own consequent assessment of local market conditions in responding to requests for waivers.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: Emergency Services Partners/University Medical Center Brackenridge.

For, with recommended changes: American Accreditation Healthcare Commission/URAC, Clinical Pathology Association, Emcare, Emergency Department Practice Management Association, Emergency Service Partners, Greater Houston Anesthesiology, Office of Public Insurance Counsel, Pediatrix Medical Group, Pinnacle Anesthesia, Texas Ambulatory Surgery Center Society, Texas Association of Obstetricians and Gynecologists, Texas Chapter of the American College of Cardiology,

Texas College of Emergency Physicians, Texas Fair Payment for Emergency Physicians Coalition, Texas Medical Association, Texas Medical Association Interspecialty Society, Texas Radiological Society, and Texas Urological Society.

Against: Forest Park Medical Center and Texas Association of Life and Health Insurers.

Against, with no comments: Hospital Corporation of America and Seton Healthcare.

Both for and against, with recommended changes: Texas Hospital Association.

Against, with suggested changes: Pediatrix Medical Services, Texas Association of Health Plans, and Texas Society of Anesthesiologists.

Neither for nor against, with suggested changes: Texas Society of Pathologists.

6. STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to: (i) the Insurance Code §§83.051, 521.102, 541.061, 544.002(a)(2), 544.052, 1251.006, 1301.0046, 1301.005, 1301.0055, 1301.006, 1301.007, 1301.051, 1301.058, 1301.069, 1301.151, 1301.155(b), 1301.158, 1301.159, 1301.1591, 1301.161, 1451.053, 1451.054(a), 1451.104(a) and (b), 1456.003, 1456.007, 1467.051(a), 1467.053(d), 1467.054(a), 1661.005, 1701.055(a)(2), and 36.001; (ii) the Health and Safety Code §324.101(d); and (iii) the Occupations Code §101.352(c).

Section 83.051 permits issuance of a cease and desist order.

Section 521.102 requires an insurer to maintain a toll-free number to provide information concerning its policies and to receive complaints from policyholders.

Section 541.061 specifies that it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by: (i) making an untrue statement of material fact; (ii) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made; (iii) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact; and (iv) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of the Insurance Code.

Section 544.002(a)(2) prohibits an insurer from charging an individual a rate that differs from the rate charged to other individuals for the same coverage because of the individual's geographic location. Section 544.052 prohibits an insurer from engaging in or permitting unfair discrimination between individuals of the same class and essentially the same hazard, including unfair discrimination in: (i) the amount of premium, policy fees, or rates charged for a policy or contract of insurance; (ii) the benefits payable under a policy or contract of insurance; or (iii) any of the terms or conditions of a policy or contract of insurance.

Section 1251.006 prohibits a group or blanket accident and health policy from requiring that a covered service be provided by a particular hospital or person.

Section 1301.0046 provides that an insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services.

Section 1301.005 requires that: (i) an insurer offering a preferred provider benefit plan ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area; and (ii) if services are not available through a preferred provider within the service area, an insurer is required to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

Section 1301.0055 requires the Commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the Commissioner posts on the Department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

Section 1301.006 requires that an insurer that markets a preferred provider benefit plan 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 health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

Section 1301.007 authorizes the Commissioner to adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to Texas residents.

Section 1301.051 provides that an insurer: (i) is required to afford a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners and institutional providers and to health care providers other than practitioners and institutional providers, if those other health care providers are included by the insurer as preferred providers, provided that the practitioners, institutional providers, or health care providers are licensed to treat injuries or illnesses or to provide services covered by a health insurance policy and comply with the terms established by the insurer for designation as preferred providers; (ii) is prohibited from unreasonably withholding a designation as a preferred provider; (iii) is required to give a physician or health care provider who, on the person's initial application, is not designated as a preferred provider written reasons for denial of the designation; and (iv) is prohibited from withholding a designation to a podiatrist described by Section 1301.0521.

Section 1301.151 provides that an ensured is entitled to treatment and diagnostic techniques that are prescribed by the physician or health care provider included in the plan.

Section 1301.058 requires that: (i) an insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan make available to a physician or health

care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured; and (ii) economic profiles be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

Section 1301.069 specifies that the provisions of Chapter 1301 relating to prompt payment by an insurer of a physician or health care provider and to verification of medical care or health care services apply to a nonpreferred provider who furnishes to an insured: (i) care related to an emergency or its attendant episode of care as required by state or federal law; or (ii) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network.

Section 1301.155(b) specifies that if an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider: (i) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists; (ii) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and (iii) services originating in a hospital

emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition.

Section 1301.158(a) requires an insurer to provide to a current or prospective group contract holder or insured on request an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health care plans. The description must be in a format prescribed by the Commissioner and must include a current list of preferred providers. Section 1301.158(b) requires an insurer to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must be in a readable and understandable format as prescribed by the Commissioner and must include a current list of preferred providers.

Section 1301.158(c) prohibits an insurer from using or permitting the use of untrue or misleading information for prospective insureds. Section 1301.158(d) requires an insurer to provide to an insured on request information on: (i) whether a physician or other health care provider is a participating provider in the insurer's preferred provider network; (ii) whether proposed health care services are covered by the health insurance policy; (iii) what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and (iv) coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary reimbursement rate for out-of-network services.

Section 1301.159 requires insurers to provide a current list of preferred providers at least annually. Section 1301.1591: (i) requires an insurer subject to Chapter 1301 that maintains an Internet site to list on the Internet site the preferred providers, including, if appropriate, mental health providers and substance abuse treatment providers, that insureds may use in accordance with the terms of the insured's preferred provider benefit plan.; (ii) requires that the listing identify those preferred providers who continue to be available to provide services to new patients or clients; (iii) requires the insurer to update such Internet sites at least quarterly; and (iv) authorizes the Commissioner to adopt rules as necessary to implement the section, specifying that the rules may govern the form and content of the information required to be provided.

Section 1301.161 prohibits an insurer from engaging in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has: (i) filed a complaint against the insurer or against a preferred provider; or (ii) appealed a decision of the insurer.

Section 1451.053 prohibits an accident and health insurance policy from making a benefit contingent on treatment or examination by one or more particular health care practitioners listed in §1451.001 unless the policy contains a provision that designates the practitioners whom the insurer will and will not recognize. Section 1451.054(a) mandates that a provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by §1451.001 with the meanings assigned by that section.

Section 1451.104(a) prohibits an insurer from classifying, differentiating, or discriminating between scheduled services or procedures provided by a health care practitioner selected under the subchapter and performed in the scope of that practitioner's license and the same services or procedures provided by another type of health care practitioner whose services or procedures are covered by a health insurance policy, in regard to: (i) the payment schedule or payment provisions of the policy; or (ii) the amount or manner of payment or reimbursement under the policy. Section 1451.104(b) prohibits an insurer from denying payment or reimbursement for services or procedures in accordance with the policy payment schedule or payment provisions solely because the services or procedures were performed by a health care practitioner selected under the subchapter.

Section 1456.003 requires a preferred provider benefit plan to provide notice that facility-based physicians may not be included in the network and may balance bill the enrollee and to clearly identify any health care facilities within the provider network in which facility-based physicians do not participate in the plan's provider network and specifies that health care facilities identified under the subsection are required to be identified in a separate and conspicuous manner in any provider network directory or website directory.

Section 1456.007 requires a preferred provider benefit plan to, on the request of an enrollee, provide an estimate of payments that will be made for any health care service or supply and to specify any deductibles, copayments, coinsurance, or other amounts for which the enrollee is responsible. The preferred provider benefit plan must

advise the enrollee that: (i) the actual payment and charges for the services or supplies will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and (ii) the enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage.

Section 1467.051(a) specifies that an enrollee may request mediation of a settlement of an out-of-network health benefit claim if: (i) the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000; and (ii) the health benefit claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator. Section 1467.053(d) provides that a facility-based physician who makes a disclosure under §1467.053(c) and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge under the subchapter if the amount billed is less than or equal to the maximum amount projected in the disclosure. Section 1467.054(a) authorizes an enrollee to request mandatory mediation under the chapter.

Section 1661.005 requires physicians, hospitals, or other health care providers that receive an overpayment from an enrollee to refund the amount of the overpayment to the enrollee no later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made.

Section 1701.055(a)(2) authorizes the Commissioner to disapprove or, after notice and hearing, withdraw approval of a form if the form contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive, subject to the exception specified in subsection (d) of the section.

The Health and Safety Code §324.101(d) requires a facility to provide an estimate of the facility's charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service. The facility must advise the consumer that: (i) the request for an estimate of charges may result in a delay in the scheduling and provision of the inpatient admission, outpatient surgical procedure, or other service; (ii) the actual charges for an inpatient admission, outpatient surgical procedure, or other service will vary based on the person's medical condition and other factors associated with performance of the procedure or service; (iii) the actual charges for an inpatient admission, outpatient surgical procedure, or other service may differ from the amount to be paid by the consumer or the consumer's third-party payor; (iv) the consumer may be personally liable for payment for the inpatient admission, outpatient surgical procedure, or other service depending on the consumer's health benefit plan coverage; and (v) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for the inpatient admission, outpatient surgical procedure, or other service.

The Occupations Code §101.352(c) mandates that on the request of a patient who is seeking services that are to be provided on an out-of-network basis or who does not have coverage under a government program, health insurance policy, or health maintenance organization evidence of coverage, a physician shall provide an estimate of the charges for any health care services or supplies. A physician must advise the consumer that: (i) the request for an estimate of charges may result in a delay in the scheduling and provision of the services; (ii) the actual charges for the services or supplies will vary based on the patient's medical condition and other factors associated with performance of the services; (iii) the actual charges for the services or supplies may differ from the amount to be paid by the patient or the patient's third-party payor; and (iv) the patient may be personally liable for payment for the services or supplies depending on the patient's health benefit plan coverage.

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

§3.3701. Application.

(a) Except as otherwise specified in this subchapter, the sections of this subchapter apply to any preferred provider benefit plan as specified in this subsection.

(1) This subchapter applies to any preferred provider benefit plan policy delivered, issued for delivery, or renewed on or after May 19, 2012.

Any preferred provider benefit plan policy delivered, issued for delivery, or renewed prior to May 19, 2012, is subject to the statutes and provisions of this subchapter in effect at the time the policy was delivered, issued for delivery, or renewed.

(2) The sections of this subchapter do not apply to provisions for dental care benefits in any health insurance policy.

(b) This subchapter is not an interpretation of and has no application to any law requiring licensure to act as a principal or agent in the insurance or related businesses including, but not limited to, health maintenance organizations.

(c) The provisions of this subchapter are subject to the Insurance Code §§1451.001, 1451.053, and 1451.054; Chapter 1301; §§1451.101 - 1451.127; and §1353.001 and §1353.002 as they relate to insurers and the practitioners named therein.

(d) These sections do not create a private cause of action for damages or create a standard of care, obligation, or duty that provides a basis for a private cause of action. These sections do not abrogate a statutory or common law cause of action, administrative remedy, or defense otherwise available.

(e) If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

§3.3702. Definitions. The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(2) Contract holder--An individual who holds an individual health insurance policy, or an organization which holds a group health insurance policy.

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

(4) Facility--

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

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

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

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

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

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

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

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

(21) Rural area--

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

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

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

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

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

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

§3.3703. Contracting Requirements.

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

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

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

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

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

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

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

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

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

(7) A contract between a preferred provider and an insurer may not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This

subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

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

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

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

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims, including the Insurance Code Chapter 1301, Subchapter C and §§21.2801 – 21.2820 of this title (relating to Submission of Clean Claims) with respect to payment to the provider for covered services that are rendered to insureds.

(12) 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 the Insurance Code §1301.067 about any of the matters set forth therein.

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

(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 the Insurance Code §1301.059(b).

(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 such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act, Chapters 551 - 566 and Chapters 568 – 569 of the Occupations Code, and rules promulgated thereunder.

(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 the Insurance Code §1301.160(b).

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

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including e-mail, computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided pursuant to this paragraph are required to be made in accordance with subparagraph (D) 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 methodologies 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 pursuant to this paragraph; and

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

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

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

to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

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

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

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

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

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

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

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

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

(iii) may not rely upon information provided pursuant to 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.

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

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

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

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

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

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

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005 (relating to refunds of overpayments from enrollees).

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

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with the Insurance Code Chapter 542, Subchapter A, and the provisions of that subchapter will be utilized insofar as 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 for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of the Insurance Code Chapter 1301 and this subchapter; or

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

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

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

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

(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 the Insurance Code §§1301.152 – 1301.154;

(5) insureds have the right to emergency care services as set forth in the Insurance Code §1301.155;

(6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 50 percent less than the higher level of coverage. 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 are not restricted by the insurer;

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

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan is taken pursuant to the Insurance Code Chapter 4201 and Chapter 19, Subchapter R of this title (relating to Utilization Review Agents);

(10) a preferred 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 subchapter (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations); and

(11) both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

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

(c) 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 against the insurer or a preferred provider or has appealed a decision of the insurer.

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

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

(1) be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer’s designated service area, taking into account the

number of insureds and their characteristics, medical, and health care needs, including the:

(A) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and

(B) projected utilization of covered health care services;

(2) include an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area;

(3) include sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area;

(4) include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;

(5) provide for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;

(6) provide, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area;

(7) provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers;

(8) provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:

(A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and

(B) 75 miles for specialty care and specialty hospitals;

(9) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;

(10) ensure that routine care is available and accessible from preferred providers:

(A) within three weeks for medical conditions; and

(B) within two weeks for behavioral health conditions;

(11) ensure that preventive health services are available and accessible from preferred providers:

(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and

(B) within three months for an adult.

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

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

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

(2) one or more Texas counties; or

(3) the first three digits of ZIP Codes in Texas.

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

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this chapter (relating to Plain Language Requirements).

(b) Disclosure of Terms and Conditions of the Policy. The insurer is required, upon request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection

including the level of disclosure required. The written description is required to be in a readable and understandable format, by category, and is required to include a clear, complete, and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an insurance company, the name of the insurance company, and that the insurance contract contains preferred provider benefits;

(2) a toll free number, unless exempted by statute or rule, and address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

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

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients, both of which may be provided electronically with the agreement of the insured provided that information about how to obtain a nonelectronic provider listing free of charge is also provided;

(13) the service area(s); and

(14) information that is updated at least annually regarding the following network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this subchapter (relating to Geographic Regions), if the plan is offered on a statewide service area basis:

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

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

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

(c) Filing Required. A copy of the written description required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if applicable, must be submitted to the following e-mail address: hwcn@tdi.state.tx.us. Nonelectronic filings are required to be submitted

to the department at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104.

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

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

(1) an Internet-based provider listing for use by current and prospective insureds and group contract holders;

(2) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP Code area, as applicable, that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) an Internet-based listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of Rights under a Network Plan Required. An insurer is required to include the notice specified in Figure: 28 TAC §3.3705(f) in all policies, certificates, and outlines of coverage in at least 12 point font:

FIGURE: 28 TAC §3.3705(f):

Texas Department of Insurance Notice

- *You have the right to an adequate network of preferred providers.*
    - *If you believe that the network is inadequate, you may file a complaint with the Department of Insurance.*
    - *If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network coinsurance rate and your out-of-pocket expenses counted toward your in-network, out-of-network, or general out-of-pocket maximum, as appropriate.*
- *You have the right to obtain advance estimates:*
    - *of the amounts that the providers may bill for projected services, from your out-of-network provider; and*
    - *of the amounts that the insurer may pay for the projected services, from your insurer.*
- *You may obtain a current directory of preferred providers at the following website:* [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by

current or prospective insureds or group contract holders] *or by calling* [to be filled out by the insurer] *for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.*

- *If you are treated by a provider or hospital that is not contracted with your insurer, you may be billed for anything not paid by the insurer.*
- *If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.state.tx.us/consumer/cpmmediation.html.*

(g) Untrue or Misleading Information Prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure Concerning Access to Preferred Provider Listing. The insurer is required to provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how a nonelectronic copy of the

listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

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

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

(k) Reliance Upon Provider Listing in Certain Cases. A claim for services rendered by a nonpreferred provider must be paid at the applicable preferred benefit coinsurance percentage if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

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

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

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

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

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

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

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

(B) In those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with

preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider.

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

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

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

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

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

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

(B) whether the provider is accepting new patients.

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

(8) The provider information must be provided in fonts of not less than 10-point type.

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

(10) The provider information must be dated.

(m) Annual Policyholder Notice Concerning Use of Access Plan. An insurer operating a preferred provider benefit plan that relies upon an access plan as specified in §3.3709 of this subchapter is required to provide notice of this fact to each individual and group policyholder participating in such plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes made available pursuant to subsection (e)(2) of this section.

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

(1) A decrease is substantial if:

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

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

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

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

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

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

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

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

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

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

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

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

(B) the later of:

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

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

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

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

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

(3) If an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer is required to:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) An insurer initially sponsoring a preferred provider benefit plan is required to notify all physicians and practitioners in the service area covered by the plan of its intent to offer the plan and of the opportunity to apply to participate.

(2) Subsequently, an insurer is required to annually notify all non-contracting physicians and practitioners in the service area covered by the plan of the existence of the plan and the opportunity to apply to participate in the plan.

(3) An insurer is required, upon request, to make available to any physician or provider information concerning the application process and qualification requirements, including the use of economic profiling by the insurer, used by the insurer to admit a provider to the plan.

(4) All notifications required to be made by an insurer pursuant to this subsection are required to be made by publication or distributed in writing to each physician and practitioner in the same manner.

(5) Selection standards used by the insurer in choosing participating preferred providers must not directly or indirectly:

(A) avoid high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization; or

(B) exclude a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses or health services utilization.

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

(1) An insurer is required to provide written notice of denial of any initial application to a physician or health care provider, which includes:

(A) the specific reason(s) for the denial; and

(B) in the case of physicians and practitioners, the right to a review of the denial as set forth in paragraph (2) of this subsection.

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

(A) The advisory review panel is required to be composed of not less than three individuals selected by the insurer from the list of physicians or practitioners in the applicable service area contracting with the insurer.

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

(C) The list of physicians or practitioners required by subparagraph (A) of this paragraph is required to be provided to the insurer by the physicians or practitioners who contract with the insurer in the applicable service area.

(D) The recommendation of the advisory review panel is required to be provided upon request to the affected physician or practitioner.

(E) In the event that the insurer makes a determination that is contrary to the recommendation of the advisory review panel, a written explanation of

the insurer's determination is required to be provided to the affected physician or practitioner upon request.

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

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

(1) the specific reason(s) for the termination; and

(2) in the case of physicians or practitioners, notice of the right to request a review prior to termination that is conducted in the same manner as the review mechanism set forth in subsection (b)(2) of this section and that complies with the timelines set forth in subsections (e) – (h) of this section for requesting review, except in cases involving:

(A) imminent harm to patient health;

(B) an action by a state medical or other physician licensing board or other government agency which impairs the physician's or practitioner's ability to practice medicine or to provide services; or

(C) fraud or malfeasance.

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

(1) make a written request to the insurer for a review of that decision within 10 business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 20 business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

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

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

(1) make a written request to the insurer for a review of that decision within five business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 10 business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

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

(i) Confidentiality of Information Concerning the Insured.

(1) An insurer is required to preserve the confidentiality of individual medical records and personal information used in its termination review process. Personal information of the insured includes, at a minimum, the insured’s name, address, telephone number, social security number, and financial information.

(2) An insurer may not disclose or publish individual medical records or other confidential information about an insured without the prior written consent of the insured or unless otherwise required by law. An insurer may provide confidential information to the advisory review panel for the sole purpose of performing its advisory

review function. Information provided to the advisory review panel is required to remain confidential.

(j) Notice to Insureds.

(1) If the contract of a physician or practitioner is terminated for reasons other than at the preferred provider's request, an insurer may not notify insureds of the termination until the effective date of the termination or at such time as an advisory review panel makes a formal recommendation regarding the termination, whichever is later.

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

(3) If the contract of a physician or practitioner is terminated for reasons related to imminent harm, an insurer may notify insureds immediately.

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

(a) In accordance with the Insurance Code §1301.0055(3), an insurer may apply for waiver from one or more of the network adequacy requirements in §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers). The commissioner may grant the waiver if there is good cause based upon one or more of the criteria specified in this subsection and may impose reasonable conditions on the grant of such waiver. The commissioner may find good cause to grant the waiver if the

insurer demonstrates that providers or physicians necessary for an adequate local market network:

(1) are not available to contract; or

(2) have refused to contract with the insurer on any terms or on terms that are reasonable.

(b) An insurer seeking a waiver under subsection (a) of this section is required to file the request with the department at the Office of the Chief Clerk, MC 113-2A, P.O. Box 149104, Austin, TX 78714-9104. The insurer is also required to submit a copy of the request to any provider or physician named in the request for waiver at the same time that the request is filed with the department. The insurer may use any reasonable means to submit the copy of the request to the provider or physician and is required to maintain proof of such submission.

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

(d) If the department grants a waiver under subsection (a) of this section, the department shall post on the department's website the name of the preferred provider benefit plan for which the request is granted, the insurer offering the plan, and the affected service area.

(e) An insurer is required to apply for renewal of a waiver described in subsection (a) of this section annually and at the same time the insurer files the annual

network adequacy report required under §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan).

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

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

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

(1) requiring emergency care;

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

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

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

(1) pay such claim at the preferred benefit coinsurance level; and

(2) credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum.

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

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

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

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

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

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

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

(e) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer is required to include a notice on each explanation of benefits that the insured has the right to request information concerning negotiated rates for comparison purposes. Upon the request of an insured, the insurer must furnish the median per-service amount the insurer has negotiated with preferred providers for the service furnished, excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount.

§3.3709. Annual Network Adequacy Report; Access Plan.

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

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

(1) the trade name of each preferred provider benefit plan in which insureds currently participate;

(2) the applicable service area of each plan; and

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

(c) Additional Content Applicable Only to Annual Reports. As a part of the annual report on network adequacy, each insurer is required to provide additional demographic data as specified in paragraphs (1) – (6) of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this subchapter (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer is required to specify in the report that there is no applicable data for that region. The report must include the number of:

(1) claims for basic benefits, excluding claims paid at the preferred benefit coinsurance level;

(2) claims for basic benefits that were paid at the preferred benefit coinsurance level;

(3) complaints by nonpreferred providers;

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

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

(6) complaints by insureds relating to the accuracy of preferred provider listings.

(d) Additional Content Applicable if Inadequate Networks are Utilized. As a part of the annual report on network adequacy, an insurer is required to submit a local

market access plan as specified in subsection (e) of this section if any of the insurer's preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements specified in §3.3704 of this subchapter.

(e) Content of Local Market Access Plan.

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

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

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

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

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

(E) procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures

for compliance with §3.3708 of this subchapter (relating to Payment of Certain Basic Benefit Claims and Related Disclosures; Waiver).

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

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

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

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

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

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

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

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

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

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

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

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

§3.3710. Failure to Provide an Adequate Network.

(a) If the commissioner determines, after notice and opportunity for hearing, that the insurer’s preferred provider service delivery network and any access plan supporting such network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the health insurance policy are provided in a

manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions pursuant to the authority of the commissioner in the Insurance Code Chapter 83 to issue cease and desist orders:

(1) reduction of a service area;

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

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

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

§3.3711. Geographic Regions. The 11 Texas geographic regions that an insurer is permitted to use for purposes of defining a smaller than statewide service area as described in §3.3704(g)(1) of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers) are as follows:

(1) Region 1--Panhandle, including Amarillo and Lubbock, comprised of the following ZIP Coded areas: 79001, 79002, 79003, 79005, 79007, 79008, 79009, 79010, 79011, 79012, 79013, 79014, 79015, 79016, 79018, 79019, 79021, 79022, 79024, 79025, 79027, 79029, 79031, 79032, 79033, 79034, 79035, 79036, 79039, 79040, 79041, 79042, 79043, 79044, 79045, 79046, 79051, 79052, 79053, 79054,

79056, 79057, 79058, 79059, 79061, 79062, 79063, 79064, 79065, 79066, 79068, 79070, 79072, 79073, 79077, 79078, 79079, 79080, 79081, 79082, 79083, 79084, 79085, 79086, 79087, 79088, 79091, 79092, 79093, 79094, 79095, 79096, 79097, 79098, 79101, 79102, 79103, 79104, 79105, 79106, 79107, 79108, 79109, 79110, 79111, 79114, 79116, 79117, 79118, 79119, 79120, 79121, 79124, 79159, 79166, 79168, 79172, 79174, 79178, 79185, 79187, 79189, 79201, 79220, 79221, 79226, 79229, 79230, 79231, 79233, 79234, 79235, 79236, 79237, 79239, 79240, 79241, 79243, 79244, 79245, 79250, 79251, 79255, 79256, 79257, 79258, 79259, 79261, 79311, 79312, 79313, 79314, 79316, 79320, 79322, 79323, 79324, 79325, 79326, 79329, 79330, 79336, 79338, 79339, 79343, 79344, 79345, 79346, 79347, 79350, 79351, 79353, 79355, 79356, 79357, 79358, 79363, 79364, 79366, 79367, 79369, 79370, 79371, 79372, 79373, 79376, 79378, 79379, 79380, 79381, 79382, 79383, 79401, 79402, 79403, 79404, 79405, 79406, 79407, 79408, 79409, 79410, 79411, 79412, 79413, 79414, 79415, 79416, 79423, 79424, 79430, 79452, 79453, 79457, 79464, 79490, 79491, 79493, and 79499;

(2) Region 2--Northwest Texas, including Wichita Falls and Abilene, comprised of the following ZIP Coded areas: 76228, 76230, 76239, 76251, 76255, 76261, 76265, 76270, 76301, 76302, 76305, 76306, 76307, 76308, 76309, 76310, 76311, 76351, 76352, 76354, 76357, 76360, 76363, 76364, 76365, 76366, 76367, 76369, 76370, 76371, 76372, 76373, 76374, 76377, 76379, 76380, 76384, 76385, 76388, 76389, 76424, 76427, 76429, 76430, 76432, 76435, 76437, 76442, 76443, 76444, 76445, 76448, 76450, 76452, 76454, 76455, 76458, 76459, 76460, 76464,

76466, 76468, 76469, 76470, 76471, 76474, 76481, 76483, 76486, 76491, 76801, 76802, 76803, 76804, 76821, 76823, 76827, 76828, 76834, 76845, 76857, 76861, 76865, 76873, 76875, 76878, 76882, 76884, 76888, 76890, 79223, 79225, 79227, 79247, 79248, 79252, 79501, 79502, 79503, 79504, 79505, 79506, 79508, 79510, 79512, 79516, 79517, 79518, 79519, 79520, 79521, 79525, 79526, 79527, 79528, 79529, 79530, 79532, 79533, 79534, 79535, 79536, 79537, 79538, 79539, 79540, 79541, 79543, 79544, 79545, 79546, 79547, 79548, 79549, 79550, 79553, 79556, 79560, 79561, 79562, 79563, 79565, 79566, 79567, 79601, 79602, 79603, 79604, 79605, 79606, 79607, 79608, 79697, 79698, and 79699;

(3) Region 3--Metroplex, including Fort Worth and Dallas, comprised of the following ZIP Coded areas: 75001, 75002, 75006, 75007, 75009, 75010, 75011, 75013, 75014, 75015, 75016, 75017, 75019, 75020, 75021, 75022, 75023, 75024, 75025, 75026, 75027, 75028, 75029, 75030, 75032, 75034, 75035, 75037, 75038, 75039, 75040, 75041, 75042, 75043, 75044, 75045, 75046, 75047, 75048, 75049, 75050, 75051, 75052, 75053, 75054, 75056, 75057, 75058, 75060, 75061, 75062, 75063, 75065, 75067, 75068, 75069, 75070, 75071, 75074, 75075, 75076, 75077, 75078, 75080, 75081, 75082, 75083, 75085, 75086, 75087, 75088, 75089, 75090, 75091, 75092, 75093, 75094, 75097, 75098, 75099, 75101, 75102, 75104, 75105, 75106, 75109, 75110, 75114, 75115, 75116, 75118, 75119, 75120, 75121, 75123, 75125, 75126, 75132, 75134, 75135, 75137, 75138, 75141, 75142, 75143, 75144, 75146, 75147, 75149, 75150, 75151, 75152, 75153, 75154, 75155, 75157, 75158, 75159, 75160, 75161, 75164, 75165, 75166, 75167, 75168, 75172, 75173, 75180,

75181, 75182, 75185, 75187, 75189, 75201, 75202, 75203, 75204, 75205, 75206, 75207, 75208, 75209, 75210, 75211, 75212, 75214, 75215, 75216, 75217, 75218, 75219, 75220, 75221, 75222, 75223, 75224, 75225, 75226, 75227, 75228, 75229, 75230, 75231, 75232, 75233, 75234, 75235, 75236, 75237, 75238, 75240, 75241, 75242, 75243, 75244, 75245, 75246, 75247, 75248, 75249, 75250, 75251, 75252, 75253, 75254, 75258, 75260, 75261, 75262, 75263, 75264, 75265, 75266, 75267, 75270, 75275, 75277, 75283, 75284, 75285, 75286, 75287, 75301, 75303, 75310, 75312, 75313, 75315, 75320, 75323, 75326, 75334, 75336, 75339, 75340, 75342, 75343, 75344, 75353, 75354, 75355, 75356, 75357, 75358, 75359, 75360, 75363, 75364, 75367, 75368, 75370, 75371, 75372, 75373, 75374, 75376, 75378, 75379, 75380, 75381, 75382, 75386, 75387, 75388, 75389, 75390, 75391, 75392, 75393, 75394, 75395, 75396, 75397, 75398, 75401, 75402, 75403, 75404, 75407, 75409, 75413, 75414, 75418, 75422, 75423, 75424, 75428, 75429, 75438, 75439, 75442, 75443, 75446, 75447, 75449, 75452, 75453, 75454, 75458, 75459, 75474, 75475, 75476, 75479, 75485, 75488, 75489, 75490, 75491, 75492, 75495, 75496, 76001, 76002, 76003, 76004, 76005, 76006, 76007, 76008, 76009, 76010, 76011, 76012, 76013, 76014, 76015, 76016, 76017, 76018, 76019, 76020, 76021, 76022, 76023, 76028, 76031, 76033, 76034, 76035, 76036, 76039, 76040, 76041, 76043, 76044, 76048, 76049, 76050, 76051, 76052, 76053, 76054, 76058, 76059, 76060, 76061, 76063, 76064, 76065, 76066, 76067, 76068, 76070, 76071, 76073, 76077, 76078, 76082, 76084, 76085, 76086, 76087, 76088, 76092, 76093, 76094, 76095, 76096, 76097, 76098, 76099, 76101, 76102, 76103, 76104, 76105, 76106, 76107, 76108,

76109, 76110, 76111, 76112, 76113, 76114, 76115, 76116, 76117, 76118, 76119, 76120, 76121, 76122, 76123, 76124, 76126, 76127, 76129, 76130, 76131, 76132, 76133, 76134, 76135, 76136, 76137, 76140, 76147, 76148, 76150, 76155, 76161, 76162, 76163, 76164, 76166, 76177, 76179, 76180, 76181, 76182, 76185, 76191, 76192, 76193, 76195, 76196, 76197, 76198, 76199, 76201, 76202, 76203, 76204, 76205, 76206, 76207, 76208, 76209, 76210, 76225, 76226, 76227, 76233, 76234, 76238, 76240, 76241, 76244, 76245, 76246, 76247, 76248, 76249, 76250, 76252, 76253, 76258, 76259, 76262, 76263, 76264, 76266, 76267, 76268, 76271, 76272, 76273, 76299, 76401, 76402, 76426, 76431, 76433, 76439, 76446, 76449, 76453, 76461, 76462, 76463, 76465, 76467, 76472, 76475, 76476, 76484, 76485, 76487, 76490, 76623, 76626, 76639, 76641, 76651, 76670, 76679, and 76681;

(4) Region 4--Northeast Texas, including Tyler, comprised of the following ZIP Coded areas: 75103, 75117, 75124, 75127, 75140, 75148, 75156, 75163, 75169, 75410, 75411, 75412, 75415, 75416, 75417, 75420, 75421, 75425, 75426, 75431, 75432, 75433, 75434, 75435, 75436, 75437, 75440, 75441, 75444, 75448, 75450, 75451, 75455, 75456, 75457, 75460, 75461, 75462, 75468, 75469, 75470, 75471, 75472, 75473, 75477, 75478, 75480, 75481, 75482, 75483, 75486, 75487, 75493, 75494, 75497, 75501, 75503, 75504, 75505, 75507, 75550, 75551, 75554, 75555, 75556, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 75565, 75566, 75567, 75568, 75569, 75570, 75571, 75572, 75573, 75574, 75599, 75601, 75602, 75603, 75604, 75605, 75606, 75607, 75608, 75615, 75630, 75631, 75633, 75636, 75637, 75638, 75639, 75640, 75641, 75642, 75643, 75644, 75645, 75647, 75650, 75651,

75652, 75653, 75654, 75656, 75657, 75658, 75659, 75660, 75661, 75662, 75663, 75666, 75667, 75668, 75669, 75670, 75671, 75672, 75680, 75681, 75682, 75683, 75684, 75685, 75686, 75687, 75688, 75689, 75691, 75692, 75693, 75694, 75701, 75702, 75703, 75704, 75705, 75706, 75707, 75708, 75709, 75710, 75711, 75712, 75713, 75750, 75751, 75752, 75754, 75755, 75756, 75757, 75758, 75759, 75762, 75763, 75764, 75765, 75766, 75770, 75771, 75772, 75773, 75778, 75779, 75780, 75782, 75783, 75784, 75785, 75789, 75790, 75791, 75792, 75797, 75798, 75799, 75801, 75802, 75803, 75832, 75839, 75853, 75861, 75880, 75882, 75884, 75886, 75925, and 75976;

(5) Region 5--Southeast Texas, including Beaumont, comprised of the following ZIP Coded areas: 75760, 75788, 75834, 75835, 75844, 75845, 75847, 75849, 75851, 75856, 75858, 75862, 75865, 75901, 75902, 75903, 75904, 75915, 75926, 75928, 75929, 75930, 75931, 75932, 75933, 75934, 75935, 75936, 75937, 75938, 75939, 75941, 75942, 75943, 75944, 75946, 75948, 75949, 75951, 75954, 75956, 75958, 75959, 75960, 75961, 75962, 75963, 75964, 75965, 75966, 75968, 75969, 75972, 75973, 75974, 75975, 75977, 75978, 75979, 75980, 75990, 77326, 77331, 77332, 77335, 77350, 77351, 77359, 77360, 77364, 77371, 77374, 77376, 77399, 77519, 77585, 77611, 77612, 77613, 77614, 77615, 77616, 77619, 77622, 77624, 77625, 77626, 77627, 77629, 77630, 77631, 77632, 77639, 77640, 77641, 77642, 77643, 77651, 77655, 77656, 77657, 77659, 77660, 77662, 77663, 77664, 77670, 77701, 77702, 77703, 77704, 77705, 77706, 77707, 77708, 77709, 77710, 77713, 77720, 77725, and 77726;

(6) Region 6--Gulf Coast, including Houston and Huntsville, comprised of the following ZIP Coded areas: 77001, 77002, 77003, 77004, 77005, 77006, 77007, 77008, 77009, 77010, 77011, 77012, 77013, 77014, 77015, 77016, 77017, 77018, 77019, 77020, 77021, 77022, 77023, 77024, 77025, 77026, 77027, 77028, 77029, 77030, 77031, 77032, 77033, 77034, 77035, 77036, 77037, 77038, 77039, 77040, 77041, 77042, 77043, 77044, 77045, 77046, 77047, 77048, 77049, 77050, 77051, 77052, 77053, 77054, 77055, 77056, 77057, 77058, 77059, 77060, 77061, 77062, 77063, 77064, 77065, 77066, 77067, 77068, 77069, 77070, 77071, 77072, 77073, 77074, 77075, 77076, 77077, 77078, 77079, 77080, 77081, 77082, 77083, 77084, 77085, 77086, 77087, 77088, 77089, 77090, 77091, 77092, 77093, 77094, 77095, 77096, 77097, 77098, 77099, 77201, 77202, 77203, 77204, 77205, 77206, 77207, 77208, 77209, 77210, 77212, 77213, 77215, 77216, 77217, 77218, 77219, 77220, 77221, 77222, 77223, 77224, 77225, 77226, 77227, 77228, 77229, 77230, 77231, 77233, 77234, 77235, 77236, 77237, 77238, 77240, 77241, 77242, 77243, 77244, 77245, 77246, 77247, 77248, 77249, 77250, 77251, 77252, 77253, 77254, 77255, 77256, 77257, 77258, 77259, 77260, 77261, 77262, 77263, 77265, 77266, 77267, 77268, 77269, 77270, 77271, 77272, 77273, 77274, 77275, 77276, 77277, 77278, 77279, 77280, 77282, 77284, 77285, 77286, 77287, 77288, 77289, 77290, 77291, 77292, 77293, 77294, 77296, 77297, 77298, 77299, 77301, 77302, 77303, 77304, 77305, 77306, 77315, 77316, 77318, 77320, 77325, 77327, 77328, 77333, 77334, 77336, 77337, 77338, 77339, 77340, 77341, 77342, 77343, 77344, 77345, 77346, 77347, 77348, 77349, 77353, 77354, 77355, 77356, 77357, 77358, 77362, 77365,

77367, 77368, 77369, 77372, 77373, 77375, 77377, 77378, 77379, 77380, 77381, 77382, 77383, 77384, 77385, 77386, 77387, 77388, 77389, 77391, 77393, 77396, 77401, 77402, 77404, 77406, 77410, 77411, 77412, 77413, 77414, 77415, 77417, 77418, 77419, 77420, 77422, 77423, 77428, 77429, 77430, 77431, 77432, 77433, 77434, 77435, 77436, 77437, 77440, 77441, 77442, 77443, 77444, 77445, 77446, 77447, 77448, 77449, 77450, 77451, 77452, 77453, 77454, 77455, 77456, 77457, 77458, 77459, 77460, 77461, 77463, 77464, 77465, 77466, 77467, 77468, 77469, 77470, 77471, 77473, 77474, 77475, 77476, 77477, 77478, 77479, 77480, 77481, 77482, 77483, 77484, 77485, 77486, 77487, 77488, 77489, 77491, 77492, 77493, 77494, 77496, 77497, 77501, 77502, 77503, 77504, 77505, 77506, 77507, 77508, 77510, 77511, 77512, 77514, 77515, 77516, 77517, 77518, 77520, 77521, 77522, 77530, 77531, 77532, 77533, 77534, 77535, 77536, 77538, 77539, 77541, 77542, 77545, 77546, 77547, 77549, 77550, 77551, 77552, 77553, 77554, 77555, 77560, 77561, 77562, 77563, 77564, 77565, 77566, 77568, 77571, 77572, 77573, 77574, 77575, 77577, 77578, 77580, 77581, 77582, 77583, 77584, 77586, 77587, 77588, 77590, 77591, 77592, 77597, 77598, 77617, 77623, 77650, 77661, 77665, 78931, 78933, 78934, 78935, 78943, 78944, 78950, 78951, and 78962;

(7) Region 7--Central Texas, including Austin and Waco, comprised of the following ZIP Coded areas: 73301, 73344, 75831, 75833, 75838, 75840, 75846, 75848, 75850, 75852, 75855, 75859, 75860, 76055, 76436, 76457, 76501, 76502, 76503, 76504, 76505, 76508, 76511, 76513, 76518, 76519, 76520, 76522, 76523, 76524, 76525, 76526, 76527, 76528, 76530, 76531, 76533, 76534, 76537, 76538, 76539,

76540, 76541, 76542, 76543, 76544, 76545, 76546, 76547, 76548, 76549, 76550, 76554, 76556, 76557, 76558, 76559, 76561, 76564, 76565, 76566, 76567, 76569, 76570, 76571, 76573, 76574, 76577, 76578, 76579, 76596, 76597, 76598, 76599, 76621, 76622, 76624, 76627, 76628, 76629, 76630, 76631, 76632, 76633, 76634, 76635, 76636, 76637, 76638, 76640, 76642, 76643, 76644, 76645, 76648, 76649, 76650, 76652, 76653, 76654, 76655, 76656, 76657, 76660, 76661, 76664, 76665, 76666, 76667, 76671, 76673, 76676, 76678, 76680, 76682, 76684, 76685, 76686, 76687, 76689, 76690, 76691, 76692, 76693, 76701, 76702, 76703, 76704, 76705, 76706, 76707, 76708, 76710, 76711, 76712, 76714, 76715, 76716, 76795, 76797, 76798, 76799, 76824, 76831, 76832, 76844, 76853, 76864, 76870, 76871, 76877, 76880, 76885, 77363, 77426, 77801, 77802, 77803, 77805, 77806, 77807, 77808, 77830, 77831, 77833, 77834, 77835, 77836, 77837, 77838, 77840, 77841, 77842, 77843, 77844, 77845, 77850, 77852, 77853, 77855, 77856, 77857, 77859, 77861, 77862, 77863, 77864, 77865, 77866, 77867, 77868, 77869, 77870, 77871, 77872, 77873, 77875, 77876, 77878, 77879, 77880, 77881, 77882, 78602, 78605, 78606, 78607, 78608, 78609, 78610, 78611, 78612, 78613, 78615, 78616, 78617, 78619, 78620, 78621, 78622, 78626, 78627, 78628, 78630, 78633, 78634, 78635, 78636, 78639, 78640, 78641, 78642, 78643, 78644, 78645, 78646, 78648, 78650, 78651, 78652, 78653, 78654, 78655, 78656, 78657, 78659, 78660, 78661, 78662, 78663, 78664, 78665, 78666, 78667, 78669, 78672, 78673, 78674, 78676, 78680, 78681, 78682, 78683, 78691, 78701, 78702, 78703, 78704, 78705, 78708, 78709, 78710, 78711, 78712, 78713, 78714, 78715, 78716, 78717, 78718, 78719, 78720, 78721,

78722, 78723, 78724, 78725, 78726, 78727, 78728, 78729, 78730, 78731, 78732, 78733, 78734, 78735, 78736, 78737, 78738, 78739, 78741, 78742, 78744, 78745, 78746, 78747, 78748, 78749, 78750, 78751, 78752, 78753, 78754, 78755, 78756, 78757, 78758, 78759, 78760, 78761, 78762, 78763, 78764, 78765, 78766, 78767, 78768, 78769, 78772, 78773, 78774, 78778, 78779, 78780, 78781, 78783, 78785, 78786, 78788, 78789, 78798, 78799, 78932, 78938, 78940, 78941, 78942, 78945, 78946, 78947, 78948, 78949, 78952, 78953, 78954, 78956, 78957, 78960, 78961, and 78963;

(8) Region 8--South Central Texas, including San Antonio, comprised of the following ZIP Coded areas: 76883, 77901, 77902, 77903, 77904, 77905, 77951, 77954, 77957, 77960, 77961, 77962, 77963, 77964, 77967, 77968, 77969, 77970, 77971, 77973, 77974, 77975, 77976, 77977, 77978, 77979, 77982, 77983, 77984, 77986, 77987, 77988, 77989, 77991, 77993, 77994, 77995, 78001, 78002, 78003, 78004, 78005, 78006, 78008, 78009, 78010, 78011, 78012, 78013, 78014, 78015, 78016, 78017, 78019, 78021, 78023, 78024, 78025, 78026, 78027, 78028, 78029, 78039, 78050, 78052, 78054, 78055, 78056, 78057, 78058, 78059, 78061, 78062, 78063, 78064, 78065, 78066, 78069, 78070, 78073, 78074, 78101, 78107, 78108, 78109, 78111, 78112, 78113, 78114, 78115, 78116, 78117, 78118, 78119, 78121, 78122, 78123, 78124, 78130, 78131, 78132, 78133, 78135, 78140, 78141, 78143, 78144, 78147, 78148, 78150, 78151, 78152, 78154, 78155, 78156, 78159, 78160, 78161, 78163, 78164, 78201, 78202, 78203, 78204, 78205, 78206, 78207, 78208, 78209, 78210, 78211, 78212, 78213, 78214, 78215, 78216, 78217, 78218, 78219,

78220, 78221, 78222, 78223, 78224, 78225, 78226, 78227, 78228, 78229, 78230, 78231, 78232, 78233, 78234, 78235, 78236, 78237, 78238, 78239, 78240, 78241, 78242, 78243, 78244, 78245, 78246, 78247, 78248, 78249, 78250, 78251, 78252, 78253, 78254, 78255, 78256, 78257, 78258, 78259, 78260, 78261, 78262, 78263, 78264, 78265, 78266, 78268, 78269, 78270, 78275, 78278, 78279, 78280, 78283, 78284, 78285, 78286, 78287, 78288, 78289, 78291, 78292, 78293, 78294, 78295, 78296, 78297, 78298, 78299, 78604, 78614, 78618, 78623, 78624, 78629, 78631, 78632, 78638, 78658, 78670, 78671, 78675, 78677, 78801, 78802, 78827, 78828, 78829, 78830, 78832, 78833, 78834, 78836, 78837, 78838, 78839, 78840, 78841, 78842, 78843, 78847, 78850, 78852, 78853, 78860, 78861, 78870, 78871, 78872, 78873, 78877, 78879, 78880, 78881, 78883, 78884, 78885, 78886, and 78959;

(9) Region 9--West Texas, including Midland, Odessa, and San Angelo comprised of the following ZIP Coded areas: 76820, 76825, 76836, 76837, 76841, 76842, 76848, 76849, 76852, 76854, 76855, 76856, 76858, 76859, 76862, 76866, 76869, 76872, 76874, 76886, 76887, 76901, 76902, 76903, 76904, 76905, 76906, 76908, 76909, 76930, 76932, 76933, 76934, 76935, 76936, 76937, 76939, 76940, 76941, 76943, 76945, 76949, 76950, 76951, 76953, 76955, 76957, 76958, 78851, 79331, 79342, 79359, 79360, 79377, 79511, 79701, 79702, 79703, 79704, 79705, 79706, 79707, 79708, 79710, 79711, 79712, 79713, 79714, 79718, 79719, 79720, 79721, 79730, 79731, 79733, 79735, 79738, 79739, 79740, 79741, 79742, 79743, 79744, 79745, 79748, 79749, 79752, 79754, 79755, 79756, 79758, 79759, 79760,

79761, 79762, 79763, 79764, 79765, 79766, 79768, 79769, 79770, 79772, 79776, 79777, 79778, 79780, 79781, 79782, 79783, 79785, 79786, 79788, 79789, and 79848;

(10) Region 10--Far West Texas, including El Paso, comprised of the following ZIP Coded areas: 79734, 79821, 79830, 79831, 79832, 79834, 79835, 79836, 79837, 79838, 79839, 79842, 79843, 79845, 79846, 79847, 79849, 79851, 79852, 79853, 79854, 79855, 79901, 79902, 79903, 79904, 79905, 79906, 79907, 79908, 79910, 79911, 79912, 79913, 79914, 79915, 79916, 79917, 79918, 79920, 79922, 79923, 79924, 79925, 79926, 79927, 79928, 79929, 79930, 79931, 79932, 79934, 79935, 79936, 79937, 79938, 79940, 79941, 79942, 79943, 79944, 79945, 79946, 79947, 79948, 79949, 79950, 79951, 79952, 79953, 79954, 79955, 79958, 79960, 79961, 79968, 79976, 79978, 79980, 79990, 79995, 79996, 79997, 79998, 79999, 88510, 88511, 88512, 88513, 88514, 88515, 88516, 88517, 88518, 88519, 88520, 88521, 88523, 88524, 88525, 88526, 88527, 88528, 88529, 88530, 88531, 88532, 88533, 88534, 88535, 88536, 88538, 88539, 88540, 88541, 88542, 88543, 88544, 88545, 88546, 88547, 88548, 88549, 88550, 88553, 88554, 88555, 88556, 88557, 88558, 88559, 88560, 88561, 88562, 88563, 88565, 88566, 88567, 88568, 88569, 88570, 88571, 88572, 88573, 88574, 88575, 88576, 88577, 88578, 88579, 88580, 88581, 88582, 88583, 88584, 88585, 88586, 88587, 88588, 88589, 88590, and 88595; and

(11) Region 11--Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo, comprised of the following ZIP Coded areas: 77950, 77990, 78007, 78022, 78040, 78041, 78042, 78043, 78044, 78045, 78046, 78049, 78060, 78067, 78071,

78072, 78075, 78076, 78102, 78104, 78125, 78142, 78145, 78146, 78162, 78330, 78332, 78333, 78335, 78336, 78338, 78339, 78340, 78341, 78342, 78343, 78344, 78347, 78349, 78350, 78351, 78352, 78353, 78355, 78357, 78358, 78359, 78360, 78361, 78362, 78363, 78364, 78368, 78369, 78370, 78371, 78372, 78373, 78374, 78375, 78376, 78377, 78379, 78380, 78381, 78382, 78383, 78384, 78385, 78387, 78389, 78390, 78391, 78393, 78401, 78402, 78403, 78404, 78405, 78406, 78407, 78408, 78409, 78410, 78411, 78412, 78413, 78414, 78415, 78416, 78417, 78418, 78419, 78426, 78427, 78460, 78461, 78463, 78465, 78466, 78467, 78468, 78469, 78470, 78471, 78472, 78473, 78474, 78475, 78476, 78477, 78478, 78480, 78501, 78502, 78503, 78504, 78505, 78516, 78520, 78521, 78522, 78523, 78526, 78535, 78536, 78537, 78538, 78539, 78540, 78541, 78543, 78545, 78547, 78548, 78549, 78550, 78551, 78552, 78553, 78557, 78558, 78559, 78560, 78561, 78562, 78563, 78564, 78565, 78566, 78567, 78568, 78569, 78570, 78572, 78573, 78574, 78575, 78576, 78577, 78578, 78579, 78580, 78582, 78583, 78584, 78585, 78586, 78588, 78589, 78590, 78591, 78592, 78593, 78594, 78595, 78596, 78597, 78598, and 78599.

§3.3713. Submission of Plan; Collection and Analysis of Information Concerning the Effects of Undercompensated Care.

(a) An insurer is required to submit to the department on July 1, 2014, a plan outlining how the insurer will collect information sufficient to determine the following information concerning the effects of undercompensated care:

(1) whether the contracted charges for each preferred provider facility reflect the facility's cost of undercompensated care; and

(2) a financial analysis of the monetary impact of undercompensated care on the contracted charges of each contracted facility.

(b) For purposes of this section, the term "undercompensated care" means care that is not reimbursed through an agreement between an insurer and a facility and that is either uncompensated or is reimbursed at an amount less than the facility's billed charges.

(c) The plan required by subsection (a) of this section is required to be submitted to the department electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The plan must be submitted to the following e-mail address: lhlmail@tdi.state.tx.us.

(d) Effective July 1, 2015, an insurer is required to implement its plan developed pursuant to subsection (a) of this section for the collection and analysis of information concerning the effects of undercompensated care.

CERTIFICATION. This agency hereby certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on May 19, 2011.

Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§3.3701 – 3.3706, new §§3.3707 – 3.3711, and new §3.3713 specified herein, concerning preferred provider benefit plans and network adequacy requirements, are adopted.

AND IT IS SO ORDERED.

MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

David Durden, Associate Commissioner
Via Commissioner's Order No. 11-0361

COMMISSIONER'S ORDER NO. 11-0430

MAY 19 2011