SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
DIVISION 1. GENERAL REQUIREMENTS
28 TAC §3.3705

INTRODUCTION. The Texas Department of Insurance proposes amendments to 28 TAC Chapter 3, Subchapter X, Division 1, §3.3705, relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. The amendments are necessary because of an inadvertent clerical error omitting unchanged subsections (l)(3) - (q) in the adoption of amendments to the section.

EXPLANATION. Section 3.3705 needs to be amended to restore subsections inadvertently omitted from the order adopting amendments to another subsection of the section. In the May 27, 2016, issue of the *Texas Register* (41 TexReg 3832), the department proposed amendments to 28 TAC §3.3705(f) and §3.3708(e). The department also proposed §3.3705(a) - (e) and (g) - (q) and the remainder of §3.3708 with no changes. Subsections (g) - (q) of §3.3705 were specifically proposed as "No change."

On October 14, 2016, the commissioner adopted amendments to 28 TAC §3.3705 and §3.3708, specifically noting three changes to the proposed amendments to §3.3705(f) and three changes to the proposed amendments to §3.3708(3). The order noted that the department was making no further changes to either section.

The adoption order was required to reproduce the entirety of §3.3705 and §3.3708 for publication in the *Texas Register*. This required copying and pasting the unchanged text of §3.3705 (g) - (q) into the order after the amended text of subsection (f). Due to a clerical error, only the unchanged text of subsections (g) - (l)(2) was pasted in. As a result, the adoption order omitted the unchanged text of §3.3705(l)(3) - (q). The adoption order was published in the October 28, 2016, issue of the *Texas Register* (41 TexReg 8605) with §3.3705(l)(3) - (q) still missing. The omission was not noticed during the period the *Texas Register* allows for correction of error, and the adoption became effective on November 3, 2016.

To correct the error, §3.3705 needs to be amended to restore the inadvertently omitted subsections.

A description of changes to specific sections follows.

Section 3.3705. The proposal restores the text of subsections (l) - (q) that was excluded from the publication of §3.3705 in the October 28, 2016, issue of of the *Texas Register*.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Deanna Osmonson, assistant director, Life and Health Lines Office, has determined that during each year of the first five years that the proposed amendment is in effect, there will be no fiscal impact on state or local governments as a result of enforcing or administering the sections, since the amendment merely restores subsections (l) through (q) that was inadvertently excluded from the publication of §3.3705 in the October 28, 2016, issue of of the *Texas Register*. There will not be any measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. Ms. Osmonson has also determined that for each year of the first five years the amendment is in effect, the public benefit anticipated as a result of administration and enforcement of the amended sections will be compliance with subsections (l) through (q) and communication by insurers with insureds. There is no anticipated economic cost to persons who are required to comply with the proposed amendments because these are requirements already included in §3.3705 prior to the October 28, 2016, issue of of the *Texas Register*. The subsections deal with communications already made by regulated entities, which the department believes regulated entities have continued to do despite the inadvertent omission in the rule.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. As required by Government Code §2006.002(c), the department has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses because, to the extent they contain requirements, they simply restore §3.3705(l) - (q) to their state before November 3, 2016. Therefore, in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property

that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. The department invites the public to comment on this proposal. Submit your written comments no later than 5 p.m., Central time, on January 9, 2017. Send written comments by mail to the Office of the Chief Clerk, MC 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov. You must simultaneously submit an additional copy of the comments by mail to Patricia Brewer, Team Lead, Life and Health Regulatory Initiatives Team, Regulatory Policy Division, MC 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to LHLComments@tdi.texas.gov. You must submit any request for a public hearing separately to the Office of the Chief Clerk, MC 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov before the close of the public comment period. If a hearing is held, written comments and public testimony presented at the hearing will be considered.

STATUTORY AUTHORITY. These amendments are proposed under Insurance Code §§36.001, 1301.007, and 1301.0042.

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

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

Insurance Code §1301.0042 provides that a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

CROSS REFERENCE TO STATUTE. The proposed amendments implement Insurance Code §1301.007 and §1301.0042.

TEXT.

SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS

DIVISION 1. GENERAL REQUIREMENTS

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

(a) - (k) (No change.)

(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 must comply with the requirements in paragraphs (1) - (9) 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 provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

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

(B) whether the provider is accepting new patients.

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

(7) The provider information must be provided in at least 10 point font.

(8) 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.

(9) The provider information must be dated.

(m) Annual policyholder notice concerning use of a local market access plan. An insurer operating a preferred provider benefit plan that relies on a local market access plan as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must provide notice of this fact to each individual and group policyholder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available pursuant to subsection (e)(2) of this section;

(2) information on how to obtain or view any local market access plan or plans the insurer uses; and

(3) a link to the department's website where the department posts information relevant to the grant of waivers.

(n) Disclosure of substantial decrease in the availability of certain preferred providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians 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 title (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 so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer provides to the department, by e-mail to mcqa@tdi.texas.gov, a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers), as those standards apply to the applicable provider specialty.

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

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

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

(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 mcqa@tdi.texas.gov, 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 must post notice as specified in paragraph (3) of this subsection and 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 out-of-network services. An insurer must make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

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

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

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

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

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

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

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

(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 title without reliance on 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 title, the insurer is required to disclose that the plan has a "Limited Hospital Care Network":

(1) on the insurer's outline of coverage; and

(2) on the cover page of any 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 title and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer must:

(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.

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

Issued at Austin, Texas, on November 22, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance