January 22, 2024

Submitted electronically to chiefclerk@tdi.texas.gov

Office of the Chief Clerk
MC: GC-CCO
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

Re: Proposed amendments to 28 TAC Chapter 3, Subchapter S, § 3.308, relating to mandatory guaranteed renewability under certain health plans and 28 TAC Chapter 3, Subchapter X, §§ 3.3702-3.3705, 3.3707-3.3711, and new §§ 3.3712 and 3.3713, relating to preferred and exclusive provider plans, as published in the Texas Register on December 8, 2023, at 48 Tex. Reg. 7129, et seq.

Dear Chief Clerk:

On behalf of over 57,000 physician and medical student members, the Texas Medical Association ("TMA") and the undersigned Associations (collectively referred to herein as the "Associations") express their appreciation for the opportunity to provide comment on the Texas Department of Insurance ("TDI" or the "Department")'s proposed amendments to 28 TAC Chapter 3, Subchapter S, relating to mandatory guaranteed renewability under certain health plans and Subchapter X, relating to preferred and exclusive provider benefit plans.

As TDI stated in the preamble, the proposed amendments are intended to implement House Bills 711, 1647, 1696, 2002, and 3359, 88th Legislature, 2023; Senate Bill 1264, 86th Legislature, 2019; and Senate Bills 1003 and 2476, 88th Legislature, 2023, and address the court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020).

As TDI is aware, the Associations have a well-demonstrated interest in ensuring that patients/consumers obtain value for their premium dollars through the creation and maintenance of adequate networks for preferred provider benefit plans (PPBPs). Ensuring the creation and maintenance of adequate networks (as well as robust regulatory oversight over such networks) is even more important in the context of exclusive provider benefit plans (EPBPs). EPBPs are closed networks for which no benefits are afforded for services provided by non-preferred providers, aside from certain limited instances.

The Associations understand the complexity involved in drafting regulations (especially those concerning PPBPs and EPBPs) and appreciate TDI's efforts; however, we have numerous concerns regarding the proposed rules.

Our comments are largely directed at addressing our concerns that the proposed rules: (1) fail to conform to the underlying statutory authority; (2) undo or lessen important transparency provisions that were critical consumer protections previously in TDI rules; and (3) would authorize less robust networks than the Legislature intended and do so both ***with and without*** requiring waivers from network adequacy requirements.

The Associations offer the following specific comments on the rule proposal:

I. Proposed Implementation Timeframe and Applicability

First, we appreciate and support TDI's stated intent to "begin reviewing networks according to network adequacy standards in advance of September 1, 2024," and to apply the new rules (after adoption) to network adequacy reports due by April 1, 2024. **We concur that it is important for the Department to begin reviewing networks according to final adopted network adequacy standards in advance of September 1, 2024 in order to meet the statutory timelines and requirements under HB 3359.** We, therefore, oppose the extensions requested by the Texas Association of Health Plans (TAHP) at the TDI hearing on January 10, 2024.

As noted in the rule proposal preamble, HB 3359 applies to policies delivered, issued for delivery, or renewed on or after September 1, 2024. Under the law, TDI is required to perform

network adequacy examinations ***before*** a plan is offered and to hold a public hearing ***before*** approving a waiver request.

In the rule preamble it also states that "[a] network that will not be used with any plan issued or renewed on or after September 1, 2024 will continue to be subject to the rules in effect at the time the plan was issued or renewed."[1] We appreciate this clarification as well; however, we note that the Department does not propose any amendments to current 28 TAC §3.3701 (regarding applicability and scope) or (a)(1) of that section, which provides that:

> This subchapter applies to any preferred or exclusive provider benefit plan policy that is offered, delivered, issued for delivery, or renewed on or after 150 days from the effective date of this section. Any preferred or exclusive provider benefit plan policy delivered, issued for delivery, or renewed prior to this applicability date is subject to the statute and provisions of this chapter in effect at the time the policy was delivered issued for delivery, or renewed.

We query whether the Department intends to make any modifications to Section 3.3701 regarding the timing of the various provisions and if so, how the language will interact with TDI's proposed network adequacy reviews.

Furthermore, we underscore the importance of maintaining the language in Section 3.3701(a) and (f) that clarifies the scope of the rules (i.e., the application to both PPBPs ***and*** EPBPs). More specifically, Section 3.3701(f) provides that "a provision of this title applicable to a preferred provider benefit plan is applicable to an exclusive provider benefit plan unless otherwise specified." This language is critical since the current construct of the rules refers only to "preferred provider benefit plans" when they actually apply to ***both*** PPBPs ***and*** EPBPs. It is imperative that there be clarity that, for example, the network adequacy standard requirements in 3.3704 apply to ***both*** PPBPs ***and*** EPBPs (as this was clearly the Legislature's intent in passing HB 3359).

II. Proposed Amendments to §3.3703. Contracting Requirements.

A. Proposed amendments to Section 3.3703(a) – Introductory clause

Next, in the introductory clause to Section 3.3703(a), the Department makes a technical correction (i.e., changing the word "assure" to "ensure" in one instance). However, we note that the introductory clause has two references to "assure" that should be "ensure." Thus, the Associations recommend that the Department modify the proposed language in the introductory clause of Section 3.3703(a) in each of those instances to read as follows:

> (a) An insurer marketing a preferred provider benefit plan must contract with physicians and health care providers to <u>ensure</u> [~~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

[1] 48 Tex. Reg. 7129, 7130.

plan in a manner that ensures [~~assures~~] both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must meet the following requirements:

B. Proposed amendments to Section 3.3703(a)(20)

Next, as a general comment, we note that TDI did not appear to implement Insurance Code Section 1301.0642, regarding the prohibition of contracting provisions that allow certain adverse material changes, as added by HB 3359, in the rule proposal. Implementing this provision of the Insurance Code would seemingly require amendments to Section 3.3703, as the language in Section 3.3703(a)(20) of the rule proposal does not currently contemplate compliance with Insurance Code Section 1301.0642. Thus, the Associations recommend the following amendment to the Department's proposed amendments in Section 3.3703(a)(20) (and queries whether the Department intends to issue any further rulemaking implementing this new statutory provision):

§3.3703. Contracting Requirements.

(a) …. Each contract must meet the following requirements:

…

(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…. Amendments, revisions, or substitutions of any information provided in accordance with this paragraph are required to be made under subparagraph (D) of this paragraph <u>and, when applicable, subparagraph (J) of this paragraph</u>. 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.

…

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

Pursuant to ***current*** Section 3.3703(a)(20)(D), no amendment, revision, or substitution of claims procedures or any other information required to be provided by §3.3703(a)(20) 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. In other words, the effective date of the amendment, revision, or substitution must be 90 days or

more away from the date that the insurer provides the preferred provider written notice of the specific amendment, revision, or substitution.

With the passage of HB 3359, ***in addition*** to the notice requirements of 3.3703(a)(20)(D), for any contract between a preferred provider and an insurer to which Section 1301.0642 applies, no adverse material change[2] to the contract will be effective as to the preferred provider unless the adverse material change is made in accordance with the provisions of Section 1301.0642, including the requirement for a mutual agreement of the parties. If the preferred provider agrees to the adverse material change, the adverse material change cannot go into effect until the 120th day after the date the preferred provider affirmatively agreed to the adverse material change in writing, as required by Section 1301.0642(c).

Insurance Code Section 1301.0642 should be incorporated into the rule so that it ***supplements*** the existing requirements of Section 3.3703(a)(20). Thus, for any adverse material change that complies with Section 1301.0642 and is mutually agreed to in writing, the 120-day waiting period required by Section 1301.0642(c) will subsume the 90-day notice period required by 3.3703(a)(20)(D) (as the insurer will be required to provide written notice of the specific amendment, revision, or substitution on or before the date the preferred provider affirmatively agrees to the adverse material change in writing). For any proposed adverse material change that is not mutually agreed to in writing, there is no effective date to reference against the 90-days' notice requirement of Section 3.3703(a)(20)(D), as an adverse material change cannot go into effect without the written mutual agreement of the parties when Section 1301.0642 applies. For any amendment, revision, or substitution that is not an adverse material change or for a contract that is not subject to Section 1301.0642, the requirements of Section 3.3703(a)(20)(D) will continue to operate as they do today.

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[2] In Insurance Code § 1301.0642, an "adverse material change" is defined as:

> a change to a preferred provider contract with a physician, health care practitioner, or organization of physicians or health care practitioners that would decrease the preferred provider's payment or compensation, change the provider's tier to a less preferred tier, or change the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses or decrease the provider's payment or compensation. The term does not include:
>
> > (1) a decrease in payment or compensation resulting solely from a change in a published governmental fee schedule on which the payment or compensation is based if the applicability of the schedule is clearly identified in the contract;
> >
> > (2) a decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;
> >
> > (3) an administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;
> >
> > (4) a change that is required by federal or state law;
> >
> > (5) a termination for cause; or
> >
> > (6) a termination without cause at the end of the term of the contract.

As such, Section 3.3703(a)(20) should be amended, as recommended above, to inform relevant stakeholders of the additional requirements of Section 1301.0642, that apply to certain provider contracts, regarding proposed adverse material changes.

We would also like to clarify that Insurance Code Section 1301.0642 supplements the existing requirements of Section 3.3703(a)(20), and the existence of a proposed adverse material change or the written mutual agreement of an adverse material change does not alter: (1) the requirements of Section 3.3703(a)(20), including the requirement of an insurer to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request, (2) the requirements of Section 3.3703(a)(20)(F), which require an insurer to provide the information required by subparagraphs (A) – (D) of Section 3.3703(a)(20) by the 30th day after the date the insurer receives the preferred provider's request for such information, or (3) the requirements of Section 3.3703(a)(20)(H), including the provision that authorizes a preferred provider to terminate the contract on or before the 30th day after the date the preferred provider receives information requested under Section 3.3703(a)(20).

C. Proposed amendments to Section 3.3703(a)(29)

TDI implements House Bill 711 ("HB 711"), in part, in Section 3.3703(a)(29) by requiring all contracts between a preferred provider and an insurer to comply with Insurance Code Section 1458.101, concerning provider network contract requirements. However, certain provisions of Section 1458.101 only apply to a contract between a preferred provider and an insurer if the insurer also, in the ordinary course of business, establishes provider networks for access by another party (that does not operate under the same brand licensee program as the insurer[3])—such as subsection (h)—which only applies to parties to a "provider network contract."[4] Thus, we recommend that TDI amend its proposed language as follows:

> (29) A contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning Contracting Requirements, if:

[3] TEX. INS. CODE § 1458.003(1).

[4] "Provider network contract" is defined as "a contract between a ***contracting entity*** and ***a provider*** for the delivery of, and payment for, health care services to a covered individual." TEX. INS. CODE § 1458.001(8) (emphasis added); *see also* "contracting entity" which is defined as "a person who: (A) enters into a direct contract with a provider for the delivery of health care services to covered individuals; ***and (B) in the ordinary course of business establishes a provider network or networks for access by another party***." TEX. INS. CODE § 1458.001(2) (emphasis added).

Note the definition of "general contracting entity" in Chapter 1458 of the Insurance Code provides that a general contracting entity is a person that enters into a direct contract with a provider for the delivery of health care services to covered individuals ***without regard to whether the person***, in the ordinary course of business, establishes a provider network for access by another party. In other words, a general contracting entity is a catch-all term that includes entities that establish provider networks for access by another party (i.e., contracting entities) *as well as* entities that do not establish provider networks for access by another party (i.e., general contracting entities that aren't also contracting entities).

(A) the insurer is considered a contracting entity, as defined by Insurance Code §1458.001, concerning General Definitions, and

(B) the exemptions in Insurance Code §1458.003, concerning Exemptions, do not apply.

D. Proposed amendments to Section 3.3703(a)(30)

Next, in proposed Section 3.3703(a)(30), TDI proposes requiring a contract between an insurer and a preferred provider to comply with Insurance Code Chapter 1451, Subchapter D. The Associations note, however, that the relevant managed care plan provisions in that subchapter are really limited to Section 1451.155 (rather than the entire subchapter) and to contracts with optometrists or therapeutic optometrists (rather than all preferred providers). Thus, TDI's proposed language is drafted in an overly broad manner. The Associations, therefore, recommend that TDI amend its proposed language as follows:

(30) A contract between an insurer and a preferred provider that is an optometrist or therapeutic optometrist must comply with Insurance Code Section 1451.155, concerning Contracts with Optometrists or Therapeutic Optometrists [~~Chapter 1451, Subchapter D, concerning Access to Optometrists Used Under Managed Care Plan~~].

Or alternatively as:

(30) A contract between an insurer and a preferred provider must comply with Insurance Code Section 1451.155, concerning Contracts with Optometrists or Therapeutic Optometrists to the extent applicable. [~~Chapter 1451, Subchapter D, concerning Access to Optometrists Used Under Managed Care Plan~~].

III. Proposed Amendments to §3.3704. Freedom of Choice; Availability of Preferred Providers.

Next, Section 3.3704 provides several fairness, freedom of choice, and access requirements that PPBPs and EPBPs must comply with, as well as several exceptions to those requirements.

A. Proposed amendments to Section 3.3704(a)(7).

In proposed Section 3.3704(a)(7), the Departments propose amending the rule to provide that a PPBP is not unjust provided that:

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

In the rule preamble, TDI states that this language is to "affirm TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care."[5] We agree that PPBPs and EPBPs cannot engage in these kinds of practices and therefore support the intent of TDI's proposed amendment.

B. Proposed amendments to Section 3.3704(a)(9).

In proposed Section 3.3704(a)(9), TDI proposes the following language:

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

In the rule preamble, TDI states that it is proposing this language to "prohibit an insurer from penalizing an insured based solely on a failure to obtain a preauthorization, as TDI views such practices unjust under Insurance Code §1701.055(a)(2)." TDI then adds the following:

> This does not impact contractual requirements with preferred providers related to preauthorization requirements and does prevent an insurer from retrospectively reviewing a claim for a service that was not preauthorized and denying a claim if it fails to meet medical necessity standards. To the extent that an insurer is currently imposing and collecting such penalties, this provision could decrease the portion of claims paid by insureds and increase the portion paid by the insurer. TDI does not have data available that allows it to estimate how often such penalties are imposed and invites comment.[6]

Given TDI's very vague and limited explanation of this proposal, we do not have sufficient information to meaningfully comment on this proposal. More information on the "penalties" being referenced by TDI, the impetus for this proposed amendment, and the impact of this proposed language is respectfully requested prior to TDI moving forward with this proposed language and we would respectfully request another opportunity to comment after that additional information is made available to stakeholders.

C. Proposed amendments to Section 3.3704(e).

In its proposal, TDI implements HB 711, in part, in Section 3.3704(e), as a new exception to the freedom of choice requirements in Section 3.3704, as follows:

[5] 48 Tex. Reg. 7129, 7131.
[6] 48 Tex. Reg. 7129, 7134

(e) Steering and tiering. An insurer may use steering or a tiered network to encourage an insured to obtain a health care service from a particular provider without impeding the insured's freedom of choice under this section only if the insurer engages in that conduct for the primary benefit of the insured or policyholder, consistent with Insurance Code §1458.101(i), concerning Contract Requirements. For the purposes of this section:

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

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

We are ***opposed*** to inclusion of the proposed language in subsection (e) as it does not conform with either the statutory authority or plain language under HB 711 and we are concerned that it will encourage unlawful steering and tiering. More specifically, TDI's proposed language is broadly drafted and could be misconstrued as granting blanket permission to steer and use a tiered network provided that the insurer meets only one requirement – i.e., engages in that conduct for the primary benefit of the insured or policyholder.

Put simply, the Texas Legislature did ***not*** grant that kind of authority (or ***any*** authority for that matter) to insurers to steer or tier under §1458.101(i). Nothing in the language states that an insurer "may" rank or steer or "is authorized" to rank and tier if they only meet one requirement – i.e., engaging in that conduct for the primary benefit of the enrollee.

Rather the statutory language states as follows:

(i) A health benefit plan issuer that encourages an enrollee to obtain a health care service from a particular provider, including offering incentives to encourage enrollees to use specific providers, or that introduces or modifies a tiered network plan or assigns providers into tiers has a fiduciary duty to the enrollee or policyholder to engage in that conduct only for the primary benefit of the enrollee or policyholder.

This statutory language is ***not*** a grant of authority at all, but rather the imposition of an ***additional*** obligation—a fiduciary duty, no less—on insurers that steer or tier ***within the confines of current law*** to also do so only for the primary benefit of the enrollee. In other words, it provides a heightened fiduciary duty overlay and additional limitation on top of the existing statutory framework that regulates steering and tiering. Imposing some heightened duty under the law makes sense as HB 711 limits the freedom to contract certain additional steering and tiering limitations.

Importantly, the HB 711 language does ***nothing*** to supersede or otherwise impact the application of numerous laws that impose limitations on steering and tiering, such as (but not limited to)

Chapter 1460, Texas Insurance Code (which prohibits health benefit plan issuers from ranking or tiering physicians unless certain requirements are met); Section 1301.068, Texas Insurance Code (which prohibits an insurer from using any financial incentive that acts directly or indirectly as an inducement to limit medically necessary services), or Section 1251.006, Texas Insurance Code (which provides that a group accident and health insurance policy or blanket accident and health insurance policy may not require that a covered service be provided by a particular hospital or person). Rather, HB 711 was directed at certain anti-steering and anti-tiering ***contracting*** provisions. As the Author's statement of intent provides, "H.B. 711 would amend the Insurance Code to prohibit insurance companies and providers from entering into provider network contracts with anti-competitive clauses." [7]

HB 711 also contains no repealers of statutory provisions impacting ranking, tiering, or steering and can be harmonized with existing statutory limitations. As TDI knows, it is a basic tenet of statutory construction that statutes are to be construed so that whenever possible effect is given to all provisions. Thus, ***all*** of those laws remain in effect.

Moreover, the Texas Legislature considered and rejected bills during the 88th Legislature that would have provided more authority to insurers to rank and tier (HB 3351) and steer (HB 2414). The Legislature did ***not*** pass those bills, which further evidences an intent ***not*** to modify the underlying steering and tiering statutory framework. Put simply, TDI cannot do through rulemaking that which the Legislature opted not do in the legislative process. The rule, therefore, exceeds TDI's statutory authority.

For the foregoing reasons, inclusion of the proposed language in subsection (e) conflicts with the law and is not authorized by HB 711. We, therefore, strongly recommend that this language be struck from the rule proposal.

If, however, TDI seeks to move forward with this language over this stated objection, we also note the following additional specific concerns with the proposed language in Section 3.3704(e).

First, the rule fails to mention that an insurer that encourages an enrollee to obtain a health care service from a particular physician or provider also has a *fiduciary duty* to the enrollee or policyholder. A fiduciary duty is a serious undertaking that brings a special relationship of trust and confidence that usually arises as a matter of law in formal relationships, such as attorney-client relationships, partnerships, and trustee relationships. However, the Legislature has now determined this type of duty applies to an insurer that encourages an enrollee to obtain a health care service from a particular physician or provider or that assigns providers into tiers. **As such, we strongly recommend that TDI restate the creation of this fiduciary duty, in the rule.**

Second, while an insurer is required to provide a current or prospective insured an accurate written description of the terms and conditions of the policy (plan disclosures), it is not clear that the plan disclosures must include notice that the insurer intends to use steering or a tiered network to encourage the insured to obtain a health care service from a particular provider. **We recommend requiring an insurer to provide notice of steering or a tiered network, as well**

[7] Author's/Sponsor's Statement of Intent; available at: HB00711E.pdf (texas.gov)

as the existence of the insurer's fiduciary duty to an insured in the plan disclosures required by Section 3.3705(b)(7) of the rule (discussed further in section IV.A of this comment letter). As such, in this subsection, we recommend creating a requirement that providing these notices in the plan disclosure is part of an insurer's fiduciary duty owed to an insured.

Third, because the Legislature created this fiduciary duty as a matter of law and otherwise "[t]here is no general fiduciary duty between an insurer and its insured,"[8] owing a fiduciary duty to an insured is a novel concept to state-regulated insurers in this context. **We thus strongly encourage TDI to add an explicit set of fiduciary duties in the rule to ensure PPBPs and EPBPs are aware of the duties of a fiduciary and that they uphold these duties. Without a defined set of fiduciary duties in the rule, the duty owed to an insured will vary from insurer to insurer and would make it very difficult, costly, and time consuming for TDI to appropriately enforce this duty owed to each insured.**

Fourth, violating a fiduciary duty carries penalties and remedies other than the penalties for "impeding the insured's freedom of choice." As such, any rule implementing Section 1458.101(i) must also explain the penalties for an insurer that violates their fiduciary duty as well as the remedies available to insureds when an insurer violates that fiduciary duty.

To address the concerns raised above, we strongly recommend amending proposed Section 3.3704(e), as follows:

> (e) Steering and tiering. An insurer may use steering or a tiered network to encourage an insured to obtain a health care service from a particular provider without impeding the insured's freedom of choice under this section only if the insurer complies with all other law related to or affecting steering or use of a tiered network, including Chapter 1460, Texas Insurance Code, Section 1251.006, Insurance Code and Section 1301.068, Insurance Code, and the insurer complies with its fiduciary duty to the insured or policyholder to engage[~~s~~] in that conduct only for the primary benefit of the insured or policyholder, consistent with Insurance Code §1458.101(i), concerning Contract Requirements. For the purposes of this section:
>
> > (1) "steering" refers to offering incentives to encourage enrollees to use specific providers;
> >
> > (2) a "tiered network" refers to a network of preferred providers in which an insurer assigns preferred providers to tiers within the network that are associated with different levels of cost sharing;

[8] *Wayne Duddlesten, Inc. v. Highland Ins. Co.*, 110 S.W.3d 85, 96 (Tex. App.—Houston [1st Dist.] 2003, pet. denied) (citing *Garrison Contractors, Inc. v. Liberty Mut. Ins. Co*., 927 S.W.2d 296, 301 (Tex. App.—El Paso 1996), *aff'd on other grounds*, 966 S.W.2d 482 (Tex. 1998)).

(3) an insurer complies with its fiduciary duty to the insured or policy holder to engage in that conduct only for the primary benefit of the insured or policy holder if the insurer:

(A) does not use a financial incentive to directly or indirectly act as an inducement to limit medically necessary services or to encourage receipt of lower quality services or receipt of services in violation of state or federal law;

(B) does not encourage, incentivize, or tier based solely on cost measures, standards, or considerations;

(C) complies with all other applicable state and federal law, including any law concerning ranking and tiering of physicians;

(D) establishes policies and procedures that ensure the quality of care received by the patient is paramount in any encouragement, incentivization, ranking, or tiering made under this section, including by ensuring that physicians currently in clinical practice are actively involved in the development of any standards or encouragement or incentivization decision made under this section;

(E) does not make inaccurate statements or representations or create misimpressions regarding a physician's or health care provider's quality of care or costs;

(F) only uses objectively and verifiably accurate and valid information as the basis of any encouragement or incentive under this subsection;

(G) does not directly or indirectly benefit the insurer financially or inure to the benefit of the insurer's shareholders;

(H) provided an accurate and complete description of the plan disclosures required under Section 3.3705(b)(7) of this title;

(I) files a copy of any policies, procedures, or information required by this paragraph as well as any policies, procedures, or information to be utilized in making any encouragement or incentive under this this section with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes to any of the policies, procedures, or information described by this subparagraph; and

(J) does not engage in any other conduct associated with the steering or tiering that is not for the primary benefit of the insured

or policyholder, consistent with Insurance Code §1458.101(i), concerning Contract Requirements.

(4) An insurer that violates paragraph (3) of this subsection:

(A) commits an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of Insurance Code §541.003, concerning Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Prohibited;

(B) is subject to administrative penalties under Insurance Code Chapters 82 and 84;

(C) may be subject to any other remedy or procedure provided by law, including the common law, that an insured may seek against the insurer.

Without this kind of guidance in the rule, it is unclear how TDI will monitor and ensure that an insurer upholds its fiduciary duty owed to an insured or policyholder. Moreover, as proposed, TDI's rule would permit each insurer to determine the insureds "primary benefit" each time they encourage an insured to use a particular provider. In other words, TDI's proposal trusts that the fox can determine what primarily benefits each hen, and that the fox will always choose the option that primarily benefits each hen.

Thus, to properly implement and enforce HB 711, TDI must: (1) specify the scope of the fiduciary duty an insurer owes to an insured, (2) explain how an insurer can demonstrate it is complying with that fiduciary duty, and (3) enforce non-compliance with that fiduciary duty.

D. Proposed amendments to Section 3.3704(f).

Next, we appreciate that TDI's proposal implements many of the network adequacy requirements of HB 3359 by requiring compliance with specific sections of the Insurance Code in Section 3.3704(f)(1) of the rule. **However, we oppose the proposed requirements in paragraphs (2) and (3) of Section 3.3704(f) of the rule as currently drafted, because they conflict with the underlying statutory language and would permit an insurer to utilize a less robust network than the law requires (and without seeking a waiver).**

1. Section 3.3704(f)(2)

First, we note that paragraph (2) would permit 10% of insureds in the insurer's service area to have ***no*** freedom of choice of preferred providers, despite the provisions in Section 1301.0055(b)(3) & (b)(12) of the Insurance Code that require PPBPs and EPBPs to ensure "sufficient choice, access, and quality" of preferred providers to ***all*** insureds. Permitting 10% of insureds to have ***no*** freedom of choice of preferred providers clearly conflicts with the statute.

Second, paragraph (2) fails to conform to the underlying law as it doesn't require compliance with the network adequacy standards applicable for **each physician specialty and class of health care providers**. It merely requires that all insureds can access at least one preferred provider (and for 90% of insureds, access to at least two preferred providers) within the statutory time and distance standards. Thus, paragraph (2) is drafted in such a way that a PPBP or EPBP could argue that their network is adequate so long as every insured has access to ***a single*** preferred provider (and for 90% of insureds, access to just two preferred providers) within the time and distance standards specified in Insurance Code §1301.0053 and §1301.00554 even if there were failures to satisfy the statutory requirements regarding accessing ***each*** of the other physician specialties or classes of health care providers within the time and distance requirements.

Third, paragraph (2) fails to take into consideration the interaction of the law's provisions regarding time and distance with the law's: (1) appointment wait time standards; and (2) requirements that the plan "ensure sufficient choice, access, and quality of physicians and health care providers in number, size, and geographic distribution, to be capable of providing the health care services covered by the plan, ***taking into account the insureds' characteristics, medical conditions, and health care needs***." (emphasis added).

Thus, we are concerned that paragraph (2) could be misapplied to construe a network as adequate when, for example, all insureds can access at least one preferred provider but perhaps the accessible preferred provider does not have an appointment available within the maximum appointment wait time and /or does not treat the patient's medical condition. This would be an inadequate network under the statute, but would not be under TDI rules if these points are analyzed in isolation and TDI moves forward with the proposed rule as currently drafted.

Fourth, proposed paragraph (2) sets the bar incredibly low for patient choice, which contravenes the underlying statutory authority. Clearly, the Legislature would have expected the insured to have ***much*** more choice within the network when TDI deems it adequate than it will have if there is a network failure and §3.3707(j) of the proposed rules has to be utilized (which is supposed to be the failsafe for an inadequate network).

For all the foregoing reasons, we recommend that TDI amend the language in proposed Section 3.3704(f)(2) as follows:

> (2) An adequate network must [~~,~~][~~for each~~] ensure that all insureds [~~residing in the service area, ensure that all insureds can access at least one preferred provider and 90% of insureds can~~] are able to access and receive an appointment with a choice of at least two preferred providers for each physician specialty and for each class of health care provider, within the time and distance standards specified for each physician specialty and for each class of health care provider identified in Insurance Code §1301.00553 and §1301.00554 and within the maximum appointment wait times under Section 1301.0055, taking into account the insured's characteristics, medical conditions, and health care needs.

2. Section 3.3704(f)(3)

Next, we also **oppose** TDI's proposed language in paragraph (3) as it improperly implements Section 1301.0055(b)(4) of the Insurance Code by arbitrarily determining that the "sufficient number of [preferred physicians for each applicable specialty] at each preferred hospital, ambulatory surgical center, or freestanding emergency center…to ensure all insureds are able to receive covered benefits…at that preferred location" is always two.

The construction of the proposed rule ignores the fact-specific nature of the statute's operative language concerning the need to "ensure all insureds are able of receive covered benefits, at that preferred location." Variables that would affect the "sufficient number" of preferred physician specialists at a facility include (but are not limited to): (1) the location of the facility, (2) the number of insureds that receive covered benefits or are projected to receive covered benefits from that facility each month (in total and categorized by physician specialty), (3) the insureds' characteristics, medical conditions and health care needs, (4) the number of operating rooms or other sites of care applicable to each specialty; and (5) the number of total patients treated by that facility per month. However, none of these factors are considered by the proposed rule, which places the rule at odds with the underlying statute. To underscore this point, two in-network physicians may be enough to meet patient needs at a small ambulatory surgery center, but would be woefully inadequate at a large urban hospital with dozens of operating rooms and hundreds of patients per day. This is particularly true where – as will frequently be the case – those two physicians will also be providing care for other plans' members, Medicare and Medicaid patients, and self-pay patients.

The construction of the proposed rule language in (f)(3) also sets the bar so low for preferred physicians at in-network facilities that it conflicts with the clear intent of the statutory language in Insurance Code Section 1301.00565(e) that provides that "the commissioner may not consider a prohibition on balance billing in determining whether to grant a waiver from network adequacy." The Legislature included this statutory language to ensure that TDI did not permit the plans to use the patient protections from surprise billing implemented under Sections 1301.0053, 1301.155, 1301.164, or 1301.165 to undercut network adequacy (as the entire value that a network-based plan offers is dependent upon how robust its network is and it was never the Legislature's intent to diminish robust networks through the enactment of those balance billing protections).

In circumvention of this Legislative intent, TDI now seeks to do directly that which the Legislature prevented it from doing indirectly in the network adequacy waiver context – i.e., it seeks to make patients rely on the balance billing protections under Section 1301.164, for out-of-network services provided by facility-based providers at in-network facilities, rather than requiring health plans to meet robust network adequacy requirements that would provide insureds with access to a sufficient in-network physicians and in-network facilities. Simply put, this circumvention of the law is unacceptable. If the Legislature had intended this result, it never would have enacted Section 1301.0055(b)(4) or 1301.00565(e) in the first place as the language is largely rendered meaningless by TDI's proposed rule.

It is, therefore, important that TDI ***not*** adopt proposed Section 3.3704(f) as currently proposed. Should TDI wish to move forward with language regarding Section 1301.0055(b), we recommend the following:

> (3) To provide a sufficient number of the specified types of preferred providers with the specialty types and diagnostic services, including radiology and laboratory services, listed in Insurance Code §1301.0055(b)(4), a network must include at least two preferred physicians for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility, including diagnostic services and must consider the factors in subparagraphs (A)-(F) of this paragraph, to aid in determining whether additional preferred physicians for each applicable specialty type are required to ensure all insureds are able to receive covered benefits at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care center.
>
> (A) the geographic location of the preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility;
> (B) the number of insureds that receive covered benefits or are projected to receive covered benefits at the preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility, per month:
>
> (i) for each preferred physician specialty type listed in Insurance Code §1301.0055(b)(4); and
>
> (ii) in total;
> (C) the number of total patients treated by that preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility, per month;
> (D) the insureds' characteristics, medical conditions, and health care needs;
> (E) the number of operating rooms or other sites of care applicable to each specialty; and
> (F) the number of physicians credentialed at the preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility in each of the listed specialties.

The language in (F) regarding credentialing was added to further address patient needs. It will be important, for example, that anesthesiologists who are pain management doctors not be counted the same as anesthesiologists who are provided operating room anesthesia (as the type of services provided by these anesthesiologists will differ).

Again, we urge TDI to make these changes, as it is imperative that TDI implement the provisions of the statute in a clear and effective manner that does not contravene the plain meaning or intent of HB 3359.

E. Proposed amendments to Section 3.3704(g).

Next, we recommend that TDI make two changes to the language in proposed Section 3.3704(g) to better conform to the statutory language. First, we recommend that TDI amend the proposed language to state that the insurer must "promptly" take any corrective action required to ensure the network is compliant not later than the 90th day after the date the material deviation occurred. The addition of the statutory word "promptly" is important, because under the law, an insurer has two obligations: (1) to act promptly and (2) to ensure the network is compliant not later than the 90th day. Thus, if the insurer drags its feet (waiting to do anything to correct the material deviation until the last minute), it would still be in violation of the statutory requirement and subject to TDI disciplinary action and penalties.

Second, we ask that "area" be changed to "county" in the exception language regarding no uncontracted physicians or health care providers in the affected "area." To implement those two changes, we recommend that subsection (g) be amended as follows:

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

IV. Proposed amendments to Section 3.3705.

Next, Section 3.3705 specifies certain information that an insurer must communicate to an insured, as well as the way in which that information must be communicated to an insured.

A. Proposed amendments to Section 3.3705(b).

In Section 3.3705(b), TDI proposes to implement HB 3359's requirement to disclose the existence of a waiver (and certain waiver related information, including the insurer's access plan) in all promotions or advertisements of a plan with an active waiver by including this information in the network demographics section of the plan's written terms and conditions that must be provided anytime an insurer promotes, advertises, or offers enrollment in their plan.

1. Concerns Regarding the Implementation of Statutory Requirements in Insurance Code Section 1301.0055(a)(4)

The Associations strongly oppose the language in Section 3.3705(b) as currently drafted because the proposal doesn't require the disclosure of an active waiver (and the other

information required by Insurance Code Section 1301.0055(a)(4)) to be in the actual promotion or advertisement of the PPBP or EPBP, as is required by the underlying statute.

In Insurance Code Section 1301.0055(a)(4), the Legislature directs TDI to adopt rules that "require disclosure by the insurer of the information [regarding waivers of network adequacy standards] ***in*** all promotion and advertisement of the preferred provider benefit plan for which a waiver is allowed…" (emphasis added). But TDI's proposal only requires an insurer to provide disclosure of an active waiver in the network demographics section of the plan's written description of the terms and conditions that must be provided anytime the insurer promotes, advertises, or offers enrollment in their plan. By allowing the disclosure to be provided in a separate document and buried within a health insurance policy's terms and conditions, TDI's rule falls short of Insurance Code Section 1301.0055(a)(4)'s requirement to disclose an active waiver ***in*** the promotion or advertisement itself.

This shortcoming is readily apparent considering the existing requirements of Insurance Code Section 1301.158:

> Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER BENEFIT PLANS.
>
> …
>
> (b) An insurer shall provide to a current or prospective group contract holder or current or prospective 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 current or prospective insured to make comparisons and an informed decision before selecting among health care 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. The insurer may satisfy this requirement by providing its handbook if:
>
> > (1) the handbook's content is substantively similar to and achieves the same level of disclosure as the written description prescribed by the commissioner; and
> >
> > (2) the current list of preferred providers is provided.
> >
> > …

If the Legislature intended for TDI to adopt rules that require insurers to disclose information related to active waivers in promotions and advertisements in the same manner that insurers provide a written description of the terms of the health insurance policy, there would have been no need for enacting the language in Section 1301.0055(a)(4). Certainly, a waiver of network adequacy requirements and the accompanying access plan are "terms of the health insurance policy" that would already be provided pursuant to Section 1301.158. This fact is evident in

current TDI rules, which already (i.e., pre-passage of HB 3359) required disclosure of waivers and access plans in health plans terms and conditions under Section 3.3705(b)(15).

Thus, the Legislature must have intended the disclosure of an active waiver to appear in a more conspicuous manner than solely within the litany of information required under Section 1301.158.[9] In fact, the plain language of the statute directs TDI to require insurers to disclose information related to an active waiver *in* all promotion and advertisement of the PPBP (or EPBP).

Yet, despite this legislative mandate, the Department's proposal treats the disclosure of an active waiver as if it were any other term or condition of a health insurance policy. But this interpretation ignores the fact that Section 1301.158 already requires the disclosure of an active waiver in the terms and conditions of an insurance policy and that the Department must give effect to both Sections 1301.158 and 1301.0055(a)(4) (rather than treating Section 1301.0055(a)(4) as mere surplusage). It also ignores the fact that Section 3.3705(d) of TDI rules currently requires certain disclosures to be placed directly in a plan's promotional or advertising material (thus acknowledging that there is a distinction with a meaningful difference between a disclosure being placed directly ***in*** a promotion or advertisement or being two steps removed by being buried in another document that is then provided with the promotional item or advertisement).

The Legislature's direction is abundantly clear. It mandated disclosure of the waiver-related information specified in Section 1301.0055(a)(4) directly in the promotional item or advertisement. This serves multiples purposes. First, it ensures that consumers will be informed that the plan received a waiver to meet state standards (before making a purchasing decision, thereby enabling them to make a more informed decision and to appropriately compare plans on this all-important component of a plan). Second, it ensures that consumers will get the most up-to-date information as health plans will need to update the waiver information to be timely when provided in the advertising or promotions in order to avoid false, deceptive, or misleading advertisements. Third, it incentivizes insurers to comply with the Legislature's network adequacy requirements (and contract with a robust network of physicians) so that they might not need a waiver from the state's network adequacy standards (and are able to competitively tout that fact when advertising their plans to prospective insureds). Put another way, the Legislature is telling insurers: "fill out your network or be prepared to advertise that your plan required a waiver to do business in this state."

We are very concerned that TDI has not followed this clear Legislative directive. For all the foregoing reasons, we ask that TDI amend its proposal to conform to the statutory directive (as reflected in our proposed amendment language in 4 (below)).

2. Additional Concerns Regarding the Implementation of Statutory Requirements in Section 1301.158

[9] "A statute is presumed to have been enacted by the legislature with complete knowledge of the existing law and with reference to it." *See In re Allen*, 366 S.W.3d 696, 706 (Tex. 2012) (quoting *Acker v. Tex. Water Comm'n*, 790 S.W.2d 299, 301 (Tex. 1990)).

The Associations also oppose the language in proposed 3.3705(b), because of its inappropriate comingling of Sections 1301.0055(a)(4) and 1301.158 in the rule in other respects.

In particular, we oppose the Department's proposal to strike language from the current rules that permits insureds to request that an insurer provide the insured with an accurate written description of the terms and conditions of the policy. This language was struck from the rule despite Insurance Code Section 1301.158 explicitly authorizing an insured to make such a request.

The proposed rule would also permit an insurer to utilize its policy, certificate, or handbook to satisfy its requirement to provide an insured with an accurate written description of the terms and conditions of the policy, despite Insurance Code Section 1301.158 explicitly only authorizing an insurer to satisfy this requirement using the format prescribed by the commissioner or its handbook (if the handbook's content is "substantively similar to and achieves the same level of disclosure as the written description prescribed by the commissioner"[10]). We, therefore, oppose this proposed change as well.

3. Concerns Regarding Important Consumer Protection Language to Permit Comparisons of Terms and Conditions

Finally, we strongly oppose TDI's proposed removal of language that requires the terms and conditions of a health insurance policy to be provided in the order prescribed by the commissioner. By removing the "in the following order" language and simultaneously authorizing an insurer to use its policy, certificate, or handbook to provide insureds a written description of the terms and conditions of the insurance policy, an insurer could place some of the terms and conditions in its policy, some in its certificate, and some in its handbook and in any indecipherable order. This could confuse many insureds and would also conflict with the plain language of Insurance Code Section 1301.158 which requires the format of the terms and conditions in a handbook to be "substantively similar to and achieve the same level of disclosure as the written description prescribed by the commissioner."[11] It would also abrogate the commissioner's duty to prescribe a readable and understandable format that an insurer may use to provide a written description of the terms and conditions of an insurance policy.

Essentially, under TDI's proposal, insurers wouldn't have to provide all of the plan's terms and conditions in a single document, and in a certain order, that would allow insureds and prospective insureds to "shop" between plans. Insurers would be authorized to re-order the terms and conditions of each plan among several documents, seriously frustrating Insurance Code Section 1301.158's intent to allow "current or prospective insured to make comparisons and an informed decision before selecting among health care plans."[12] Nor would the commissioner have to prescribe a readable and understandable format that an insurer could use (in lieu of

[10] Tex. Ins. Code § 1301.158(b)(1).
[11] Tex. Ins. Code § 1301.158(b).
[12] *Id.*

utilizing their handbook), as the proposed rule just describes the substantive content that must be included in a plan's written description of the terms and conditions.

4. Recommended amendments to Proposed Section 3.3705(b) Taking Into Consideration the Concerns Noted Above

Thus, for statutory compliance and the preservation of existing consumer protections (taking into account all the concerns we expressed above), we request that proposed subsection (b) and (d) be amended to read as follows (underlines reflect changes requested from the proposed language (not current TDI rule language"):

> (b) Plan disclosure. The insurer is required, in any promotion, advertisement, or enrollment opportunity and any other time on a request from a current or prospective group contract holder or current or prospective insured, 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 (plan disclosure) 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 [~~policy, certificate, or~~] handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. An insurer that is required by federal law to provide a summary of benefits and coverage (SBC) must include in the SBC a link to the plan disclosure required in this subsection. The written plan disclosure must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items in the following order:
>
> …
>
> (d) Promotional disclosures required.
>
> > (1) The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of basic benefits, except in the case of an exclusive provider benefit plan.
> >
> > (2) Any promotion or advertisement of a preferred provider benefit plan that received a waiver for a departure from network adequacy standards under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must disclose:
> >
> > > (A) that the preferred provider benefit plan received a waiver for a departure from network adequacy standards;

(B) the name of the insurer offering the plan;

(C) the effective dates of the waiver;

(D) the specific network adequacy standards waived;

(E) each county affected by the waiver; and

(F) describe the purpose of the access plan as well as the access plan, including the procedures developed pursuant to §3.3707(j) of this title.

Please note that our recommended amendments to subsection (b) do not alter TDI's proposed language in subsection (b)(14)(B), as the existence of an active waiver and access plan are "terms of a health insurance policy" that must be included in the written description required under Section 1301.158 of the Insurance Code.

B. Proposed amendments to Section 3.3705(f).

In Section 3.3705(f), an insurer must provide the notice specified in Figure: 28 TAC §3.3705(f)(1) for a PPBP, or the notice specified in Figure: 28 TAC §3.3705(f)(2) for an EPBP, in all policies, certificates, plan disclosures provided to comply with Section 3.3705(b), and outlines of coverage in at least a 12-point font.

In both figures, we are concerned that: (1) the notices fail to clearly inform insureds that a "preferred provider" is the same as an "in-network provider" or that "preferred providers make up the plan's network"; (2) the description of "network adequacy" under "Your plan's network" doesn't mention or indicate network adequacy requirements related to time and distance or maximum appointment wait times; (3) the notices fail to conspicuously inform consumers that they have the right to file complaints with TDI if they believe the network is inadequate; and (4) the third sentence under "List of doctors" doesn't note an insured might be protected from balance billing when they relied on the plan's directory to pick an in-network health care provider.

Additionally, in Figure: 28 TAC §3.3705(f)(1), we are concerned that the third sentence under "Health care bills" which states ", and you didn't pick the doctor *or facility…*" is confusing since this sentence is referring to care received while at an in-network facility.

And in Figure: 28 TAC §3.3705(f)(2), we are concerned that the description under "Your plan" implies an EPBP doesn't have to pay for medically necessary covered services that aren't available in the network. Also, in line two under "Bills for health care," we recommend inserting a comma between "doctor" and "you."

To address the concerns raised above, we recommend that TDI amend the figures in Section 3.3705(f) to read as follows:

Figure 28 TAC §3.3705(f)(1)

Your rights with a preferred provider (PPO) health plan

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors and facilities to treat its members at discounted rates. [~~These p~~] Providers [~~make~~] that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. Certain doctors and facilities within your plan's network must be readily accessible to you so you don't have to travel too far or wait too long, to receive covered services. This is called "network adequacy." If you can't find or access the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit. **If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.**

Health care costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay for any health care service or supply.

List of doctors

You can get a directory of doctors, facilities, and other health care providers that are in your plan's network. You can get the directory online at [enter website] or by calling [enter phone number]. If you used your health plan's directory to pick an in-network doctor, [~~or~~] facility, or other health care provider, and the doctor, [~~or~~] facility, or other health care provider, turns out to be out-of-network, you might not have to pay the extra cost that out-of-network doctors, [~~or~~] facilities, or other health care providers, charge.

Health care bills

If you want to see a doctor or facility that isn't in your plan's network (called "out-of-network"), you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay. If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor [~~or facility~~], you won't have to pay more than your regular copay, coinsurance, and deductible.

Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care. If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

Figure 28 TAC §3.3705(f)(2)

Your rights with an exclusive provider (EPO) health plan
Notice from the Texas Department of Insurance

Your plan
Your health plan contracts with doctors and facilities to treat its members at discounted rates. [~~These p~~] Providers [~~make~~] that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network. However, [~~T~~]there are some exceptions, including: [~~for~~] emergencies, when you didn't pick the doctor, and for air ambulance services.

Your plan's network
Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. Certain doctors and facilities within your plan's network must be readily accessible to you so you don't have to travel too far or wait too long, to receive covered services. This is called "network adequacy." If you can't find or access the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit. **If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.**

List of doctors
You can get a directory of doctors, [~~and~~] facilities, and other health care providers that are in your plan's network. You can get the directory online at [enter website] or by calling [enter phone number]. If you used your health plan's directory to pick an in-network doctor, [~~or~~] facility, or other health care provider, and the doctor, [~~or~~] facility, or other health care provider, turns out to be out-of-network, you might not have to pay the extra cost that out-of-network doctors, [~~or~~] facilities, or other health care providers, charge.

Bills for health care
If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible.

> Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care. If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

C. Proposed amendments Section 3.3705(m)

Next, in Section 3.3705(m)(1), an insurer must provide a link (in its annual policyholder notice concerning the use of an access plan) to a webpage listing of information on network waivers and access plans "made available under subsection (e)(2)" of Section 3.3705. However, the website "made available under subsection (e)(2)" would only require an insurer to link to a limited set of information regarding each county's network adequacy. It would not require providing a link to a webpage listing of information regarding network waivers and access plans. Thus, we recommend amending Section 3.3705(m)(1) to read as follows:

> (1) a link to any webpage listing of information on network waivers and access plans disclosed under subsection (b)(14)(B) of this section and made available under subsection (e)[~~(2)~~] of this section;

D. Proposed amendments to Section 3.3705(n).

In Section 3.3705(n), regarding disclosure of a substantial decrease in the availability of preferred providers of a specialty at a preferred provider facility, TDI proposes to insert "or provider" after each instance the term "physician" is used in existing subsection (n). However, because "specialty" is undefined, the Associations have concerns that by inserting "or provider" without any other amendments to subsection (n), insurers could inappropriately interpret this lack of specificity to include non-physician health care professionals within a ***physician*** specialty for that area. When calculating a substantial decrease (a decrease of 75% or more) of the preferred providers for that specialty at the facility, such an interpretation would allow an insurer to inflate the appliable denominator with physicians and non-physicians to raise the threshold necessary for required notice.

We have serious concerns with such a result. It would be disingenuous and detrimental to the public if TDI's rule could be interpreted to treat a non-physician provider as having attained the same level of licensure or certification held by a physician practicing in a specialty. Second, there is no statutory authority for treating non-physician providers the same as a physician practicing in a specialty. Third, as mentioned above, by inappropriately and erroneously considering both physician specialists and certain health care providers as practicing in the same specialty, the total number of individual preferred providers considered to hold that specialty at the facility would be increased. This dilutes the number of physician specialists at the facility and raises the threshold for a substantial decrease of "specialists" at the facility.

Consider the following hypothetical. Facility "A" contracts with 10 facility-based physician specialists and 5 facility-based health care providers that assist those facility-based physician

specialists. Under the existing rule, if 8 facility-based physician specialists were terminated by facility "A," an insurer would be required to provide the notice of a substantial decrease in accordance with subsection (n). But under proposed rule, due to potential ambiguity about whether other provider types could now be counted within what were previously exclusively physician specialties, if those same 8 facility-based physician specialists were terminated by facility "A," an insurer might interpret the proposed rules to conclude that no such notice would be required (i.e., the 75% or more threshold wouldn't be met because the number of "specialists" is increased by including the 5 facility-based health care providers that assist the facility-based physician specialists).

Leaving an ambiguity that could authorize a supermajority of preferred facility-based physicians practicing in certain specialty to be terminated without notifying insureds that the services at that facility are primarily provided by non-physician providers. And insurers and facilities would be incentivized to retain only a handful of physicians to delegate/supervise the non-physician providers providing "specialty" care at that facility.

We have similar concerns with the proposed changes in subsection (n)(2)(A). As proposed, subsection (n)(2)(A) wouldn't require notice of a substantial decrease when the terminated preferred providers are replaced by alternative preferred providers "of the same *specialty* as the physician *or provider* group that terminates a contract." (emphasis added). As with subsections (n)(1)(A) and (B), the proposed rules are unclear whether this could be interpreted to include physicians and non-physicians within a single "specialty." Such an interpretation, coupled with TDI's determination in proposed Section 3.3704(f)(3) that a "sufficient number" of preferred facility-based physician specialists at each preferred facility is two physicians could set the stage for a race to the bottom. Insurers and facilities would be incentivized to replace all but two of the preferred facility-based physician specialists with non-physician provider "specialists."

Lastly, we are concerned that TDI removed the requirement for an insurer to certify to TDI that the termination of a provider contract will not cause their provider network to be noncompliant with network adequacy standards, in order to bypass the otherwise required notification to insureds of a substantial decrease of preferred providers at a facility. Instead, TDI's proposal would allow an insurer to unilaterally determine that the termination will not cause their network to be noncompliant with network adequacy standards. TDI explained it removed this requirement "in recognition of the robust network adequacy requirements contained in HB 3359." **However, despite the robust network adequacy standards of HB 3359, the enforcement of these network adequacy standards is best upheld when the regulator, TDI, is informed of any substantial decrease of preferred providers at a preferred facility. As such, we oppose the removal of this requirement.**

Given these undesirable outcomes, we recommend that TDI amend the proposal to make it clearer that facility-based physicians are separate from non-physician facility-based providers, for purposes of calculating a substantial decrease in Section 3.3705(n). Specifically, we recommend the following amendments to proposed section 3.3705(n):

> (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 or providers at a preferred provider facility.

(1) A decrease is substantial if:

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

(B) the contract between the insurer and any facility-based provider group that comprises 75% or more of the preferred providers of that provider type at the facility terminates;

(C) the contract between the facility and any facility-based physician [~~or provider~~] group that comprises 75% 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); or

(D) the contract between the facility and any facility-based provider group that comprises 75% or more of the preferred providers of that provider type 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 facility-based physicians [~~providers~~] of the same specialty as the physician group that terminates a contract as specified in subparagraphs (A) or (C) of 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) alternative preferred facility-based providers of the same provider type as the provider group that terminates a contract as specified in subparagraphs (B) or (D) of paragraph (1) of this subsection are made available to insureds at the facility so the percentage level of preferred providers of that provider type 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

(C) the insurer [~~determines~~] provides to the department, by email 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.

E. Proposed deletion of Section 3.3705(p) and (q)

Next, the Associations oppose the Department's proposed deletion of the plan designations (concerning approved and limited hospital care networks) and other associated disclosures and requirements as set forth in current TDI rules at Section 3.3705(p) and (q). In the rule proposal preamble, the Department states that it is proposing deletion of these requirements "in recognition of the robust network adequacy requirements contained in HB 3359."

We oppose this deletion, as these requirements have been important consumer protections historically under TDI rules and we believe they will continue to be going forward. As TDI itself has previously noted, the plan designations in subsection (p) provide a convenient shorthand that allows consumers to quickly compare health plans based on whether they comply with the network hospital requirements. Further, TDI has previously stated that the designation, notice, and marketing requirements in subsection (q) are designed to assist the Department in monitoring network status and helping to prevent inappropriate, misleading, or deceptive marketing. We contend that ***all*** of these functions are still important consumer protections under HB 3359's framework and, therefore, must be retained.

We are concerned that the Department may be proposing deletion on these subsections because the Department thinks these disclosures are now less vital since the Legislature has imposed balance billing protections associated with certain facility-based care. However, we again note that the Legislature included language in HB 3359 (i.e., Insurance Code Section 1301.00565(e)) that provides that "the commissioner may not consider a prohibition on balance billing in determining whether to grant a waiver from network adequacy"). Thus, the Legislature has expressed a clear intent that the SB 1264 balance billing protections do not serve as a substitute for the insurer's obligations to fulfill its network adequacy requirements. Similarly, these balance billing protections should not be used as a shield to curtail the public's right to know if the insurer is falling short of its network adequacy obligations. We are very concerned that removal of provisions, such as current 3.3705(p) and (q) will disincentivize health plans from building adequate networks for facility-based services in direct contravention of the intent and plain language of HB 3359 (as it allows the plans to hide their deficiencies from the public and discourages competition on robust networks).

V. Proposed amendments to §3.3707. Waiver Due to Failure to Contract in Local Markets.

Next, the Department proposes to implement the procedure for determining whether to grant or deny a waiver from network adequacy standards in Section 3.3707. This procedure includes holding a public hearing, the evidence to be considered and the submission of that evidence, and the "good cause" or "good faith attempt" thresholds that the commissioner must find before granting a waiver (as applicable), which are key provisions added by HB 3359. **However, we are concerned that the Department's proposal fails to adhere to the statutory text added by HB 3359.**

A. Proposed amendments to Section 3.3707(a).

First, we note that Section 3.3707(a) authorizes the commissioner to grant a waiver if, after considering all pertinent evidence at a public hearing, the insurer "shows good cause *based on one or more of the criteria specified in this subsection* and subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5)." (emphasis added). The rule then provides:

> The commissioner may find good cause to grant the waiver if the insurer demonstrates that:
>
> > (1) there is an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area; [~~are not available to contract;~~] or
> >
> > (2) physicians or health care providers necessary for an adequate network have refused to contract with the insurer on any terms or on terms that are reasonable.

However, these two criteria (as currently drafted by TDI) are not contemplated by the authorizing statute. The statute, located at Insurance Code §1301.0055(a)(3), also directs the commissioner to consider the insurer's good faith contracting efforts and to receive all pertinent evidence at a public hearing, including the provisions of Insurance Code §1301.00565, before determining good cause is shown. There is no "magic bullet" an insurer may put forth that will guarantee good cause is shown. The statute requires the commissioner to make a determination based on the facts and circumstances of each unique request for a waiver.

Despite this, TDI's proposal limits the commissioner's ability to determine when good cause is present (or absent) based on all pertinent evidence by requiring the commissioner to base their determination of good cause on at least one of the two criteria specified in the rule. We are concerned that this construction (particularly with the currently proposed two criteria, which are similar to what TDI has used in the past) restricts the commissioner's authority regarding good cause determinations in a manner contrary to the statute and formalizes waivers as a feature of a plan's network, rather than an exception to mandatory network adequacy standards. It also makes it very difficult for the commissioner to justify denying a waiver when one of the criteria specified in subsection (a) is present, but, for example, there is conflicting evidence (or a failure of the insurer to contract in good faith with some physicians or providers).

As a result, we are concerned that the rule effectively asks the commissioner to rubber-stamp any insurer's request when one of the criteria is present. This construction runs counter to both the language and the intent of HB 3359 (and is compounded by the check list type of network adequacy analysis that TDI proposes to utilize in the forms associated with network adequacy and waiver requests, which is contrary to the patient-focused and fact-specific approach intended by the Legislature particularly with regard to good faith contracting**). For this reason, we are opposed to the language in Section 3.3707(a) as currently drafted.**

1. **Proposed amendments to Section 3.3707(a)(1)**

Additionally, we are concerned that the language in proposed subsection (a)(1) conflicts with the underlying statutory language of HB 3359 and will encourage insurers not to contract with physicians and other providers.

In the statute, the Legislature makes certain references to waivers when there are "no uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area." However, in the rule proposal the Department deviates from this statutory language and instead creates a broader stand-alone category of good cause to be found if the insurer demonstrates that there is a "an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area."

We are very concerned that this "insufficient number" proposal is a ***much*** lower threshold for granting a waiver than exists under current TDI rules and the law as amended by HB 3359. HB 3359's "no uncontracted physicians or health care providers" language was directed at granting waivers due to an impossibility standard based upon no availability of any physicians (i.e., there were ***no*** uncontracted physicians or health care providers in the area to meet the specific standard for a county in the service area). If for example, a certain specialty of physician did not practice in a county in the service area and thus that specialty was entirely unavailable, one could not reasonably expect an insurer to comply with the standard (thus, this could be the basis for a waiver request).

However, TDI now provides that good cause may be found if the insurer demonstrates "there is an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area." We are concerned that, under this language (in conjunction with the two paths specified in subsection (b)), the commissioner would not be required to consider whether the insurer make good faith efforts to contract with the remaining available uncontracted physicians or health care providers in that county (however many that may be, even if contracting with all would be insufficient to meet the specific standard for a county in a service area). An insurer should ***not*** be able to receive a waiver for good cause in this scenario without having also made good faith efforts to contract with whatever number of uncontracted physicians and providers ***are*** available.

By requiring the commissioner to only consider whether there is "an insufficient number of uncontracted physicians or health care providers," insurers could be incentivized to cease all contracting efforts with the remaining uncontracted physicians or health care providers in that area since they know they can receive a waiver on this ground (particularly as TDI merely requires the insurer to state that there is an insufficient number available in proposed Section 3.3705(b)(2)). This kind of gamesmanship is the antithesis of HB 3359's intent and will decrease patient choice and access in contravention of the law. Additionally, we are unclear as to how TDI will interpret "insufficient" as used in subsection (a)(1), which could lead to inconsistent results.

2. **Proposed amendments to Section 3.3707(a)(2)**

Next, in subsection (a)(2), TDI proposes that the commissioner may find good cause if the insurer demonstrates that physicians or health providers necessary for an adequate network have refused to contract with the insurer on any terms or on terms that are reasonable.

As we have stated in the past, we oppose the insurance industry bias contained within the drafting of this language. The aforementioned language implies that the physician or provider is always the party who is "refusing to contract," or "seeking contract terms that are unreasonable." Certainly, the Department understands that two parties are necessary to enter into a contract and that either party may be responsible for "refusing to contract" or for "seeking unreasonable terms." This is especially true, since many insurance contracts are in reality contracts of adhesion (i.e., take it or leave it types of contracts).

With the passage of HB 3359, the Legislature now ***very*** clearly requires the Department to consider the insurer's good faith contracting efforts and other pertinent evidence in determining good cause. We are concerned that the drafting of subsection (a), however, does not sufficiently acknowledge this legislative directive. The language in proposed subsection (a) could, therefore, potentially be construed to require the Department to grant a waiver when the provider has refused to contract but there was also a failure of the insurer to engage in good faith contracting efforts.

For example, there could be a scenario in which the insurer purportedly offered to contract on "reasonable" terms, but then failed to engage in other good faith contracting efforts (e.g., if the insurer provided an unreasonably short period of time for the physician to consider the offer, which was the basis of the purported "refusal" or if the insurer failed to negotiate on basic terms and then withdrew the original offer and offered a lower amount). The insurer should not be able to obtain a waiver (i.e., good cause shouldn't be found) in these scenarios when the insurer's lack of good faith conduct impacted the so-called "refusal" to contract. Also, a physician or provider's lack of response to an offer to contract should not be counted as a "refusal" to contract on reasonable terms if, e.g., the insurer failed to exercise reasonable care in contacting the physician or provider at the correct address.

We are also concerned that the ambiguous drafting of subsection (a)(2) could be read to permit and/or require the commissioner to grant a waiver if physicians or health care providers necessary for an adequate network have "refused" to contract with the insurer "on any terms," only (i.e., if the insurer only offered the physician or health care provider unreasonable terms). Clearly this would be an unjust result and contrary to the Legislature's directive to consider good faith contracting efforts by the insurer.

Next, we are also concerned that the language as currently drafted in subsection (a)(2) would require the commissioner to grant a waiver when some physicians or providers have "refused" to contract with the insurer on terms that are reasonable but the insurer has not engaged in good faith contracting efforts with other physicians or providers who would have been willing to accept those terms. These are the types of issues the commissioner must evaluate for each unique waiver request from a totality of the circumstances perspective.

To focus the determination of good cause on the totality of the evidence before the commissioner, we recommend the Department amend Section 3.3707(a), to read as follows:

> (a) Consistent with Insurance Code §1301.0055(a)(3), concerning Network Adequacy Standards, where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a county that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. The commissioner may grant the waiver if, after considering the waiver application and all pertinent evidence in a public hearing under Insurance Code §1301.00565, concerning Public Hearing on Network Adequacy Standards Waivers, the commissioner determines there is good cause [~~based on~~] for the insurer's inability to meet the specific network adequacy standard in that county and subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5). The commissioner may deny a waiver request if good cause is not shown and may impose reasonable conditions on the grant of the waiver. [~~The commissioner may find good cause to grant the waiver if the insurer demonstrates that~~
>
> [~~(1) there is an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area; or~~
>
> ~~(2) physicians or health care providers necessary for an adequate network have refused to contract with the insurer on any terms or on terms that are reasonable.~~]

These amendments make clear the commissioner must consider all pertinent evidence that is unique to each waiver request, and may only grant a waiver if, based on that evidence, there is good cause for the insurer's inability to meet the specific network adequacy standards in that county.

B. Proposed amendments to Section 3.3707(b).

Next, Section 3.3707(b) requires an insurer to submit information justifying the waiver request using the attempt to contract form available on TDI's website.

In Section 3.3707(b)(1)(B), the rule states the attempt to contract form will include "a description of *how* and *when* the insurer last contacted *each* [uncontracted] provider or physician that *demonstrates* that the insurer made a good faith effort to contract…." (emphasis added).

The drafting of this proposed language seems to be very procedurally focused and to presume that information collected on the form regarding how and when contacts were made will alone be sufficient to ***demonstrate*** that the insurer made a good faith effort to contract.

The Associations note that the information on the form is scant and nowhere near sufficient to actually fulfill the highly fact-specific analysis intended by the Texas Legislature. And nothing in the rule proposal explains how providing: (1) a description of how the insurer generally reaches out to uncontracted physicians or providers, (2) the uncontracted physician's or provider's contact information, (3) a description of the best offer of reimbursement rates made by the insurer, and (4) the date of the offer, will *demonstrate* that the insurer made a "good faith effort" to contract.

Again, this is largely procedural/process-oriented information and does not focus on substantive efforts or outcomes. It also does not seem to sufficiently take into consideration the statutory definition of a "good faith effort," which is defined as: "honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patient's access to in-network care."[13]

Examples of additional information that could be relevant to a good faith effort determination, include:

- Did the insurer offer a take-it-or-leave it contract?
- How open was the insurer to negotiating the terms of the contract?
- Did the insurer renege on any offers or mischaracterize information provided to the physician or provider?
- Did the insurer respond in a timely fashion to the physician and particularly in response to any counteroffers made by the physician? How did the insurer respond substantively (rather than the contact method)?
- Did the insurer negotiate on any terms other than reimbursement? If so, what terms?
- Did the insurer make multiple offers of materially differing rates? (the proposed rules currently only focus on the insurer's best reimbursement rate offer).
- Did the insurer seek to pressure or intimidate the physician or provider?
- Did the insurer engage in other actions that negatively impacted the physician or provider's response to the contract?
- What timeframe did the insurer give the physician or provider to respond to its offer(s)?
- Did the insurer make reasonable efforts to contact the physician or provider at the correct contact information and to identify the correct contact information?
- Did the insurer address all the questions asked by the physician or provider in a timely fashion?
- For those subject to Texas' surprise billing laws, the outcomes of those Texas arbitration proceedings and/or arbitration settlements.

We strongly urge the Department to include additional substantive information and information reflective of the good faith effort statutory language in the attempt to contract form and attendant rules.

1. Proposed 3.3707(b)(1)(C)

[13] Ins. Code § 1301.00565(a).

Next, in proposed Section 3.3707(b)(1)(C), the Department proposes the following**:**

> **(**C) For each provider or physician contacted, a description of the best offer of reimbursement rates made by the issuer, computed by describing the rate for each service of which a contract was offered as a percentage of:
>
> > (i) The Medicare rates for those services that applied at the time the contract was attempted and providing an average of the rates as a percent of the Medicare rates (e.g., rates offered were 135% of the Medicare rate); and
> >
> > (ii) the insurer's average contracted rate with preferred providers in a similar geographic area for those services and providing an average of the rates as a percent of the average contracted rate (e.g., rates offered were 108% of the average contracted rate.

We are strongly opposed to the rule's proposed requirement for insurers to provide the best rate offered to a physician or provider as a percentage of the Medicare rates for those services and as a percentage of the insurer's average contracted rate with preferred providers in a similar geographic area for those services.

a. Proposed Section 3.3707(b)(1)(C)(i)

First, as the Department knows, Medicare payments are ***not*** market driven and should not be used in any form as a benchmark or point of comparison for commercially reasonable rates. Put simply, Medicare rates are governmental rates that are politically-derived, budget neutral fees. As such, they have no bearing on what is occurring in the private market and have not kept up with inflation or costs.[14] This is an apples-to-watermelons comparison.

The lack of relevance of Medicare payments in the commercial market has been recognized previously by both the Texas Legislature and Congress. More specifically, Medicare rates are expressly prohibited by Congress from being considered by independent dispute resolution (IDR) entities in determining the appropriate out-of-network rate for services subject to the No Surprises Act. Congress specified in §300gg-111(c)(5)(D) that, among the factors that IDR entities "shall not consider" are "the amount that would have been paid by a public payor, including ***Medicare***, Medicaid, the Children's Health Insurance Program, Tricare, or 38 U.S.C.. §1701."(emphasis added).

Similarly, the Texas Legislature carefully developed a finite list of ten factors to be considered in the arbitration process under SB 1264, which enacted Texas' surprise billing IDR process.

[14] Medicare physician payments have not come close to keeping up with inflation for more than 20 years. Since 2001, Medicare physician payments have lagged 26% behind inflation while hospital and other health industry payments have kept pace, according to the American Medical Association. Over the same period, the CPI for physician services in U.S. cities increased by 65%.

Medicare rates are conspicuously (and quite intentionally) missing from the elements that are to be considered by the Texas arbitrator in determining the reasonable amount for the health care service. Texas' factors are the following:

> (1) whether there is a gross disparity between the fee billed by the out-of-network provider and:
>
> > (A) fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and
> >
> > (B) fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;
>
> (2) the level of training, education, and experience of the out-of-network provider;
>
> (3) the out-of-network provider's usual billed charge for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider;
>
> (4) the circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service or supply;
>
> (5) individual enrollee characteristics;
>
> (6) the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar

> specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;
>
> (7) the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;
>
> (8) the history of network contracting between the parties;
>
> (9) historical data for the percentiles described by Subdivisions (6) and (7); and
>
> (10) an offer made during the informal settlement teleconference required under Section 1467.084(d).

The Legislature's intent for the above-listed arbitration factors to be ***exclusive*** is manifest by the plain language of the bill, as well as by the following excerpt of legislative intent reduced to writing in the House Journal on May 20, 2019:

> J. TURNER: Finally, Representative, there's a section in the bill regarding the factors that an arbitrator must consider when an arbitrator is involved in adjudicating a balanced billing dispute. Am I correct that your bill has a list of factors that are to be considered by that arbitrator and that those are exclusive factors? In other words, there are not supposed to be other factors considered by the arbitrator?
>
> OLIVERSON: That is an exclusive list. And it's a good, balanced list.
>
> J. TURNER: And so it's your intent that the arbitrator, the decision maker, should not take under consideration other kinds of—
>
> OLIVERSON: The arbitrator, according to the bill, is limited to the factors which are specified in the bill, and so that's what they can consider.[15]

Medicare rates were clearly not included on the exclusive list. It is, therefore, abundantly clear that the Legislature rejected them from consideration (thereby recognizing their irrelevance in the commercial market).

[15] House Journal, Monday, May 20, 2019; available at: Monday, May 20, 2019 — 69th Day (texas.gov)

Moreover, we are very concerned with the Medicare datapoint being proposed to be used as a comparison point to the best offer of reimbursement rates made by the issuer in the proposed rules because in addition to its inherent incompatibility with commercial rates and the clear lack of statutory authority for using this as a comparison point:

(1) we have no idea what percentage TDI would deem "reasonable" under this construct;

(2) whatever the lowest amounts the Departments begin sanctioning as "reasonable" through network adequacy waiver requests will likely become de facto rates offered by insurers in the commercial market (thus, the commissioner would be taking on a contract rate setting role in the commercial market that is VERY clearly neither contemplated nor authorized by the Texas Legislature);

(3) there are services for which there are no Medicare rates (e.g., pediatrics) and it is unclear how those will be addressed;

(4) adopting this language could create a race to the bottom for commercial contractual rates, when the Texas Legislature and Congress have both rejected this benchmark. This could result in severe patient access issues if adopted (as it will create practice viability issues for many specialties of physicians), which will only serve to compound current network adequacy access issues to the detriment of the very consumers that TDI is charged with protecting; and

(5) the statute defines "good faith effort" as "honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patient's access to in-network care." Using Medicare rates as a comparison point for network adequacy reviews does not prioritize patients access to in-network care as it will promote the granting of network waivers rather than upfront compliance with the Legislature's network adequacy standards.

We also, again, want to strongly underscore that the proposed language regarding Medicare rates has no statutory support in HB 3359 and is arbitrarily determined by the Department as a comparison point. There's nothing in HB 3359 requiring the Department to look at "a failure to contract on reasonable terms" and taking that further into a mandatory comparison of Medicare rates blatantly skirts the bounds of the Department's statutory authority.

b. Proposed Section 3.3707(b)(1)(C)(ii)

The Associations are also opposed to the language in proposed (C)(ii) (as currently drafted) which has the comparison point for the highest offer submitted by the insurer the insurer's average contracted rate with preferred providers in a similar geographic area for those services and providing an average of the rates as a percent of the average contracted rate.

Our concerns with this proposed language are numerous. First, we note that the comparison point is the insurer's ***average contracted rate***. Using the average rather than the median will allow the low and high ends of contract rates to distort the insurer's computation of the compared amounts.

Second, even if the median contracted rate were used, the language that TDI proposes does not provide a timeframe for the calculation of the median contracted rate. Many contract rates have been lowered in recent years in the wake of the No Surprises Act. Thus, we are concerned that the starting point is already flawed and artificially deflated (which will make the insurer's unreasonable offer appear more reasonable).

Third, the language in (C)(ii) does not require the rate to be calculated with the same or similar specialty provider of the same licensure. This is important for an apples-to-apples comparison as there are different motivations to negotiate contract rates based upon the physician specialty and engaging in a non-specialty specific comparison may lead to the inclusion of ghost rates that artificially deflate the comparison point (i.e., average contracted rate as currently proposed).

Fourth, requiring insurers to provide the rate offered as a percentage of the insurer's average contracted rate with preferred providers "in a similar geographic area for those services," provides a lack of defined area that would enable insurers to manipulate these figures for their benefit. Insurers would be authorized to unilaterally determine what is a "similar geographic area for those services" and if there are multiple "similar geographic areas for those services" the insurer would be incentivized to use the area with the lowest average contracted rate (thereby enhancing the percentage offered to the uncontracted physician or provider).

Fifth, the Department's proposal has no transparency regarding the methodology of calculation of the average contracted rate and expresses no intent to audit the insurer's calculations. Thus, insurers will be incentivized to deflate the average contracted rate in order to make the offer seem more reasonable.

For all the foregoing reasons, we oppose the language in Section 3.3707(b)(1)(C)(ii). As the Department may know, in *Texas Medical Association, et. Al v. United States Department of Health and Human Services*, TMA successfully challenged at the district court level certain methodologies used by health plans to calculate the "qualifying payment amount" or "QPA" under the No Surprises Act. Among the provisions that we challenged were those that: (1) permitted insurers to calculate the QPA using ghost rates (rather than rates for services that were actually provided by the physician or provider); and (2) permitted insurers to include out-of-specialty rates in the calculation of the QPA. **We are concerned that the Department's proposal builds in many of these same flaws that will skew the comparison data point.**

Given all the above-stated concerns with Section 3.3707(b)(1)(C), if the Department is looking for a data comparison point (which is NOT required by the statute), it could instead consider looking to the history of network contracting between the parties (including past contract rates between the parties, taking into consideration inflation). It should also consider other factors that impact good faith contracting, as defined in the statute (and referenced above) as they are

reflective of whether (under TDI's current proposed construct, a physician refused to contact on reasonable terms).

In other words, rather than just looking at the insurer's best offer, which might have resulted after months of haggling with the insurer (which was not reflective of good faith efforts to contract), the Department should also look at all the circumstances surrounding the negotiations and the outcome.

2. Exclusivity arrangement

We are also unclear on what information TDI is seeking in Section 3.3707(b)(1)(D) by requiring the attempt to contract form to include, "a description of any reason each provider or physician gave for refusing to contract with the insurer, *including information on any exclusivity arrangement or other external factors that affect the ability of the parties to contrac*t." (emphasis added). There is no statutory authority for the commissioner to consider this kind of information (in granting or denying a waiver—the commissioner need only consider whether there is an inability to contract with an uncontracted physician or provider). Because the purpose of HB 3359 can be achieved without collecting this information, it is out of scope of TDI's authority to require the disclosure of these types of arrangements.

3. Proposed Section 3.3707(b)(2)

Lastly, we are very concerned with TDI's proposed change to Section 3.3707(b)(2). As explained in section V.A.1. of this comment letter, there is no statutory authority for granting a waiver based on an "insufficient number" of physicians or providers available within the relevant service area. Allowing this will incentivize insurers to cease all contracting efforts with the remaining uncontracted physicians or health care providers in that area. It also instills waivers as a feature of a plan's network, rather than the exception.

Thus, if TDI moves forward with language in (b)(2) we propose modifying the language to track the statutory language regarding no uncontracted physicians.

C. Proposed amendments to Section 3.3707(c)

Next, we note that in Section 3.3707(c)(2), language added by TDI's proposal refers to "Section 3.3712(c)(2)(E)(iii) of this title." However, we do not see Section 3.3712(c)(2)(E)(iii) in the rule packet. **Please advise where or how the access plan is required to be filed with TDI as this seems to be a significant omission in the rule proposal**.

D. Proposed amendments to Section 3.3707(d) & (e).

In Section 3.3707(d), TDI proposes to send notice of a hearing to physicians or providers named in the insurer's waiver request. This is a departure from the plain language of the statute, which states:

> (c) The commissioner shall notify **affected physicians and health care providers that may be the subject of a discussion of good faith efforts on behalf of the insurer**… with an opportunity to submit evidence, including written testimony, and to attend the public hearing and offer testimony either in person or virtually.[16]

The rule departs from the statute again in Section 3.3707(e) by only affording physicians and providers an opportunity to respond to an insurer's request for a waiver if the physician or provider received notice from the Department (i.e., were named in the insurer's waiver request). The statute clearly directs the commissioner to notify any "affected physicians or providers that may be subject of good faith efforts made by the insurer" and authorizes such physicians or providers to submit evidence, including written or oral testimony.

By only affording the physicians or providers named in the insurer's waiver request to submit evidence and testimony, the rule authorizes an insurer to purposefully omit the names of certain physicians or providers that the insurer attempted to contract in a manner that would not be considered a "good faith effort." In other words, the rule authorizes an insurer to select which "efforts to contract" are reviewed during the public hearing (since the commissioner is prohibited from receiving evidence and testimony from a physician or provider unless that physician or provider is named in the waiver request). This construction ignores the fact that an insurer's "bad faith efforts to contract" affect physicians and providers as well and may be "the subject of a discussion of good faith efforts on behalf of the insurer" in that there was no "good faith effort." Clearly, this kind of information should be considered during the public hearing.

But, as proposed, the rule would exclude affected physicians and providers not named in the insurer's waiver request. Nor would it require the commissioner to inform a named physician or provider that they may attend the public hearing and offer testimony either in person or virtually. The result is a rule that rule inappropriately limits the type of physicians or providers that may submit evidence (only those that were named in the waiver request), authorizes insurers to skew which "efforts to contract" are considered by the commissioner, and fails to inform named physicians and providers that they may attend the hearing and offer testimony.

Additionally, the rule requires physicians and providers to determine whether they consent to being identified at the hearing at the same time that they submit evidence—both within 15 days (not business days) of receiving notice from TDI. However, the statute provides that a physician or provider may not be identified by name at the hearing "unless they consent to being identified in advance of the hearing." Not that a physician or provider must determine whether they consent to being identified within 15 days of receiving notice from TDI. Let alone require physicians and providers to submit evidence **and** consent to being identified at the same time, and within 15 days of receiving notice from TDI, as provided in the proposal.

Even if the proposal didn't require a physician or provider to consent to being identified at the same time they submit evidence, we would still be concerned with the 15-day timeline. Physicians may be on call, working on weekends, or attending to an emergency as physicians

[16] TEX. INS. CODE §1301.00565(c) (emphasis added).

have a duty to provide a certain standard of care to their existing patients. This duty will always come before administrative tasks, like collecting pertinent evidence (such as old emails and draft contracts with an insurer) and drafting written testimony, which take time away from a physician's existing duties. As such, we strongly encourage TDI to extend the timeline that a physician may submit evidence to ensure all physicians are granted "an opportunity to submit evidence, including written testimony, and to attend the public hearing and offer testimony in person or virtually."[17]

In sum, we cannot support Section 3.3707(d) & (e), as proposed, because: (1) they are discretionary provisions introduced by TDI without any statutory authority, (2) they arbitrarily limit the number of physicians and providers that are authorized to submit evidence, (3) they fail to inform the physicians and providers that they may attend the public hearing and offer testimony, and (4) they will rush the physician or provider into gathering evidence and determining whether they consent to being identified at the hearing, within 15 days. Thus, the proposal will have the effect of suppressing physicians and providers from submitting evidence and from attending hearings. It will also encourage insurers to omit naming physicians or providers in their waiver requests unless naming the physician or provider is required by the attempt to contract form.

For statutory compliance and to ensure the commissioner provides all affected physicians and health care providers an opportunity to submit evidence (including written testimony), and notice that they may attend the public hearing and offer testimony, the rule must be amended.

To implement this change, we recommend that TDI amend Section 3.3707(d) & (e) to read as follows:

> (d) If the insurer believes that the information provided under subsection (b) of this section in the attempt to contract form includes proprietary information that is confidential and not subject to disclosure as public information under Government Code Chapter 552, concerning Public Information, the insurer must mark the document as confidential in SERFF. If the insurer marks the document as confidential, it must include in the filing an explanation of which information contained in the document is proprietary, and which information is not. However, consistent with Insurance Code 1301.00565(g), certain information is subject to release regardless of marking, and the department may publish or otherwise release such information. The insurer is not permitted to mark the entire filing as confidential. When scheduling a hearing related to a waiver request, the department will send a notice of the hearing to any affected provider or physician that may the subject of a discussion of good faith efforts on behalf of the insurer to meet network adequacy standards [~~named in the waiver request~~].
>
> (e) Any provider or physician may elect to provide a response to an insurer's request for waiver by sending an email to networkwaivers@tdi.texas.gov within 30 [~~15~~] days after receiving notice from the department. The department's notice

[17] *Id.*

must inform a provider or physician that they will only be identified by name at the hearing if they consent to being identified, and that they may consent to being identified at any time before the hearing begins. The response, if filed, [~~must~~][~~indicate whether the provider or physician consents to being identified at a hearing related to the waiver request and~~] may include evidence that is pertinent to the waiver request for the commissioner's consideration.

e. Proposed amendments to Section 3.3707(j) and 3.3708

Next, in Section 3.3707(j)(2), as part of an insurer's access plan (when a preferred provider is not available), TDI's proposal authorizes an insurer to recommend a particular physician or provider that the insured may use without being liable for any amount charged by the physician or provider that exceeds the insured's cost-sharing responsibility under the preferred provider benefit level. In other words, the insurer can encourage an insured to use a particular physician or provider, including an OON physician or provider, by dangling certain cost incentives in front of the insured (i.e., protection from balance billing).

However, by allowing an insurer to recommend "at least one" (i.e., only one) physician or provider that the insured may use without being liable for any amount charged by the physician or provider that exceeds the insured's cost sharing responsibility under the preferred provider benefit level, many insureds will be forced into receiving services from that particular physician or provider. Presenting two options to insureds where one option protects them from balance billing and the other option does not, is an illusion of choice. And requiring a covered service to be provided by a particular physician or provider is prohibited by Section 1251.006 of the Insurance Code.

We, therefore, recommend amending Section 3.3707(j)(2) so that an insurer is required to recommend at least three physicians or providers to ensure the insured is not required to receive a covered service to be provided by a particular physician or provider and has some freedom of choice. The Associations strongly contend that the framework of only recommending one physician or provider inappropriately rewards insurers who wait rather than proactively act when it comes to developing an adequate network. As previously stated in this letter, the Associations believe that it is imperative that network development occur ***before*** the insurer is certified to offer the PPBP or EPBP in the market. We also note that under TDI's previous rules, a similar framework was in place that permitted the insured to choose from a list of three physicians or providers. HB 3359 was designed to strengthen network adequacy requirements, not weaken them. Thus, it is unclear why the patient choice of physicians or providers was reduced in the Department's latest rule proposal.

Next, in addition to our above comments related to proposed Section 3.3708, we also note that in proposed Section 3.3708, the Department proposes deleting subsection (c)(1), which states as follows:

> (c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy re required to be calculated pursuant to an appropriate methodology that:

> (1) if based on 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

We note that this language was not invalidated by the court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020) and there is no reason to remove it from the rule proposal as it provides parameters ***if*** the methodology is based upon usual, reasonable, or customary charges.

VI. Proposed Amendments to §3.3709. Annual Network Adequacy Report.

Next, in Section 3.3709, TDI proposes to implement the requirements of Insurance Code §1301.0056, in part, by requiring an insurer to provide access to or submit data or information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards, as part of the insurer's annual network adequacy report. **However, we oppose the proposed amendments to Section 3.3709 of the rule as they conflict with the underlying statutory language and would permit an insurer to submit a diminished set of information than what is required by the underlying statute.**

A. Proposed amendments to Section 3.3709.

First, we note that Section 3.3709(b)(2), as proposed, attempts to provide the information required by Section 1301.0056(e)(1) by requiring an insurer to submit the network configuration information specified in Section 3.3712, when they submit their annual network adequacy report. However, the provisions of Section 3.3712, as proposed, do not capture all the information specified in Section 1301.0056(e)(1). In section VII.A. of this letter, we recommend amendments to Section 3.3712 to ensure the information provided in a network configuration filing includes all the information specified in Section 1301.0056(e)(1).

Second, in Section 3.3709(c)(1), as proposed, an insurer's annual network adequacy report is required to include the number of "insureds served by the network in the most recent calendar year and the number of insureds projected to be served by the network in the upcoming calendar year." We note, however, that subsection (c)(1) fails to require an insurer to provide this information **by county**—as required by Section 1301.0056(e)(2)[18]. We also note that TDI's proposal would only require a projected number of insureds for the upcoming calendar year, **despite no such "upcoming calendar year" limitation on the actuarial projection** required by Section 1301.0056(e)(2). Actuarial data on the projected number of insureds that looks beyond the next year is very likely information that is necessary for the commissioner to determine whether an insurer's plan is compliant with Section 1301.0055(b)(3)(B)[19] and should be included

[18] We also ask throughout the rules when national provider identifier (NPI) is required that TDI specify that individual NPI is always required and organizational NPI should be required where it is available.
[19] Insurance Code § 1301.0055(b)(3)(B) requires:

pursuant to Section 1301.0056(e)(4).[20] Thus, TDI should amend Section 3.3709(c)(1) so that it requires an insurer to provide actuarial data of the current number of insureds, by county; and actuarial data of the projected number of insureds for the next two years.

Third, in Section 3.3709(c)(7), as proposed, an insurer's annual network adequacy report is required to include:

> (7) actuarial data on the current and projected utilization of each type of physician or provider within each region, including:
>
> (A) the current and projected number of preferred providers of each specialty type;
>
> (B) claims data for the most recent calendar year, including:
>
> (i) the number of preferred provider claims;
>
> (ii) the number of claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;
>
> (iii) the number of claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;
>
> (iv) the number of unique enrollees with one or more claims; and
>
> (v) the number of unique providers with one or more claims.

However, we note that TDI's proposed language fails to capture the information required by Section 1301.0056(e)(3). Section 1301.0056(e)(3) requires an insurer to submit "actuarial data of current and projected utilization of each preferred provider type listed in Section 1301.00553 and described by Section 1301.00554 by county." Thus, TDI should require an insurer to submit

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> [A] preferred provider benefit plan to ensure sufficient choice, access, and quality of physicians and health care providers, in number, size, and geographic distribution, to be capable of providing the health care services covered by the plan from preferred providers to all insureds within the insurer's designated service area, taking into account the insureds' characteristics, medical conditions, and health care needs, including:
>
> (A) the current utilization of covered health care services within the counties of the service area; and
>
> **(B) an actuarial projection of utilization of covered health care services, physicians, and health care providers needed within the counties of the service area to meet the needs of the number of projected insureds;**

[20] Insurance Code § 1301.0056(e)(4) requires the commissioner to require that an insurer provides access to or submits data or information to "any other data or information considered necessary by the commissioner to make a determination to authorize the use of the preferred provider benefit plan in the most efficient and effective manner possible."

actuarial data of current and projected utilization of **each physician specialty listed in Section 1301.00553, each health care practitioner discipline listed in Section 1301.00553, each type of institutional provider listed in Section 1301.00553, each setting listed in Section 1301.00553, and each physician specialty not specifically listed in Section 1301.00553, as required by Section 1301.00554**, and must require the insurer to submit this information **by county**.

Additionally, the report should include information regarding the current and projected utilization of physicians credentialed at each of the institutional providers by specialty (e.g., pain versus anesthesia) listed in the report to ensure the commissioner is informed of information that is necessary to ensure the PPBP is used in the most efficient and effective manner possible. Without the current and projected utilization of physicians credentialed at each institutional provider, as applicable, for each physician specialty, the commissioner will be unable to determine whether the plan's network is capable of efficiently and effectively adjusting to meet the projected utilization of certain physicians required to meet the needs of the plan's insureds. We also note the current construction of Section 3.3709(c) could create confusion as it asks insurers to provide "the number of actuarial data" that they have on the provisions within paragraph (7)—not the specific data listed within paragraph (7).

Finally, in response to comments made by the TAHP at the January 10, 2024, public hearing regarding subsection (f)'s adherence to the underlying statutory authority, we are opposed to TAHP's recommendation to strike "provider" and replace it with "pharmacist" or "pharmacy." We believe that the rule as proposed by TDI conforms with the statutory authority and should be adopted as proposed.

TAHP also commented that the rule does not recognize the exception in statute for certain hospitals. If TDI is concerned that the reference to Insurance Code § 1369.764 in the rule is not sufficient to recognize the exception in Insurance Code § 1369.763 (which applies to the whole subchapter), we would recommend the following edits to subsection (f):

> (f) An insurer must cover a clinician-administered drug under the preferred level of coverage if it <u>is subject to Subchapter Q of Chapter 1369 of the Insurance Code and</u> meets the criteria under Insurance Code §1369.764, concerning Certain Limitations on Coverage of Clinician-Administered Drugs Prohibited, even if it is dispensed by a nonpreferred provider.

B. Recommended Amendments to Section 3.3709.

For statutory compliance and to ensure the commissioner receives information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards, we recommend amending Section 3.3709 so that it requires insurers to submit the information listed in the underlying statute and information that is necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards.

We also recommend making conforming amendments to the proposed form for the Annual Network Adequacy Report.[21] In the included spreadsheet for the actuarial data on the current and projected utilization required under proposed §3.3709(c)(7), the Associations have concerns that the "Specialty Type" column does not clearly reflect which of categories listed therein are physician specialties. In the underlying statute, the 27 listed physician specialties are explicitly identified as such (i.e. "for the following physicians, as designated by physician specialty…").[22] Other provider types are grouped under "health care practitioners" or "types of institutional providers."[23]

In the proposed form, though, all three categories have been combined together. The Associations have concerns that this lack of delineation could be interpreted as allowing non-physician clinicians that practice in a similar population or clinical area to be included in the utilization categories that the Legislature intended to be limited to physicians. As such the Associations strongly recommend that the proposed form be revised to identify the physician specialties as such.

VII. Proposed New Section 3.3712 – Network Configuration Filings.

Next, in new Section 3.3712, TDI proposes requiring insurers to submit information that will assist the insurer in demonstrating compliance with network adequacy standards and allows TDI to aggregate and publish information concerning networks and waivers. We oppose the language in proposed new Section 3.3712(c) as it fails to capture all the information specified in Insurance Code § 1301.0056(e)(1), contains problematic language concerning telehealth, and ceases to require the submission of maps for each physician specialty demonstrating the location and distribution of each physician and the provider network within the insurer's service area.

A. Concerns regarding lack of compliance with Section 1301.0056(e)(1)

As mentioned in section VI.A of this comment letter, the provisions in Section 3.3712(c) fail to capture all of the information specified in Section 1301.0056(e)(1), which requires TDI to adopt rules that require insurers to provide access to or submit data or information that includes, "a searchable and sortable database of network physicians and health care providers by national provider identifier, county, **physician specialty**, **hospital privileges and credentials**, **and type of health care provider or licensure, as applicable**." Further, various provisions of new Section 3.3712 conflict with the requirements of Section 1301.0056(e)(1).

[21] The form is included with the rulemaking proposal on TDI's Proposed and Adopted Rules for 2023.
[22] See, e.g., Tex. Ins. Code §1301.00553(c) (listing (1) Allergy and Immunology (2) Cardiology, (3) Cardiothoracic Surgery, (4) Dermatology, (5) Emergency Medicine, (6) Endocrinology, (7) Ear, Nose, and Throat/Otolaryngology, (8) Gastroenterology, (9) General Surgery, (10) Gynecology and Obstetrics, (11) Infectious Diseases, (12) Nephrology, (13) Neurology, (14) Neurosurgery, (15) Oncology, Medical, Surgical, (16) Oncology: Radiation, (17) Ophthalmology, (18) Orthopedic Surgery, (19) Physical Medicine and Rehabilitation, (20) Plastic Surgery (21) Primary Care: Adults, (22) Primary Care: Pediatric, (23) Psychiatry, (24) Pulmonology, (25) Rheumatology, (26) Urology, (27) Vascular Surgery.)
[23] Id.

Proposed new Section 3.3712(c)(1)(B)(iii) and the provider listings form both erroneously conflate a "physician specialty" with "type of health care provider or licensure," in conflict with the underlying statute. Proposed new Section 3.3712(c)(1)(C) fails to require an insurer to include information related to "hospital privileges **and credentials**," also in conflict with the underlying statute. And proposed new Section 3.3712(c)(2) and the network compliance and waiver request form both erroneously conflate a "physician specialty" with "type of health care provider or licensure," in conflict with the underlying statute.

We recommend that the Department address all of these departures from the law and make conforming amendments to TDI's draft provider listings form to clearly demarcate between a physician specialty and a health care provider type or license, as applicable.

B. Concerns regarding "telehealth" language

Next in proposed Section 3.3712(c)(1), the Department sets forth the provider listing data that must be provided as part of a network configuration filing. In Section 3.3712(c)(1)(B)(iv), TDI specifies that the insurer must use the provider listings form available at www.tdi.tex.gov to provide a comprehensive searchable and sortable listing of physicians and health care provider in the plan's network that includes information about each preferred provider, including: "(iv) whether the provider offers telehealth;"

The Associations have multiple concerns with this language. First, since this information is intended to include information for physicians, referencing only "telehealth" could be confusing. Texas state law differentiates between "telehealth" and "telemedicine," with the former provided by non-physician health professionals, and the latter provided by physicians or a health professional acting under a physician's delegation and supervision.[24] As such, the Associations recommend that the proposed rule—and corresponding spreadsheet column in the draft form—be amended to include "or telemedicine."[25]

Additionally, the Department's intent in including this column is unclear, as this is the only reference to "telehealth" or "telemedicine" in the entire TDI network adequacy rule proposal. The Texas Legislature has made it very clear through the amended language added by HB 3359 that specific time and distance standards must be met in order to satisfy the network adequacy requirements for PPBPs and EPBPs. These time and distance standards clearly anticipate access to ***in-person*** care. Otherwise, there would be no need to specify the maximum amount of travel time and distance.

The Associations ***oppose*** counting physicians or health care providers who ***only*** offer telemedicine or telehealth services, respectively, towards network adequacy requirements as telemedicine or telehealth only physicians or providers cannot provide the full panoply of services that can be provided in-person in a physician's office or at a facility. To count

[24] Tex. Occ. Code §111.001.

[25] Also, as these terms are not defined for Chapter 3 or Subchapter X, additional clarity could be accomplished by adding definitions for telehealth and telemedicine to §3.3702 (i.e., "telehealth--telehealth services, as defined in Occupations Code §111.001; telemedicine--telemedicine medical services, as defined in Occupations Code §111.001").

telemedicine or telehealth-only preferred providers would severely diminish the strength of the networks and undermine the Texas Legislature's intent in providing more, not less, robust network adequacy requirements in place under HB 3359.

The Associations contend that in-network physicians who provide both in-person and telemedicine services should only be counted towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards (i.e., based upon regulatory discretion when there is a shortage of physicians in the needed specialty within the area).

Further, if the Department wants to include network adequacy standards associated with telemedicine or telehealth, it should develop and re-propose for comment separate standards that are telemedicine and telehealth specific and reflect the unique nature of telemedicine and the availability of it in Texas, but it is imperative that TDI maintain standards for in-person care as this type of access should prioritized, given the inherent limitations that technology places on the scope of services that may be provided appropriately through telemedicine and telehealth.[26]

Given our above-stated concerns, we therefore recommend that TDI amend the proposed rules to provide as follows:

> … (B) information about each preferred provider, including:
>
> (i) the preferred provider's name, address of practice location, county, and telephone number;
>
> (ii) the provider's national provider identifier (NPI) number and Texas license number;
>
> (iii) the provider's specialty type or facility type, as applicable, using the categories specified in the form; and
>
> (iv) whether the provider offers telehealth or telemedicine in addition to in-person services; and

We recommend that conforming amendments be made to TDI's draft provider listing form and that the form be updated to instruct insurers that physician and providers solely offering telemedicine or telehealth services either must not be listed or must be clearly identified as such so that TDI can exclude them from their network adequacy calculations.

Additionally, we strongly recommend that TDI include amendments to proposed Section 3.3704 to include a new subsection that expressly states that physicians *or* health care providers who *only* offer telemedicine or telehealth services, respectively, will *not* be counted towards network adequacy requirements.

C. Concerns Regarding Proposed Deletion of Map Requirements

[26] Note that under Texas law (Tex. Occ. Code Section 111.007), a health professional providing a health care service or procedure as a telemedicine service or a telehealth service is subject to the same standard of care that would apply if the service were provided in an in-person setting. Clearly, not all services can services can meet this standard through telemedicine, given the technological limitations that affect this ability.

Lastly, we strongly recommend continuing to require insurers to submit maps for each specialty demonstrating the location and distribution of each physician and any waiver for that physician specialty in the provider network within the insurer's service area. This is an important tool for TDI to ensure an insurer's network covers the entire service area, for each specialty, and provides a visual aid to TDI that assists the insurer in demonstrating compliance with network adequacy standards. A map would also be very useful to TDI in monitoring compliance with network adequacy standards related to distance to each preferred physician specialty.

VIII. Proposed Amendments to Sections 3.3722 and 3.3723.

Next, in Sections 3.3722 and Section 3.3723, we note that TDI did not add some language needed to implement the provisions of Section 1301.0056, which require: (1) that an insurer is subject to a qualifying examination and subsequent quality of care and network adequacy examinations in connection with a public hearing under Section 1301.00565 concerning a material deviation from network adequacy standards by a previously authorized plan or a request for a waiver of a network adequacy standard, and (2) that insurers must provide access to or submit data or information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards, including the information described by Section 1301.0056(e)(1)-(4), in connection with a public hearing under Section 1301.00565.

In Section 3.3722(c)(10), we recommend striking "(k)" from the end of the paragraph (10)'s reference to "§3.3707(k) of this title" and replacing it with "(j)-(m)" so that an insurer must provide documentation demonstrating that its plan documents and procedures are compliant with all of the access plan requirements located in Section 3.3707.

To address our concerns raised above, we recommend TDI amend Section 3.3722 to read as follows:

(c) Contents of application. A complete application includes…

…

(10) The applicant must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3707(j)-(m) [~~(k)~~] of this title (relating to Waiver Due to Failure to Contract in Local Markets) and §3.3708 of this title (relating to Payment of Certain Out-of-Network Claims).

…

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

…

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

(8) the most recent demographic data provided by the insurer in accordance with Section 3.3709 of this title.

And that TDI amend Section 3.3723 to read as follows:

(a) The commissioner must conduct an examination relating to a preferred or exclusive benefit plan in connection with a public hearing under Section 1301.00565 concerning a material deviation from network adequacy standards by a previously authorized plan or a request for a waiver of a network adequacy standard and may conduct an examination relating to a preferred or exclusive provider benefit plan as often as the commissioner considers necessary, but no less than once every three years.

…

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

(7) reports—any reports the insurer submits to a governmental entity, including the most recent demographic data provided by the insurer in accordance with Section 3.3709 of this title.

These amendments are necessary to comply with the underlying statute and to ensure the commissioner is provided with access to data or information necessary for the commissioner to evaluate and make a determination of compliance with quality of care and network adequacy standards, as required by Section 1301.0056.

IX. Additional Comments Based upon TDI Hearing On January 10, 2024

Finally, at the TDI hearing on January 10, 2024, the TAHP noted that they would be submitting written comments to make sure that the rules mirror federal requirements. Presumably, TAHP is referring to the Medicare Advantage network adequacy standards at 42 CFR §422.116. In response to this, we note that the Texas Legislature did not engage in a wholesale adoption of the federal network adequacy standards. This is clearly evidenced by the fact that that the Legislature did not cite to the Medicare Advantage network adequacy standards (which they could have done had that been the intent). There are also some significant variances between the state law and the Medicare Advantage standards. Thus, we encourage TDI to apply the plain language of the law as enacted by the Texas Legislature, rather than inappropriately deferring to inapplicable federal law (which was clearly not the Texas Legislature's intent).

X. Conclusion

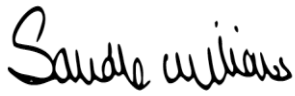
In summary, the Associations appreciate the Department's efforts to develop the proposed rules, but we are concerned for all the reasons set forth above that the rule proposal provides very little incentive for a health insurer to build or maintain an adequate network. Among some of our major concerns are the following:

- the Department establishes low minimums for network adequacy standard compliance for health plan contracting with physicians and providers providing services in and outside of facilities (thereby allowing a deficient network to be sold to unsuspecting consumers without a network waiver being required to be in place);
- the Department authorizes an insurer to build something akin to an ad hoc network of one physician or provider to address medically necessary patient care when a preferred physician is not available and the network is deficient (with no patient choice unless the patient, not the insurer, bears the balance bill);
- the insurer does not face any negative repercussion in terms of marketing or selling its deficient network because TDI proposes to bury the network deficiencies/waiver disclosure in the terms and conditions rather than placing them front and center in the advertising and promotion as the Texas Legislature mandated;
- the Department removes other important consumer disclosures regarding network deficiencies, including long-standing disclosures regarding approved and limited hospital networks;
- the insurer can obtain a waiver easily by either: (a) claiming there aren't a sufficient number of uncontracted physicians or providers available to meet the standard when the insure has also failed to contract with those who ***were*** available; or (b) claiming a failure to contract on reasonable terms which TDI inappropriately (and without statutory authority) compares to Medicare rates (which is a politically-derived, budget neutral amount and not reflective of the commercial market) and compares to a flawed and non-transparent average contracted rate; and
- the lack of clarity in the rules may permit a telemedicine only-physician or a telehealth-only health care professional to count towards the network adequacy requirements and avoid the time-distance standards set forth by the Texas Legislature (despite their inability to provide the full panoply of health care services that can be provided by a physician or health care professional in-person), which may lead to networks that are much less robust than the consumer thinks when purchasing a plan.

Again, the Associations thank the Department for this opportunity to comment on the proposed rules. If you have any questions, please do not hesitate to contact any of the following TMA staff at TMA's main number, 512-370-1300, or by email: Clayton Stewart, Vice President, TMA Public Affairs, at clayton.stewart@texmed.org; Ben Wright, Director of TMA Public Affairs, at ben.wright@texmed.org; Kelly Walla, TMA Vice President and General Counsel, at kelly.walla@texmed.org; or Erik Avots, TMA Assistant General Counsel, at erik.avots@texmed.org.

Sincerely,

Richard W. “Rick” Snyder, II, MD
President, Texas Medical Association



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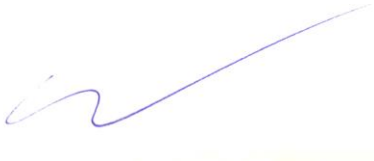

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