TDI EPO/PPO Adoption

Legislation from the 88th Session

April 9, 2024

ADVOCACY UPDATE
TAHP

TDI has adopted a proposal amending the rules applicable to commercial PPO and EPO plans. Among other changes, the amendments implement the following bills from the 88th Legislative Session:

- HB 711, prohibiting anticompetitive contract provisions;
- HB 1647, providing protections for certain clinician-administered drugs;
- HB 1696, expanding protections for optometrists and therapeutic optometrists in contracts with health plans;
- HB 2002, requiring insurers to credit certain out-of-network payments to the enrollee's deductible and maximum out-of-pocket amounts;
- HB 3359, establishing extensive network adequacy standards and requirements;
- SB 1003, expanding facility-based provider types that must be listed in provider directories; and
- SB 2476, creating new payment standards and balance billing protections for emergency medical services.

For other dates and documents related to this action, visit TDI's Proposed and Adopted Rules for 2023 Webpage. You may also view revised draft submission forms here. **TAHP will be hosting a call to discuss the adoption at 9:00 am on April 12th.**

Key Takeaways:

- The adoption removed the proposed requirement to include additional information to show "good faith" in waiver requests, such as the percentage of Medicare offered and the average contracted rate in the geographic region.
- The network adequacy portion defines a "sufficient" number of providers to mean two or more, which maintains previous state standards rather than aligning with federal standards. This also applies to "gap providers."
- The new network adequacy standards will apply to '24 filings, but the submission due date has been moved from April 1 to May 1.
- The adoption removes the proposed requirement to include plan documents in all advertisements, and instead requires them only on request.

Subchapter S. Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies

Section 3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions. These amendments expand the exceptions related to guaranteed renewability to permit insurers to discontinue a plan if the insured no longer resides, lives, or works in the service area of the issuer. This will align TDI rules with current federal requirements related to guaranteed renewability. The amendments also require insurers to notify the commission of a discontinuance and clarify the requirements for uniform modifications.

Subchapter X. Preferred and Exclusive Provider Plans

Division 1. General Requirements

Section 3.3702. Definitions. These amendments modify the definition of "facility-based physician," remove the definition of "rural area," and adjust citations to conform with other amendments.

Section 3.3703. Contracting Requirements. These amendments implement HB 711 (anti-competitive contracts) and HB 1696 (contracts with optometrists). The proposed language requires that insurers comply with the relevant statutes rather than reiterating each specific requirement.

> **Key Changes:** In response to comments, TDI added a new subparagraph (J), which states that no adverse material change shall be effective unless it complies with Ins. Code Sec. 1301.0642, as added by HB 3359.

Section 3.3704. Freedom of Choice; Availability of Preferred Providers. These amendments affirm TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care. They also add language prohibiting insurers from penalizing an insured based solely on a failure to obtain preauthorization. The amendments also add a provision from HB 711 that restricts the use of steering or a tiered network only to situations in which such conduct is for the primary benefit of the insured.

> **Key Changes:** In response to comments, a new paragraph has been added to the subsection on steering and tiering to provide examples of conduct that would violate an insurer's fiduciary duty to enrollees, including:

- Using steering or tiering to provide a financial incentive to limit medically necessary services or encourage lower quality services.
- Failing to implement reasonable processes to ensure enrollees are not encouraged to see providers of materially lower quality.
- Failing to use objectively and verifiably accurate and valid information as the basis of any encouragement or incentive.

These amendments add requirements that plans comply with new network adequacy standards, provide sufficient choice and number of providers, monitor compliance, report material deviations to TDI, and promptly take corrective action, as required by HB 3359.

> **Key Changes:** In response to comments, TDI has raised the required number of providers within the time and distance standards from requiring that 90% of enrollees have access to two providers and 10% may have access to one. The new requirement will be that all enrollees have access to two providers. The agency also added that, for specialties not listed in state law, an enrollee must have access to at least two of the specialty types within 75 miles.

The amendments also require a service area to be defined in terms of one or more Texas counties, removing options to define a service area by ZIP codes or Texas geographic regions, and specifying that a plan may not divide a county into multiple service areas, as required by HB 3359.

Section 3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. The amendments to subsections implement SB 1003 by updating references to "facility-based physician" and by deleting the related listing of included specialist categories. The amendments also add the provider types listed in SB 1003 to the requirements relating to health care directories.

As a result of HB 3359, the amendments remove requirements to notify TDI of provider terminations that do not impact network compliance. The adoption makes other clarifying corrections and updates citations.

The amendments to this section also make changes to plan disclosure documents.

> **Key Changes:** Under the proposed rules, insurers would have been required to include their plan disclosure in any promotion, advertisement, or enrollment

opportunity. In response to comments, the agency requires plan disclosures only "on request."

Section 3.3707. Waiver Due to Failure to Contract in Local Markets. The amendments to this section implement HB 3359 by updating the requirements for a finding of good cause for granting a waiver and requiring that a waiver request include certain information, including information demonstrating a good faith effort to contract (if providers are available).

> **Key Changes:** In response to comments, the agency has removed the specific criteria relating to how an insurer shows good faith. The adoption removes the requirement that issuers include the amount of the best offer of reimbursement rates made by the issuer, computed as a percentage of Medicare rates and the insurer's average contracted rate.

Required documents must be submitted in SERFF, which makes filed information publicly available, unless the insurer marks a document as confidential. The amendments require insurers to use TDI's electronic form to provide evidence supporting a waiver.

Amendments in subsection (d) also remove the requirement for insurers to send notices of waiver requests to physicians and providers. Instead, TDI will send notices to those providers in advance of a waiver hearing. The amendments also clarify the process for providers to respond to a waiver request.

New subsection (j) updates the required processes that an insurer must develop to facilitate access to covered services, provide insureds with an option to obtain care without being subject to balance billing, and ensure that insureds understand what options they have when no in-network provider is reasonably available.

> **Key Changes:** In response to comment, subsection (j)(2) as proposed was changed to require insurers to make at least two physicians or providers (rather than at least one) available to insureds when no preferred provider is available.

New subsection (m) replaces previous access plan requirements with the requirement that insurers submit a general access plan that will apply in any unforeseen circumstance where an insured is unable to access in-network care within the network adequacy standards.

Section 3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures. Amendments to this section remove provisions invalidated by the *TAHP v. TDI* Order. The existing rules required insurers to pay billed charges, while the new subsections provide for payment standards consistent with state balance billing laws, SB 2476 and SB 1264, and consumer protections for network gaps.

Current subsection (e), which is no longer in effect, is replaced by a new subsection (e), which implements HB 2002 by clarifying that an insurer must credit certain direct payments to nonpreferred providers towards the insured's in-network cost-sharing maximums.

> **Key Changes:** In response to comments, and to more closely align with HB 2002, the agency removed references to non-preferred providers, clarifying that an enrollee may receive cost-sharing credits from out-of-pocket payments to preferred or non-preferred providers.

Existing subsection (f) is deleted because application of the section should no longer be limited to exclusive provider plans. The subsection is replaced by a new subsection (f), which implements HB 1647 by clarifying that insurers must cover certain clinician-administered drugs at the in-network benefit level.

> **Key Changes:** In response to comments, the agency removed language outside of the citation to the applicable subchapter. This resolved a concern that dispensing by non-pharmacy "providers" would be included in the rule, and the concern that exceptions for drugs dispensed in hospitals were not included in the rule.

Section 3.3709. Annual Network Adequacy Report. Amendments to this section revise the subsections to expand the content to be included in the annual network adequacy report, including requirements for insurer identifying information and information relating to network configuration, facility access, waiver requests and access plans, enrollee demographics, complaints, and actuarial data. The amendments also require that annual network adequacy reports be submitted to TDI via the SERFF system, which has been agency practice.

Section 3.3710. Failure to Provide an Adequate Network. Amendments to this section clarify the scope of the commissioner's sanction authority, as well as make nonsubstantive changes and citation corrections.

Section 3.3711. Geographic Regions. Amendments to this section replace ZIP code listings with county listings, consistent with the requirement in HB 3359 that service areas may not divide a county.

Section 3.3712. Network Configuration Filings. This section implements HB 3359 by requiring submission of network configuration information currently addressed in §3.3722. The filings must be submitted in SERFF, and they are required in connection with a waiver request under §3.3707, an annual report under §3.3709, or an application or modification under §3.3722. The section specifies that insurers must use TDI's electronic forms when making network configuration filings and lists the information that must be included. The purposes of these electronic forms are to assist the insurer in demonstrating compliance with the network adequacy requirements. The section also clarifies that submitted information is considered public information subject to publication by TDI.

Section 3.3713. County Classifications for Maximum Time and Distance Standards. This section implements HB 3359, which specifies that counties are classified based on determinations made by the Centers for Medicare and Medicaid Services as of March 1, 2023. The new section lists each Texas county according to its classification as a large metro, metro, micro, or rural county, or a county with extreme access considerations.

Division 2. Application, Examination, and Plan Requirements

Section 3.3720. Preferred and Exclusive Provider Benefit Plan Requirements. The amendments to this section correct citations, remove unnecessary references, and change titles in citations.

Section 3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications. The amendments to this section update network configuration filing requirements and cross-references to conform to changes made in §§3.3038, 3.3707, 3.3708, and 3.3712, and the repeal of §3.3725. Requirements for network modifications are also clarified to align with current practices. The amendments make other changes for consistency with statute and to replace citations.

Section 3.3723. Examinations. These amendments make nonsubstantive changes and correct citations.

Section 3.3725. Payment of Certain Out-of-Network Claims. Amendments to §3.3708 remove existing subsections (a) and (b), which contain provisions invalidated by the TAHP Order, and change the section title to replace "Basic Benefit" with "Out-of-Network" and to delete "and Related Disclosures." This text is replaced by a new subsection (a) and (b). New subsection (a) provides payment standards for certain out-of-network claims and reflect balance billing protections, consistent with SB 2476 and SB 1264. New subsection (b) provides consumer protections for network gaps.