INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(1-a) "Anti-steering clause" means a provision in a provider network contract that restricts the ability of a general contracting entity to encourage an enrollee to obtain a health care service from a competitor of the provider, including offering incentives to encourage enrollees to use specific providers.

(1-b) "Anti-tiering clause" means a provision in a provider network contract that:

(A) restricts the ability of a general contracting entity to introduce or modify a tiered network plan or assign providers into tiers; or

(B) requires a general contracting entity to place all members of a provider in the same tier of a tiered network plan.

(2) "Contracting entity" means 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.

(3) "Covered individual" means an individual who is covered under a health benefit plan.

(4) "Express authority" means a provider's consent that is obtained through separate signature lines for each line of business.

(4-a) "Gag clause" means a provision in a provider

network contract that restricts the ability of a general contracting entity or provider to disclose:

(A) price or quality information, including the allowed amount, negotiated rates or discounts, fees for services, or other claim-related financial obligations included in the contract, to a governmental entity as authorized by law or its contractors or agents, an enrollee, a treating provider of an enrollee, a plan sponsor, or potential eligible enrollees and plan sponsors; or

(B) out-of-pocket costs to an enrollee.

(4-b) "General contracting entity" means a person who enters into a direct contract with a provider for the delivery of health care services to covered individuals regardless of whether the person, in the ordinary course of business, establishes a provider network for access by another party. The term does not include a health care provider or facility unless the provider or facility is entering into the contract in the provider's or facility's role as a health benefit plan.

(5) "Health care services" means services provided for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

(5-a) "Most favored nation clause" means a provision in a provider network contract that:

(A) prohibits or grants an option to prohibit:

(i) a provider from contracting with another general contracting entity to provide health care services at a lower rate; or

(ii) a general contracting entity from contracting with another provider to provide health care services at a higher rate;

(B) requires or grants an option to require:

(i) a provider to accept a lower rate for health care services if the provider agrees with another general contracting entity to accept a lower rate for the services; or

(ii) a general contracting entity to pay a higher rate for health care services if the entity agrees with another provider to pay a higher rate for the services;

(C) requires or grants an option to require termination or renegotiation of an existing provider network contract if:

(i) a provider agrees with another general contracting entity to accept a lower rate for providing health care services; or

(ii) a general contracting entity agrees with a provider to pay a higher rate for health care services; or

(D) requires:

(i) a provider to disclose the provider's contractual reimbursement rates with other general contracting entities; or

(ii) a general contracting entity to disclose the general contracting entity's contractual reimbursement rates with other providers.

(6) "Person" has the meaning assigned by Section 823.002.

(7)(A) "Provider" means:

(i) an advanced practice nurse;

(ii) an optometrist;

(iii) a therapeutic optometrist;

(iv) a physician;

(v) a physician assistant;

(vi) a professional association composed solely of physicians, optometrists, or therapeutic optometrists;

(vii) a single legal entity authorized to practice medicine owned by two or more physicians;

(viii) a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code;

(ix) a partnership composed solely of physicians, optometrists, or therapeutic optometrists;

(x) a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts; or

(xi) an institution that is licensed under Chapter 241, Health and Safety Code.

(B) "Provider" does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to another party.

(8) "Provider network contract" means a contract between a contracting entity and a provider for the delivery of, and payment for, health care services to a covered individual.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 639 (H.B. 711), Sec. 1, eff. June 12, 2023.

Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means:

(1) a hospital and medical expense incurred policy;

(2) a nonprofit health care service plan contract;

(3) a health maintenance organization subscriber contract; or

(4) any other health care plan or arrangement that pays for or furnishes medical or health care services.

(b) "Health benefit plan" does not include one or more or any combination of the following:

(1) coverage only for accident or disability income insurance or any combination of those coverages;

(2) credit-only insurance;

(3) coverage issued as a supplement to liability insurance;

(4) liability insurance, including general liability insurance and automobile liability insurance;

(5) workers' compensation or similar insurance;

(6) a discount health care program, as defined by Section 7001.001;

(7) coverage for on-site medical clinics;

(8) automobile medical payment insurance;

(9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(10) other similar insurance coverage, as specified by

federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:

(1) dental or vision benefits;

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits;

(3) other similar, limited benefits, including benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or

(4) a Medicare supplement benefit plan described by Section 1652.002.

(d) "Health benefit plan" does not include coverage limited to a specified disease or illness or hospital indemnity coverage or other fixed indemnity insurance coverage if:

(1) the coverage is provided under a separate policy, certificate, or contract of insurance;

(2) there is no coordination between the provision of the coverage and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and

(3) the coverage is paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.003. EXEMPTIONS. This chapter does not apply:

(1) under circumstances in which access to the provider network is granted to an entity that operates under the same brand licensee program as the contracting entity; or

(2) to a contract between a contracting entity and a discount health care program operator, as defined by Section 7001.001.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.004. RULEMAKING AUTHORITY. The commissioner may adopt rules to implement this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Unless the person holds a certificate of authority issued by the department to engage in the business of insurance in this state or operates a health maintenance organization under Chapter 843, a person must register with the department not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.

(b) Notwithstanding Subsection (a), under Section 1458.055 a contracting entity that holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization shall file with the commissioner an application for exemption from registration under which the affiliates may access the contracting entity's network.

(c) An application for an exemption filed under Subsection (b) must be accompanied by a list of the contracting entity's affiliates. The contracting entity shall update the list with the commissioner on an annual basis.

(d) A list of affiliates filed with the commissioner under Subsection (c) is public information and is not exempt from disclosure under Chapter 552, Government Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.052. DISCLOSURE OF INFORMATION. (a) A person

required to register under Section 1458.051 must disclose:

(1) all names used by the contracting entity, including any name under which the contracting entity intends to engage or has engaged in business in this state;

(2) the mailing address and main telephone number of the contracting entity's headquarters;

(3) the name and telephone number of the contracting entity's primary contact for the department; and

(4) any other information required by the commissioner by rule.

(b) The disclosure made under Subsection (a) must include a description or a copy of the applicant's basic organizational structure documents and a copy of organizational charts and lists that show:

(1) the relationships between the contracting entity and any affiliates of the contracting entity, including subsidiary networks or other networks; and

(2) the internal organizational structure of the contracting entity's management.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.053. SUBMISSION OF INFORMATION. Information required under this subchapter must be submitted in a written or electronic format adopted by the commissioner by rule.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.054. FEES. The department may collect a reasonable fee set by the commissioner as necessary to administer the registration process. Fees collected under this chapter shall be deposited in the Texas Department of Insurance operating fund.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) The commissioner shall grant an exemption for affiliates of a

contracting entity if the contracting entity holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization if the commissioner determines that:

(1) the affiliate is not subject to a disclaimer of affiliation under Chapter 823; and

(2) the relationships between the person who holds a certificate of authority and all affiliates of the person, including subsidiary networks or other networks, are disclosed and clearly defined.

(b) An exemption granted under this section applies only to registration. An entity granted an exemption is otherwise subject to this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. (a) In this section, the following are each considered a single separate line of business:

(1) preferred provider benefit plans covering individuals and groups;

(2) exclusive provider benefit plans covering individuals and groups;

(3) health maintenance organization plans covering individuals and groups;

(4) Medicare Advantage or similar plans issued in connection with a contract with the Centers for Medicare and Medicaid Services;

(5) Medicaid managed care; and

(6) the state child health plan established under Chapter 62, Health and Safety Code, or the comparable plan under Chapter 63, Health and Safety Code.

(b) A contracting entity may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the provider network contract without the express authority of

and prior adequate notification to the provider. The prior adequate notification may be provided in the written format specified by a provider network contract subject to this chapter.

(c) A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the contracting entity may contract with a person to provide access to the contracting entity's rights and responsibilities under the provider network contract.

(d) The provider network contract must require that on the request of the provider, the contracting entity will provide information necessary to determine whether a particular person has been authorized to access the provider's health care services and contractual discounts.

(e) To be enforceable against a provider, a provider network contract, including the lines of business described by Subsections (a) and (f), must also specify or reference a separate fee schedule for each such line of business. The separate fee schedule may describe specific services or procedures that the provider will deliver along with a corresponding payment, may describe a methodology for calculating payment based on a published fee schedule, or may describe payment in any other reasonable manner that specifies a definite payment for services. The fee information may be provided by any reasonable method, including electronically.

(f) The commissioner may, by rule, add additional lines of business for which express authority is required.

(g) A provider may not:

(1) offer to a general contracting entity a written provider network contract that includes an anti-steering, anti-tiering, gag, or most favored nation clause;

(2) enter into a provider network contract that includes an anti-steering, anti-tiering, gag, or most favored nation clause; or

(3) amend or renew an existing provider network contract previously entered into with a general contracting entity so that the contract as amended or renewed adds or retains an

anti-steering, anti-tiering, gag, or most favored nation clause.

(h) Any provision in a provider network contract that is an anti-steering, anti-tiering, gag, or most favored nation clause is void and unenforceable. The remaining provisions in the provider network contract remain in effect and are enforceable.

(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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 639 (H.B. 711), Sec. 2, eff. June 12, 2023.

Sec. 1458.102. CONTRACT ACCESS. (a) A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the person must comply with all applicable terms, limitations, and conditions of the provider network contract.

(b) For the purposes of this section, a contracting entity shall permit reasonable access, including electronic access, during business hours for the review of the provider network contract. The information may be used or disclosed only for the purposes of complying with the terms of the contract or state law.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1, eff. September 1, 2013.

Sec. 1458.103. ENFORCEMENT. The commissioner may impose a sanction under Chapter 82 or assess an administrative penalty under Chapter 84 on a contracting entity that violates this chapter or a rule adopted to implement this chapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 197 (S.B. 822), Sec. 1,

eff. September 1, 2013.