INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE D. PROVIDER PLANS

CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1301.001. DEFINITIONS. In this chapter:

(1) "Exclusive provider benefit plan" means a benefit plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services required under Section 1301.155, provided by a physician or health care provider who is not a preferred provider.

(1-a) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist and a pharmacy. The term does not include a physician.

(2) "Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(3) "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code.

(4) "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

(5) "Insurer" means a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

(5-a) "Out-of-network provider" means a physician or health care provider who is not a preferred provider.

(6) "Physician" means a person licensed to practice

medicine in this state.

(6-a) "Post-emergency stabilization care" means health care services that are furnished by an out-of-network provider, including an out-of-network hospital, freestanding emergency medical care facility, or comparable emergency facility, regardless of the department of the facility in which the services are furnished, after an insured is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency care, as defined by Section 1301.155, is furnished.

(7) "Practitioner" means a person who practices a healing art and is a practitioner described by Section 1451.001 or 1451.101.

(7-a) "Preauthorization" means a determination by an insurer that medical care or health care services proposed to be provided to a patient are medically necessary and appropriate.

(8) "Preferred provider" means a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy.

(9) "Preferred provider benefit plan" means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

(10) "Service area" means a geographic area or areas specified in a health insurance policy or preferred provider contract in which a network of preferred providers is offered and available.

(11) "Verification" means a reliable representation by an insurer to a physician or health care provider that the insurer will pay the physician or provider for proposed medical care or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, and any other term that would be a reliable representation by an insurer to a physician or provider.

(12) "Freestanding emergency medical care facility" means a facility licensed under Chapter 254, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.033(a), eff. September 1, 2005.

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. 1357), Sec. 4, eff. March 1, 2010.

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 2, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 7, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 915 (H.B. 1358), Sec. 2, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 4, eff. September 1, 2015.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 1, eff. September 1, 2023.

Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS. This chapter does not apply to a provision for dental care benefits in a health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS AND EXCLUSIVE PROVIDER BENEFIT PLANS PERMITTED. A preferred provider benefit plan or an exclusive provider benefit plan that meets the requirements of this chapter is not:

(1) unjust under Chapter 1701;

(2) unfair discrimination under Subchapter A or B, Chapter 544; or

(3) a violation of Subchapter B or C, Chapter 1451.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 3, eff. September 1, 2011.

Sec. 1301.0041. APPLICABILITY. (a) Except as otherwise specifically provided by this chapter, this chapter applies to each preferred provider benefit plan in which an insurer provides, through the insurer's health insurance policy, for the payment of a level of coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider.

(b) Unless otherwise specified, an exclusive provider benefit plan is subject to this chapter in the same manner as a preferred provider benefit plan.

Text of subsection effective until April 01, 2025

(c) This chapter does not apply to:

(1) the child health plan program under Chapter 62, Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 533, Government Code.

Text of subsection effective on April 01, 2025

(c) This chapter does not apply to:

(1) the child health plan program under Chapter 62, Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 540 or 540A, Government Code, as applicable.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0271(b), eff. September 1, 2007.

Added by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 9.0271(b), eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 4, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.122, eff. April 1, 2025.

Sec. 1301.0042. APPLICABILITY OF INSURANCE LAW. (a) Except as provided by Subsection (b), a provision of this code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan

except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

(b) An exclusive provider benefit plan may not provide dental care benefits.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 5, eff. September 1, 2011.

Sec. 1301.0045. CONSTRUCTION OF CHAPTER. (a) Except as provided by Section 1301.0046, this chapter may not be construed to limit the level of reimbursement or the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions, that are applicable to preferred providers or, for plans other than exclusive provider benefit plans, nonpreferred providers.

Text of subsection effective until September 01, 2025

(b) Except as provided by Sections 1301.0052, 1301.0053, 1301.155, 1301.164, 1301.165, and 1301.166, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

Text of subsection effective on September 01, 2025

(b) Except as provided by Sections 1301.0052, 1301.0053, 1301.155, 1301.164, and 1301.165, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

Added by Acts 2005, 79th Leg., Ch. 1221 (H.B. 1030), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 6, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.05, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 6(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 6(b),

eff. September 1, 2025.

Sec. 1301.0046. COINSURANCE REQUIREMENTS FOR SERVICES OF NONPREFERRED PROVIDERS. The insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. This section does not apply to an exclusive provider benefit plan.

Added by Acts 2005, 79th Leg., Ch. 1221 (H.B. 1030), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 7, eff. September 1, 2011.

Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS; SERVICE AREA LIMITATIONS. (a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level benefits, including benefits for emergency care, as defined by Section 1301.155, and post-emergency stabilization care, are reasonably available to all insureds within a designated service area. This subsection does not apply to an exclusive provider benefit plan.

(b) If services are not available through a preferred provider within a designated service area under a preferred provider benefit plan or an exclusive provider benefit plan, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(c) Subsection (b) does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience.

(d) A service area, other than a statewide service area, may include noncontiguous geographic areas but may not divide a county.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 8, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 2, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 3, eff. September 1, 2023.

Sec. 1301.0051. EXCLUSIVE PROVIDER BENEFIT PLANS: QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT. (a) An insurer that offers an exclusive provider benefit plan shall establish procedures to ensure that health care services are provided to insureds under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of care or practice. The procedures must include:

(1) mechanisms to ensure availability, accessibility, quality, and continuity of care;

(2) subject to Section 1301.059, a continuing quality improvement program to monitor and evaluate services provided under the plan, including primary and specialist physician services and ancillary and preventive health care services, provided in institutional or noninstitutional settings;

(3) a method of recording formal proceedings of quality improvement program activities and maintaining quality improvement program documentation in a confidential manner;

(4) subject to Section 1301.059, a physician review panel to assist the insurer in reviewing medical guidelines or criteria;

(5) a patient record system that facilitates documentation and retrieval of clinical information for the insurer's evaluation of continuity and coordination of services and assessment of the quality of services provided to insureds under the plan;

(6) a mechanism for making available to the commissioner the clinical records of insureds for examination and review by the commissioner on request of the commissioner; and

(7) a specific procedure for the periodic reporting of quality improvement program activities to:

(A) the governing body and appropriate staff of the insurer; and

(B) physicians and health care providers that provide health care services under the plan.

(b) Minutes of a formal proceeding of the quality improvement program established under Subsection (a) shall be made available to the commissioner on request of the commissioner.

(c) Insured records made available to the commissioner under Subsection (a)(6) are confidential and privileged, and are not subject to Chapter 552, Government Code, or to subpoena, except to the extent necessary for the commissioner to enforce this chapter.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 9, eff. September 1, 2011.

Sec. 1301.0052. EXCLUSIVE PROVIDER BENEFIT PLANS: REFERRALS FOR MEDICALLY NECESSARY SERVICES. (a) If a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider, shall:

(1) approve the referral of an insured to a nonpreferred provider within a reasonable period; and

(2) fully reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider.

(b) An exclusive provider benefit plan must provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested under Subsection (a) before the issuer of the plan may deny the referral.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 9, eff. September 1, 2011.

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE. (a) If an out-of-network provider provides emergency care as defined by Section 1301.155 or post-emergency stabilization care to an enrollee in an exclusive

provider benefit plan, the issuer of the plan shall reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network provider for the provision of the services and any supply related to those services. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(b) For emergency care or post-emergency stabilization care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's exclusive provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, a modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(c) This section may not be construed to require the imposition of a penalty under Section 1301.137.

(d) Post-emergency stabilization care that is subject to this section and a supply related to that care are subject to Chapter 1467 in the same manner as if the care and supply are emergency care, as defined by Section 1301.155.

(e) This section does not apply to claims for post-emergency stabilization care if all of the conditions described by 42 U.S.C. Section 300gg-111(a)(3)(C)(ii)(II) are met.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 9, eff. September 1, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.06, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 4, eff. September 1, 2023.

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. (a) The commissioner shall by rule adopt network adequacy standards that:

(1) require an insurer offering a preferred provider benefit plan to:

(A) monitor compliance with network adequacy standards, including provisions of this chapter relating to network adequacy, on an ongoing basis, reporting any material deviation from network adequacy standards to the department within 30 days of the date the material deviation occurred; and

(B) promptly take any corrective action required to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred unless:

(i) there are no uncontracted licensed physicians or health care providers in the affected county; or

(ii) the insurer requests a waiver under this subsection;

(2) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide current and projected utilization of health care services for adult and minor insureds;

(3) may allow a waiver for a departure from network adequacy standards for a period not to exceed one year if the commissioner determines after receiving public testimony at a public hearing under Section 1301.00565 that good cause is shown and posts on the department's Internet website the name of the preferred provider benefit plan, the insurer offering the plan, each affected county, the specific network adequacy standards waived, and the insurer's access plan;

(4) require disclosure by the insurer of the

information described by Subdivision (3) in all promotion and advertisement of the preferred provider benefit plan for which a waiver is allowed under that subdivision;

(5) except as provided by Subdivision (6), limit a waiver from being issued to a preferred provider benefit plan:

(A) more than twice consecutively for the same network adequacy standard in the same county unless the insurer demonstrates, in addition to the good cause described by Subdivision (3), multiple good faith attempts to bring the plan into compliance with the network adequacy standard during each of the prior consecutive waiver periods; or

(B) more than a total of four times within a 21-year period for each county in a service area for issues that may be remedied through good faith efforts; and

(6) authorize the commissioner to issue a waiver that would otherwise be unavailable under Subdivision (5) if the waiver request demonstrates, and the department confirms annually, that there are no uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area.

(b) The standards described by Subsection (a)(2) must include factors regarding time, distance, and appointment availability. The factors must:

(1) require that all insureds are able to receive an appointment with a preferred provider within the maximum travel times and distances established under Sections 1301.00553 and 1301.00554;

(2) require that all insureds are able to receive an appointment with a preferred provider within the maximum appointment wait times established under Section 1301.00555;

(3) require 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;

(4) require a sufficient number of preferred providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, oncology, including medical, surgical, and radiation oncology, surgery, and hospitalist, intensivist, and diagnostic services, including radiology and laboratory services, at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility that credentials the particular specialty to ensure all insureds are able to receive covered benefits, including access to clinical trials covered by the health benefit plan, at that preferred location;

(5) require that all insureds have the ability to access a preferred institutional provider listed in Section 1301.00553 within the maximum travel times and distances established under Section 1301.00553 for the corresponding county classification;

(6) require that insureds have the option of facilities, if available, of pediatric, for-profit, nonprofit, and tax-supported institutions, with special consideration to contracting with:

(A) teaching hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load; and

(B) teaching facilities that specialize in providing care for rare and complex medical conditions and conducting clinical trials;

(7) require that there is an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;

(8) provide for necessary hospital services by

requiring contracting with general, pediatric, specialty, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;

(9) ensure that emergency care, as defined by Section 1301.155, is available and accessible 24 hours a day, seven days a week, by preferred providers;

(10) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;

(11) require an adequate number of preferred providers to be available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area; and

(12) require sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area.

(c) Subsection (b)(6) does not apply to an exclusive provider benefit plan if the plan has:

(1) contracted with preferred provider hospitals in sufficient number capable of meeting the covered inpatient and outpatient health care benefits for current and actuarially projected utilization in accordance with Subsection (b)(3); or

(2) received a waiver under Subsection (a).

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 2, eff. June 19, 2009.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 5, eff. September 1, 2023.

Sec. 1301.00553. MAXIMUM TRAVEL TIME AND DISTANCE STANDARDS BY PREFERRED PROVIDER TYPE. (a) In this section, "maximum distance" means the miles calculated to drive by automobile within a service area to a particular type of preferred provider.

(b) For purposes of this section, each county in this state is classified as a large metro, metro, micro, or rural county, or a county with extreme access considerations as determined by the federal Centers for Medicare and Medicaid Services by population

and density thresholds as of March 1, 2023.

(c) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each large metro county are:

(1) for the following physicians, as designated by physician specialty:

| | Time | Distance |
|---|---|---|
| Allergy and Immunology | 30 | 15 |
| Cardiology | 20 | 10 |
| Cardiothoracic Surgery | 30 | 15 |
| Dermatology | 20 | 10 |
| Emergency Medicine | 20 | 10 |
| Endocrinology | 30 | 15 |
| Ear, Nose, and Throat/Otolaryngology | 30 | 15 |
| Gastroenterology | 20 | 10 |
| General Surgery | 20 | 10 |
| Gynecology and Obstetrics | 10 | 5 |
| Infectious Diseases | 30 | 15 |
| Nephrology | 30 | 15 |
| Neurology | 20 | 10 |
| Neurosurgery | 30 | 15 |
| Oncology: Medical, Surgical | 20 | 10 |
| Oncology: Radiation | 30 | 15 |
| Ophthalmology | 20 | 10 |
| Orthopedic Surgery | 20 | 10 |
| Physical Medicine and Rehabilitation | 30 | 15 |
| Plastic Surgery | 30 | 15 |
| Primary Care: Adults | 10 | 5 |
| Primary Care: Pediatric | 10 | 5 |
| Psychiatry | 20 | 10 |
| Pulmonology | 20 | 10 |
| Rheumatology | 30 | 15 |
| Urology | 20 | 10 |
| Vascular Surgery | 30 | 15 |

(2) for health care practitioners in the following disciplines:

| | Time | Distance |
|---|---|---|

| | | |
|---|---|---|
| Chiropractic | 30 | 15 |
| Occupational Therapy | 20 | 10 |
| Physical Therapy | 20 | 10 |
| Podiatry | 20 | 10 |
| Speech Therapy | 20 | 10 |

(3) for the following types of institutional providers:

| | Time | Distance |
|---|---|---|
| Acute Inpatient Hospitals (Emergency Services Available 24/7) | 20 | 10 |
| Cardiac Catheterization Services | 30 | 15 |
| Cardiac Surgery Program | 30 | 15 |
| Critical Care Services: Intensive Care Units | 20 | 10 |
| Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology) | 20 | 10 |
| Inpatient or Residential Behavioral Health Facility Services | 30 | 15 |
| Mammography | 20 | 10 |
| Outpatient Infusion/Chemotherapy | 20 | 10 |
| Skilled Nursing Facilities | 20 | 10 |
| Surgical Services (Outpatient or Ambulatory Surgical Center) | 20 | 10 |

(4) for the following settings:

| | Time | Distance |
|---|---|---|
| Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) | 10 | 5 |
| Urgent Care | 20 | 10 |

(d) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each metro county are:

(1) for the following physicians, as designated by physician specialty:

| | Time | Distance |
|---|---|---|
| Allergy and Immunology | 45 | 30 |
| Cardiology | 30 | 20 |
| Cardiothoracic Surgery | 60 | 40 |

| | | |
|---|---|---|
| Dermatology | 45 | 30 |
| Emergency Medicine | 45 | 30 |
| Endocrinology | 60 | 40 |
| Ear, Nose, and Throat/Otolaryngology | 45 | 30 |
| Gastroenterology | 45 | 30 |
| General Surgery | 30 | 20 |
| Gynecology and Obstetrics | 15 | 10 |
| Infectious Diseases | 60 | 40 |
| Nephrology | 45 | 30 |
| Neurology | 45 | 30 |
| Neurosurgery | 60 | 40 |
| Oncology: Medical, Surgical | 45 | 30 |
| Oncology: Radiation | 60 | 40 |
| Ophthalmology | 30 | 20 |
| Orthopedic Surgery | 30 | 20 |
| Physical Medicine and Rehabilitation | 45 | 30 |
| Plastic Surgery | 60 | 40 |
| Primary Care: Adults | 15 | 10 |
| Primary Care: Pediatric | 15 | 10 |
| Psychiatry | 45 | 30 |
| Pulmonology | 45 | 30 |
| Rheumatology | 60 | 40 |
| Urology | 45 | 30 |
| Vascular Surgery | 60 | 40 |

(2) for health care practitioners in the following disciplines:

| | Time | Distance |
|---|---|---|
| Chiropractic | 45 | 30 |
| Occupational Therapy | 45 | 30 |
| Physical Therapy | 45 | 30 |
| Podiatry | 45 | 30 |
| Speech Therapy | 45 | 30 |

(3) for the following types of institutional providers:

| | Time | Distance |
|---|---|---|
| Acute Inpatient Hospitals (Emergency Services Available 24/7) | 45 | 30 |

| | | |
|---|---|---|
| Cardiac Catheterization Services | 60 | 40 |
| Cardiac Surgery Program | 60 | 40 |
| Critical Care Services: Intensive Care Units | 45 | 30 |
| Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology) | 45 | 30 |
| Inpatient or Residential Behavioral Health Facility Services | 70 | 45 |
| Mammography | 45 | 30 |
| Outpatient Infusion/Chemotherapy | 45 | 30 |
| Skilled Nursing Facilities | 45 | 30 |
| Surgical Services (Outpatient or Ambulatory Surgical Center) | 45 | 30 |

(4) for the following settings:

| | Time | Distance |
|---|---|---|
| Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) | 15 | 10 |
| Urgent Care | 45 | 30 |

(e) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each micro county are:

(1) for the following physicians, as designated by physician specialty:

| | Time | Distance |
|---|---|---|
| Allergy and Immunology | 80 | 60 |
| Cardiology | 50 | 35 |
| Cardiothoracic Surgery | 100 | 75 |
| Dermatology | 60 | 45 |
| Emergency Medicine | 80 | 60 |
| Endocrinology | 100 | 75 |
| Ear, Nose, and Throat/Otolaryngology | 80 | 60 |
| Gastroenterology | 60 | 45 |
| General Surgery | 50 | 35 |
| Gynecology and Obstetrics | 30 | 20 |
| Infectious Diseases | 100 | 75 |
| Nephrology | 80 | 60 |
| Neurology | 60 | 45 |

| | | |
|---|---|---|
| Neurosurgery | 100 | 75 |
| Oncology: Medical, Surgical | 60 | 45 |
| Oncology: Radiation | 100 | 75 |
| Ophthalmology | 50 | 35 |
| Orthopedic Surgery | 50 | 35 |
| Physical Medicine and Rehabilitation | 80 | 60 |
| Plastic Surgery | 100 | 75 |
| Primary Care: Adults | 30 | 20 |
| Primary Care: Pediatric | 30 | 20 |
| Psychiatry | 60 | 45 |
| Pulmonology | 60 | 45 |
| Rheumatology | 100 | 75 |
| Urology | 60 | 45 |
| Vascular Surgery | 100 | 75 |

(2) for health care practitioners in the following disciplines:

| | Time | Distance |
|---|---|---|
| Chiropractic | 80 | 60 |
| Occupational Therapy | 80 | 60 |
| Physical Therapy | 80 | 60 |
| Podiatry | 60 | 45 |
| Speech Therapy | 80 | 60 |

(3) for the following types of institutional providers:

| | Time | Distance |
|---|---|---|
| Acute Inpatient Hospitals (Emergency Services Available 24/7) | 80 | 60 |
| Cardiac Catheterization Services | 160 | 120 |
| Cardiac Surgery Program | 160 | 120 |
| Critical Care Services: Intensive Care Units | 160 | 120 |
| Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology) | 80 | 60 |
| Inpatient or Residential Behavioral Health Facility Services | 100 | 75 |
| Mammography | 80 | 60 |
| Outpatient Infusion/Chemotherapy | 80 | 60 |

| | | |
|---|---|---|
| Skilled Nursing Facilities | 80 | 60 |
| Surgical Services (Outpatient or Ambulatory Surgical Center) | 80 | 60 |

(4) for the following settings:

| | Time | Distance |
|---|---|---|
| Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) | 30 | 20 |
| Urgent Care | 80 | 60 |

(f) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider type for each rural county are:

(1) for the following physicians, as designated by physician specialty:

| | Time | Distance |
|---|---|---|
| Allergy and Immunology | 90 | 75 |
| Cardiology | 75 | 60 |
| Cardiothoracic Surgery | 110 | 90 |
| Dermatology | 75 | 60 |
| Emergency Medicine | 75 | 60 |
| Endocrinology | 110 | 90 |
| Ear, Nose, and Throat/Otolaryngology | 90 | 75 |
| Gastroenterology | 75 | 60 |
| General Surgery | 75 | 60 |
| Gynecology and Obstetrics | 40 | 30 |
| Infectious Diseases | 110 | 90 |
| Nephrology | 90 | 75 |
| Neurology | 75 | 60 |
| Neurosurgery | 110 | 90 |
| Oncology: Medical, Surgical | 75 | 60 |
| Oncology: Radiation | 110 | 90 |
| Ophthalmology | 75 | 60 |
| Orthopedic Surgery | 75 | 60 |
| Physical Medicine and Rehabilitation | 90 | 75 |
| Plastic Surgery | 110 | 90 |
| Primary Care: Adults | 40 | 30 |
| Primary Care: Pediatric | 40 | 30 |
| Psychiatry | 75 | 60 |

| | | |
|---|---|---|
| Pulmonology | 75 | 60 |
| Rheumatology | 110 | 90 |
| Urology | 75 | 60 |
| Vascular Surgery | 110 | 90 |

(2) for health care practitioners in the following disciplines:

| | Time | Distance |
|---|---|---|
| Chiropractic | 90 | 75 |
| Occupational Therapy | 75 | 60 |
| Physical Therapy | 75 | 60 |
| Podiatry | 75 | 60 |
| Speech Therapy | 75 | 60 |

(3) for the following types of institutional providers:

| | Time | Distance |
|---|---|---|
| Acute Inpatient Hospitals (Emergency Services Available 24/7) | 75 | 60 |
| Cardiac Catheterization Services | 145 | 120 |
| Cardiac Surgery Program | 145 | 120 |
| Critical Care Services: Intensive Care Units | 145 | 120 |
| Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology) | 75 | 60 |
| Inpatient or Residential Behavioral Health Facility Services | 90 | 75 |
| Mammography | 75 | 60 |
| Outpatient Infusion/Chemotherapy | 75 | 60 |
| Skilled Nursing Facilities | 75 | 60 |
| Surgical Services (Outpatient or Ambulatory Surgical Center) | 75 | 60 |

(4) for the following settings:

| | Time | Distance |
|---|---|---|
| Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) | 40 | 30 |
| Urgent Care | 75 | 60 |

(g) Maximum travel time in minutes and maximum distance in miles for preferred provider benefit plans by preferred provider

type for each county with extreme access considerations are:

(1) for the following physicians, as designated by physician specialty:

| | Time | Distance |
|---|---|---|
| Allergy and Immunology | 125 | 110 |
| Cardiology | 95 | 85 |
| Cardiothoracic Surgery | 145 | 130 |
| Dermatology | 110 | 100 |
| Emergency Medicine | 110 | 100 |
| Endocrinology | 145 | 130 |
| Ear, Nose, and Throat/Otolaryngology | 125 | 110 |
| Gastroenterology | 110 | 100 |
| General Surgery | 95 | 85 |
| Gynecology and Obstetrics | 70 | 60 |
| Infectious Diseases | 145 | 130 |
| Nephrology | 125 | 110 |
| Neurology | 110 | 100 |
| Neurosurgery | 145 | 130 |
| Oncology: Medical, Surgical | 110 | 100 |
| Oncology: Radiation | 145 | 130 |
| Ophthalmology | 95 | 85 |
| Orthopedic Surgery | 95 | 85 |
| Physical Medicine and Rehabilitation | 125 | 110 |
| Plastic Surgery | 145 | 130 |
| Primary Care: Adults | 70 | 60 |
| Primary Care: Pediatric | 70 | 60 |
| Psychiatry | 110 | 100 |
| Pulmonology | 110 | 100 |
| Rheumatology | 145 | 130 |
| Urology | 110 | 100 |
| Vascular Surgery | 145 | 130 |

(2) for health care practitioners in the following disciplines:

| | Time | Distance |
|---|---|---|
| Chiropractic | 125 | 110 |
| Occupational Therapy | 110 | 100 |
| Physical Therapy | 110 | 100 |

| | | |
|---|---|---|
| Podiatry | 110 | 100 |
| Speech Therapy | 110 | 100 |

(3) for the following institutional providers:

| | Time | Distance |
|---|---|---|
| Acute Inpatient Hospitals (Emergency Services Available 24/7) | 110 | 100 |
| Cardiac Catheterization Services | 155 | 140 |
| Cardiac Surgery Program | 155 | 140 |
| Critical Care Services: Intensive Care Units | 155 | 140 |
| Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology) | 110 | 100 |
| Inpatient or Residential Behavioral Health Facility Services | 155 | 140 |
| Mammography | 110 | 100 |
| Outpatient Infusion/Chemotherapy | 110 | 100 |
| Skilled Nursing Facilities | 95 | 85 |
| Surgical Services (Outpatient or Ambulatory Surgical Center) | 110 | 100 |

(4) for the following settings:

| | Time | Distance |
|---|---|---|
| Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified) | 70 | 60 |
| Urgent Care | 110 | 100 |

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 6, eff. September 1, 2023.

Sec. 1301.00554. OTHER MAXIMUM DISTANCE STANDARD REQUIREMENTS; COMMISSIONER AUTHORITY. (a) In this section, "maximum distance" has the meaning assigned by Section 1301.00553.

(b) For a physician specialty not specifically listed in Section 1301.00553, the maximum distance, in any county classification, is 75 miles.

(c) When necessary due to utilization or supply patterns, the commissioner by rule may decrease the base maximum travel time and distance standards listed in this section or Section 1301.00553 for specific counties.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 6, eff. September 1, 2023.

Sec. 1301.00555. MAXIMUM APPOINTMENT WAIT TIME STANDARDS. An insurer must ensure that:

(1) routine care is available and accessible from preferred providers:

(A) within three weeks for medical conditions; and

(B) within two weeks for behavioral health conditions; and

(2) preventive health care services are available and accessible from preferred providers:

(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive health care services; and

(B) within three months for an adult.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 6, eff. September 1, 2023.

Sec. 1301.0056. EXAMINATIONS AND FEES. (a) The commissioner shall by rule adopt a process for the commissioner to examine a preferred provider benefit plan before an insurer offers the plan for delivery to insureds to determine whether the plan meets the quality of care and network adequacy standards of this chapter. An insurer may not offer a preferred provider benefit plan or an exclusive provider benefit plan before the commissioner determines that the network meets the quality of care and network adequacy standards of this chapter or the insurer receives a waiver under Section 1301.0055.

(a-1) An insurer is subject to a qualifying examination of the insurer's preferred provider benefit plans and subsequent quality of care and network adequacy examinations by the commissioner at least once every three years, 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 whenever the commissioner considers an examination necessary. Documentation provided to the commissioner during an examination conducted under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) An insurer examined under this section shall pay the cost of the examination in an amount determined by the commissioner.

(c) The department shall collect an assessment in an amount determined by the commissioner from the insurer at the time of the examination to cover all expenses attributable directly to the examination, including the salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of this chapter.

(d) The department shall deposit an assessment collected under this section to the credit of the account described by Section 401.156(a). Money deposited under this subsection shall be used to pay the salaries and expenses of examiners and all other expenses relating to the examination of insurers under this section.

(e) Rules adopted under this section must require insurers 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. The rules must require insurers to provide access to or submit data or information that includes:

(1) 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;

(2) actuarial data of current and projected number of insureds by county;

(3) 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; and

(4) 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.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 9, eff. September 1, 2011.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1316 (H.B. 3911), Sec. 1, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 7, eff. September 1, 2023.

Sec. 1301.00565. PUBLIC HEARING ON NETWORK ADEQUACY STANDARDS WAIVERS. (a) In this section, "good faith effort" means honesty in fact, timely participation, observance of reasonable commercial standards of fair dealing, and prioritizing patients' access to in-network care.

(b) The commissioner shall set a public hearing for a determination of whether there is good cause for a waiver when an insurer:

(1) requests a waiver that does not satisfy Section 1301.0055(a)(6);

(2) requests a waiver that the commissioner does not deny; and

(3) does not complete corrective action for a material deviation reported under Section 1301.0055.

(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 to meet network adequacy standards and provide the physicians and health care providers with an opportunity to submit evidence, including written testimony, and to attend the public hearing and offer testimony either in person or virtually. An out-of-network physician or hospital, including a physician group or health care system referenced in the insurer's waiver request or notice of material deviation, may not be identified by name at the hearing unless the physician or hospital consents to the identification in advance of the hearing.

(d) At the hearing, the commissioner shall consider all written and oral testimony and evidence submitted by the insurer

and the public pertinent to the requested waiver, including:

(1) the total number of physicians or health care providers in each preferred provider type listed in Section 1301.00553 within the county and service area being submitted for the waiver and whether the insurer made a good faith effort to contract with those required preferred provider types to meet network adequacy standards of this chapter;

(2) the total number of facilities, and availability of pediatric, for-profit, nonprofit, tax-supported, and teaching facilities, within the county and service area being submitted for a waiver and whether the insurer made a good faith effort to contract with these facilities and facility-based physicians and health care providers to meet network adequacy standards of this chapter;

(3) population, density, and geographical information to determine the possibility of meeting travel time and distance requirements within the county and service area being submitted for a waiver; and

(4) availability of services, population, and density within the county and service area being submitted for the waiver.

(e) The commissioner may not consider a prohibition on balance billing in determining whether to grant a waiver from network adequacy standards.

(f) The commissioner may not grant a waiver without a public hearing.

(g) Except as provided by this subsection, any evidence submitted to the commissioner as evidence for the public hearing that is proprietary in nature is confidential and not subject to disclosure as public information under Chapter 552, Government Code. Information related to provider directories, credentials, and privileges, estimates of patient populations, and actuarial estimates of needed providers to meet the estimated patient population is not protected under this subsection.

(h) A policyholder is entitled to seek judicial review of the commissioner's decision to grant a waiver under this section in a Travis County district court. Review by the district court under this subsection is de novo.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 8, eff. September 1, 2023.

Sec. 1301.00566. EFFECT OF NETWORK ADEQUACY STANDARDS WAIVER ON BALANCE BILLING PROHIBITIONS. After a network adequacy standards waiver is granted by the commissioner, an insurer may refer to the provisions prohibiting balance billing under Sections 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable, in an access plan submitted to the department for the sole purpose of explaining how the insurer will coordinate care to limit the likelihood of a balance bill for services subject to those provisions and not to justify a departure from network adequacy standards.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 8, eff. September 1, 2023.

Sec. 1301.0057. ACCESS TO OUT-OF-NETWORK PROVIDERS. An insurer may not terminate, or threaten to terminate, an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 5, eff. September 1, 2015.

Sec. 1301.0058. PROTECTED COMMUNICATIONS BY PREFERRED PROVIDERS. (a) An insurer may not in any manner prohibit, attempt to prohibit, penalize, terminate, or otherwise restrict a preferred provider from communicating with an insured about the availability of out-of-network providers for the provision of the insured's medical or health care services.

(b) An insurer may not terminate the contract of or otherwise penalize a preferred provider solely because the provider's patients use out-of-network providers for medical or health care services.

(c) An insurer's contract with a preferred provider may require that, except in a case of a medical emergency as determined by the preferred provider, before the provider may make an out-of-network referral for an insured, the preferred provider

inform the insured:

(1) that:

(A) the insured may choose a preferred provider or an out-of-network provider; and

(B) if the insured chooses the out-of-network provider the insured may incur higher out-of-pocket expenses; and

(2) whether the preferred provider has a financial interest in the out-of-network provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 5, eff. September 1, 2015.

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. (a) An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

(b) A contract between an insurer that markets a plan regulated under this chapter and an institutional provider may not, as a condition of staff membership or privileges, require a physician or other practitioner to enter into a preferred provider contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 10.01, eff. September 28, 2011.

Sec. 1301.0061. TERMS OF ENROLLEE ELIGIBILITY. (a) A contract between an insurer and a group policyholder under a preferred provider benefit plan must provide that:

(1) in addition to any other premiums for which the group policyholder is liable, the group policyholder is liable for an individual insured's premiums from the time the individual is no longer part of the group eligible for coverage under the policy

until the end of the month in which the policyholder notifies the insurer that the individual is no longer part of the group eligible for coverage under the policy; and

(2) the individual remains covered under the policy until the end of that period.

(b) Each insurer that enters into a contract described by Subsection (a) shall notify the group policyholder periodically as provided by this section that the policyholder is liable for premiums on an individual who is no longer part of the group eligible for coverage until the insurer receives notification of termination of the individual's eligibility for coverage.

(c) If the insurer charges the group policyholder on a monthly basis for the premiums, the insurer shall include the notice required by Subsection (b) in each monthly statement sent to the group policyholder. If the insurer charges the group policyholder on other than a monthly basis for the premiums, the insurer shall notify the group policyholder periodically in the manner prescribed by the commissioner by rule.

(d) The notice required by Subsection (b) must include a description of methods preferred by the insurer for notification by a group policyholder of an individual's termination from coverage eligibility.

Added by Acts 2005, 79th Leg., Ch. 669 (S.B. 51), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1217 (S.B. 1143), Sec. 2, eff. September 1, 2009.

Sec. 1301.007. RULES. The commissioner shall adopt rules as necessary to:

(1) implement this chapter; and

(2) ensure reasonable accessibility and availability of preferred provider services to residents of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 1221 (H.B. 1030), Sec. 2, eff. September 1, 2005.

Sec. 1301.008. CONFLICT WITH OTHER LAW. To the extent of any conflict between this chapter and Subchapter C, Chapter 1204, this chapter controls.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(c), eff. September 1, 2005.

Sec. 1301.009. ANNUAL REPORT. (a) Not later than March 1 of each year, an insurer shall file with the commissioner a report relating to the preferred provider benefit plan offered under this chapter and covering the preceding calendar year.

(b) The report shall:

(1) be verified by at least two principal officers;

(2) be in a form prescribed by the commissioner; and

(3) include:

(A) a financial statement of the insurer, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year; and

(C) a statement of:

(i) an evaluation of enrollee satisfaction;

(ii) an evaluation of quality of care;

(iii) coverage areas;

(iv) accreditation status;

(v) premium costs;

(vi) plan costs;

(vii) premium increases;

(viii) the range of benefits provided;

(ix) copayments and deductibles;

(x) the accuracy and speed of claims payment by the insurer for the plan;

(xi) the credentials of physicians who are preferred providers;

(xii) the number of preferred providers;

(xiii) any waiver requests made and waivers of network adequacy standards granted under Section 1301.00565;

(xiv) any material deviation from network adequacy standards reported to the department under Section 1301.0055; and

(xv) any corrective actions, sanctions, or penalties assessed against the insurer by the department for deficiencies related to the preferred provider benefit plan.

(c) The annual report filed by the insurer shall be made publicly available on the department's website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by insurers under this section.

(d) An insurer providing group coverage of $10 million or less in premiums or individual coverage of $2 million or less in premiums is not required to report the data required under Subsection (b)(3)(C).

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 10, eff. September 1, 2007.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 9, eff. September 1, 2023.

Text of section effective until September 01, 2025

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, 1301.165, or 1301.166, as applicable;

(2) the total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Section 1301.0053, 1301.155, 1301.164, 1301.165, or 1301.166, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.07, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 7(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 7(b), eff. September 1, 2025.

Text of section effective on September 01, 2025

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable;

(2) the total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment

under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.07, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 7(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 7(b), eff. September 1, 2025.

## SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR HEALTH CARE PROVIDERS

Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER. (a) An insurer shall afford a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners and institutional providers and to health care providers other than practitioners and institutional providers, if those other health care providers are included by the insurer as preferred providers, provided that the practitioners, institutional providers, or health care providers:

(1) are licensed to treat injuries or illnesses or to provide services covered by a health insurance policy; and

(2) comply with the terms established by the insurer for designation as preferred providers.

(b) An insurer may not unreasonably withhold a designation as a preferred provider.

(c) An insurer shall give a physician or health care provider who, on the person's initial application, is not designated as a preferred provider written reasons for denial of the designation.

(d) Unless otherwise limited by this code, this section does not prohibit an insurer from rejecting a physician's or health care provider's application for designation based on a determination that the preferred provider benefit plan has sufficient qualified providers.

(e) An insurer may not withhold a designation to:

(1) a podiatrist described by Section 1301.0521; or

(2) an optometrist, therapeutic optometrist, or ophthalmologist described by Section 1301.0522.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.034(a), eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1271 (S.B. 684), Sec. 1, eff. September 1, 2015.

Sec. 1301.0515. ACUPUNCTURIST SERVICES. (a) An insurer offering a preferred provider benefit plan that includes acupuncture in the services covered by the plan may not refuse to provide reimbursement for the performance of a covered acupuncture service solely because the service is provided by an acupuncturist.

(b) This section does not require an insurer to offer acupuncture as a covered service.

Added by Acts 2005, 79th Leg., Ch. 622 (H.B. 2371), Sec. 2, eff. September 1, 2005.

Sec. 1301.0516. CHIROPRACTIC SERVICES. (a) An insurer offering a preferred provider benefit plan that covers a service that is within the scope of a chiropractor's license may not refuse to provide reimbursement for the performance of the covered service solely because the service is provided by a chiropractor.

(b) This section does not require an insurer to cover a particular medical or health care service.

(c) This section does not affect the right of an insurer to determine whether a medical or health care service is medically necessary.

(d) An insurer that violates this section is subject to an administrative penalty as provided by Chapter 84 of not more than $1,000 for each claim that remains unpaid in violation of this section. Each day a violation continues constitutes a separate violation.

Added by Acts 2019, 86th Leg., R.S., Ch. 116 (S.B. 1739), Sec. 2, eff. September 1, 2019.

Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR PHYSICIAN ASSISTANT AS PREFERRED PROVIDER. An insurer offering a preferred provider benefit plan may not refuse a request made by a physician participating as a preferred provider under the plan and an advanced practice nurse or physician assistant to have the advanced practice nurse or physician assistant included as a preferred provider under the plan if:

(1) the advanced practice nurse or physician assistant is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code; and

(2) the advanced practice nurse or physician assistant meets the quality of care standards previously established by the insurer for participation in the plan by advanced practice nurses and physician assistants.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.0521. DESIGNATION OF CERTAIN PODIATRISTS AS PREFERRED PROVIDERS. (a) Notwithstanding Section 1301.051, an insurer may not withhold the designation of preferred provider to a podiatrist licensed by the Texas Department of Licensing and Regulation who:

(1) joins the professional practice of a contracted preferred provider;

(2) applies to the insurer for designation as a preferred provider; and

(3) complies with the terms and conditions of eligibility to be a preferred provider.

(b) A podiatrist designated as a preferred provider under this section must comply with the terms of the preferred provider contract used by the insurer or the insurer's network provider.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.035(a), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.013, eff. September 1, 2019.

Sec. 1301.0522. DESIGNATION OF CERTAIN OPTOMETRISTS,

THERAPEUTIC OPTOMETRISTS, AND OPHTHALMOLOGISTS AS PREFERRED PROVIDERS. (a) Notwithstanding Section 1301.051, an insurer may not withhold the designation of preferred provider to an optometrist or therapeutic optometrist licensed by the Texas Optometry Board or an ophthalmologist licensed by the Texas Medical Board who:

(1) joins the professional practice of a contracted preferred provider;

(2) applies to the insurer for designation as a preferred provider; and

(3) complies with the terms and conditions of eligibility to be a preferred provider.

(b) An optometrist, therapeutic optometrist, or ophthalmologist designated as a preferred provider under this section must comply with the terms of the preferred provider contract used by the insurer or the insurer's network provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 1271 (S.B. 684), Sec. 2, eff. September 1, 2015.

Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED PROVIDER. (a) An insurer that does not designate a practitioner as a preferred provider shall provide a reasonable mechanism for reviewing that action. The review mechanism must incorporate, in an advisory role only, a review panel.

(b) A review panel must be composed of at least three individuals selected by the insurer from a list of participating practitioners and must include one member who is a practitioner in the same or similar specialty as the affected practitioner, if available. The practitioners contracting with the insurer in the applicable service area shall provide the list of practitioners to the insurer.

(c) On request, the insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider benefit plan, an insurer shall immediately notify each practitioner in the plan's service area of the insurer's intent to offer the plan and of the opportunity to participate. The notification must be made by publication or in writing to each practitioner.

(b) After establishing a preferred provider benefit plan, an insurer shall annually provide notice of and an opportunity to participate in the plan to practitioners in the plan's service area who do not participate in the plan.

(c) On request, an insurer shall provide to any physician or health care provider information concerning the application process and qualification requirements for participation as a preferred provider in the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.055. COMPLAINT RESOLUTION. (a) Each contract under a preferred provider benefit plan between an insurer and a physician or other practitioner or a physicians' group must have a mechanism for resolving complaints initiated by an insured, a physician or other practitioner, or a physicians' group.

(b) A complaint resolution mechanism must provide for reasonable due process that includes, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurer or third-party administrator may not reimburse a physician or other practitioner, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless:

(1) the insurer or third-party administrator has contracted with either:

(A) the physician or other practitioner, institutional provider, or organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and that has contracted with the physician or other practitioner, institutional provider, or organization of physicians and health care providers;

(2) the physician or other practitioner, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer or third-party administrator has agreed to provide coverage for those health care services under the health insurance policy.

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner of insurance or the commissioner of workers' compensation under this code or Title 5, Labor Code, to request and obtain information.

(c) An insurer or third-party administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542; and

(2) is subject to administrative penalties under Chapters 82 and 84.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 6.061, eff. September 1, 2005.

Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED REVIEW PROCESS. (a) Before terminating a contract with a preferred provider, an insurer shall:

(1) provide written reasons for the termination; and

(2) if the affected provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving:

(A) imminent harm to a patient's health;

(B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice medicine; or

(C) fraud or malfeasance.

(b) The review mechanism described by Subsection (a)(2) must incorporate, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b) and must be completed within a period not to exceed 60 days.

(c) The insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) on request, a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

(d) On request, an insurer shall provide to a practitioner whose participation in a preferred provider benefit plan is being terminated:

(1) an expedited review conducted in accordance with a process that complies with rules established by the commissioner; and

(2) all information on which the insurer wholly or partly based the termination, including the economic profile of the preferred provider, the standards by which the provider is measured, and the statistics underlying the profile and standards.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 6, eff. September 1, 2015.

Sec. 1301.058. ECONOMIC PROFILING. An insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers

in a preferred provider benefit plan shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section, "quality assessment" means a mechanism used by an insurer to evaluate, monitor, or improve the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with the care delivered by an ordinary, reasonable, and prudent physician or health care provider under the same or similar circumstances.

(b) An insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that either the insurer or the preferred provider organization on the insurer's behalf will comply

with the notice requirements and other requirements imposed on the insurer by this subchapter.

(b) An insurer that enters into an agreement with a preferred provider organization under this section shall meet the requirements of this chapter or ensure that those requirements are met.

(c) Each preferred provider benefit plan offered in this state must comply with this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 3B.0271(a), eff. September 1, 2007.

Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN INSURERS AND PODIATRISTS. A preferred provider contract between an insurer and a podiatrist licensed by the Texas Department of Licensing and Regulation must provide that:

(1) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;

(3) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(4) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.014, eff. September 1, 2019.

Sec. 1301.0625. HEALTH CARE COLLABORATIVES. (a) Subject to the requirements of this chapter, a health care collaborative may be designated as a preferred provider under a preferred

provider benefit plan and may offer enhanced benefits for care provided by the health care collaborative.

(b) A preferred provider contract between an insurer and a health care collaborative may use a payment methodology other than a fee-for-service or discounted fee methodology. A reimbursement methodology used in a contract under this subsection is not subject to Chapter 843.

(c) A contract authorized by Subsection (b) must specify that the health care collaborative and the physicians or providers providing health care services on behalf of the collaborative will hold an insured harmless for payment of the cost of covered health care services if the insurer or the health care collaborative do not pay the physician or health care provider for the services.

(d) An insurer issuing an exclusive provider benefit plan authorized by another law of this state may limit access to only preferred providers participating in a health care collaborative if the limitation is consistent with all requirements applicable to exclusive provider benefit plans.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.03, eff. September 28, 2011.

Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

(1) serves as physician of record at a hospital for a hospitalized patient of another physician; and

(2) returns the care of the patient to that other physician at the end of the patient's hospitalization.

(b) A preferred provider contract between an insurer and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF CLAIMS. Subject to Subchapter C, a preferred provider contract must provide for payment to a physician or health care provider for health care services and benefits provided to an insured under the

contract and to which the insured is entitled under the terms of the contract not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.0641. CONTRACT PROVISIONS PROHIBITING REJECTION OF BATCHED CLAIMS. (a) If requested by a preferred provider, an insurer shall include a provision in the preferred provider's contract providing that the insurer or the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim, as defined by Subchapter C, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim.

(b) In accordance with Chapters 82 and 84, the commissioner may issue a cease and desist order against or impose sanctions on an insurer that violates this section or a contract provision adopted under this section.

Added by Acts 2005, 79th Leg., Ch. 668 (S.B. 50), Sec. 2, eff. September 1, 2005.

Sec. 1301.0642. CONTRACT PROVISIONS ALLOWING CERTAIN ADVERSE MATERIAL CHANGES PROHIBITED. (a) In this section, "adverse material change" means 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.

(b) An adverse material change to a preferred provider contract may only be made during the term of the preferred provider contract with the mutual agreement of the parties. A provision in a preferred provider contract that allows the insurer to unilaterally make an adverse material change during the term of the contract is void and unenforceable.

(c) Any adverse material change to the preferred provider contract may not go into effect until the 120th day after the date the preferred provider affirmatively agrees to the adverse material change in writing.

(d) A proposed amendment by an insurer seeking an adverse material change to a preferred provider contract must include notice that clearly and conspicuously states that a preferred provider may choose to not agree to the amendment and that the decision to not agree to the amendment may not affect:

(1) the terms of the provider's existing contract with the insurer; or

(2) the provider's participation in other health plans or products.

(e) A preferred provider's failure to agree to an adverse material change to a preferred provider contract does not affect:

(1) the terms of the provider's existing contract with the insurer; or

(2) the provider's participation in other health care products or plans.

(f) An insurer's failure to include the notice described by Subsection (d) with the proposed amendment makes an otherwise agreed-to adverse material change void and unenforceable.

(g) This section does not apply to a preferred provider contract:

(1) with an unspecified and indefinite duration;

(2) with no stated or automatic renewal period or event; and

(3) that may only be terminated by notice from one party to the other.

Added by Acts 2023, 88th Leg., R.S., Ch. 740 (H.B. 3359), Sec. 10, eff. September 1, 2023.

Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY PROHIBITED. A preferred provider contract may not require any physician, health care provider, or physicians' group to execute a hold harmless clause to shift the insurer's tort liability resulting from the insurer's acts or omissions to the preferred provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. An insurer may not engage in any retaliatory action against a physician or health care provider, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract, because the physician or provider has:

(1) on behalf of an insured, reasonably filed a complaint against the insurer; or

(2) appealed a decision of the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An insurer may not, as a condition of a preferred provider contract

with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a person designated by a patient, information or an opinion:

(1) regarding the patient's health care, including the patient's medical condition or treatment options; or

(2) in good faith regarding the provisions, terms, requirements, or services of the health insurance policy as they relate to the patient's medical needs.

(a-1) An insurer may not, as a condition of payment with a physician or health care provider or in any other manner, require a physician or health care provider to provide a notification form stating that the physician or health care provider is an out-of-network provider to a current, prospective, or former patient, or a person designated by the patient, if the form contains additional information that is intended, or is otherwise required to be presented in a manner that is intended, to intimidate the patient.

(b) An insurer may not in any way penalize, terminate the participation of, or refuse to compensate for covered services a physician or health care provider for discussing or communicating with a current, prospective, or former patient, or a person designated by a patient, pursuant to this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 275 (H.B. 574), Sec. 7, eff. September 1, 2015.

Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) An insurer may not use any financial incentive or make payment to a physician or health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.069. SERVICES PROVIDED BY CERTAIN PHYSICIANS AND HEALTH CARE PROVIDERS. The provisions of this chapter relating to prompt payment by an insurer of a physician or health care provider and to verification of medical care or health care services apply to a physician or provider who:

(1) is not a preferred provider included in the preferred provider network; and

(2) provides to an insured:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(d), eff. September 1, 2005.

SUBCHAPTER C. PROMPT PAYMENT OF CLAIMS

Sec. 1301.101. DEFINITION. In this subchapter, "clean claim" means a claim that complies with Section 1301.131.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.102. SUBMISSION OF CLAIM. (a) A physician or health care provider must submit a claim to an insurer not later than the 95th day after the date the physician or provider provides the medical care or health care services for which the claim is made.

(b) Except as provided by Chapter 1213, a physician or health care provider may, as appropriate:

(1) mail a claim by United States mail, first class, or by overnight delivery service;

(2) submit the claim electronically;

(3) fax the claim; or

(4) hand deliver the claim.

(c) An insurer shall accept as proof of timely filing a claim filed in compliance with Subsection (b) or information from another insurer or health maintenance organization showing that the physician or health care provider submitted the claim to the insurer or health maintenance organization in compliance with Subsection (b).

(d) If a physician or health care provider fails to submit a claim in compliance with this section, the physician or provider forfeits the right to payment.

(e) The period for submitting a claim under this section may be extended by:

(1) contract;

(2) notice published by the commissioner allowing an extension of prompt payment deadlines to a later date chosen by the commissioner due to a catastrophic event; or

(3) the department's approval of a physician's or health care provider's request for an extension due to a catastrophic event that substantially interferes with the normal business operations of the physician or provider.

(e-1) The commissioner may adopt rules to implement Subsection (e), including rules establishing requirements for a request made under Subsection (e)(3).

(f) A physician or health care provider may not submit a duplicate claim for payment before the 46th day after the date the original claim was submitted. The commissioner shall adopt rules under which an insurer may determine whether a claim is a duplicate claim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. 1286), Sec. 3, eff. September 1, 2023.

Sec. 1301.1021. RECEIPT OF CLAIM. (a) If a claim for

medical care or health care services provided to a patient is mailed, the claim is presumed to have been received by the insurer on the fifth day after the date the claim is mailed or, if the claim is mailed using overnight service or return receipt requested, on the date the delivery receipt is signed.

(b) If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the insurer or the insurer's clearinghouse. If the insurer or the insurer's clearinghouse does not provide a confirmation within 24 hours of submission by the physician or health care provider, the physician's or provider's clearinghouse shall provide the confirmation. The physician's or provider's clearinghouse must be able to verify that the filing contained the correct payor identification of the entity to receive the filing.

(c) If the claim is faxed, the claim is presumed to have been received on the date of the transmission acknowledgment.

(d) If the claim is hand delivered, the claim is presumed to have been received on the date the delivery receipt is signed.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections 1301.104 and 1301.1054, not later than the 45th day after the date an insurer receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date an insurer receives a clean claim from a preferred provider that is electronically submitted, the insurer shall make a determination of whether the claim is payable and:

(1) if the insurer determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) if the insurer determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) if the insurer determines that the claim is not payable, notify the preferred provider in writing why the claim will not be paid.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 8, eff. September 1, 2011.

Sec. 1301.104. DEADLINE FOR ACTION ON PHARMACY CLAIMS; PAYMENT. (a) An insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is electronically submitted shall pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated.

(b) An insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is not electronically submitted shall pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 9, eff. September 1, 2011.

Sec. 1301.105. AUDITED CLAIMS. (a) Except as provided by Section 1301.1054, an insurer that intends to audit a claim submitted by a preferred provider shall pay the charges submitted at 100 percent of the contracted rate on the claim not later than:

(1) the 30th day after the date the insurer receives the clean claim from the preferred provider if the claim is

submitted electronically; or

(2) the 45th day after the date the insurer receives the clean claim from the preferred provider if the claim is submitted nonelectronically.

(b) The insurer shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule that the clean claim is being paid at 100 percent of the contracted rate, subject to completion of the audit.

(c) If the insurer requests additional information to complete the audit, the request must describe with specificity the clinical information requested and relate only to information the insurer in good faith can demonstrate is specific to the claim or episode of care. The insurer may not request as a part of the audit information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a preferred provider.

(d) If the preferred provider does not supply information reasonably requested by the insurer in connection with the audit, the insurer may:

(1) notify the provider in writing that the provider must provide the information not later than the 45th day after the date of the notice or forfeit the amount of the claim; and

(2) if the provider does not provide the information required by this section, recover the amount of the claim.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.1051. COMPLETION OF AUDIT. The insurer must complete an audit under Section 1301.105 on or before the 180th day after the date the clean claim is received by the insurer, and any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the completion of the audit.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a),

eff. September 1, 2005.

Sec. 1301.1052. PREFERRED PROVIDER APPEAL AFTER AUDIT. If a preferred provider disagrees with a refund request made by an insurer based on an audit under Section 1301.105, the insurer shall provide the provider with an opportunity to appeal, and the insurer may not attempt to recover the payment until all appeal rights are exhausted.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.1053. DEADLINES NOT EXTENDED. The investigation and determination of payment, including any coordination of other payments, does not extend the period for determining whether a claim is payable under Section 1301.103 or 1301.104 or for auditing a claim under Section 1301.105.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.1054. REQUESTS FOR ADDITIONAL INFORMATION. (a) If an insurer needs additional information from a treating preferred provider to determine payment, the insurer, not later than the 30th calendar day after the date the insurer receives a clean claim, shall request in writing that the preferred provider provide an attachment to the claim that is relevant and necessary for clarification of the claim. The request must describe with specificity the clinical information requested and relate only to information the insurer can demonstrate is specific to the claim or the claim's related episode of care. The preferred provider is not required to provide an attachment that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a preferred provider.

(b) An insurer that requests an attachment under Subsection (a) shall determine whether the claim is payable on or before the later of the 15th day after the date the insurer receives the

requested attachment or the latest date for determining whether the claim is payable under Section 1301.103 or 1301.104.

(c) An insurer may not make more than one request under Subsection (a) in connection with a claim. Sections 1301.102(b) and 1301.1021 apply to a request for and submission of an attachment under Subsection (a).

(d) If an insurer requests an attachment or other information from a person other than the preferred provider who submitted the claim, the insurer shall provide notice containing the name of the physician or health care provider from whom the insurer is requesting information to the preferred provider who submitted the claim. The insurer may not withhold payment pending receipt of an attachment or information requested under this subsection. If on receiving an attachment or information requested under this subsection the insurer determines that there was an error in payment of the claim, the insurer may recover any overpayment under Section 1301.132.

(e) The commissioner shall adopt rules under which an insurer can easily identify attachments or other information submitted by a physician or health care provider under this section.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.106. CLAIMS PROCESSING PROCEDURES AND CLAIMS PAYMENT PROCESSES. (a) An insurer shall provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures.

(b) An insurer's claims payment processes shall:

(1) use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers; and

(2) be consistent with nationally recognized, generally accepted bundling edits and logic.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.107. CONTRACTUAL WAIVER AND OTHER ACTIONS PROHIBITED. Except as provided by Section 1301.102(e), the provisions of this subchapter may not be waived, voided, or nullified by contract.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may recover reasonable attorney's fees and court costs in an action to recover payment under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person, including a pharmacy benefit manager, with whom an insurer contracts to:

(1) process or pay claims;

(2) obtain the services of physicians and health care providers to provide health care services to insureds; or

(3) issue verifications or preauthorizations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 11, eff. September 1, 2011.

## SUBCHAPTER C-1. OTHER PROVISIONS RELATING TO PAYMENT OF CLAIMS

Sec. 1301.131. ELEMENTS OF CLEAN CLAIM. (a) A

nonelectronic claim by a physician or health care provider, other than an institutional provider, is a "clean claim" if the claim is submitted using the Centers for Medicare and Medicaid Services Form 1500 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or the committee's successor. An electronic claim by a physician or provider, other than an institutional provider, is a "clean claim" if the claim is submitted using the Professional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or the center's successor.

(b) A nonelectronic claim by an institutional provider is a "clean claim" if the claim is submitted using the Centers for Medicare and Medicaid Services Form UB-92 or, if adopted by the commissioner by rule, a successor to that form developed by the National Uniform Billing Committee or the committee's successor. An electronic claim by an institutional provider is a "clean claim" if the claim is submitted using the Institutional 837 (ASC X12N 837) format or, if adopted by the commissioner by rule, a successor to that format adopted by the Centers for Medicare and Medicaid Services or the centers' successor.

(c) The commissioner may adopt rules that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

(d) The commissioner may not require any data element for an electronic claim that is not required in an electronic transaction set needed to comply with federal law.

(e) An insurer and a preferred provider may agree by contract to use fewer data elements than are required in an electronic transaction set needed to comply with federal law.

(f) An otherwise clean claim submitted by a physician or health care provider that includes additional fields, data elements, attachments, or other information not required under this section is considered to be a clean claim for the purposes of this chapter.

(g) Except as provided by Subsection (e), the provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.132. OVERPAYMENT. (a) An insurer may recover an overpayment to a physician or health care provider if:

(1) not later than the 180th day after the date the physician or provider receives the payment, the insurer provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds; and

(2) the physician or provider does not make arrangements for repayment of the requested funds on or before the 45th day after the date the physician or provider receives the notice.

(b) If a physician or health care provider disagrees with a request for recovery of an overpayment, the insurer shall provide the physician or provider with an opportunity to appeal, and the insurer may not attempt to recover the overpayment until all appeal rights are exhausted.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.133. VERIFICATION. (a) In this section, "verification" includes preauthorization only when preauthorization is a condition for the verification.

(b) On the request of a preferred provider for verification of a particular medical care or health care service the preferred provider proposes to provide to a particular patient, the insurer shall inform the preferred provider without delay whether the service, if provided to that patient, will be paid by the insurer and shall specify any deductibles, copayments, or coinsurance for which the insured is responsible.

(c) An insurer shall have appropriate personnel reasonably available at a toll-free telephone number to provide a verification under this section between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal

holidays. An insurer must have a telephone system capable of accepting or recording incoming phone calls for verifications after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls on or before the second calendar day after the date the call is received.

(d) An insurer may decline to determine eligibility for payment if the insurer notifies the physician or preferred provider who requested the verification of the specific reason the determination was not made.

(e) An insurer may establish a specific period during which the verification is valid of not less than 30 days.

(f) An insurer that declines to provide a verification shall notify the physician or provider who requested the verification of the specific reason the verification was not provided.

(g) If an insurer has provided a verification for proposed medical care or health care services, the insurer may not deny or reduce payment to the physician or provider for those medical care or health care services if provided to the insured on or before the 30th day after the date the verification was provided unless the physician or provider has materially misrepresented the proposed medical care or health care services or has substantially failed to perform the proposed medical care or health care services.

(h) The provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.134. COORDINATION OF PAYMENT. (a) An insurer may require a physician or health care provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the insurer on the applicable form described by Section 1301.131. Except as provided by this subsection, an insurer may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of payment under this section does not

extend the period for determining whether a service is eligible for payment under Section 1301.103 or 1301.104 or for auditing a claim under Section 1301.105.

(c) A physician or health care provider who submits a claim for particular medical care or health care services to more than one health maintenance organization or insurer shall provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) On receipt of notice under Subsection (c), an insurer shall coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or health care provider.

(e) Except as provided by Subsection (f), if an insurer is a secondary payor and pays a portion of a claim that should have been paid by the insurer or health maintenance organization that is the primary payor, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary insurer was also paid by the primary health maintenance organization or insurer, the secondary insurer may recover the amount of overpayment under Section 1301.132 from the physician or health care provider who received the payment. An insurer processing an electronic claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. Primary payor information may be submitted electronically by the primary payor to the secondary payor.

(g) An insurer may share information with a health maintenance organization or another insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

(h) The provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.135. PREAUTHORIZATION OF MEDICAL AND HEALTH CARE SERVICES. (a) An insurer that uses a preauthorization process for medical care or health care services shall provide to each preferred provider, not later than the fifth business day after the date a request is made, a list of medical care and health care services that require preauthorization and information concerning the preauthorization process.

(b) If proposed medical care or health care services require preauthorization as a condition of the insurer's payment to a preferred provider under a health insurance policy, the insurer shall determine whether the medical care or health care services proposed to be provided to the insured are medically necessary and appropriate.

(c) On receipt of a request from a preferred provider for preauthorization, the insurer shall review and issue a determination indicating whether the proposed medical care or health care services are preauthorized. The determination must be issued and transmitted not later than the third calendar day after the date the request is received by the insurer.

(d) If the proposed medical care or health care services involve inpatient care and the insurer requires preauthorization as a condition of payment, the insurer shall review the request and issue a length of stay for the admission into a health care facility based on the recommendation of the patient's physician or health care provider and the insurer's written medically accepted screening criteria and review procedures. If the proposed medical or health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed, the insurer shall review the request and issue a determination indicating whether proposed services are preauthorized within 24 hours of the request by the physician or provider.

(e) An insurer shall have appropriate personnel reasonably available at a toll-free telephone number to respond to requests for a preauthorization between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal

holidays. An insurer must have a telephone system capable of accepting or recording incoming phone calls for preauthorizations after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays and responding to each of those calls not later than 24 hours after the call is received.

(f) If an insurer has preauthorized medical care or health care services, the insurer may not deny or reduce payment to the physician or health care provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services.

(g) This section applies to an agent or other person with whom an insurer contracts to perform, or to whom the insurer delegates the performance of, preauthorization of proposed medical or health care services.

(h) The provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.03, eff. September 1, 2019.

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) except as provided by Subsection (c) or (d), conspicuously in a location on the Internet website that does not

require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) except for the screening criteria under Subdivision (4)(C), be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve a request for the service;

(C) the applicable screening criteria, which may include Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding calendar year, including statistics in the following categories:

(i) physician or health care provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned by an independent review organization; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(c) This section may not be construed to require an insurer

to provide specific information that would violate any applicable copyright law or licensing agreement. To comply with a posting requirement described by Subsection (b), an insurer may, instead of making that information publicly available on the insurer's Internet website, supply a summary of the withheld information sufficient to allow a licensed physician or other health care provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the insurer's medical necessity or appropriateness determinations.

(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the insurer has received from a third party with which the insurer has contracted, to comply with a posting requirement described by Subsection (b), the insurer may, instead of making that information publicly available on the insurer's Internet website, provide the material to a physician or health care provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

(e) The provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.04, eff. September 1, 2019.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the insurer's newsletter or network bulletin, if any, and on the insurer's Internet website.

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall

provide notice of the change in the preauthorization requirement and disclose the change in the insurer's newsletter or network bulletin, if any, and on the insurer's Internet website not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an insurer shall update its Internet website to disclose the change to the insurer's preauthorization requirements or process and the date and time the change is effective.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.04, eff. September 1, 2019.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any medical care or health care service affected by the violation.

(b) The provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 2.04, eff. September 1, 2019.

Sec. 1301.136. AVAILABILITY OF CODING GUIDELINES. (a) A contract between an insurer and a preferred provider must provide that:

(1) the preferred provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the preferred provider will receive under the contract;

(2) the insurer or the insurer's agent will provide the

coding guidelines and fee schedules not later than the 30th day after the date the insurer receives the request;

(3) the insurer or the insurer's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the preferred provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) the contract may be terminated by the preferred provider on or before the 30th day after the date the preferred provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) A preferred provider who receives information under Subsection (a) may only:

(1) use or disclose the information for the purpose of practice management, billing activities, and other business operations; and

(2) disclose the information to a governmental agency involved in the regulation of health care or insurance.

(c) The insurer shall, on request of the preferred provider, provide the name, edition, and model version of the software that the insurer uses to determine bundling and unbundling of claims.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.137. VIOLATION OF CLAIMS PAYMENT REQUIREMENTS; PENALTY. (a) Except as provided by this section, if a clean claim submitted to an insurer is payable and the insurer does not determine under Subchapter C that the claim is payable and pay the claim on or before the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay the preferred provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of:

(1) 50 percent of the difference between the billed

charges, as submitted on the claim, and the contracted rate; or

(2) $100,000.

(b) If the claim is paid on or after the 46th day and before the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty in the amount of the lesser of:

(1) 100 percent of the difference between the billed charges, as submitted on the claim, and the contracted rate; or

(2) $200,000.

(c) If the claim is paid on or after the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty computed under Subsection (b) plus 18 percent annual interest on that amount. Interest under this subsection accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(d) Except as provided by this section, an insurer that determines under Subchapter C that a claim is payable, pays only a portion of the amount of the claim on or before the date the insurer is required to make a determination or adjudication of the claim, and pays the balance of the contracted rate owed for the claim after that date shall pay to the preferred provider, in addition to the contracted amount owed, a penalty on the amount not timely paid in the amount of the lesser of:

(1) 50 percent of the underpaid amount; or

(2) $100,000.

(e) If the balance of the claim is paid on or after the 46th day and before the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty on the balance of the claim in the amount of the lesser of:

(1) 100 percent of the underpaid amount; or

(2) $200,000.

(f) If the balance of the claim is paid on or after the 91st day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty on the balance of the claim computed under Subsection (e) plus 18 percent

annual interest on that amount. Interest under this subsection accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

(g) For the purposes of Subsections (d) and (e), the underpaid amount is computed on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate.

(h) An insurer is not liable for a penalty under this section:

(1) if the failure to pay the claim in accordance with Subchapter C is a result of a catastrophic event and:

(A) the commissioner published a notice allowing an extension of the applicable prompt payment deadlines due to the catastrophic event; or

(B) the department approved the insurer's request for an extension due to the substantial interference of the catastrophic event with the normal business operations of the insurer; or

(2) if the claim was paid in accordance with Subchapter C, but for less than the contracted rate, and:

(A) the preferred provider notifies the insurer of the underpayment after the 270th day after the date the underpayment was received; and

(B) the insurer pays the balance of the claim on or before the 30th day after the date the insurer receives the notice.

(i) Subsection (h) does not relieve the insurer of the obligation to pay the remaining unpaid contracted rate owed the preferred provider.

(j) An insurer that pays a penalty under this section shall clearly indicate on the explanation of payment statement in the manner prescribed by the commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

(k) In addition to any other penalty or remedy authorized by this code, an insurer that violates Section 1301.103, 1301.104, or

1301.105 in processing more than two percent of clean claims submitted to the insurer is subject to an administrative penalty under Chapter 84. For each day an administrative penalty is imposed under this subsection, the penalty may not exceed $1,000 for each claim that remains unpaid in violation of Section 1301.103, 1301.104, or 1301.105. In determining whether an insurer has processed preferred provider claims in compliance with Section 1301.103, 1301.104, or 1301.105, the commissioner shall consider paid claims, other than claims that have been paid under Section 1301.105, and shall compute a compliance percentage for physician and provider claims, other than institutional provider claims, and a compliance percentage for institutional provider claims.

(l) Notwithstanding any other provision of this section, this subsection governs the payment of a penalty under this section. For a penalty under this section relating to a clean claim submitted by a preferred provider other than an institutional provider, the insurer shall pay the entire penalty to the preferred provider, except for any interest computed under Subsection (c), which shall be paid to the Texas Health Insurance Risk Pool. For a penalty under this section relating to a clean claim submitted by an institutional provider, the insurer shall pay 50 percent of the penalty amount computed under this section, including interest, to the institutional provider and the remaining 50 percent of that amount to the Texas Health Insurance Risk Pool.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 435 (S.B. 1884), Sec. 2, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 265 (H.B. 2064), Sec. 2, eff. January 1, 2010.

Acts 2023, 88th Leg., R.S., Ch. 90 (S.B. 1286), Sec. 4, eff. September 1, 2023.

Sec. 1301.138. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person described by Section

1301.109.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(b), eff. September 1, 2005.

Sec. 1301.139. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding payment of claims to preferred providers who are pharmacists or pharmacies apply to all insurers and pharmacy benefit managers unless otherwise prohibited by federal law.

Added by Acts 2011, 82nd Leg., R.S., Ch. 798 (H.B. 2292), Sec. 12, eff. September 1, 2011.

Sec. 1301.140. OUT-OF-POCKET EXPENSE CREDIT. (a) An insurer shall credit toward an insured's deductible and annual maximum out-of-pocket expenses an amount the insured pays directly to any physician or health care provider for a medically necessary covered medical or health care service or supply if a claim for the service or supply is not submitted to the insurer and the amount paid by the insured to the physician or health care provider is less than the average discounted rate for the service or supply paid to an equivalently licensed or authorized preferred provider under the insured's preferred provider benefit plan.

(b) An insurer shall:

(1) establish a procedure by which an insured may claim a credit under Subsection (a); and

(2) identify documentation necessary to support a claim for a credit under Subsection (a).

(c) Information about the procedure and documentation described by Subsection (b) must be readily accessible to an insured on the insurer's Internet website.

Added by Acts 2023, 88th Leg., R.S., Ch. 437 (H.B. 2002), Sec. 1, eff. September 1, 2023.

SUBCHAPTER D. RELATIONS BETWEEN INSUREDS AND PREFERRED PROVIDERS

Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured is entitled to treatment and diagnostic techniques that are

prescribed by the physician or health care provider included in the preferred provider benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An insurer shall establish reasonable procedures for ensuring a transition of insureds to physicians or health care providers and for continuity of treatment.

(b) An insurer shall:

(1) provide, subject to Section 1301.160, reasonable advance notice to an insured of the impending termination of the participation in the plan of a physician or health care provider who is currently treating the insured; and

(2) in the event of termination of a preferred provider's participation in the plan, make available to the insured a current listing of preferred providers.

(c) A contract between an insurer and a physician or health care provider must include a procedure for resolving disputes regarding the necessity for continued treatment by the physician or provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

(1) "Life-threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(2) "Special circumstances" means a condition regarding which the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the insured. Examples of an insured who has a special circumstance include an insured with a disability, acute condition, or life-threatening illness or an insured who is past the 24th week of pregnancy.

(b) Each contract between an insurer and a physician or health care provider must provide that the termination of the physician's or provider's participation in a preferred provider benefit plan, except for reason of medical competence or

professional behavior, does not:

(1) release the physician or health care provider from the generally recognized obligation to:

(A) treat an insured whom the physician or provider is currently treating; and

(B) cooperate in arranging for appropriate referrals; or

(2) release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured, at the same preferred provider rate if, at the time a physician's or provider's participation is terminated, an insured whom the physician or provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

(c) The treating physician or health care provider shall identify a special circumstance. The treating physician or health care provider shall:

(1) request that the insured be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the insured of any amount for which the insured would not be responsible if the physician or provider were still a preferred provider.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF INSURER. (a) Except as provided by Subsection (b), Sections 1301.152 and 1301.153 do not extend an insurer's obligation to reimburse the terminated physician or provider or, if applicable, the insured at the preferred provider level of coverage for ongoing treatment of an insured after:

(1) the 90th day after the effective date of the termination; or

(2) if the insured has been diagnosed as having a terminal illness at the time of the termination, the expiration of the nine-month period after the effective date of the termination.

(b) If an insured is past the 24th week of pregnancy at the time of termination, an insurer's obligation to reimburse, at the preferred provider level of coverage, the physician or provider or,

if applicable, the insured, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the six-week period after delivery.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.155. EMERGENCY CARE. (a) In this section, "emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(1) placing the person's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of a bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the usual and customary rate or at an agreed rate and at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition;

(3) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition; and

(4) supplies related to a service described by this subsection.

(c) For emergency care subject to this section or a supply

related to that care, an insurer shall make a payment required by this section directly to the out-of-network provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(d) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, a modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(e) This section may not be construed to require the imposition of a penalty under Section 1301.137.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1273 (H.B. 1357), Sec. 5, eff. March 1, 2010.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.08, eff. September 1, 2019.

Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer shall comply with Subchapter B, Chapter 542, with respect to prompt payment to insureds.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health insurance policy, health benefit plan certificate, endorsement, amendment, application, or rider must:

(1) be written in plain language;

(2) be in a readable and understandable format; and

(3) comply with all applicable requirements relating to minimum readability requirements.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" means:

(1) for group coverage, an individual or an individual's dependent who is eligible for coverage under a health insurance policy issued to the group; or

(2) for individual coverage, an individual or an individual's dependent who is eligible for coverage and who has expressed an interest in purchasing an individual health insurance policy.

(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.

(c) An insurer or an agent or representative of an insurer may not use or distribute, or permit the use or distribution of,

information for prospective insureds that is untrue or misleading.

(d) An insurer shall provide to an insured on request information on:

(1) whether a physician or other health care provider is a participating provider in the insurer's preferred provider network;

(2) whether proposed health care services are covered by the health insurance policy;

(3) what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and

(4) coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary reimbursement rate for out-of-network services.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 14, eff. September 1, 2007.

Sec. 1301.1581. INFORMATION CONCERNING EXCLUSIVE PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" has the meaning assigned by Section 1301.158.

(b) In addition to the information required to be provided under Section 1301.158, an insurer that offers an exclusive provider benefit plan shall provide to a current or prospective group contract holder or current or prospective insured notice that the benefit plan includes limited coverage for services provided by a physician or health care provider that is not a preferred provider.

(c) An identification card or similar document issued by an insurer to an insured in an exclusive provider benefit plan must display:

(1) the first date on which the insured became insured under the plan;

(2) a toll-free number that a physician or health care provider may use to obtain the date on which the insured became insured under the plan; and

(3) the acronym "EPO" or the phrase "Exclusive

Provider Organization" on the card in a location of the insurer's choice.

Added by Acts 2011, 82nd Leg., R.S., Ch. 288 (H.B. 1772), Sec. 10, eff. September 1, 2011.

Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A current list of preferred providers shall be provided to each insured at least annually.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.1591. PREFERRED PROVIDER INFORMATION ON INTERNET. (a) An insurer subject to this chapter that maintains an Internet site shall list on the Internet site the preferred providers, including, if appropriate, mental health providers and substance abuse treatment providers, that insureds may use in accordance with the terms of the insured's preferred provider benefit plan. The listing must identify those preferred providers who continue to be available to provide services to new patients or clients.

(b) The insurer shall update at least quarterly an Internet site subject to this section.

(c) The commissioner may adopt rules as necessary to implement this section. The rules may govern the form and content of the information required to be provided under Subsection (a).

(d) Notwithstanding any other provision of this chapter, this section applies to an entity subject to Chapter 941 or 942 and to a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.036(a), eff. September 1, 2005.

Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's participation in a preferred provider benefit plan is terminated for a reason other than at the practitioner's request, an insurer may not notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) the time at which a review panel makes a formal

recommendation regarding the termination.

(b) A physician or health care provider that voluntarily terminates the physician's or provider's participation in a preferred provider benefit plan shall provide reasonable notice to each insured under the physician's or provider's care. The insurer shall provide assistance to the physician or provider in ensuring that the notice requirements of this subsection are met.

(c) If a practitioner's participation in a preferred provider benefit plan is terminated for reasons related to imminent harm, an insurer may notify insureds immediately.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An insurer may not engage in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has:

(1) filed a complaint against the insurer or against a preferred provider; or

(2) appealed a decision of the insurer.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.162. IDENTIFICATION CARD. An identification card or other similar document issued by an insurer regulated by this code and subject to this chapter to an individual insured must display:

(1) the first date on which the individual became insured under the plan; or

(2) a toll-free number a physician or health care provider may use to obtain that date.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.037(e), eff. September 1, 2005.

Sec. 1301.163. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person to whom an insurer contracts to:

(1) process or pay claims;

(2) obtain the services of physicians or other providers to provide health care services to enrollees; or

(3) issue verifications or preauthorizations.

Added by Acts 2007, 80th Leg., R.S., Ch. 997 (S.B. 1731), Sec. 15, eff. September 1, 2007.

Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDERS. (a) In this section, "facility-based provider" means a physician or health care provider who provides medical care or health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), an insurer shall pay for a covered medical care or health care service performed for or a covered supply related to that service provided to an insured by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a preferred provider. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, a modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an insured elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the insured that:

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

(e) This section may not be construed to require the imposition of a penalty under Section 1301.137.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.09, eff. September 1, 2019.

Sec. 1301.165. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), an insurer shall pay for a covered medical care or health care service performed by or a covered supply related to that service provided to an insured by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a medical care or health care service performed by a preferred provider. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an

electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, the modified amount as determined under the insurer's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an insured elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the insured that:

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

(e) This section may not be construed to require the

imposition of a penalty under Section 1301.137.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.09, eff. September 1, 2019.

For expiration of this section, see Subsection (g).

Sec. 1301.166. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), an insurer shall pay for a covered medical care or health care service performed for, or a covered supply or covered transport related to that service provided to, an insured by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) An insurer shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The insurer shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those

services that includes all information necessary for the insurer to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply or transport described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that is based on:

(1) the amount initially determined payable by the insurer; or

(2) if applicable, the modified amount as determined under the insurer's internal appeal process.

(f) This section may not be construed to require the imposition of a penalty under Section 1301.137.

(g) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 8, eff. September 1, 2023.

## SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE FIRST ASSISTANTS. A preferred provider may not refuse to:

(1) contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network; or

(2) reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1301.202. CONTRACTS WITH HOSPITALS. (a) An insurer that contracts with hospitals to provide services to insureds under a preferred provider benefit plan may not deny a hospital the opportunity to participate in providing health care services as a preferred provider solely because the hospital is not accredited by

the Joint Commission on Accreditation of Healthcare Organizations or another specified national accrediting body. If a hospital is certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or another national accrediting body, an insurer shall accept that certification or accreditation.

(b) This section does not limit an insurer's authority to establish other reasonable terms under which a hospital may provide health care services to individuals covered by a preferred provider benefit plan.

(c) On the request of a hospital, the commissioner shall conduct an investigation, review, hearing, or other proceeding to determine whether an insurer is complying with this section.

(d) The commissioner shall take reasonable action to ensure compliance with this section, including issuing orders and imposing sanctions.

Added by Acts 2005, 79th Leg., Ch. 1305 (H.B. 2999), Sec. 1, eff. June 18, 2005.