By: Bonnen of Galveston, Oliverson, et al. H.B. No. 2760

Substitute the following for H.B. No. 2760:

By: Phillips C.S.H.B. No. 2760

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan provider networks; authorizing an assessment.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 842.261, Insurance Code, is amended by adding Subsections (a-1) and (a-2) and amending Subsection (c) to read as follows:

(a-1) The listing required by Subsection (a) must meet the requirements of a provider directory under Sections 1451.504 and 1451.505. The group hospital service corporation is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing.

(a-2) Notwithstanding Subsection (b), a group hospital service corporation shall update the listing required by Subsection (a) at least once every five business days.

(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 this section [~~Subsection (a)~~].

SECTION 2. Section 843.2015, Insurance Code, is amended by adding Subsections (a-1) and (a-2) and amending Subsection (c) to read as follows:

(a-1) The listing required by Subsection (a) must meet the

requirements of a provider directory under Sections 1451.504 and 1451.505. The health maintenance organization is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing.

(a-2) Notwithstanding Subsection (b), the health maintenance organization shall update the listing required by Subsection (a) at least once every five business days.

(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 this section [~~Subsection (a)~~].

SECTION 3. Sections 1301.0056(a) and (d), Insurance Code, are amended to read as follows:

(a) The commissioner shall [~~may~~] examine an insurer to determine the quality and adequacy of a network used by a preferred provider benefit plan or an exclusive provider benefit plan offered by the insurer under this chapter. An insurer is subject to a qualifying examination of the insurer's preferred provider benefit plans and exclusive provider benefit plans and subsequent quality of care and network adequacy examinations by the commissioner at least once every two [~~five~~] years. 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.

(d) The department shall deposit an assessment collected under this section to the credit of the account described by Section

401.156(a) [~~Texas Department of Insurance operating account~~]. 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.

SECTION 4. Section 1301.1591, Insurance Code, is amended by adding Subsections (a-1) and (a-2) and amending Subsection (c) to read as follows:

(a-1) The listing required by Subsection (a) must meet the requirements of a provider directory under Sections 1451.504 and 1451.505. The insurer is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing.

(a-2) Notwithstanding Subsection (b), an insurer shall update the listing required by Subsection (a) at least once every five business days.

(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 this section [~~Subsection (a)~~].

SECTION 5. Section 1451.504(b), Insurance Code, is amended to read as follows:

(b) The directory must include the name, specialty, if any, street address, and telephone number of each physician and health care provider described by Subsection (a) and indicate whether the physician or provider is accepting new patients.

SECTION 6. The heading to Section 1451.505, Insurance Code, is amended to read as follows:

Sec. 1451.505. ACCESSIBILITY AND ACCURACY OF PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORY [~~ON INTERNET WEBSITE~~].

SECTION 7. Section 1451.505, Insurance Code, is amended by amending Subsections (c), (d), and (e) and adding Subsections (d-1), (d-2), (d-3), and (f) through (p) to read as follows:

(c) The directory must be:

(1) electronically searchable by physician or health care provider name, specialty, if any, and location; and

(2) publicly accessible without necessity of providing a password, a user name, or personally identifiable information.

(d) The health benefit plan issuer shall conduct an ongoing review of the directory and correct or update the information as necessary. Except as provided by Subsections (d-1), (d-2), (d-3), and (f) [~~Subsection (e)~~], corrections and updates, if any, must be made not less than once every five business days [~~each month~~].

(d-1) Except as provided by Subsection (d-2), the health benefit plan issuer shall update the directory to:

(1) list a physician or health care provider not later than three business days after the effective date of the physician's or health care provider's contract with the health benefit plan issuer; or

(2) remove a physician or health care provider not later than three business days after the effective date of the termination of the physician's or health care provider's contract with the health benefit plan issuer.

(d-2) Except as provided by Subsection (d-3), if the

termination of the physician's or health care provider's contract with the health benefit plan issuer was not at the request of the physician or health care provider and the health benefit plan issuer is subject to Section 843.308 or 1301.160, the health benefit plan issuer shall remove the physician or health care provider from the directory not later than three business days after the later of:

(1) the date of a formal recommendation under Section 843.306 or 1301.057, as applicable; or

(2) the effective date of the termination.

(d-3) If the termination was related to imminent harm, the health benefit plan issuer shall remove the physician or health care provider from the directory in the time provided by Subsection (d-1)(2).

(e) The health benefit plan issuer shall conspicuously display in at least 10-point boldfaced font in the directory required by Section 1451.504 a notice that an individual may report an inaccuracy in the directory to the health benefit plan issuer or the department. The health benefit plan issuer shall include in the notice:

(1) an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in the directory to the health benefit plan issuer; and

(2) an e-mail address and Internet website address or link for the appropriate complaint division of the department.

(f) Notwithstanding any other law, if [~~If~~] the health benefit plan issuer receives an oral or written [~~a~~] report from any

person that specifically identified directory information may be inaccurate, the issuer shall:

(1) immediately:

(A) inform the individual of the individual's right to report inaccurate directory information to the department; and

(B) provide the individual with an e-mail address and Internet website address or link for the appropriate complaint division of the department;

(2) investigate the report and correct the information, as necessary, not later than:

(A) the third business [~~seventh~~] day after the date the report is received if the report concerns the health benefit plan issuer's representation of the network participation status of the physician or health care provider; or

(B) the fifth day after the date the report is received if the report concerns any other type of information in the directory; and

(3) promptly enter the report in the log required under Subsection (h).

(g) A health benefit plan issuer that receives an oral report that specifically identified directory information may be inaccurate may not require the individual making the oral report to file a written report to trigger the time limits and requirements of this section.

(h) The health benefit plan issuer shall create and maintain for inspection by the department a log that records all reports

received under this section or otherwise regarding inaccurate network directories or listings. The log required under this subsection must include supporting information as required by the commissioner by rule, including:

(1) the name of the person, if known, who reported the inaccuracy and whether the person is an insured, enrollee, physician, health care provider, or other individual;

(2) the alleged inaccuracy that was reported;

(3) the date of the report;

(4) steps taken by the health benefit plan issuer to investigate the report, including the date each of the steps was taken;

(5) the findings of the investigation of the report;

(6) a copy of the health benefit plan issuer's correction or update, if any, made to the network directory as a result of the investigation, including the date of the correction or update;

(7) proof that the health benefit plan issuer made the disclosure required by Subsection (f)(1); and

(8) the total number of reports received each month for each network offered by the health benefit plan issuer.

(i) A health benefit plan issuer shall submit the log required by Subsection (h) at least once annually on a date specified by the commissioner by rule and as otherwise required by Subsection (l).

(j) A health benefit plan issuer shall retain the log for three years after the last entry date unless the commissioner by

rule requires a longer retention period.

(k) The following elements of a log provided to the department under this section are confidential and are not subject to disclosure as public information under Chapter 552, Government Code:

(1) personally identifiable information or medical information about the individual making the report; and

(2) personally identifiable information about a physician or health care provider.

(l) If, in any 30-day period, the health benefit plan issuer receives three or more reports that allege the health benefit plan issuer's directory inaccurately represents a physician's or a health care provider's network participation status and that are confirmed by the health benefit plan issuer's investigation, the health benefit plan issuer shall immediately report that occurrence to the commissioner and provide to the department a copy of the log required by Subsection (h).

(m) The department shall review a log submitted by a health benefit plan issuer under Subsection (i) or (l). If the department determines that the health benefit plan issuer appears to have engaged in a pattern of maintaining an inaccurate network directory, the commissioner shall investigate the health benefit plan issuer's compliance with Subsections (d-1) and (d-2).

(n) A health benefit plan issuer investigated under this section shall pay the cost of the investigation in an amount determined by the commissioner.

(o) The department shall collect an assessment in an amount

determined by the commissioner from the health benefit plan issuer at the time of the investigation to cover all expenses attributable directly to the investigation, including the salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of this section. The department shall deposit an assessment collected under this section to the credit of the account described by Section 401.156(a).

(p) Money deposited under this section shall be used to pay the salaries and expenses of investigators and all other expenses related to the investigation of a health benefit plan issuer under this section.

SECTION 8. This Act takes effect September 1, 2017.