By: Hancock S.B. No. 2210

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan provider network listings and directories; 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. 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 4. 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 5. 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 6. 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 (j) 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 [~~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 four 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 four 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 four 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 the directory required by Section 1451.504 an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in the directory. If the issuer receives a report from any person that specifically identified directory

information may be inaccurate, the issuer shall investigate the report and correct the information, as necessary, not later than:

(1) the second 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

(2) the fifth day after the date the report is received if the report concerns any other type of information in the directory.

(f) 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.

(g) On receipt of a report under Subsection (f), the commissioner shall investigate the health benefit plan issuer's compliance with Subsections (d-1), (d-2), and (d-3).

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

(i) 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 Texas Department of Insurance operating account.

(j) 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 7. This Act takes effect September 1, 2017.