By: Hancock S.B. No. 2210

A BILL TO BE ENTITLED

AN ACT

relating to requirements for updating information provided by certain health benefit plans through the Internet.

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

SECTION 1. Sections 842.261(b) and (c), Insurance Code, are amended to read as follows:

(b) The group hospital service corporation shall update at least once every two business days [~~quarterly~~] an Internet site subject to this section and adhere to the requirements of Sections 1451.504 and 1451.505, including time frames for updating information, with regard to the Internet site listing required under 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 this section [~~Subsection (a)~~].

SECTION 2. Sections 843.2015(b) and (c), Insurance Code, are amended to read as follows:

(b) The health maintenance organization shall update at least once every two business days [~~quarterly~~] an Internet site subject to this section and adhere to the requirements of Sections 1451.504 and 1451.505, including time frames for updating information, with regard to the Internet site listing required under 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 this section [~~Subsection (a)~~].

SECTION 3. Sections 1301.1591(b) and (c), Insurance Code, are amended to read as follows:

(b) The insurer shall update at least once every two business days [~~quarterly~~] an Internet site subject to this section and adhere to the requirements of Sections 1451.504 and 1451.505, including time frames for updating information, with regard to the Internet site listing required under 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 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. Section 1451.505, Insurance Code, is amended by amending Subsections (c), (d), and (e) and adding Subsections (d-1), (d-2), 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), and [~~Subsection~~] (e), corrections and updates, if any, must be made not less than once every two business days [~~each month~~].

(d-1) The health benefit plan issuer must update the directory to:

(1) appropriately list a physician or health care provider not later than four business days after the effective date of a contract that establishes the physician or health care provider's network participation in a health benefit plan offered by the health benefit plan issuer; or

(2) remove from a corresponding network listing in the directory, not later than four business days after the effective date of the termination, a physician or health care provider who voluntarily requests termination of a contract on which the physician or health care provider's participation in a network used by a health benefit plan issued by the health benefit plan issuer is based.

(d-2) If a physician or health care provider's contract, on which network participation is based, is terminated for a reason other than the physician or health care provider's request, the health benefit plan issuer:

(1) if otherwise subject to the notification waiting

period of Section 843.308 or 1301.160 and the termination is not for a reason related to imminent harm:

(A) may not remove the physician or health care provider's corresponding network listing in the directory until the date described by Paragraph (B); and

(B) must remove the physician or health care provider's corresponding network listing in the directory not later than four business days after the later of:

(i) the effective date of the termination; or

(ii) the time at which a review panel makes a formal recommendation regarding the termination;

(2) if otherwise subject to the notification waiting period of Section 843.308 or 1301.160 and the termination is for a reason related to imminent harm:

(A) may remove the physician or health care provider's corresponding network listing in the directory immediately; and

(B) must remove the physician or health care provider's corresponding network listing in the directory not later than four business days after the effective date of the termination; or

(3) if not otherwise subject to the notification waiting period of Section 843.308 or 1301.160, must remove the physician or health care provider's corresponding network listing in the directory not later than four business days after the effective date of the termination.

(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 information identified in 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 information identified in 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 alleging that the health benefit plan issuer's directory erroneously listed a physician or health care provider as participating in a network used by a health benefit plan offered by the issuer when the physician or provider was not participating in that network or alleging that the health benefit plan issuer's directory erroneously listed a physician or health care provider as not participating in a network in which the physician or health care provider was participating and the health benefit plan issuer's investigation results in a finding that substantiates those allegations, the health benefit plan issuer shall immediately report this 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) and (d-2).

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

(i) The department shall deposit an assessment collected under this section to the credit of the Texas Department of Insurance operating account. Money deposited under this subsection shall be used to pay the salaries and expenses of investigators and all other expenses relating to the investigation of health benefit plan issuers under Subsection (g).

(j) The commissioner's authority under Subsection (g) is in addition to the authority of the commissioner to take any other action or order any other appropriate corrective action, sanction, or penalty under the authority of the commissioner in this code.

SECTION 6. This Act takes effect September 1, 2017.