BILL ANALYSIS

C.S.H.B. 1880
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been noted that adequate health benefit plan provider networks and accurate network directories help insured individuals select in-network providers, potentially reducing individual out-of-pocket costs and health care costs in general. Conversely, reports indicate that narrow provider networks and inaccurate and outdated provider directories prevent patients from making informed decisions, which adversely affects the patient down the line. C.S.H.B. 1880 seeks to address this issue by requiring health benefit plans to improve the quality and management of network adequacy and provider directories to ensure consumers have the information necessary to make a responsible decision when selecting a health care provider.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTION 7 of this bill.

ANALYSIS

C.S.H.B. 1880 amends the Insurance Code to require a physician and health care provider directory maintained by certain health benefit plan issuers to include the specialty, if any, of each physician or health care provider in the directory and to require the directory to be electronically searchable by specialty. The bill sets out specified deadlines by which an issuer is required to update the directory after a change in a physician's or provider's network participation status for a health benefit plan offered by the issuer. The bill revises the requirement that an issuer conspicuously display in the directory certain contact information so that any individual may report an inaccuracy in the directory to include the display of a certain notice. The bill sets out the required duties of an issuer that receives an oral or written report from any person that specifically identified directory information may be inaccurate and prohibits such an issuer from requiring an individual making such an oral report to file a written report to trigger those requirements.

C.S.H.B. 1880 requires an issuer to create and maintain for inspection by the Texas Department of Insurance (TDI) a log that records all reports regarding inaccurate network directories or listings and requires the log to include supporting information as required by the commissioner of insurance by rule, including specified information. The bill requires the issuer to submit the log, certain elements of which are confidential and not subject to disclosure under state public information law, at least once annually on a date specified by the commissioner by rule and as otherwise required, and to retain the log for three years after the last entry date unless the commissioner by rule requires a longer retention period. The bill requires an issuer to

immediately report to the commissioner an occurrence in which the issuer, in any 30-day period, receives three or more reports that allege the directory inaccurately represents a physician's or provider's network participation status and that are confirmed by the issuer's investigation and to provide to TDI a copy of the required log. The bill requires TDI to review an applicable log and requires the commissioner, if TDI determines that the issuer appears to have engaged in a pattern of maintaining an inaccurate network directory, to examine the issuer's compliance with the requirements to update the directory. The bill requires an issuer that is examined to pay the cost of the applicable examination in an amount determined by the commissioner. The bill requires TDI to collect an assessment in an amount determined by the commissioner from the issuer at the time of the examination to cover all expenses attributable directly to the examination and to deposit the assessment to the credit of the account with the Texas Treasury Safekeeping Trust Company. The bill requires such money to be used to pay the salaries and expenses of examiners and all other expenses related to the examination of an issuer.

C.S.H.B. 1880 subjects a group hospital service corporation, a health maintenance organization, an applicable preferred provider plan, and the listings of physicians and providers maintained by such entities, as applicable, to the requirements of provisions relating to physician and health care provider directories. The bill replaces the authorization for the commissioner to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer with a requirement to examine an insurer to determine the quality and adequacy of a network used by a preferred provider benefit plan offered by the insurer. The bill changes the frequency with which such an insurer is subject to such a qualifying examination from at least once every five years to at least once every three years and whenever the commissioner considers an examination necessary. The bill changes the account to which TDI is required to credit the deposit of an assessment collected to cover all expenses attributable directly to such examinations from the TDI operating account to an account with the Texas Treasury Safekeeping Trust Company that is used exclusively for certain purposes.

C.S.H.B. 1880 requires TDI, at the beginning of each calendar year, to review mediation request information collected by TDI for the preceding calendar year to identify, among certain insurers, the two insurers with the highest percentage of claims that are subject to mediation requests relating to out-of-network claim dispute resolution in comparison to other insurers offering health benefit plans subject to mediation for the reviewed year. The bill requires TDI, not later than May 1 of each year, to examine any insurer so identified to determine the quality and adequacy of networks offered by the insurer. The bill makes documentation provided to the commissioner during an examination confidential and not subject to disclosure under state public information law. The bill requires an insurer that is examined to pay the cost of the examination in an amount determined by the commissioner. The bill requires TDI to 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 and to deposit the assessment to the credit of the account with the Texas Treasury Safekeeping Trust Company. The bill requires such money to be used to pay the salaries and expenses of examiners and all other expenses related to the examination of an insurer. The bill establishes that the examination is in addition to any examination of an insurer required by other law. The bill requires the commissioner to publish and make available on the TDI website for at least 10 years after the date of such an examination information regarding the examination, including the name of an insurer and health benefit plan whose networks were examined and each year in which the insurer was subject to an examination.

C.S.H.B. 1880 with regard to termination of the provider network or preferred provider contract between a physician, practitioner, health care provider, or facility and an insurer without cause:

- requires an insurer, on the 15th day of each month, to give certain notification to TDI of the total number of terminations without cause made by the insurer during the preceding month with respect to a health benefit plan that is subject to provisions related to out-of-network claim dispute resolution;

- authorizes TDI to investigate any insurer notifying TDI of a significant number of terminations without cause;
- requires the investigation to emphasize such terminations that may impact the quality or adequacy of the plan's network or that occur within the first three months after an open enrollment period closes;
- requires TDI to impose an administrative penalty on an insurer if TDI makes a determination that such terminations caused, wholly or partly, an inadequate network to be used by a plan that is offered by the insurer; and
- prohibits TDI from granting a waiver from any related network adequacy requirements to an insurer offering a plan with an inadequate network caused, wholly or partly, by terminations without cause.

The bill makes personally identifiable information regarding a physician or practitioner included in documentation provided to or collected by TDI for the purposes of these provisions confidential and not subject to disclosure under state public information law.

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1880 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute retains a provision removed in the original requiring the commissioner to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer.

The substitute changes the frequency with which an insurer is subject to subsequent quality of care and network adequacy examinations from at least once every two years to at least once every three years.

The substitute revises the conditions under which a health benefit plan issuer is required to update and correct the physician and health care provider directory.