By: Davis of Harris H.B. No. 1880

A BILL TO BE ENTITLED

AN ACT

relating to health benefit plan provider networks; providing an administrative penalty; 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 Subsection (a-1) 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. Notwithstanding Subsection (b), the group hospital service corporation is subject to the requirements of Sections 1451.504 and 1451.505, including, with respect to the listing, the time limits for updating the Internet site to reflect directory corrections and updates.

(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 Subsection (a-1) 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. Notwithstanding Subsection (b), the health maintenance

1 organization is subject to the requirements of Sections 1451.504
2 and 1451.505, including, with respect to the listing, the time
3 limits for updating the Internet site to reflect directory
4 corrections and updates.
5 (c) The commissioner may adopt rules as necessary to
6 implement this section. The rules may govern the form and content
7 of the information required to be provided under this section
8 [Subsection (a)].
9 SECTION 3. Sections 1301.0056(a) and (d), Insurance Code,
10 are amended to read as follows:
11 (a) The commissioner shall [may] examine an insurer to
12 determine the quality and adequacy of a network used by a preferred
13 provider benefit plan or an exclusive provider benefit plan offered
14 by the insurer under this chapter. An insurer is subject to a
15 qualifying examination of the insurer's preferred provider benefit
16 plans and exclusive provider benefit plans and subsequent quality
17 of care and network adequacy examinations by the commissioner at
18 least once every three [five] years and whenever the commissioner
19 considers an examination necessary. Documentation provided to the
20 commissioner during an examination conducted under this section is
21 confidential and is not subject to disclosure as public information
22 under Chapter 552, Government Code.
23 (d) The department shall deposit an assessment collected
24 under this section to the credit of the [Texas Department of
25 Insurance operating] account with the Texas Treasury Safekeeping
26 Trust Company described by Section 401.156. Money deposited under
27 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 Subsection (a-1) 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. Notwithstanding Subsection (b), the insurer is subject to the requirements of Sections 1451.504 and 1451.505, including, with respect to the listing, the time limits for updating the Internet site to reflect directory corrections and updates.

(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), 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), and (f) [~~Subsection (e)~~], corrections and updates, if any, must be made not less than once each month.

(d-1) Except as provided by Subsection (d-2), the health benefit plan issuer shall update the directory to reflect a change in a physician's or provider's network participation status not later than two business days after the effective date of the change.

(d-2) If the termination of the physician's or health care provider's contract 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 update the directory to reflect the change in the physician's or provider's network participation status not later than two 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.

(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 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

1 (B) the fifth day after the date the report is
2 received if the report concerns any other type of information in the
3 directory; and
4 (3) promptly enter the report in the log required
5 under Subsection (h).
6 (g) A health benefit plan issuer that receives an oral
7 report that specifically identified directory information may be
8 inaccurate may not require the individual making the oral report to
9 file a written report to trigger the time limits and requirements of
10 this section.
11 (h) The health benefit plan issuer shall create and maintain
12 for inspection by the department a log that records all reports
13 regarding inaccurate network directories or listings. The log
14 required under this subsection must include supporting information
15 as required by the commissioner by rule, including:
16 (1) the name of the person, if known, who reported the
17 inaccuracy and whether the person is an insured, enrollee,
18 physician, health care provider, or other individual;
19 (2) the alleged inaccuracy that was reported;
20 (3) the date of the report;
21 (4) steps taken by the health benefit plan issuer to
22 investigate the report, including the date each of the steps was
23 taken;
24 (5) the findings of the investigation of the report;
25 (6) a copy of the health benefit plan issuer's
26 correction or update, if any, made to the network directory as a
27 result of the investigation, including the date of the correction

1 or update;

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

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

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

10 (j) A health benefit plan issuer shall retain the log for
11 three years after the last entry date unless the commissioner by
12 rule requires a longer retention period.

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

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

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

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

1 required by Subsection (h).

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

8 (n) A health benefit plan issuer examined under this section
9 shall pay the cost of the examination in an amount determined by the
10 commissioner.

11 (o) The department shall collect an assessment in an amount
12 determined by the commissioner from the health benefit plan issuer
13 at the time of the examination to cover all expenses attributable
14 directly to the examination, including the salaries and expenses of
15 department employees and all reasonable expenses of the department
16 necessary for the administration of this section. The department
17 shall deposit an assessment collected under this section to the
18 credit of the account with the Texas Treasury Safekeeping Trust
19 Company described by Section 401.156.

20 (p) Money deposited under this section shall be used to pay
21 the salaries and expenses of examiners and all other expenses
22 related to the examination of a health benefit plan issuer under
23 this section.

24 SECTION 8. The heading to Chapter 1467, Insurance Code, is
25 amended to read as follows:

26 CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION; NETWORK
27 ADEQUACY

1 SECTION 9. The heading to Subchapter D, Chapter 1467,
2 Insurance Code, is amended to read as follows:
3 SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION; NETWORK ADEQUACY
4 SECTION 10. Subchapter D, Chapter 1467, Insurance Code, is
5 amended by adding Sections 1467.152 and 1467.153 to read as
6 follows:
7 Sec. 1467.152. NETWORK ADEQUACY EXAMINATIONS AND FEES. (a)
8 At the beginning of each calendar year, the department shall review
9 mediation request information collected by the department for the
10 preceding calendar year to identify the two insurers with the
11 highest percentage of claims that are subject to mediation requests
12 under this chapter in comparison to other insurers offering health
13 benefit plans subject to mediation for the reviewed year.
14 (b) Not later than May 1 of each year, the department shall
15 examine any insurer identified under Subsection (a) to determine
16 the quality and adequacy of networks offered by the insurer.
17 (c) Documentation provided to the commissioner during an
18 examination conducted under this section is confidential and is not
19 subject to disclosure as public information under Chapter 552,
20 Government Code.
21 (d) An insurer examined under this section shall pay the
22 cost of the examination in an amount determined by the
23 commissioner.
24 (e) The department shall collect an assessment in an amount
25 determined by the commissioner from the insurer at the time of the
26 examination to cover all expenses attributable directly to the
27 examination, including the salaries and expenses of department

1 employees and all reasonable expenses of the department necessary
2 for the administration of this section. The department shall
3 deposit an assessment collected under this section to the credit of
4 the account with the Texas Treasury Safekeeping Trust Company
5 described by Section 401.156.
6 (f) Money deposited under this section shall be used to pay
7 the salaries and expenses of examiners and all other expenses
8 related to the examination of an insurer under this section.
9 (g) An examination conducted by the department under this
10 section is in addition to any examination of an insurer required by
11 other law, including Section 1301.0056.
12 (h) The commissioner shall publish and make available on the
13 department's Internet website for at least 10 years after the date
14 of the examination information regarding an examination under this
15 section, including:
16 (1) the name of an insurer and health benefit plan
17 whose networks were examined under this section; and
18 (2) each year in which the insurer was subject to an
19 examination under this section.
20 Sec. 1467.153. TERMINATION WITHOUT CAUSE. (a) In this
21 section, "termination without cause" means the termination of the
22 provider network or preferred provider contract between a
23 physician, practitioner, health care provider, or facility and an
24 insurer for a reason other than:
25 (1) at the request of the physician, practitioner,
26 health care provider, or facility; or
27 (2) fraud or a material breach of contract.

1 (b) An insurer shall notify the department on the 15th day
2 of each month of the total number of terminations without cause made
3 by the insurer during the preceding month with respect to a health
4 benefit plan that is subject to this chapter. The notification
5 shall include information identifying:
6 (1) the type and number of physicians, practitioners,
7 health care providers, or facilities that were terminated;
8 (2) the location of the physician, practitioner,
9 health care provider, or facility that was terminated; and
10 (3) each health benefit plan offered by the insurer
11 that is affected by the termination.
12 (c) The department may investigate any insurer notifying
13 the department of a significant number of terminations without
14 cause with respect to a health benefit plan subject to this chapter.
15 The investigation must emphasize terminations without cause that:
16 (1) may impact the quality or adequacy of a health
17 benefit plan's network; or
18 (2) occur within the first three months after an open
19 enrollment period closes.
20 (d) Except for good cause shown, the department shall impose
21 an administrative penalty in accordance with Chapter 84 on an
22 insurer if the department makes a determination that the
23 terminations without cause made by an insurer caused, wholly or
24 partly, an inadequate network to be used by a health benefit plan
25 that is offered by the insurer. The department may not grant a
26 waiver from any related network adequacy requirements to an insurer
27 offering a health benefit plan with an inadequate network caused,

1 wholly or partly, by terminations without cause made by the
2 insurer.
3 (e) Personally identifiable information regarding a
4 physician or practitioner included in documentation provided to or
5 collected by the department under this section is confidential and
6 is not subject to disclosure as public information under Chapter
7 552, Government Code.
8 SECTION 11. This Act takes effect September 1, 2019.