BILL ANALYSIS

Senate Research Center
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C.S.S.B. 2210
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

When an individual signs up for a health plan, such as a preferred provider benefit plan (PPBP), exclusive provider benefit plan (EPBP), or health maintenance organization (HMO) plan, that individual is provided with a network of physicians and other health care providers (i.e., physicians and other health care providers that the health plan has a contract with to provide care).

If a health plan enrollee uses a physician or other health care provider who is not in their network, a greater out-of-pocket expense is typically incurred by the enrollee. If a network directory contains incorrect information, the enrollee could unexpectedly select an out-of-network provider and, as a result, pay more out-of-pocket. For this reason, it is important for health benefit plan issuers to maintain accurate network directories. Yet, there are many reports of health benefit plan issuers using outdated directories, which may make it difficult for enrollees to select and receive treatment in-network.

S.B. 2210 seeks to help remedy this situation by requiring health benefit plan issuers to generally update their network directories once every two business days, rather than monthly. This shorter timeframe is designed to ensure that consumers are able to make more informed decisions regarding the selection of their health plan and health care providers. The bill also adds that a provider's specialty, if any, be listed in the directory. In the case of a new contract with a physician or other health care provider or voluntary contract termination, S.B. 2210 requires a network directory to reflect that provider's change in network status within four business days.

If the health benefit plan issuer receives a report from any person that specifically identifies an inaccuracy in the directory information, the issuer shall investigate and correct the incorrect information not later than two business days after the report is received if the report concerns the issuer's representation of the network participation status of the physician or health care provider and not later than five days after the report is received regarding any other type of inaccurate information in the directory (e.g., address, specialty, acceptance of new patients, etc.).

If, in any 30-day period, a health benefit plan issuer receives three or more substantiated reports of directory inaccuracies regarding the network participation status of a physician or health care provider, the issuer shall immediately report this occurrence to the Texas Department of Insurance (TDI) commissioner and the commissioner shall investigate once the report is received. All costs of the investigation shall be paid by the health benefit plan issuer under investigation through an assessment that is deposited to TDI's operating account. (Original Author's / Sponsor's Statement of Intent)

C.S.S.B. 2210 amends current law relating to health benefit plan provider network listings and directories and authorizes an assessment.

RULEMAKING AUTHORITY

Rulemaking authority previously granted to the commissioner of insurance is modified in SECTION 1 (Section 842.261, Insurance Code), SECTION 2 (Section 843.2015, Insurance Code), and SECTION 3 (Section 1301.1591, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Sections 842.261, Insurance Code, by adding Subsections (a-1) and (a-2) and amending Subsection (c), as follows:

(a-1) Requires that the listing required by Subsection (a) (relating to requiring a group hospital service corporation (corporation) that maintains an Internet site to list certain information on the Internet site) meet the requirements of a provider directory under Sections 1451.504 (Physician and Health Care Provider Directories) and 1451.505 and provides that the 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) Requires that a corporation, notwithstanding Subsection (b) (relating to requiring that the corporation update the site at least quarterly) to update the required listing at least once every five business days.

(c) Authorizes the rules adopted by the commissioner of insurance (commissioner) to govern the form and content of the information required to be provided under this section, rather than under Subsection (a).

SECTION 2. Amends Sections 843.2015, Insurance Code, by adding Subsections (a-1) and (a-2) and amending Subsection (c), as follows:

(a-1) Requires that the listing required by Subsection (a) (relating to requiring a health maintenance organization (HMO) that maintains an Internet site to list certain information on the Internet site) meet the requirements of a provider directory under Sections 1451.504 and 1451.505 and provides that the HMO 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) Requires that an HMO, notwithstanding Subsection (b) (relating to requiring the HMO to update at least quarterly an Internet site), update the required listing at least once every five business days.

(c) Authorizes the rules adopted by the commissioner to govern the form and content of the information required to be provided under this section, rather than under Subsection (a).

SECTION 3. Amends Sections 1301.1591, Insurance Code, by adding Subsections (a-1) and (a-2) and amending Subsection (c), as follows:

(a-1) Requires that the listing required by Subsection (a) (relating to requiring a certain insurer that maintains an Internet site to list certain information on the Internet site) meet the requirements of a provider directory under Sections 1451.504 and 1451.505 and provides that 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) Requires that an insurer, notwithstanding Subsection (b) (relating to requiring the insurer to update at least quarterly an Internet site), update the required listing at least once every five business days.

(c) Authorizes the rules adopted by the commissioner to govern the form and content of the information required to be provided under this section, rather than under Subsection (a).

SECTION 4. Amends Section 1451.504(b), Insurance Code, to require the physician and provider directory (directory) to include the name, specialty, if any, street address, and telephone number of each physician and health care (provider) described by Subsection (a) (relating to

requiring a health benefit plan issuer (issuer) to develop and maintain a directory) and to indicate whether the physician or provider is accepting new patients.

SECTION 5. Amends the heading to Section 1451.505, Insurance Code, to read as follows:

Sec. 1451.505. ACCESSIBILITY AND ACCURACY OF PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORY.

SECTION 6. Amends Section 1451.505, Insurance Code, by amending Subsections (c), (d), and (e) and adding Subsections (d-1), (d-2), (d-3), and (f) through (j), as follows:

(c) Requires that the directory be electronically searchable by physician or provider name, specialty, if any, and location.

(d) Requires that any corrections and updates to the directory, except as provided by Subsections (d-1), (d-2), (d-3), and (e), be made not less than once every five business days, rather than requires that any corrections and updates to the directory, except as provided by Subsection (e), be made not less than once each month.

(d-1) Requires the issuer, except as provided by Subsection (d-2), to update the directory to:

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

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

(d-2) Requires the issuer, except as provided by Subsection (d-3), if the termination of the physician's or provider's contract with the issuer was not at the request of the physician or provider and the issuer is subject to Section 843.308 (Notification of Patients of Deselected Physicians or Providers) or 1301.160 (Notification of Termination of Participation of Preferred Provider), to remove the physician or provider from the director not later than four business days after the later of a certain date.

(d-3) Requires the issuer, if the termination was related to imminent harm, to remove the physician or provider from the directory in the time provided by Subsection (d-1)(2).

(e) Requires the issuer, if the issuer receives a report from any person that specifically identified directory information may be inaccurate, to investigate the report and correct the information, as necessary, not later than a certain date.

(f) Requires the issuer, if, in any 30-day period, the issuer receives three or more reports that allege the issuer's directory inaccurately represents a physician's or a provider's network participation status and that are confirmed by the issuer's investigation, to immediately report that occurrence to the commissioner.

(g) Requires the commissioner, on receipt of a report under Subsection (f), to investigate the issuer's compliance with Subsections (d-1), (d-2), and (d-3).

(h) Requires an issuer investigated under this section to pay the cost of the investigation in an amount determined by the commissioner.

(i) Requires the Texas Department of Insurance (TDI) to collect an assessment in an amount determined by the commissioner from the issuer at the time of the investigation to cover all expenses attributable directly to the investigation, including the salaries and expenses of TDI employees and all reasonable expenses of TDI necessary for administration of this section. Requires TDI to deposit an assessment collected under this section to the credit of the TDI operating account.

(j) Requires that money deposited under this section be used to pay the salaries and expenses of investigators and all other expenses related to the investigation of an issuer under this section.

SECTION 7. Effective date: September 1, 2017.