SUBJECT: Requiring examination of insurer's network adequacy, directory updates

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Lucio, Oliverson, G. Bonnen, S. Davis, Julie Johnson, Lambert, Paul, C. Turner, Vo

0 nays

WITNESSES: For — John Scott, Texas Society of Anesthesiologists, Texas Medical Association; (*Registered, but did not testify*: Cynthia Humphrey, Association of Substance Abuse Programs; Will Francis, National Association of Social Workers-Texas Chapter; Daniel Chepkauskas, Patient Choice Coalition of Texas; Marshall Kenderdine, Texas Academy of Family Physicians, Texas Society for Gastroenterology and Endoscopy; Kyle Frazier, Texas Coalition for Quality Patient Care; Price Ashley, Texas College of Emergency Physicians; Shannon Noble, Texas Counseling Association; Cameron Duncan, Texas Hospital Association; Casey Haney, Texas Nurse Practitioners; Sandra Fortenberry, Texas Optometric Association; Tucker Frazier, Texas Pain Society; Jenna Courtney, Texas Radiological Society; Bonnie Bruce, Texas Society of Anesthesiologists; Idona Griffith)

Against — Jamie Dudensing, Texas Association of Health Plans

On — (*Registered, but did not testify*: Debra Diaz-Lara, Texas Department of Insurance)

BACKGROUND: Insurance Code secs. 842.261 and 843.2015 require group hospital service corporations and health maintenance organizations, respectively, that maintain a website to list on the site the physicians and providers that may be used by members or enrollees. Sec. 1301.1591 requires an insurer providing preferred provider benefit plans that maintains a website to list on its site the preferred providers that insureds could use.

Sec. 1451.504 requires a health benefit plan issuer that offers coverage

through preferred providers, exclusive providers, or a network of physicians or health care providers to develop and maintain a physician and health care provider directory. Under sec. 1451.505, the directory must be displayed on a public website.

Sec. 1301.0056 allows the commissioner of insurance to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer. An insurer is subject to a qualifying examination of the insurer's exclusive provider benefit plans and subsequent quality of care examinations by the commissioner at least once every five years.

Interested parties have noted that adequate health benefit plan provider networks and accurate network directories help insured individuals select in-network providers, which could reduce out-of-pocket expenses and health care costs in general. Some suggest requiring health benefit plans to improve the quality and management of network adequacy and provider directories.

DIGEST:

CSHB 1880 would require the Texas Department of Insurance (TDI) to conduct certain examinations and investigations related to the adequacy of health benefit plan provider networks and would revise provider directory requirements.

Revisions to examinations. CSHB 1880 would amend Insurance Code sec. 1301.0056 to require, rather than allow, the commissioner of insurance to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the provider. The commissioner also would examine preferred provider benefit plans offered by the provider.

The bill would expand qualifying examinations to include examinations of the insurer's preferred provider benefit plans and subsequent network adequacy examinations at least once every three years and whenever the commissioner considered necessary.

Mediation requests. CSHB 1880 would require TDI, at the beginning of each calendar year, to review mediation request information collected for the preceding year to identify the two insurers with the highest percentage of claims subject to mediation. No later than May 1, TDI would have to examine any identified insurers to determine the quality and adequacy of networks offered by the insurer.

This examination would be in addition to any examination of an insurer required by other law.

The commissioner would have to publish and make available on TDI's website for at least 10 years information regarding an examination, including the name of an insurer and health benefit plan and each year the insurer was subject to an examination.

Termination without cause. CSHB 1880 would require an insurer to notify TDI on the 15th day of each month of the total number of terminations without cause made by the insurer during the preceding month with respect to a health benefit plan. The notification would have to include information identifying:

- the type, number, and location of physicians, practitioners, health care providers, or facilities that were terminated; and
- each plan that was affected by the termination.

"Terminations without cause" would mean the termination of the provider network or preferred provider contract between a physician, practitioner, health care provider, or facility and an insurer for a reason other than at the request of the terminated party or for fraud or material breach of contract.

TDI could investigate any insurer that notified the department of a significant number of terminations without cause. The investigation would have to emphasize terminations that could impact the quality or adequacy of a health benefit plan's network or that occurred within the first three months after an open enrollment period closed.

Except for good cause shown, TDI would have to impose an administrative penalty on an insurer if it was determined that the terminations caused an inadequate network to be used by a health benefit plan offered by the insurer. TDI could not grant a waiver from any related network adequacy requirements to the insurer.

Provider directory. The bill would subject a group hospital service corporation, health maintenance organization, and provider of a preferred provider plan to the requirements relating to physician and health care provider directories under Insurance Code secs. 1451.504 and 1451.505. The website listings of physicians and providers maintained by such entities also would be subject to those laws as amended by this bill.

A provider directory would have to include the specialty, if any, of each physician and health care provider and be searchable by specialty.

CSHB 1880 would require a health benefit plan issuer to update its provider directory to reflect a change in a physician's or provider's network participation status no later than two business days after the change.

If the termination of the contract was not at the request of the physician or provider and the health benefit plan issuer was subject to certain statutory notification requirements, the issuer would have to update the directory to reflect the change no later than two business days after the later of the date of a formal recommendation or the effective date of the termination.

The health benefit plan issuer would have to display a notice that an individual could report an inaccuracy in the directory to the issuer or TDI. The notice would have to include an email address and website for the appropriate complaint division of TDI.

Upon receipt of a report that identified information that could be inaccurate, the issuer would have to immediately inform the individual of his or her right to report inaccurate directory information to TDI and provide the individual with an email address and website for the

complaint division of the department. The issuer also would have to investigate the report and correct information as necessary. The action would have to be taken no later than the second business day after the report was received if it concerned the issuer's representation of the network participation status of a physician or health care provider or by the fifth day for other types of information. The issuer promptly would have to report in the log required by this bill.

The bill would prohibit a health benefit plan issuer that received an oral report that specifically identified directory information that could be inaccurate from requiring the individual to file a written report to trigger the time limits and requirements of this bill.

Inaccurate reports log. CSHB 1880 would require a health benefit plan issuer to create and maintain for inspection by TDI a log recording all reports regarding inaccurate network directories or listings. The log would have to include supporting information as required by TDI rule, including:

- the name of the person who reported the inaccuracy;
- whether the person was an insured, enrollee, physician, health care provider, or other individual;
- the alleged inaccuracy;
- the date of the report;
- steps taken to investigate the report;
- the findings of the investigation;
- a copy of the issuer's corrections, if any, to the directory;
- proof that the issuer made a required disclosure; and
- the total number of reports received each month.

The bill would require the issuer to submit the log at least once annually on a date specified by the commissioner by rule. The issuer would have to retain the log for three years after the last entry date.

If, in a 30-day period, the issuer received three or more reports that alleged the directory inaccurately represented a physician's or provider's network participation status and were confirmed by investigation, the

issuer would have to immediately report that occurrence to the commissioner and provide a copy of the log to TDI.

TDI would review the log and, upon determination that the issuer appeared to have engaged in a pattern of maintaining an inaccurate network directory, the commissioner would have to examine the issuer's compliance with provisions of this bill.

Examination assessments. CSHB 1880 would require an entity under examination to pay the cost of the examination. TDI would collect an assessment to cover all expenses attributable to the examination and deposit the money to an account with the Texas Treasury Safekeeping Trust Company. Money deposited could be used only to pay the salaries and expenses of examiners and other expenses related to the examination.

Confidential information. Certain information related to the examinations and investigations required by this bill would be made confidential and not subject to public disclosure laws, including:

- documentation provided to TDI during a mediation examination;
- personally identifiable information provided to TDI during investigation of terminations without cause; and
- personally identifiable information or medical information maintained in a provider directory report log.

The bill would take effect September 1, 2019.