BILL ANALYSIS

Senate Research Center

S.B. 2210
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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 Yet, there are many reports of health benefit plan issuers using outdated directories, which may make it difficult for enrollees to select and receive treatment in-network.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.

As proposed, S.B. 2210 amends current law relating to requirements for updating information provided by certain health benefit plans through the Internet.

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(b) and (c), Insurance Code, as follows:

(b) Requires the group hospital service corporation to update at least once every two business days, rather than quarterly, a website subject to this section (Information Available Through Internet Site) and adhere to the requirements of Sections 1451.504 (Physician and Health Care Provider Directories) and 1451.505 (Physician and Health Care Provider Directory on Internet Website), including time frames for updating information, with regard to the Internet site listing required under this section.

(c) Authorizes the commissioner of insurance (commissioner) to adopt rules as necessary to implement this section. Authorizes the rules 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(b) and (c), Insurance Code, as follows:

(b) Requires the health maintenance organization to update at least once every two business days, rather than quarterly, a website subject to this section (Information Available Through Internet Site) 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) Authorizes the commissioner to adopt rules as necessary to implement this section. Authorizes the rules to govern the form and content of the information required to be provided under this section, rather than Subsection (a).

SECTION 3. Amends Sections 1301.1591(b) and (c), Insurance Code, as follows:

(b) Requires the insurer to update at least once every two business days, rather than quarterly, a website subject to this section (Preferred Provider Information on Internet) 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) Authorizes the commissioner to adopt rules as necessary to implement this section. Authorizes the rules to govern the form and content of the information required to be provided under this section, rather than Subsection (a).

SECTION 4. Amends Section 1451.504(b), Insurance Code, to require the physician and health care 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 to display the directory on a public Internet website) and to indicate whether the physician or provider is accepting new patients.

SECTION 5. Amends Section 1451.505, Insurance Code, by amending Subsections (c), (d), and (e) and adding Subsections (d-1), (d-2), and (f) through (j), as follows:

(c) Makes a conforming change.

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

(d-1) Requires the health benefit plan issuer (issuer) to update the directory to appropriately list a physician or health care provider by a certain date or remove from a corresponding network listing in the directory, by a certain date, 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 issuer is based.

(d-2) Requires the issuer, 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, if otherwise subject to certain notification waiting periods and the termination is not for a reason related to imminent harm, to take certain actions in removing the physician or health care provider's corresponding network listing.

(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, by a certain date.

(f) Requires the issuer, if, in any 30-day period, the issuer receives three or more reports alleging that the 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 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 issuer's investigation results in a finding that substantiates those allegations, to immediately report this 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) and (d-2).

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

(i) Requires TDI to deposit an assessment collected under this section to the credit of the TDI operating account. Requires money deposited under this subsection to be used to pay the salaries and expenses of investigators and all other expenses relating to the investigation of issuers under Subsection (g).

(j) Provides that 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. Effective date: September 1, 2017.