

1-1 By: Hancock S.B. No. 2210
 1-2 (In the Senate - Filed March 10, 2017; March 29, 2017, read
 1-3 first time and referred to Committee on Business & Commerce;
 1-4 May 11, 2017, reported adversely, with favorable Committee
 1-5 Substitute by the following vote: Yeas 9, Nays 0; May 11, 2017,
 1-6 sent to printer.)

1-7 COMMITTEE VOTE

	Yea	Nay	Absent	PNV
1-8 Hancock	X			
1-9 Creighton	X			
1-10 Campbell	X			
1-11 Estes	X			
1-12 Nichols	X			
1-13 Schwertner	X			
1-14 Taylor of Galveston	X			
1-15 Whitmire	X			
1-16 Zaffirini	X			

1-18 COMMITTEE SUBSTITUTE FOR S.B. No. 2210 By: Hancock

1-19 A BILL TO BE ENTITLED
 1-20 AN ACT

1-21 relating to health benefit plan provider network listings and
 1-22 directories; authorizing an assessment.

1-23 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-24 SECTION 1. Section 842.261, Insurance Code, is amended by
 1-25 adding Subsections (a-1) and (a-2) and amending Subsection (c) to
 1-26 read as follows:

1-27 (a-1) The listing required by Subsection (a) must meet the
 1-28 requirements of a provider directory under Sections 1451.504 and
 1-29 1451.505. The group hospital service corporation is subject to the
 1-30 requirements of Sections 1451.504 and 1451.505, including the time
 1-31 limits for directory corrections and updates, with respect to the
 1-32 listing.

1-33 (a-2) Notwithstanding Subsection (b), a group hospital
 1-34 service corporation shall update the listing required by Subsection
 1-35 (a) at least once every five business days.

1-36 (c) The commissioner may adopt rules as necessary to
 1-37 implement this section. The rules may govern the form and content
 1-38 of the information required to be provided under this section
 1-39 [Subsection (a)].

1-40 SECTION 2. Section 843.2015, Insurance Code, is amended by
 1-41 adding Subsections (a-1) and (a-2) and amending Subsection (c) to
 1-42 read as follows:

1-43 (a-1) The listing required by Subsection (a) must meet the
 1-44 requirements of a provider directory under Sections 1451.504 and
 1-45 1451.505. The health maintenance organization is subject to the
 1-46 requirements of Sections 1451.504 and 1451.505, including the time
 1-47 limits for directory corrections and updates, with respect to the
 1-48 listing.

1-49 (a-2) Notwithstanding Subsection (b), the health
 1-50 maintenance organization shall update the listing required by
 1-51 Subsection (a) at least once every five business days.

1-52 (c) The commissioner may adopt rules as necessary to
 1-53 implement this section. The rules may govern the form and content
 1-54 of the information required to be provided under this section
 1-55 [Subsection (a)].

1-56 SECTION 3. Section 1301.1591, Insurance Code, is amended by
 1-57 adding Subsections (a-1) and (a-2) and amending Subsection (c) to
 1-58 read as follows:

1-59 (a-1) The listing required by Subsection (a) must meet the
 1-60 requirements of a provider directory under Sections 1451.504 and

2-1 1451.505. The insurer is subject to the requirements of Sections
2-2 1451.504 and 1451.505, including the time limits for directory
2-3 corrections and updates, with respect to the listing.

2-4 (a-2) Notwithstanding Subsection (b), an insurer shall
2-5 update the listing required by Subsection (a) at least once every
2-6 five business days.

2-7 (c) The commissioner may adopt rules as necessary to
2-8 implement this section. The rules may govern the form and content
2-9 of the information required to be provided under this section
2-10 [Subsection (a)].

2-11 SECTION 4. Section 1451.504(b), Insurance Code, is amended
2-12 to read as follows:

2-13 (b) The directory must include the name, specialty, if any,
2-14 street address, and telephone number of each physician and health
2-15 care provider described by Subsection (a) and indicate whether the
2-16 physician or provider is accepting new patients.

2-17 SECTION 5. The heading to Section 1451.505, Insurance Code,
2-18 is amended to read as follows:

2-19 Sec. 1451.505. ACCESSIBILITY AND ACCURACY OF PHYSICIAN AND
2-20 HEALTH CARE PROVIDER DIRECTORY [ON INTERNET WEBSITE].

2-21 SECTION 6. Section 1451.505, Insurance Code, is amended by
2-22 amending Subsections (c), (d), and (e) and adding Subsections
2-23 (d-1), (d-2), (d-3), and (f) through (j) to read as follows:

2-24 (c) The directory must be:

2-25 (1) electronically searchable by physician or health
2-26 care provider name, specialty, if any, and location; and

2-27 (2) publicly accessible without necessity of
2-28 providing a password, a user name, or personally identifiable
2-29 information.

2-30 (d) The health benefit plan issuer shall conduct an ongoing
2-31 review of the directory and correct or update the information as
2-32 necessary. Except as provided by Subsections (d-1), (d-2), (d-3),
2-33 and [Subsection] (e), corrections and updates, if any, must be made
2-34 not less than once every five business days [each month].

2-35 (d-1) Except as provided by Subsection (d-2), the health
2-36 benefit plan issuer shall update the directory to:

2-37 (1) list a physician or health care provider not later
2-38 than four business days after the effective date of the physician's
2-39 or health care provider's contract with the health benefit plan
2-40 issuer; or

2-41 (2) remove a physician or health care provider not
2-42 later than four business days after the effective date of the
2-43 termination of the physician's or health care provider's contract
2-44 with the health benefit plan issuer.

2-45 (d-2) Except as provided by Subsection (d-3), if the
2-46 termination of the physician's or health care provider's contract
2-47 with the health benefit plan issuer was not at the request of the
2-48 physician or health care provider and the health benefit plan
2-49 issuer is subject to Section 843.308 or 1301.160, the health
2-50 benefit plan issuer shall remove the physician or health care
2-51 provider from the directory not later than four business days after
2-52 the later of:

2-53 (1) the date of a formal recommendation under Section
2-54 843.306 or 1301.057, as applicable; or

2-55 (2) the effective date of the termination.

2-56 (d-3) If the termination was related to imminent harm, the
2-57 health benefit plan issuer shall remove the physician or health
2-58 care provider from the directory in the time provided by Subsection
2-59 (d-1)(2).

2-60 (e) The health benefit plan issuer shall conspicuously
2-61 display in the directory required by Section 1451.504 an e-mail
2-62 address and a toll-free telephone number to which any individual
2-63 may report any inaccuracy in the directory. If the issuer receives
2-64 a report from any person that specifically identified directory
2-65 information may be inaccurate, the issuer shall investigate the
2-66 report and correct the information, as necessary, not later than:

2-67 (1) the second business [seventh] day after the date
2-68 the report is received if the report concerns the health benefit
2-69 plan issuer's representation of the network participation status of

3-1 the physician or health care provider; or
3-2 (2) the fifth day after the date the report is received
3-3 if the report concerns any other type of information in the
3-4 directory.

3-5 (f) If, in any 30-day period, the health benefit plan issuer
3-6 receives three or more reports that allege the health benefit plan
3-7 issuer's directory inaccurately represents a physician's or a
3-8 health care provider's network participation status and that are
3-9 confirmed by the health benefit plan issuer's investigation, the
3-10 health benefit plan issuer shall immediately report that occurrence
3-11 to the commissioner.

3-12 (g) On receipt of a report under Subsection (f), the
3-13 commissioner shall investigate the health benefit plan issuer's
3-14 compliance with Subsections (d-1), (d-2), and (d-3).

3-15 (h) A health benefit plan issuer investigated under this
3-16 section shall pay the cost of the investigation in an amount
3-17 determined by the commissioner.

3-18 (i) The department shall collect an assessment in an amount
3-19 determined by the commissioner from the health benefit plan issuer
3-20 at the time of the investigation to cover all expenses attributable
3-21 directly to the investigation, including the salaries and expenses
3-22 of department employees and all reasonable expenses of the
3-23 department necessary for the administration of this section. The
3-24 department shall deposit an assessment collected under this section
3-25 to the credit of the Texas Department of Insurance operating
3-26 account.

3-27 (j) Money deposited under this section shall be used to pay
3-28 the salaries and expenses of investigators and all other expenses
3-29 related to the investigation of a health benefit plan issuer under
3-30 this section.

3-31 SECTION 7. This Act takes effect September 1, 2017.

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