Amend **SB 1742** on third reading by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ____. Section 843.321, Insurance Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) A health maintenance organization or health maintenance organization's agent that provides a notice under Subsection (a)(3) must provide the notice to a physician or provider, including a licensed clinical social worker, in a manner that is trackable and indicates the date and time the notice was sent, including:

(1) by certified mail, return receipt requested, to the physician's or provider's address; or

(2) by e-mail to an e-mail address specified by the physician or provider.

SECTION ____. Section 1301.136, Insurance Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) An insurer or insurer's agent that provides a notice under Subsection (a)(3) must provide the notice to a preferred provider, including a licensed clinical social worker, in a manner that is trackable and indicates the date and time the notice was sent, including:

(1) by certified mail, return receipt requested, to the preferred provider's address; or

(2) by e-mail to an e-mail address specified by the preferred provider.

SECTION ____. Chapter 1452, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. CREDENTIALING OF PHYSICIANS AND PROVIDERS BY MANAGED CARE PLAN ISSUER

Sec. 1452.251. DEFINITIONS. In this subchapter:

(1) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(2) "Health benefit plan" means a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a health maintenance organization operating under Chapter 843;

(iv) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(v) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(vi) a stipulated premium company operating under Chapter 884;

(vii) a fraternal benefit society operating under Chapter 885;

(viii) a Lloyd's plan operating under Chapter 941; or

(ix) an exchange operating under Chapter 942;

(B) a small employer health benefit plan written under Chapter 1501;

(C) a health benefit plan issued under Chapter 1551, 1575, 1579, or 1601; or

(D) a health benefit plan issued under the Medicaid managed care program under Chapter 533, Government Code.

(3) "Health care practitioner" means an individual, other than a physician, who is licensed to provide and provides health care services.

(4) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with physicians or health care practitioners and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers.

(5) "Participating provider" means a physician or health care practitioner who has contracted with a managed care plan issuer to provide services to enrollees.

(6) "Physician" means an individual licensed to practice medicine in this state.

Sec. 1452.252. PROMPT CREDENTIALING REQUIRED. A managed care plan issuer shall determine in a reasonable time in accordance with commissioner rule whether to credential a physician or health care practitioner who is not eligible for expedited credentialing under Subchapter C.

Sec. 1452.253. ELIGIBILITY REQUIREMENTS. To qualify for credentialing under this subchapter and payment under Section 1452.254, an applicant must:

(1) be licensed in this state by, and in good standing with, the Texas Medical Board or other appropriate licensing authority;

(2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include the applicant in the issuer's managed care plan network; and

(3) agree to comply with the terms of the applicable managed care plan's participating provider contract.

Sec. 1452.254. PAYMENT OF APPLICANT DURING CREDENTIALING PROCESS. (a) On election by the applicant after receiving notice under Subsection (b) and on agreement to participating provider contract terms by the applicant and managed care plan issuer, and for payment purposes only, the issuer shall treat the applicant as if the applicant is a participating provider in the managed care plan network when the applicant provides services to the managed care plan's enrollees, including:

(1) authorizing the applicant to collect copayments from the enrollees; and

(2) making payments to the applicant.

(b) On receipt of a credentialing application, a managed care plan issuer shall provide notice to the applicant of the effect of failure to meet the issuer's credentialing requirements under

Section 1452.255 if the applicant elects to be considered a participating provider under Subsection (a).

Sec. 1452.255. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that an applicant who made an election under Section 1452.254 does not meet the issuer's credentialing requirements:

(1) the managed care plan issuer may recover from the applicant an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Sec. 1452.256. ENROLLEE HELD HARMLESS. An enrollee in the managed care plan is not responsible and shall be held harmless for the difference between in-network copayments paid by the enrollee to an applicant who is determined to be ineligible under Section 1452.255 and the managed care plan's charges for out-of-network services. The applicant may not charge the enrollee for any portion of the amount that is not paid or reimbursed by the enrollee's managed care plan.

Sec. 1452.257. LIMITATION ON MANAGED CARE PLAN ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter is not subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant as if the applicant were a participating provider in the managed care plan network.

Sec. 1452.258. DEPARTMENT AUDIT. A managed care plan issuer shall make available all relevant information to the department to allow the department to audit the credentialing process to determine compliance with this subchapter.

Sec. 1452.259. PUBLIC INSURANCE COUNSEL REPORT. Using existing resources, the office of public insurance counsel shall create and publish an annual report on the counsel's Internet website of the largest managed care plan issuers in this state and include information for each issuer on:

(1) the issuer's network adequacy;

(2) the percentage of enrollees receiving a bill from an out-of-network provider due to provider charges unpaid by the issuer and the enrollee's responsibility under the managed care plan; and

(3) the impact of managed care plan issuer credentialing policies on network adequacy and enrollee payment of out-of-network charges.

SECTION ____. The heading to Chapter 1453, Insurance Code, is amended to read as follows:

CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES AND AMOUNTS UNDER MANAGED CARE PLAN

SECTION ____. Section 1453.001(1), Insurance Code, is amended to read as follows:

(1) "Health care provider" means:

(A) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services; or

(B) an individual who is licensed in this state to provide health care services, including a physician who is licensed to practice medicine in this state.

SECTION ____. Chapter 1453, Insurance Code, is amended by adding Section 1453.004 to read as follows:

Sec. 1453.004. NOTICE OF CHANGE TO REIMBURSEMENT AMOUNT. (a) A managed care entity shall provide to each health care provider, including a licensed clinical social worker, under contract with the managed care entity notice of any change to a reimbursement amount that will be paid to the health care provider for a good or service provided by the health care provider. The notice must be provided before the effective date of the change.

(b) The notice required by this section must be sent:

(1) directly to each health care provider that may be affected by the reimbursement amount change; and

(2) in a manner that is trackable and indicates the date and time the notice was sent, including:

(A) by certified mail, return receipt requested, to the provider's address; or

(B) by e-mail to an e-mail address specified by the provider.