Amend **SB 1742** (house committee printing) on third reading by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill as appropriate:

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

(a-1) The listing required by Subsection (a) must meet the requirements of a provider directory under Sections 1451.504 and 1451.505. Notwithstanding Subsection (b), the group hospital service corporation is subject to the requirements of Sections 1451.504 and 1451.505, including, with respect to the listing, the time limits for updating the Internet site to reflect directory corrections and updates.

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

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

(a-1) The listing required by Subsection (a) must meet the requirements of a provider directory under Sections 1451.504 and 1451.505. Notwithstanding Subsection (b), the health maintenance organization is subject to the requirements of Sections 1451.504 and 1451.505, including, with respect to the listing, the time limits for updating the Internet site to reflect directory corrections and updates.

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

SECTION ____. Sections 1301.0056(a) and (d), Insurance Code, are amended to read as follows:

(a) The commissioner shall [~~may~~] examine an insurer to determine the quality and adequacy of a network used by a preferred provider benefit plan or an exclusive provider benefit plan offered by the insurer under this chapter. An insurer is subject to a

qualifying examination of the insurer's preferred provider benefit plans and exclusive provider benefit plans and subsequent quality of care and network adequacy examinations by the commissioner at least once every three [~~five~~] years and whenever the commissioner considers an examination necessary. Documentation provided to the commissioner during an examination conducted under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(d) The department shall deposit an assessment collected under this section to the credit of the [~~Texas Department of Insurance operating~~] account with the Texas Treasury Safekeeping Trust Company described by Section 401.156. Money deposited under this subsection shall be used to pay the salaries and expenses of examiners and all other expenses relating to the examination of insurers under this section.

SECTION ____. Section 1301.1591, Insurance Code, is amended by adding Subsection (a-1) and amending Subsection (c) to read as follows:

(a-1) The listing required by Subsection (a) must meet the requirements of a provider directory under Sections 1451.504 and 1451.505. Notwithstanding Subsection (b), the insurer is subject to the requirements of Sections 1451.504 and 1451.505, including, with respect to the listing, the time limits for updating the Internet site to reflect directory corrections and updates.

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

SECTION ____. The heading to Section 1451.505, Insurance Code, is amended to read as follows:

Sec. 1451.505. ACCESSIBILITY AND ACCURACY OF PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORY [~~ON INTERNET WEBSITE~~].

SECTION ____. Section 1451.505, Insurance Code, is amended by amending Subsections (d) and (e) and adding Subsections (d-1), (d-2), and (f) through (p) to read as follows:

(d) The health benefit plan issuer shall conduct an ongoing review of the directory and correct or update the information as

necessary. Except as provided by Subsections (d-1), (d-2), and (f) [~~Subsection (e)~~], corrections and updates, if any, must be made not less than once each month.

(d-1) Except as provided by Subsection (d-2), the health benefit plan issuer shall update the directory to reflect a change in a physician's or provider's network participation status not later than two business days after the effective date of the change.

(d-2) If the termination of the physician's or health care provider's contract was not at the request of the physician or health care provider and the health benefit plan issuer is subject to Section 843.308 or 1301.160, the health benefit plan issuer shall update the directory to reflect the change in the physician's or provider's network participation status not later than two business days after the later of:

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

(2) the effective date of the termination.

(e) The health benefit plan issuer shall conspicuously display in at least 10-point boldfaced font in the directory required by Section 1451.504 a notice that an individual may report an inaccuracy in the directory to the health benefit plan issuer or the department. The health benefit plan issuer shall include in the notice:

(1) an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in the directory to the health benefit plan issuer; and

(2) an e-mail address and Internet website address or link for the appropriate complaint division of the department.

(f) Notwithstanding any other law, if [~~If~~] the health benefit plan issuer receives an oral or written [~~a~~] report from any person that specifically identified directory information may be inaccurate, the issuer shall:

(1) immediately:

(A) inform the individual of the individual's right to report inaccurate directory information to the department; and

(B) provide the individual with an e-mail address

and Internet website address or link for the appropriate complaint division of the department;

(2) investigate the report and correct the information, as necessary, not later than:

(A) the second business [~~seventh~~] day after the date the report is received if the report concerns the health benefit plan issuer's representation of the network participation status of the physician or health care provider; or

(B) the fifth day after the date the report is received if the report concerns any other type of information in the directory; and

(3) promptly enter the report in the log required under Subsection (h).

(g) A health benefit plan issuer that receives an oral report that specifically identified directory information may be inaccurate may not require the individual making the oral report to file a written report to trigger the time limits and requirements of this section.

(h) The health benefit plan issuer shall create and maintain for inspection by the department a log that records all reports regarding inaccurate network directories or listings. The log required under this subsection must include supporting information as required by the commissioner by rule, including:

(1) the name of the person, if known, who reported the inaccuracy and whether the person is an insured, enrollee, physician, health care provider, or other individual;

(2) the alleged inaccuracy that was reported;

(3) the date of the report;

(4) steps taken by the health benefit plan issuer to investigate the report, including the date each of the steps was taken;

(5) the findings of the investigation of the report;

(6) a copy of the health benefit plan issuer's correction or update, if any, made to the network directory as a result of the investigation, including the date of the correction or update;

(7) proof that the health benefit plan issuer made the

disclosure required by Subsection (f)(1); and

(8) the total number of reports received each month for each network offered by the health benefit plan issuer.

(i) A health benefit plan issuer shall submit the log required by Subsection (h) at least once annually on a date specified by the commissioner by rule and as otherwise required by Subsection (l).

(j) A health benefit plan issuer shall retain the log for three years after the last entry date unless the commissioner by rule requires a longer retention period.

(k) The following elements of a log provided to the department under this section are confidential and are not subject to disclosure as public information under Chapter 552, Government Code:

(1) personally identifiable information or medical information about the individual making the report; and

(2) personally identifiable information about a physician or health care provider.

(l) If, in any 30-day period, the health benefit plan issuer receives three or more reports that allege the health benefit plan issuer's directory inaccurately represents a physician's or a health care provider's network participation status and that are confirmed by the health benefit plan issuer's investigation, the health benefit plan issuer shall immediately report that occurrence to the commissioner and provide to the department a copy of the log required by Subsection (h).

(m) The department shall review a log submitted by a health benefit plan issuer under Subsection (i) or (l). If the department determines that the health benefit plan issuer appears to have engaged in a pattern of maintaining an inaccurate network directory, the commissioner shall examine the health benefit plan issuer's compliance with Subsections (d-1) and (d-2).

(n) A health benefit plan issuer examined under this section shall pay the cost of the examination in an amount determined by the commissioner.

(o) The department shall collect an assessment in an amount determined by the commissioner from the health benefit plan issuer

at the time of the examination to cover all expenses attributable directly to the examination, including the salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of this section. The department shall deposit an assessment collected under this section to the credit of the account with the Texas Treasury Safekeeping Trust Company described by Section 401.156.

(p) Money deposited under this section shall be used to pay the salaries and expenses of examiners and all other expenses related to the examination of a health benefit plan issuer under this section.

SECTION _____. The heading to Chapter 1467, Insurance Code, is amended to read as follows:

CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION; NETWORK ADEQUACY

SECTION _____. The heading to Subchapter D, Chapter 1467, Insurance Code, is amended to read as follows:

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION; NETWORK ADEQUACY

SECTION _____. Subchapter D, Chapter 1467, Insurance Code, is amended by adding Sections 1467.152 and 1467.153 to read as follows:

Sec. 1467.152. NETWORK ADEQUACY EXAMINATIONS AND FEES. (a) At the beginning of each calendar year, the department shall review mediation request information collected by the department for the preceding calendar year to identify the two insurers with the highest percentage of claims that are subject to mediation requests under this chapter in comparison to other insurers offering health benefit plans subject to mediation for the reviewed year.

(b) Not later than May 1 of each year, the department shall examine any insurer identified under Subsection (a) to determine the quality and adequacy of networks offered by the insurer.

(c) Documentation provided to the commissioner during an examination conducted under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(d) An insurer examined under this section shall pay the cost of the examination in an amount determined by the

commissioner.

(e) The department shall collect an assessment in an amount determined by the commissioner from the insurer at the time of the examination to cover all expenses attributable directly to the examination, including the salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of this section. The department shall deposit an assessment collected under this section to the credit of the account with the Texas Treasury Safekeeping Trust Company described by Section 401.156.

(f) Money deposited under this section shall be used to pay the salaries and expenses of examiners and all other expenses related to the examination of an insurer under this section.

(g) An examination conducted by the department under this section is in addition to any examination of an insurer required by other law, including Section 1301.0056.

(h) The commissioner shall publish and make available on the department's Internet website for at least 10 years after the date of the examination information regarding an examination under this section, including:

(1) the name of an insurer and health benefit plan whose networks were examined under this section; and

(2) each year in which the insurer was subject to an examination under this section.

Sec. 1467.153. TERMINATION WITHOUT CAUSE. (a) In this section, "termination without cause" means 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:

(1) at the request of the physician, practitioner, health care provider, or facility; or

(2) fraud or a material breach of contract.

(b) An insurer shall notify the department 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 that is subject to this chapter. The notification shall include information identifying:

(1) the type and number of physicians, practitioners, health care providers, or facilities that were terminated;

(2) the location of the physician, practitioner, health care provider, or facility that was terminated; and

(3) each health benefit plan offered by the insurer that is affected by the termination.

(c) The department may investigate any insurer notifying the department of a significant number of terminations without cause with respect to a health benefit plan subject to this chapter. The investigation must emphasize terminations without cause that:

(1) may impact the quality or adequacy of a health benefit plan's network; or

(2) occur within the first three months after an open enrollment period closes.

(d) Except for good cause shown, the department shall impose an administrative penalty in accordance with Chapter 84 on an insurer if the department makes a determination that the terminations without cause made by an insurer caused, wholly or partly, an inadequate network to be used by a health benefit plan that is offered by the insurer. The department may not grant a waiver from any related network adequacy requirements to an insurer offering a health benefit plan with an inadequate network caused, wholly or partly, by terminations without cause made by the insurer.

(e) Personally identifiable information regarding a physician or practitioner included in documentation provided to or collected by the department under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.