BILL ANALYSIS

C.S.H.B. 2760
By: Bonnen, Greg
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties note the importance of health benefit plan issuers maintaining adequate networks and accurate network directories to prevent an insured from inadvertently selecting an out-of-network provider and paying higher out-of-pocket expenses. Concerns have been raised regarding reports of health benefit plan issuers using narrow networks and outdated directories. C.S.H.B. 2760 seeks to remedy this situation by providing for methods of improving network adequacy and management of network directories to ensure consumers are able to make more informed decisions regarding the selection of their health plans and health care providers.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 2760 amends the Insurance Code to include among the information required to be maintained in a physician and health care provider directory by certain health benefit plan issuers the specialty, if any, of each physician and health care provider in the directory and to require the directory to be electronically searchable by specialty. The bill changes from at least once every month to at least once every five business days the frequency with which a health benefit plan issuer is required to correct and update the directory, as applicable. The bill requires the health benefit plan issuer to update the directory to list a physician or health care provider not later than three business days after the effective date of the physician's or health care provider's contract with the health benefit plan issuer or to remove a physician or health care provider not later than three business days after the effective date of the termination of the physician's or health care provider's contract with the health benefit plan issuer. The bill provides for the deadlines by which the health benefit plan issuer is required to remove a physician or health care provider from the directory if the termination of the physician's or health care provider's contract with the health benefit plan issuer was related to imminent harm or was not at the request of the physician or health care provider and the health benefit plan issuer is subject to statutory provisions relating to the notification of patients of a deselected physician or provider or relating to the notification of termination of participation of a preferred provider. The bill revises the requirement for the health benefit plan issuer to conspicuously display in the required directory certain contact information that allows any individual to report any inaccuracy in the directory by requiring the health benefit plan issuer to display in a specified font a notice that an individual may report an inaccuracy in the directory to the health benefit plan issuer or the Texas Department of Insurance (TDI) and to include in the notice an email address and website address

or link for the appropriate complaint division of TDI.

C.S.H.B. 2760 requires a health benefit plan issuer that receives an oral or written report from any person that specifically identified directory information may be inaccurate to immediately inform the individual of the individual's right to report inaccurate directory information to TDI and provide the individual with an email address and website address or link for the appropriate complaint division of TDI. The bill requires such a health benefit plan issuer to promptly enter the report in the log required under the bill's provisions and revises the deadline by which the health benefit plan issuer is required to investigate the report and correct the information. The bill prohibits a health benefit plan issuer that receives such an oral report from requiring the individual making the oral report to file a written report to trigger the time limits and requirements of physician and health care provider directory provisions.

C.S.H.B. 2760 requires a health benefit plan issuer to create and maintain for inspection by TDI a log that records all reports received regarding inaccurate network directories or listings and requires the log to include certain supporting information as required by the commissioner of insurance by rule. The bill requires a health benefit plan issuer to submit the log at least once annually on a date specified by the commissioner by rule and as otherwise required by the bill and to retain the log for three years after the last entry date unless the commissioner by rule requires a longer retention period. The bill establishes that personally identifiable information or medical information about the individual making the report and personally identifiable information about a physician or health care provider contained in a log provided to TDI are confidential and are not subject to disclosure under state public information law. The bill requires the health benefit plan issuer, 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, to immediately report that occurrence to the commissioner and provide to TDI a copy of the health benefit plan issuer's log. The bill requires TDI to review a log submitted by a health benefit plan issuer and requires the commissioner, if TDI determines that the health benefit plan issuer appears to have engaged in a pattern of maintaining an inaccurate network directory, to investigate the health benefit plan issuer's compliance with the bill's provisions relating to updating and correcting the directory. The bill requires the health benefit plan issuer investigated under that provision to pay the cost of the investigation in an amount determined by the commissioner and requires TDI to collect an assessment in an amount determined by the commissioner from the health benefit plan issuer at the time of the investigation to cover all expenses attributable directly to the investigation. The bill requires TDI to deposit the collected assessment to the credit of an account with the Texas Treasury Safekeeping Trust Company that is used exclusively for certain purposes and requires the deposited money to be used to pay the salaries and expenses of investigators and all other expenses related to such an investigation of a health benefit plan issuer.

C.S.H.B. 2760 subjects a group hospital service corporation, a health maintenance organization, an insurer that is authorized to issue, deliver, or issue for delivery health insurance policies in Texas, and the listings of physicians, providers, and preferred providers listed by a group hospital service corporation, a health maintenance organization, and such an insurer, as applicable, to the requirements of provisions relating to physician and health care provider directories. The bill requires a group hospital service corporation, a health maintenance organization, and such an insurer to update its listing at least once every five business days.

C.S.H.B. 2760 replaces the commissioner's authorization to examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer with a requirement to 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 and increases the frequency with which the insurer is subject to a qualifying examination from at least once every five years to at least once every two years. The bill changes the account to which TDI is required to credit the deposit of an assessment collected to cover all

expenses attributable directly to such examinations from the TDI operating account to an account with the Texas Treasury Safekeeping Trust Company that is used exclusively for certain purposes.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2760 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 842.261, Insurance Code, is amended by adding Subsections (a-1) and (a-2) 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. The group hospital service corporation is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing. (a-2) Notwithstanding Subsection (b), a group hospital service corporation shall update the listing required by Subsection (a) at least once every business day. (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 1. Section 842.261, Insurance Code, is amended by adding Subsections (a-1) and (a-2) 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. The group hospital service corporation is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing. (a-2) Notwithstanding Subsection (b), a group hospital service corporation shall update the listing required by Subsection (a) at least once every five business days. (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 2. Section 843.2015, Insurance Code, is amended by adding Subsections (a-1) and (a-2) 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. The health maintenance organization is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing. (a-2) Notwithstanding Subsection (b), the health maintenance organization shall update the listing required by Subsection (a)	SECTION 2. Section 843.2015, Insurance Code, is amended by adding Subsections (a-1) and (a-2) 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. The health maintenance organization is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing. (a-2) Notwithstanding Subsection (b), the health maintenance organization shall update the listing required by Subsection (a)

at least once every business day.

(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 3. Section 1301.0056(a), Insurance Code, is 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 two [~~five~~] years. 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.

SECTION 4. Section 1301.1591, Insurance Code, is amended by adding Subsections (a-1) and (a-2) 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. The insurer is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing.

(a-2) Notwithstanding Subsection (b), an insurer shall update the listing required by

at least once every five business days.

(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 3. 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 two [~~five~~] years. 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 account described by Section 401.156(a) [~~Texas Department of Insurance operating account~~]. 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 4. Section 1301.1591, Insurance Code, is amended by adding Subsections (a-1) and (a-2) 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. The insurer is subject to the requirements of Sections 1451.504 and 1451.505, including the time limits for directory corrections and updates, with respect to the listing.

(a-2) Notwithstanding Subsection (b), an insurer shall update the listing required by

Subsection (a) at least once every business day.

(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 5. Section 1451.504(b), Insurance Code, is amended.

SECTION 6. The heading to Section 1451.505, Insurance Code, is amended.

SECTION 7. Section 1451.505, Insurance Code, is amended by amending Subsections (c), (d), and (e) and adding Subsections (d-1), (d-2), (d-3), and (f) through (p) to read as follows:

(c) The directory must be:

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

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

(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), (d-3), and (f) [~~Subsection (e)~~], corrections and updates, if any, must be made not less than once every business day [~~each month~~].

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

(1) list a physician or health care provider not later than two business days after the effective date of the physician's or health care provider's contract with the health benefit plan issuer; or

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

(d-2) Except as provided by Subsection (d-3), if the termination of the physician's or health care provider's contract with the health benefit plan issuer was not at the request of the physician or health care

Subsection (a) at least once every five business days.

(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 5. Same as introduced version.

SECTION 6. Same as introduced version.

SECTION 7. Same as introduced version.

provider and the health benefit plan issuer is subject to Section 843.308 or 1301.160, the health benefit plan issuer shall remove the physician or health care provider from the directory 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.

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

(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

provider and the health benefit plan issuer is subject to Section 843.308 or 1301.160, the health benefit plan issuer shall remove the physician or health care provider from the directory not later than three 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.

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

(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 third 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 received under this section or otherwise 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:

(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 received under this section or otherwise 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 investigate the health benefit plan issuer's compliance with Subsections (d-1) and (d-2).

(n) A health benefit plan issuer investigated under this section shall pay the cost of the investigation 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 investigation to cover all expenses attributable directly to the investigation, 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 Texas Department of Insurance operating account.

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

SECTION 8. The heading to Chapter 1467, Insurance Code, is amended to read as follows:

CHAPTER 1467. OUT-OF-NETWORK

(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 investigate the health benefit plan issuer's compliance with Subsections (d-1) and (d-2).

(n) A health benefit plan issuer investigated under this section shall pay the cost of the investigation 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 investigation to cover all expenses attributable directly to the investigation, 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 described by Section 401.156(a).

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

No equivalent provision.

CLAIM DISPUTE RESOLUTION; NETWORK ADEQUACY

SECTION 9. The heading to Subchapter D, Chapter 1467, Insurance Code, is amended to read as follows:

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION; NETWORK ADEQUACY

No equivalent provision.

SECTION 10. 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 total number of mediation requests under this chapter 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 Texas Department of Insurance operating account.

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

No equivalent provision.

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) the year in which the insurer had the highest or second highest total number of mediation requests under this chapter.

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 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.	
SECTION 11. This Act takes effect September 1, 2017.	SECTION 8. Same as introduced version.