BILL ANALYSIS

Senate Research Center

H.B. 1594
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State Affairs
5/3/2007
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

When a physician joins an established medical group that has a contract with a managed care plan there is a delay in credentialing. The delay causes patients to be at financial risk since the physician is required to bill any patients treated as "out-of-network" until the physician is considered to meet the plan's credentials and becomes part of the plan's network.

As it relates to health maintenance organization (HMO) plans, the Texas Department of Insurance requires that the HMO make a determination as to whether a physician meets the plan's credentials within one year from the time the application is submitted. Currently, there are no rules relating to preferred provider organization networks.

H.B. 1594 requires that it be determined whether a licensed physician in good standing with the Texas Medical Board who joins an established medical group that has a contract with a managed care plan meets or does not meet the necessary credentials of the managed care plan upon submission of all necessary documentation and information. This bill also authorizes a managed care plan to recover the difference between in-network benefits and out-of-network benefits if a physician fails to meet the managed care plan's credentials.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to any state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1452, Insurance Code, by adding Subchapter C, as follows:

SUBCHAPTER C. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PHYSICIANS

Sec. 1452.101. DEFINITIONS. Defines "applicant physician," "enrollee," "health care provider," "managed care plan," "medical group," and "participating provider."

Sec. 1452.102. APPLICABILITY. Provides that this subchapter applies only to a physician who joins an established medical group that has a current contract in force with a managed care plan.

Sec. 1452.103. ELIGIBILITY REQUIREMENTS. Requires an applicant physician, in order to qualify for expedited credentialing under this subchapter, to be licensed in this state by, and in good standing with, the Texas Medical Board, and to submit all documentation and other information required by the issuer of the managed care plan (issuer) as necessary to enable the issuer to begin the credentialing process required by the issuer to include a physician in the issuer's health benefit plan network.

Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. Requires the issuer, on submission by the applicant physician of the information required by the issuer under Section 1452.103(2), to treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides certain services to the managed care

plan's enrollees, including authorizing the applicant physician to collect copayments from enrollees and making payments to the applicant physician.

Sec. 1452.105. DIRECTORY ENTRIES. Authorizes the managed care plan, pending the approval of the application, to exclude the applicant physician from the managed care plan's directory of participating physicians, the managed care plan's website listing of participating physicians, or any other listing of participating physicians.

Sec. 1452.106. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. Authorizes the issuer to recover from the applicant physician or the physician's medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits and authorizes the applicant physician or the physician's medical group to retain any copayments collected or in the process of being collected as of the date of the issuer's determination, if, on completion of the credentialing process, the issuer determines that the applicant physician does not meet the issuer's credentialing requirements.

Sec. 1452.107. ENROLLEE HELD HARMLESS. Provides that an enrollee in the managed care plan is not responsible and requires that the enrollee be held harmless for the difference between in-network copayment paid by the enrollee to a physician who is determined to be ineligible under Section 1452.106 and the managed care plan's total payments for out-of-network services. Prohibits the physician and the physician's medical group from charging the enrollee for any portion of the physician's fee that is not paid or reimbursed by the enrollee's managed care plan.

SECTION 2. Makes application of this Act prospective.

SECTION 3. Effective date: September 1, 2007.