BILL ANALYSIS

C.S.H.B. 1594
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Currently, when a physician is newly licensed in Texas or moves to a new community to establish a practice, they are required to become 'credentialed' with the various health plans in that community. Although the health plans ultimately approve the credentials of the vast majority of physicians that apply, the process is often long.

Often, the physician joins a group of physicians who are credentialed and have contracts with those plans. However, the delay in the credentialing process puts patients at financial risk because until the plan approves the credentials of the physician, the physician is forced to bill the treated patient as an out-of-network patient, despite the fact that the physician is with a physician group that is contracted with the health plan.

This bill will assuage the issue of inadequate networks by expediting the process for applicant physician entry into various health plans when the physician joins an existing group that has a contract with the health plan.

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. 1594 relates to expedited credentialing for certain physicians providing services under a managed care plan. The bill amends Chapter 1452 of the Texas Insurance Code adding a subchapter that would discuss expediting the credentialing process for certain physicians.

The bill defines "applicant physician" as a physician applying for expedited credentialing under this subchapter and defines "enrollee" to mean an individual who is eligible to receive health care services under a managed care plan. Next, the bill defines "Health care provider" as an individual who is licensed, certified, or otherwise authorized to provide health care services in this state or a hospital, emergency clinic, outpatient clinic, or other facility providing health care services. A "Managed care plan" is defined as a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by the following: a health maintenance organization, a preferred provider benefit plan issuer; or any other entity that issues a health benefit plan, including an insurance company.

The bill then defines "Medical group" as a professional corporation or other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162 of the Occupations Code. "Participating provider" is defined as a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

Next, C.S.H.B. 1594 mentions the applicability of this subchapter and states that it applies only to a physician who joins an established medical group that has a current contract in force with a managed care plan. This bill also sets out the eligibility requirements for expedited credentialing, under this subchapter, that an applicant physician must meet. To qualify, the applicant physician must be licensed in this state by, and be in good standing with, the Texas Medical Board and the applicant physician must 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 a physician in the issuer's health benefit plan network.

C.S.H.B. 1594 then discusses payment of applicant physician during the credentialing process. The bill states that on submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), the issuer shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan's enrollees, including authorizing the applicant physician to collect copayments from the enrollees and making payments to the applicant physician.

The bill then discusses the effect of failure to meet credentialing requirements. It states that if, on completion of the credentialing process, the managed care plan issuer determines that the applicant physician does not meet the issuer's credentialing requirements the managed care plan issuer may 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-networks benefits and the applicant physician or the physician's medical group may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

C.S.H.B. 1594 further states that 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 a physician who is determined to be ineligible under Section 1452.105 and the managed care plan's total payments for out-of-network services. Also, the bill says that the physician and the physician's medical group may not charge the enrollee for any portion of the physician's fee that is not paid or reimbursed by the enrollee's managed care plan.

Lastly, the bill states that the change in law made by this Act applies only to credentialing of a physician under a contract entered into or renewed by a medical group and an issuer of a managed care plan on or after the effective date of this Act. A contract entered into or renewed before the effective date of this Act is governed by the law in effect immediately before that date, and that law is continued in effect for that purpose.

EFFECTIVE DATE

September 1, 2007.

COMPARISON OF ORIGINAL TO SUBSTITUTE

C.S.H.B. 1594 simply amends Section 1452.105 (1) by using the term "payments" instead of "charges" in regards to in-network benefits and out-of-network benefits. Also, C.S.H.B. 1594 amends Section 1452.106 to use the term "total payments" instead of "charges" regarding the total payments for out-of-network services.