House Bill 1594
Senate Amendments
Section-by-Section Analysis

HOUSE VERSION	SENATE VERSION	CONFERENCE
SECTION 1. Chapter 1452, Insurance Code, is amended by adding Subchapter C to read as follows: SUBCHAPTER C. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PHYSICIANS Sec. 1452.101. DEFINITIONS. In this subchapter: (1) "Applicant physician" means a physician applying for expedited credentialing under this subchapter. (2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan. (3) "Health care provider" means: (A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or (B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services. (4) "Managed care plan" means 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: (A) a health maintenance organization; (B) a preferred provider benefit plan issuer; or (C) any other entity that issues a health benefit plan, including an insurance company. (5) "Medical group" means a professional corporation or other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162, Occupations Code.	SECTION 1. Chapter 1452, Insurance Code, is amended by adding Subchapter C to read as follows: SUBCHAPTER C. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PHYSICIANS Sec. 1452.101. DEFINITIONS. In this subchapter: (1) "Applicant physician" means a physician applying for expedited credentialing under this subchapter. (2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan. (3) "Health care provider" means: (A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or (B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services. (4) "Managed care plan" means 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: (A) a health maintenance organization; (B) a preferred provider benefit plan issuer; or (C) any other entity that issues a health benefit plan, including an insurance company. (5) "Medical group" means a professional corporation or other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162, Occupations Code.	

HOUSE VERSION	SENATE VERSION	CONFERENCE
(6) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.	(6) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.	
Sec. 1452.102. APPLICABILITY. 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. 1452.102. APPLICABILITY. 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. To qualify for expedited credentialing under this subchapter, an applicant physician must:	Sec. 1452.103. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.104, an applicant physician must:	
(1) be licensed in this state by, and in good standing with, the Texas Medical Board; and	(1) be licensed in this state by, and in good standing with, the Texas Medical Board;	
(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 a physician in the issuer's health benefit plan network.	(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 a physician in the issuer's health benefit plan network; and	
	(3) agree to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant physician's established medical group.	
Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. 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:	Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. On submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), and for payment purposes only, 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,	

HOUSE VERSION	SENATE VERSION	CONFERENCE
(1) authorizing the applicant physician to collect copayments from the enrollees; and (2) making payments to the applicant physician. Sec. 1452.105. DIRECTORY ENTRIES. Pending the approval of the application, the managed care plan may 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. 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: (1) 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-network benefits; and (2) 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. Sec. 1452.107. 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 a physician who is determined to be ineligible under Section 1452.106 and the managed care plan's total payments for	including: (1) authorizing the applicant physician to collect copayments from the enrollees; and (2) making payments to the applicant physician. Sec. 1452.105. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section 1452.104, the managed care plan may 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. 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: (1) the managed care plan issuer may recover from the applicant physician or the physician's medical group an amount equal to the difference between charges for in-network benefits and out-of-network benefits; and (2) 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. Sec. 1452.107. 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 a physician who is determined to be ineligible under Section 1452.106 and the managed care plan's charges for out-of-	

HOUSE VERSION	SENATE VERSION	CONFERENCE
out-of-network services. 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.	network services. 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. Sec. 1452.108. LIMITATION ON MANAGED CARE 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 physician as if the physician were a participating provider in the health benefit plan network.	
No equivalent provision.	SECTION 2. Section 843.203, Insurance Code, is amended by adding Subsection (c) to read as follows: (c) For purposes of this subchapter, an applicant physician, as defined by Chapter 1452, may not be considered to be an available primary care physician or primary care provider within the health maintenance organization delivery network for selection by an enrollee.	
SECTION 2. 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	SECTION 3. Same as House version.	

HOUSE VERSION	SENATE VERSION	CONFERENCE
continued in effect for that purpose.		
SECTION 3. This Act takes effect September 1, 2007.	SECTION 4. Same as House version.	