1-1 By: Watson S.B. No. 779
1-2 (In the Senate - Filed February 11, 2009; March 4, 2009,
1-3 read first time and referred to Committee on State Affairs;
1-4 March 26, 2009, reported adversely, with favorable Committee
1-5 Substitute by the following vote: Yeas 9, Nays 0; March 26, 2009,
1-6 sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR S.B. No. 779 By: Deuell

1-8 A BILL TO BE ENTITLED
1-9 AN ACT

1-10 relating to expedited credentialing for certain individual health
1-11 care providers providing services under a managed care plan.
1-12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-13 SECTION 1. Chapter 1452, Insurance Code, is amended by
1-14 adding Subchapter D to read as follows:
1-15 SUBCHAPTER D. EXPEDITED CREDENTIALING PROCESS FOR INDIVIDUAL
1-16 HEALTH CARE PROVIDERS WHO ARE NOT PHYSICIANS
1-17 Sec. 1452.151. DEFINITIONS. (a) In this subchapter:
1-18 (1) "Applicant health care provider" means an
1-19 individual who:
1-20 (A) is a health care provider described by
1-21 Section 1452.101(3)(A); and
1-22 (B) is applying for expedited credentialing
1-23 under this subchapter.
1-24 (2) "Established professional group" means:
1-25 (A) a single legal entity owned by two or more
1-26 health care providers;
1-27 (B) a professional association composed of
1-28 licensed health care providers; or
1-29 (C) any other business entity composed of
1-30 licensed health care providers permitted under the Occupations
1-31 Code.
1-32 (b) "Enrollee," "health care provider," "managed care
1-33 plan," and "participating provider" have the meanings assigned by
1-34 Section 1452.101.
1-35 Sec. 1452.152. APPLICABILITY. This subchapter applies only
1-36 to an individual health care provider who:
1-37 (1) is not a physician; and
1-38 (2) joins an established professional group of health
1-39 care providers that has a contract in force with a managed care plan
1-40 on the date the health care provider joins the group.
1-41 Sec. 1452.153. ELIGIBILITY REQUIREMENTS. To qualify for
1-42 expedited credentialing under this subchapter and payment under
1-43 Section 1452.154, an applicant health care provider must:
1-44 (1) be licensed, certified, or otherwise authorized in
1-45 this state by, and in good standing with, the agency of this state
1-46 that issues the license, certification, or other authorization
1-47 appropriate to the profession of the applicant health care
1-48 provider;
1-49 (2) submit all documentation and other information
1-50 required by the issuer of the managed care plan as necessary to
1-51 enable the issuer to begin the credentialing process required by
1-52 the issuer to include that type of health care provider in the
1-53 issuer's health benefit plan network; and
1-54 (3) agree to comply with the terms of the managed care
1-55 plan's participating provider contract currently in force with the
1-56 applicant health care provider's established professional group.
1-57 Sec. 1452.154. PAYMENT OF APPLICANT HEALTH CARE PROVIDER
1-58 DURING CREDENTIALING PROCESS. On submission by the applicant
1-59 health care provider of the information required by the managed
1-60 care plan issuer under Section 1452.153(2), and for payment
1-61 purposes only, the issuer shall treat the applicant health care
1-62 provider as if the applicant were a participating provider in the
1-63 health benefit plan network when the applicant health care provider

2-1 provides services to the managed care plan's enrollees, including:
2-2 (1) authorizing the applicant health care provider to
2-3 collect copayments from the enrollees; and
2-4 (2) making payments to the applicant health care
2-5 provider.
2-6 Sec. 1452.155. DIRECTORY ENTRIES. Pending the approval of
2-7 an application submitted under Section 1452.154, the managed care
2-8 plan may exclude the applicant health care provider from the
2-9 managed care plan's directory of participating health care
2-10 providers, the managed care plan's website listing of participating
2-11 health care providers, or any other listing of participating health
2-12 care providers.
2-13 Sec. 1452.156. EFFECT OF FAILURE TO MEET CREDENTIALING
2-14 REQUIREMENTS. If, on completion of the credentialing process, the
2-15 managed care plan issuer determines that the applicant health care
2-16 provider does not meet the issuer's credentialing requirements:
2-17 (1) the managed care plan issuer may recover from the
2-18 applicant health care provider or the applicant's established
2-19 professional group an amount equal to the difference between
2-20 payments for in-network benefits and out-of-network benefits; and
2-21 (2) the applicant health care provider or the
2-22 applicant's established professional group may retain any
2-23 copayments collected or in the process of being collected as of the
2-24 date of the issuer's determination.
2-25 Sec. 1452.157. ENROLLEE HELD HARMLESS. An enrollee in the
2-26 managed care plan is not responsible and shall be held harmless for
2-27 the difference between in-network copayments paid by the enrollee
2-28 to a health care provider who is determined to be ineligible under
2-29 Section 1452.156 and the managed care plan's charges for
2-30 out-of-network services. The health care provider and the
2-31 provider's established professional group may not charge the
2-32 enrollee for any portion of the provider's fee that is not paid or
2-33 reimbursed by the enrollee's managed care plan.
2-34 Sec. 1452.158. LIMITATION ON MANAGED CARE ISSUER LIABILITY.
2-35 A managed care plan issuer that complies with this subchapter is not
2-36 subject to liability for damages arising out of or in connection
2-37 with, directly or indirectly, the payment by the issuer of an
2-38 applicant health care provider as if the applicant were a
2-39 participating provider in the health benefit plan network.
2-40 SECTION 2. Subsection (c), Section 843.203, Insurance Code,
2-41 is amended to read as follows:
2-42 (c) For purposes of this subchapter, an applicant
2-43 physician, as defined by Subchapter C, Chapter 1452, or an
2-44 applicant health care provider, as defined by Subchapter D, Chapter
2-45 1452, may not be considered to be an available primary care
2-46 physician or primary care provider within the health maintenance
2-47 organization delivery network for selection by an enrollee.
2-48 SECTION 3. Section 843.304, Insurance Code, is amended by
2-49 adding Subsection (f) to read as follows:
2-50 (f) Subchapter D, Chapter 1452, does not affect the
2-51 authority of a health maintenance organization under Subsection
2-52 (c), (d), or (e).
2-53 SECTION 4. Section 1301.051, Insurance Code, is amended by
2-54 adding Subsection (f) to read as follows:
2-55 (f) Subchapter D, Chapter 1452, does not affect the
2-56 authority of an insurer under Subsection (d).
2-57 SECTION 5. The change in law made by this Act applies only
2-58 to credentialing of an individual health care provider under a
2-59 contract entered into or renewed by an established professional
2-60 group and an issuer of a managed care plan on or after the effective
2-61 date of this Act. A contract entered into or renewed before the
2-62 effective date of this Act is governed by the law in effect
2-63 immediately before that date, and that law is continued in effect
2-64 for that purpose.
2-65 SECTION 6. This Act takes effect September 1, 2009.

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