

BILL ANALYSIS

C.S.H.B. 4300
By: Guillen
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Currently, once physician assistants and advanced practice nurses are hired by a physician practice, they undergo a lengthy credentialing process to gain in-network status under the practice's existing contract with an insurance provider. Although the insurers ultimately approve the credentials of the vast majority of providers that apply, the process is often long and may take up to a year in some cases. During this time, the physician assistants and advanced practice nurses are considered out-of-network. This puts patients at financial risk because, until the plan approves the credentials of the newly hired providers, the practice is forced to bill the treated patient as an out-of-network patient despite the fact that the providers are with a physician group that is contracted with the health plan. C.S.H.B. 4300 seeks to address this issue by creating an expedited credentialing process for certain physician assistants and advanced practice nurses and requiring an insurer to grant in-network status to an eligible provider under an existing contract with the provider's medical group.

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. 4300 amends the Insurance Code to provide for an expedited credentialing process for a licensed physician assistant or a registered nurse licensed by the Texas Board of Nursing to practice as an advanced practice nurse who joins, as an employee, an established medical group that has a contract with a managed care plan that already includes contracted rates for physician assistants or advanced practice nurses employed by the medical group. The bill defines "medical group" as a professional association composed solely of licensed physicians or a single legal entity authorized to practice medicine in Texas that is owned by two or more licensed physicians. The bill establishes that a managed care plan includes a health benefit plan issued by a health maintenance organization, a preferred provider benefit plan issuer, or any other entity that issues a health benefit plan, including an insurance company. To qualify for the expedited credentialing process, a physician assistant or advanced practice nurse must satisfy the following requirements:

- be licensed by, and in good standing with, the Texas Physician Assistant Board or the Texas Board of Nursing;
- submit all documentation and other information required by the managed care plan issuer to begin the credentialing process required for the issuer to include the physician assistant or advanced practice nurse in the plan's network;

- agree to comply with the terms of the managed care plan's participating provider contract with the physician assistant's or advanced practice nurse's established medical group, including the rates applicable to other physician assistants or advanced practice nurses under the contract; and
- have received express written consent from the physician assistant's or advanced practice nurse's established medical group to apply for expedited credentialing.

After a physician assistant or advanced practice nurse applicant has met such eligibility requirements, the issuer must, for payment purposes only, treat the applicant as if the applicant is a participating provider in the plan's network when the applicant provides services to the plan's enrollees as an employee of that the applicant's established medical group, including authorizing the applicant's medical group to collect copayments from the enrollees for the applicant's services and making payments to the applicant's medical group for the applicant's services.

C.S.H.B. 4300 prohibits the bill from being construed as requiring the managed care plan issuer to include an applicant in the plan's directory, website listing, or other listing of participating providers. If the issuer determines that the applicant does not meet the issuer's credentialing requirements on completion of the credentialing process, the issuer may recover from the applicant's medical group that was paid for the applicant's services an amount equal to the difference between payments for in-network benefits and out-of-network benefits, and the applicant'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. 4300 establishes that a managed care plan enrollee is not responsible and is to be held harmless for the difference between in-network copayments paid by the enrollee to an applicant's medical group for services provided by an employee applicant physician assistant or advanced practice nurse who is determined to be ineligible with respect to the credentialing requirements and for the enrollee's plan's charges for out-of-network services. The bill prohibits the physician assistant's or advanced practice nurse's medical group from charging the enrollee for any portion of the physician assistant's or advanced practice nurse's fee that is not paid or reimbursed by the plan.

C.S.H.B. 4300 exempts a managed care plan issuer in compliance with the bill's provisions from liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of a physician assistant's or advanced practice nurse's medical group for services provided by the medical group's employed physician assistant or advanced practice nurse treated as if the physician assistant or advanced practice nurse is a participating provider in the plan's network under an expedited credentialing process.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 4300 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes definitions for "physician" and "physician assistant," which did not appear in the introduced, and changes the definition of "medical group" provided in the introduced version as follows:

- includes a specification that a single legal entity owned by two or more physicians be such an entity that is authorized to practice medicine in Texas, which was not in the introduced;
- includes a specification that the professional association composed of licensed physicians be solely composed of such physicians, which was not in the introduced; and

- omits provisions from the introduced including in that term any other business entity composed of licensed physicians or two or more physicians on the medical staff of, or teaching at, a medical school or medical and dental unit.

The substitute changes a provision found in the introduced regarding the bill's applicability. Whereas the introduced applied to a physician assistant or nurse practitioner who joins an established medical group that has a contract with a managed care plan, the substitute applies to a physician assistant or advanced practice nurse who joins, as an employee, an established medical group that has a contract with a managed care plan that already includes contracted rates for physician assistants or advanced practice nurses employed by the medical group.

While both the introduced and the substitute include as a condition of eligibility for expedited credentialing that an applicant agree to comply with the terms of the managed care plan's participating provider contract with the applicant's established medical group, the substitute includes a provision not included in the introduced specifying that such terms include the rates applicable to other physician assistants or advanced practice nurses under the contract. The substitute includes as an additional eligibility requirement that the physician assistant or advanced practice nurse have received express written consent from the physician assistant's or advanced practice nurse's established medical group to apply for expedited credentialing, which did not appear in the introduced.

While both the introduced and the substitute provide for the payment of services provided by an applicable provider during the credentialing process, the versions differ in their approaches. The introduced required the issuer to treat the applicant as if the applicant is a participating provider in the plan's network when the applicant provides services to the plan's enrollees, including authorizing the applicant to collect copayments from the enrollees and making payments to the applicant. However, the substitute requires the issuer to treat the applicant as if the applicant is a participating provider in the plan's network when the applicant provides services to the plan's enrollees as an employee of the applicant's established medical group, including authorizing the applicant's medical group to collect copayments from the enrollees for the applicant's services and making payments to the applicant's medical group for the applicant's services.

Whereas the introduced authorized a managed care plan issuer to exclude an applicant from the plan's directory, website listing, or other listing of participating providers pending the approval of an application for expedited credentialing, the substitute establishes that nothing in the bill may be construed as requiring the issuer to include the applicant in the plan's directory, website listing, or other listing of participating providers.

While both the introduced and the substitute authorize an issuer to recover, on the determination that an applicant does not meet the issuer's credentialing requirements, an amount equal to the difference between payments for in-network benefits and out-of-network benefits, the introduced authorized an issuer to recover the amounts from the applicant or the applicant's medical group, whereas the substitute only authorizes an issuer to recover the amounts from the applicant's medical group. The bill versions additionally differ in who is authorized to retain copayments collected or in the process of being collected as of the date of the issuer's determination that the applicant does not meet the issuer's credentialing requirements. The introduced granted this authority to the applicant or the applicant's medical group, whereas the substitute grants this authority only to the applicant's medical group.

While the introduced prohibited a physician assistant or nurse practitioner and the applicable medical group from charging the enrollee for any portion of the physician assistant's or nurse practitioner's fee that is not paid or reimbursed by the plan, the substitute prohibits only the applicable medical group from charging the enrollee for any portion of the physician assistant's or advanced practice nurse's fee that is not paid or reimbursed by the plan.

While both the introduced and the substitute exempt from liability a managed care plan issuer that complies with the bill for damages arising out of or in connection with payments under the bill by the issuer, the introduced applied that provision to the payment by the issuer of a physician assistant or nurse practitioner treated as if the physician assistant or nurse practitioner is a participating provider in the plan's network, whereas the substitute applies that provision to the payment by the issuer of a physician assistant's or advanced practice nurse's medical group for services provided by the medical group's employed physician assistant or advanced practice nurse treated as if the physician assistant or advanced practice nurse is a participating provider in the plan's network under the bill.