BILL ANALYSIS

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S.B. 779
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Current law on expedited credentialing applies only to physicians, although all practitioners requiring individual credentialing face extended wait times to complete the process. Technically, a practitioner is prohibited from providing services until the credentialing process is complete, which can take as long as nine months.

As proposed, S.B. 779 requires that an applicant health care provider, when a health care provider is in good standing with their respective licensing boards, joins an established medical group that has a contract with a managed care plan, and submits all necessary documentation and information required by the managed care plan, be treated as a participating provider for purposes of payment until the credentialing process is complete. The bill 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 plans' credentials.

RULEMAKING AUTHORITY

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

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1452, Insurance Code, by adding Subsection D, as follows:

SUBCHAPTER D. EXPEDITED CREDENTIALING PROCESS FOR INDIVIDUAL HEALTH CARE PROVIDERS WHO ARE NOT PHYSICIANS

Sec. 1452.151. DEFINITIONS. (a) Defines "applicant health care provider" and "established professional group."

(b) Defines "enrollee," "health care provider," "managed care plan," and "participating provider."

Sec. 1452.152. APPLICABILITY. Provides that this subchapter applies only to an individual heath care provider who is not a physician and joins an established professional group of health care providers that has a contract in force with a managed care plan on the date the health care provider joins the group.

Sec. 1452.153. ELIGIBILITY REQUIREMENTS. Requires an applicant health care provider, to qualify for expedited credentialing under this subchapter and payment under Section 1452.154, to:

(1) be licensed, certified, or otherwise authorized in this state by, and in good standing with, the agency of this state that issues the license, certification, or other authorization appropriate to the profession of the applicant health care provider;

(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 that type of health care provider 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 health care provider's established professional group.

Sec. 1452.154. PAYMENT OF APPLICANT HEALTH CARE PROVIDER DURING CREDENTIALING PROCESS. Requires the issuer, on submission by the applicant health care provider of the information required by the managed care plan issuer under Section 1452.153(2), and for payment purposes only, to treat the applicant health care provider as if the applicant were a participating provider in the health benefit plan network when the applicant health care provider provides services to the managed care plan's enrollees, including authorizing the applicant health care provider to collect copayments from the enrollees and making payments to the applicant health care provider.

Sec. 1452.155. DIRECTORY ENTRIES. Authorizes the managed care plan, pending the approval of an application submitted under Section 1452.154, to exclude the applicant health care provider from the managed care plan's directory of participating health care providers, the managed care plan's website listing of participating health care providers, or any other listing of participating health care providers.

Sec. 1452.156. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. Provides that, if, on completion of the credentialing process, the managed care plan issuer determines that the applicant health care provider does not meet the issuer's credentialing requirements the managed care plan issuer is authorized to recover from the applicant health care provider or the applicant's established professional group an amount equal to the difference between payments for in-network benefits and out-of-network benefits and the applicant health care provider or the applicant's established professional group is authorized to retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Sec. 1452.157. ENROLLEE HELD HARMLESS. Exempts an enrollee in the managed care plan from responsibility and requires they be held harmless for the difference between in-network copayments paid by the enrollee to a health care provider who is determined to be ineligible under Section 1452.156 and the managed care plan's charges for out-of-network services. Prohibits the health care provider and the provider's established professional group from charging the enrollee for any portion of the provider's fee that is not paid or reimbursed by the enrollee's managed care plan.

Sec. 1452.158. LIMITATION ON MANAGED CARE ISSUER LIABILITY. Exempts a managed care plan issuer that complies with this subchapter from being subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant health care provider as if the applicant were a participating provider in the health benefit plan network.

SECTION 2. Amends Section 843.203(c), Insurance Code, as follows:

(c) Provides that, for purposes of this subchapter, an applicant physician, as defined by Subchapter C (Expedited Credentialing Process for Certain Physicians), Chapter 1452 (Physician and Provider Credentials), or an applicant health care provider, as defined by Subchapter D, Chapter 1452, are not authorized to 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 3. Amends Section 843.304, Insurance Code, by adding Subsection (f), as follows:

(f) Provides that Subchapter D, Chapter 1452, does not affect the authority of a health maintenance organization under Subsection (c) (exempts a health maintenance organization from certain requirements under this section), (d) (exempts a health maintenance organizations' authority from limitations), or (e) (requires a provider to comply with certain terms).

SECTION 4. Amends Section 1301.051, Insurance Code, by adding Subsection (f), as follows:

(f) Provides that Subchapter D, Chapter 1452, does not affect the authority of an insurer under Subsection (d) (relates to an insurer's authority to reject certain applications).

SECTION 5. Makes application of this Act prospective.

SECTION 6. Effective date: September 1, 2009.