

JOINT STATEMENT FOR THE HOUSE INSURANCE COMMITTEE

Public Hearing on the HB 1551

The Health Insurer Physician Credentialing Act

November 30, 2011

The Pennsylvania Insurance Department and Pennsylvania Department of Health would like to thank Chairmen Micozzie and DeLuca and the House Insurance Committee, for the opportunity to provide you with a joint statement regarding our agencies' perspective on House Bill 1551, which is known as the *Physician Credentialing Act*.

In general, House Bill 1551 establishes policy, definitions, and standards to be followed by physicians and health insurers for initial credentialing and recredentialing, and provides for physician reimbursement by insurers during the credentialing process. Finally, the bill identifies the circumstances under which a physician can appeal a denial decision to the Department of Health, (DOH).

Under the provisions of the bill, once a health insurer receives a credentialing application from a physician and decides to undertake the credentialing of that

applicant, the company must complete the entire credentialing process within 60 days, including a five business-day requirement to notify the applicant of the committee's decision. The DOH does not object to the timely credentialing of providers by a health insurer, however, the DOH believes that the 60-day time frame identified in the bill is too short, and that 90 days is a more realistic timeframe. Even when physicians use an electronic application the health insurer still must perform primary source verification on several items. While some primary source verification can be done electronically in a short time period, the process can take significantly longer when the physician applicant was educated in a foreign country. In addition, there is no statutory or regulatory time frame in which an insurer's credentialing committee must meet. For some companies, the committee may meet only every other month or once each quarter.

It should also be noted that the bill addresses the credentialing of physicians only; it does not address the credentialing of non-physician practitioners, such as optometrists, psychologists, physical therapists, chiropractors, pharmacists, podiatrists, dentists, and clinical social workers. These practitioners also provide important services to members and should also be appropriately credentialed by the insurer.

Under the bill, after a health insurer notifies the applicant of its intent to pursue the credentialing process, the applicant is eligible for reimbursement while the application is being processed by the insurer. While much of what is included in this bill is already covered-, for managed care plans, under Act 68 and the Department of Health's regulations-, the issue of reimbursement is not. The DOH has concerns with a process that requires reimbursement before the credentialing is complete and a decision made. The DOH believes that there should be no reimbursement to the physician until he or she is fully credentialed. This will prevent health care dollars being paid to someone who may have submitted fraudulent information, or who is providing high-cost services that he or she is not fully qualified to provide.

Under the bill, during the time that the physician applicant is providing services and while the application is being processed, the group practice with which the applicant

is associated may, but is not required to, disclose in writing to enrollees that the physician is not a participating provider, that he or she has applied to become a participating provider, and that the health insurer has not completed its assessment of the physician's credentials. The member should be informed when a treating physician is not yet credentialed so that the enrollee can make an informed decision to receive services from this provider or to select another.

The reimbursement provision in Section 5 of the bill conflicts with the current law regarding prompt pay which allows an insurer to pay a clean claim within 45 days or receipt and requires payment only for the claims considered clean. Another provision in Section 5 that is confusing states that a physician who has applied may not collect more than the cost-sharing that the enrollee is subject to pay under the contract. Many contracts have provisions for cost-sharing that varies depending on whether the services are provided in-network or out-of-network and this section of the bill is not clear in this regard.

HB 1551 differs from Act 68 in that it gives the DOH responsibility to review appeals of credentialing decisions. Under the bill, the DOH must review the appeal if the credentialing application was turned down for one of the following reasons:

- 1: The physician discussed with a patient or person the process the insurer uses to deny payment for a health care service; medically necessary and appropriate care with or on behalf of a patient; the decision of the health insurer to deny payment for a health care service;
- 2: The physician has, or wants to join, a practice that includes a number of patients with expensive medical conditions;
- 3: The physician objects to the provision of or refuses to provide a health care service on moral or religious grounds.

Although these are very narrow grounds for appeal, and there may not be many, those appeals that do occur will likely require a hearing before the DOH. In order to meet these conditions for appeal, providers will be attempting to show that plans did something for a specific reason. The matter in question will likely be one of credibility, and making a determination on that basis will require testimony. This, in turn, will either take staff time to sit as a hearing examiner, or to staff the Agency Head as he or she reviews and makes the decision, or will take funds from the DOH to refer the matter to a hearing examiner.

Further confusion arises over jurisdictional boundaries when looking at powers given to the Insurance Department (PID) in Section 7. Section 7 provides for a private cause of action and administrative action by PID. While this could theoretically occur simultaneously, it invites confusion and potential delays in the process if one is deferred until the other process is completed. Both the private cause of action and PID's administrative action would need to be coordinated with action by the DOH as provided in Section 9.

PID also has general concerns with the enforcement authority dictated to it in Section 7 due to the heavy lift it would place on the Department in continued times of financial and resources strains. Finally Section 7 references "notice and opportunity to be heard" (lines 12-13 on page 8). Is it the intent for this to be subject to the standard administrative procedures contained in Pennsylvania General Rules of Administrative Practice and Procedure (GRAPP)? If so, this should be made explicit.

Based upon these perceived weakness of House Bill 1551, the Department of Health and Department of Insurance do not support the bill. The agencies feel that it is not the role of the government to legislate the business practices between organizations. Thank you again for the opportunity to provide you with comments on House Bill 1551.