SUBJECT: Requiring prompt payment of physicians by managed care organizations

COMMITTEE: Insurance — favorable, without amendment

VOTE: 9 ayes — Smithee, Seaman, Eiland, Bonnen, Gallego, B. Keffer, Taylor, Thompson, Van Arsdale

0 nays

SENATE VOTE: On final passage, March 25 — 30-0

WITNESSES: *(On House companion bill, HB 1810:)*
For — Spencer Berthelson and Teresa Devine, Texas Medical Association; Ramona Bogard, North Texas Health Center; Frances Cason, TMGMA; David Deel, Endocrinology Association of Houston; Betty Lennon, McCann and Arthur; David Loomis, The Health Group; Linda Ross Davis, Henderson Memorial Hospital; Amy Schornick, Texas Hospital Association; Jeff White, Texas Hospital Association and Christus Health

Against — Luke Bellsnyder, Texas Association of Business; Will Davis, Texas Life and Health Insurance; Jules Delaune, M.D. and Leah Rummel, Texas Association of Health Plans; William Dowden, Golden Rule Insurance Co.; Eric Glenn and Gary Goldstein, M.D., Humana, Inc.; Pati McCandless, UNICARE; Mary Spear, Council for Affordable Health Insurance; Gary Touman, American Life Insurance Co.; Janey Treadwell, Health Smart Preferred Care

On — Jose Montemayor, Texas Department of Insurance; Darren Rogers, Blue Cross Blue Shield of Texas

BACKGROUND: Insurance Code, art. 20A governs the operation of health maintenance organizations (HMOs) in Texas, and art. 3.70 pertains to non-managed-care health insurance. The code defines a "clean claim" as a completed claim, as determined under Texas Department of Insurance (TDI) rules, that a provider submits for medical care or health-care services under a health-care plan.

A provider who submits a claim by mail may request return receipt in the form of a certified letter or other service through the U.S. mail. A provider who submits a claim electronically will receive acknowledgment of receipt electronically but not in writing. An insurer must pay an electronic claim for prescription benefits by the 21st day after the treatment is authorized. Within 45 days of receiving a medical claim from a provider, an insurer must:

- pay the total amount of the claim;
- inform the provider in writing of any dispute over a portion of the claim and pay the portion of the claim that is not in dispute;
- inform the provider in writing of a dispute over the entire claim and explain why the claim will not be paid; or
- pay 85 percent of the claim, if the insurer does not dispute coverage of an enrollee but intends to audit the provider.

An insurer that audits a provider must pay the remaining 15 percent of the claim or receive any refund from the provider within 30 days after the provider receives notice of audit results and exhausts all appeal rights. An insurer that violates the rules on payment of claims is liable to the provider for the full amount of the billed claim charges, less amounts already paid. The provider may recover reasonable attorney fees.

An insurer must provide copies of all applicable utilization review policies and claim processing procedures. If these change, the insurer must inform the provider at least 60 days before the change.

Bundling is the practice of grouping related services under a single procedure code. For example, if a patient makes an appointment for one procedure, but then asks for an additional procedure during the office visit, the two procedures could be billed separately, or bundled into one procedural code that is less than the total of the two separate codes.

For additional background, see House Research Organization Focus Report Number 77-22, *The Prompt Pay Dispute*, July 17, 2002.

DIGEST:

SB 418 would establish new prompt-payment regulations for transactions between health-care providers and insurers, including preferred provider organizations and health maintenance organizations. The new regulations

would cover clean claims, payment timelines, audits, coordination of payment, verification, penalties, and applicability. The bill would create a technical advisory committee and requirements for electronic transactions.

Clean claim. SB 418 would define a "clean claim" as one that uses the form specified by the insurance commissioner by rule. The commissioner would have to determine by rule what information must be entered to constitute a clean claim. For an electronic claim, the commissioner could not require data beyond federal requirements. An insurer and a provider could agree by contract to require fewer data elements. Additional data would not compromise the determination of a clean claim.

An insurer's payment processes would have to use nationally recognized, generally accepted Current Procedural Terminology (CPT) codes and associated guidelines that would be consistent with a nationally recognized noncommercial bundling system, if one were available.

A contract between an insurer and a provider would have to include a way for the provider to request a description of coding guidelines, which the insurer would have to provide within 30 days. The insurer would have to notify the provider of any changes at least 90 days before the changes took effect and could not make changes retroactive. During the 30 days following receipt of the notification of changes, the provider could terminate the contract without penalty. The provider could disclose the coding information only for use in business operations or to a governmental agency involved in regulating health care or insurance. The provider also could request the name and version of the software the insurer used for bundling claims.

Payment timelines. SB 418 would set the timeline for submitting a claim to an insurer and for paying the claim. The health-care provider would have to submit a claim by the 95th day after the service was rendered. The provider could submit the claim by mail, fax, electronic means, or hand delivery. The date of presumed delivery would be determined by delivery method but generally would be no longer than five days.

An insurer would have to determine if a claim was payable, partially payable, or not payable and act accordingly within 30 days for electronic submissions, or within 45 days for nonelectronic claims. A pharmacy claim submitted

electronically would have to be paid or the pharmacy provider notified within 21 days of adjudicating the claim.

An insurer that needed additional information to determine payment would have to request the information within 30 days of receiving a clean claim. The insurer could make only one request for information, which would have to be specific to the claim and be in the patient's medical or billing record. After receiving the additional information, the insurer would have to determine whether a claim was payable within 15 days.

Payment could not be delayed pending the receipt of requested information from a third party, and the insurer would have to notify the provider of the request. If, upon receiving the information, the insurer determined that there was an error in payment, the insurer could recover any overpayment. The insurance commissioner would have to adopt rules under which an insurer could identify attachments.

An insurer who overpaid a claim could recover the overpayment by reducing future payment to the provider if the insurer had notified the provider of overpayment within 180 days of the initial payment and the provider did not arrange to repay the amount within 45 days of the notice. If the provider challenged the overpayment, the insurer would have to offer an appeal process and could not recover payment until the rights to appeal were exhausted.

Audit. If an insurer intended to audit a claim, it would have to pay the full amount of the claim within the normal amount of time. The insurer would have to notify the provider that the claim was paid subject to the completion of the audit. The insurer would have to complete the audit within 180 days after the clean claim was received. Any additional payment to the provider or refund to the insurer would have to be made within 30 days of the completion of the audit. The provider could appeal any decision, and recovery could not be made until all appeal rights were exhausted.

The insurer could request additional information to complete the audit but could request only information that was specific to the claim and was in the patient's medical or billing record. If the provider failed to supply the needed information, the insurer could notify the provider in writing of the need for

the information before the 45th day after the date of the notice to audit. If the provider again failed to comply, the insurer could recover the claim amount.

Coordination of payment. SB 418 would allow the inclusion of a coordination-of-payment clause in a managed care contract to arrange for payment procedures when an enrollee was covered by more than one policy. An insurer could require a provider to maintain information about other sources of payment but could not require the provider to investigate coordination of payment.

A provider who submitted claims to multiple insurers would have to notify each insurer of that action. The secondary insurer would have to use the information submitted to the primary insurer as the basis for payment unless liability could not be determined by the information in the claim. In that case, the secondary insurer could request additional information. Coordination of payment by insurers would not extend the period of time an insurer had to pay or audit a clean claim.

If the secondary insurer paid a portion of the claim that should have been paid by the primary insurer, recovery of overpayment would be from the primary insurer. The secondary insurer could recover an overpayment from the provider only if the secondary provider notified the provider within 180 days that there was an overpayment and that the recovery would be pursued with the primary insurer and if the provider did not make arrangements for repayment within 45 days of receiving notice that the secondary insurer was unable to recover from the primary insurer.

Verification. SB 418would define “preauthorization” as a determination by an insurer that proposed health services are medically necessary and appropriate. It would define “verification” as a reliable representation by an insurer to a health-care provider that a service would be reimbursed. The term verification would include terms such as precertification, certification, or recertification. Verification would include preauthorization only when preauthorization was required for verification.

An insurer would have to respond within 10 days to a provider’s request for a list of services and procedures that require preauthorization. If a service required preauthorization, the insurer would have to determine if the service

were medically necessary and appropriate within three days of a request for preauthorization. If the service involved in-patient care and preauthorization were required for reimbursement, the insurer also would have to determine a length of stay for the admission. If the patient already were admitted to the hospital, the preauthorization determination would be required within 24 hours of the request.

When declining verification, the insurer would have to inform the provider of the reason for the denial. The validity of an affirmative verification could be limited in duration to 30 days. If a provider received affirmative verification, the insurer could not deny or reduce reimbursement for services rendered within 30 days of the verification or for preauthorized services based on medical necessity or appropriateness of care, unless the provider materially misrepresented the proposed service or failed to perform the service.

An insurer would have to reply without delay to a request for verification or preauthorization. The insurer would have to have personnel available at a toll-free number between 6 a.m. and 6 p.m. central time on Monday through Friday and between 9 a.m. and noon on Saturday, Sunday, and legal holidays. An insurer would have to have a recording system for use outside those hours and a process by which to reply to recorded requests within 24 hours for preauthorization and within two calendar days for verification.

Penalties. SB 418 would establish a tiered system of penalties based on how late a payments was. A provider could recover court costs in addition to reasonable attorney's fees in an action to recover payment.

If the insurer did not pay a clean claim on time, the insurer would owe the provider the full contracted amount of the claim and a penalty. The penalty would be the lesser of half the difference between the billed charges and the contracted rate or $100,000. If a clean claim remained unpaid after the 46th day and before the 91st day, the penalty would be the lesser of the full difference between the billed charges and the contracted rate or $200,000. If the clean claim remained unpaid after 91 days, the penalty would be the same as after the 46th day, but with 18 percent annual interest added to the amount. Interest would accrue beginning on the date the claim should have been paid. If an insurer paid a penalty, it would have to indicate the penalty clearly on the statement of payment to the provider.

If the insurer paid only a portion of the claim on time and paid the balance after payment was due, the penalty structure would be the same as for the entire amount, but the calculation of half the difference between the billed charges and the contracted rate would be replaced by half the underpaid amount.

An insurer would not be liable for penalties if the failure to pay was due to a catastrophic event, or if the claim was paid on time but at less than the contracted rate and the balance was paid within 45 days of receiving notice from the provider. The provider would have to notify the insurer of an underpayment within 180 days of receipt.

An insurer that violated the clean claim regulations on more than 2 percent of its claims also would be subject to an administrative penalty of up to $1,000 each day for each claim that remained unpaid. In determining the compliance rate, the insurance commissioner would have to consider payments made to providers and institutions.

Applicability. The clean claim regulations would apply to providers who were not preferred providers for a preferred provider organization, as well as to those who were when the care was emergency care required by state or federal law or specialty care that was not available from an in-network provider. The rules regarding preauthorization also would apply to entities contracted by the insurer to perform preauthorization services.

Technical advisory committee. SB 418 would direct the commissioner to appoint a technical advisory committee on all aspects of claims processing. Members would serve without compensation. Before adopting a rule related to claims processing, the commissioner would have to consult the advisory committee. Each even-numbered year, on or before September 1, the commissioner would have to report to the Legislature about the advisory committee's activities.

Electronic transactions. Beginning September 1, 2006, all insurers would have to include mandatory electronic submission of claims in contracts with licensed health-care providers and facilities. Contracts signed before that date could include a waiver of the requirements if the waiver met circumstances established by the commissioner, including circumstances in which there was

no mode of electronic submission available, small practices, circumstances in which electronic submission would cause undue financial or other hardship, or other circumstances. A denial of a waiver could be appealed without affecting the renewal of a contract. The waiver provision would expire September 1, 2007.

The insurer could not limit the mode of transmission that could be used to submit electronic claims. It could not charge or hold accountable a provider for the adjudication of an electronic claim. The commissioner would have to establish rules for electronic claims but could not require any data elements in addition to those required by federal law. The rules would be required within 30 days of the bill's effective date, and the commissioner could use the procedure for adopting emergency rules without the required finding of imminent peril. The new rules would apply to contracts signed or payments made on or after the 60th day after the bill's effective date.

The bill would take effect June 1, 2003, if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2003. The bill's prompt-payment provisions could not be waived, voided, or nullified by contract.

SUPPORTERS SAY:

SB 418 represents years of work and negotiation among stakeholders to develop fair prompt payment regulations. HB 610 by Janek, enacted in 1999, sought to accelerate payment to providers for their services. However, insurers have been able to work around some of these requirements in ways that run counter to prompt payment, leaving providers in similarly dire situations as before HB 610 was enacted. In 2001, the 77th Legislature enacted HB 1862 by Eiland, which would have closed loopholes, cleaned up areas of confusion in current law, and improved the payment process for providers. Gov. Perry vetoed that bill, leaving providers without remedy for another two years.

SB 418 contains many of the provisions in HB 1862 that are agreed upon by insurers and providers, but not the provisions the governor cited as reasons for vetoing the bill. In his veto proclamation, Gov. Perry stated that eliminating the ability to include an alternative dispute resolution clause in contracts likely would send more disputes to the courthouse. SB 418 would not limit or eliminate the ability for insurers to include alternative dispute

resolution clauses in their contracts with providers.

The governor also stated that, at that time, final rules implementing HB 610 had been adopted only recently and deserved greater opportunity to achieve their intended results. He directed TDI to be more aggressive in assisting physicians and health-care providers in claims disputes. Both time and additional focus by TDI have helped insurers and providers come together to work out the provisions of SB 418.

The bill would not conflict with federal laws governing the Employee Retirement Income Security Act (ERISA) program. Federal regulations for ERISA address the relationship between insurers and enrollees. SB 418 would regulate only the relationship between insurer and provider. ERISA covers policies; this bill would cover claims.

Verification. Preauthorization is meaningless unless it represents a reliable representation that the service will be reimbursed. Mechanisms are in place for insurers to deny claims if they think the services were unnecessary or inappropriate, so there is no reason why an insurer cannot tell a provider that a specific service for a specific patient will be reimbursed. A verification process would permit providers to call insurers and determine if a service will be reimbursed. Insurers still would be able to require preauthorization for cost-containment reasons.

Penalties. The graduated penalty schedule in SB 418 would be more fair to insurers and would encourage them to pay as soon as possible, even if they had missed the payment deadline. While insurers now must deny or pay clean claims within 45 days, there is no difference in penalty between paying on the 46th day or one year later. This bill would provide an incentive for insurers to pay sooner rather than later. Also, the tiered penalties would be capped to ensure that the penalties would not exceed certain levels.

OPPONENTS SAY:

While many provisions in SB 418 are acceptable both to insurers and providers, a few exceptions prevent it from taking a balanced approach to changing the business transaction of payment between insurers and providers. While it is important to ensure that providers are paid on time, some business practices by insurers cannot be changed without driving up their cost of doing business, and ultimately, the cost of health insurance.

It is not clear that the changes proposed in SB 418 would stand up to an ERISA challenge. Federal regulations could bar some of SB 418's provisions. The requirements for insurers to promise payment for services before a claim is submitted are unlikely to stand up to an ERISA challenge in court.

Verification. Insurers should not have to pay for services that are not covered. Requiring insurers to promise payment without a claim would force them to pay for services that might not be covered. Also, claims for certain services — for example, cosmetic services — cannot be adjudicated over the telephone in the absence of additional information.

Requiring insurers to respond to verification requests for any service would be unfair and likely would lead to patients going without services. Insurers cannot promise payment all the time, for any service, and be held to that promise for 30 days. For example, a provider might receive verification for surgery and schedule it two weeks into the 30-day guaranteed payment period. If the patient quit his job during those two weeks, his employer would not pay the insurance premium, yet the insurer still would have to pay for the surgery. In practice, insurers are more likely to deny verification because of scenarios in which they could be liable for payment of services to which the enrollee is not entitled. If providers require verification before performing services, patients will go without medical care.

Length of stay should not be mandated as part of preauthorization. Insurers should not have to promise to pay for a set number of days, because the level of need may change during the patient’s stay.

The proposed time frame for verification is too short, and verification every day is unnecessary. This would require that insurers have agents on staff on weekends and holidays, driving up costs that would be passed on to consumers. Also, very few providers’ offices are open on weekends, so services are needed only during normal business hours.

Penalties. The proposed penalty based on the difference between contracted and billed charges is unfair. Some providers have a billed charge that is many times higher than the contracted charge. If an insurer missed the payment by a single day, the payment for the same service could jump exponentially. A penalty of contracted charges plus interest would be more fair.

OTHER OPPONENTS SAY:

The bill should clarify the requirement that insurers use CPT codes and guidelines consistent with a nationally recognized noncommercial bundling system. If this would require that insurers use the National Correct Coding Initiative (NCCI), a federal set of edits and checks on the use of codes, then the state should consider the cost. Because the NCCI uses fewer codes than commercially available programs, it could result in insurers and the state losing millions of dollars because of fraud and abuse by providers.

NOTES:

The bill's fiscal note projects no significant fiscal impact on the state but assumes that TDI would need to hire three additional employees to handle an increase in provider complaints and two additional legal staff to implement the bill's provisions. These new employees would be funded by a gain in the insurance maintenance tax, which TDI sets at a level sufficient to cover the agency's operating expenses.

SB 418 is similar to HB 1810 by Smithee, which the House Insurance Committee considered in a public hearing on March 17 and left pending.