SUBJECT: Requiring HMOs to pay physicians and preferred providers promptly

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Eiland, Burnam, G. Lewis, J. Moreno, Olivo, Seaman, Thompson, Wise

0 nays

WITNESSES: *(On original bill:)*
For — Kirk Koepsel; Mike Lee, Baylor Health Care System and Ennis Hospital; Michael Murphy, Gulf Coast Medical Center; Ken Stephenson, Universal Health Services and Texas Hospital Association

Against — Will Davis, Texas Association of Life and Health Insurers; Jeff Kloster, Texas Association of Health Plans

BACKGROUND: Currently, there is no time limit set for health maintenance organizations (HMOs) either to pay or dispute claims submitted by physicians for health care services provided to an HMO's enrollee.

Some other insurers are required to pay claims within 45 days, as provided by art. 21.55, Insurance Code. This applies only to first-party claims for benefits paid directly to the beneficiary. The 45-day requirement does not apply to workers' compensation, mortgage guaranty, title, marine, various other guaranty, and weather disaster insurance. It also does not apply to third-party payments made by HMOs, or any other contractual arrangement for which payment would be made to third parties.

DIGEST: CSHB 610 would require health plans to act within 60 days to pay or dispute claims submitted by physicians or preferred providers. The 60-day period would begin upon receipt of the charges. Noncompliance would result in administrative penalties of up to $1,000 per day.

The bill would require a plan to pay a provider the full amount of the claim, pay the portion of the bill not in dispute, or notify the provider in writing why

a claim would not be paid within 60 days of receipt of a "clean," i.e. complete, claim. It would allow TDI to promulgate rules regarding what constitutes a clean claim.

A plan would be required to pay 85 percent of the claim within 60 days of its receipt, even if it planned to audit the provider or the claim. The bill would require any additional payment to the provider or refund to the plan be paid within 30 days following the audit or exhaustion of an enrollee's appeal rights, whichever was later.

A plan that violated prompt-payment requirements would be liable for the full amount of the claim, plus penalties imposed under the contract, minus any prepaid amounts or charges for services not covered by the plan. An administrative penalty imposed by the bill could not exceed $1,000 per day for each day the claim remained unpaid. The bill would allow providers to recover reasonable attorney's fees in an action to receive prompt payment.

A provider would be able to obtain written acknowledgment of receipt of a claim by the plan by sending the claim by U.S. mail, return receipt requested. No written acknowledgment by the company would be required for claims submitted electronically, when an electronic confirmation was provided.

The bill would allow plans to change the data elements that must be submitted on a claim, as long as providers were notified in writing at least 60 days before the change would take effect.

CSHB 610 would apply to contracts between plans and physicians, other providers, or preferred providers. The prompt-payment bill would not apply to claims submitted by an anesthesiologist or to capitation payment contracts.

The bill would take effect on September 1, 1999.

SUPPORTERS SAY:

By requiring health plans to pay or dispute claims within 60 days, CSHB 610 would help doctors, patients, and hospitals by preventing HMOs from needlessly delaying payment to providers whose claims have been submitted properly. Long gaps between rendering services and receiving payment cause doctors to cancel contracts with HMOs. It also hurts Texans in HMO plans by causing hospitals to limit services to HMO enrollees.

Many health plans operating in Texas pay claims even more slowly than Medicare. Millions of dollars of unpaid claims remain on the books for hospitals and providers as many as 180 days after the claims are submitted. Even more time is wasted as claims are resubmitted.

Doctors should spend their time treating patients, not arguing with health plans over claims submitted half a year earlier. Under current law, HMOs can delay payments even for preauthorized treatments for months. This “delay and deny” strategy leaves physicians with the choice of either accepting an HMO’s unacceptable offer or pursuing costly and even more time-consuming litigation.

This bill would requires health plans not only to pay undisputed claims promptly, but also to pay undisputed charges on claims containing some disputed items.

This bill would help HMOs by encouraging providers to make accurate and complete claims because the prompt payment rules would only apply to such claims. More clean claims would result in less additional processing work on the part of a health plan and less follow-up on the part of the provider, reducing the costs for both. Two months is sufficient time for health plans to process clean claims, request any follow-up information, and pay what is due.

Even though doctors are third parties to the enrollment contracts between enrollees and health plans, they deserve to be paid promptly for their services. The business standards that apply to insurance payments to third-parties such as auto body shops ought to apply to medical care. Doctors and hospitals should not be forced to make treatment decisions for a patient while wondering whether a claim may be left unpaid for six months or more, even if the claim is submitted completely and exactly in the format requested.

Concerns of parties opposed to the original bill were addressed by the substitute, including applying the 60-day limit only to clean claims, providing procedures to pay for audited claims, and eliminating certain interim deadlines for actions by the plan.

OPPONENTS SAY:

No apparent opposition.

NOTES: The substitute changed the original bill by:

- deleting requirements that plans acknowledge receipt of claims within two days of receipt;
- adding language applying the 60-day limit to clean claims only and deleting language requiring plans to request additional information from providers within 15 days of receipt;
- adding provisions regarding payment procedures for audited claims;
- deleting provisions regarding liability for interest accrued on unpaid claims;
- adding provisions allowing the plan to deduct charges for services not covered by the plan from the claim;
- adding provisions regarding changes in the data required for a completed claim and plans notification of providers; and
- adding provisions exempting capitation contracts and claims submitted by anesthesiologists from the prompt payment rules.

On May 3, the House passed to engrossment a related bill, HB 3041 by Smithee, revising the prompt payment requirements for first-party insurance claims, not including HMOs.