SUBJECT: Prompt payment of physicians by health maintenance organizations

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Eiland, Averitt, Burnam, G. Lewis, Moreno, Olivo, Thompson

0 nays

2 present, not voting — Smithee, Seaman

WITNESSES: *(On original version:)*

For — Greg Bonnen, M.D.; Jeff Brownawell, Memorial Hermann Hospital System; Cheryl Cook; Barbara Denison, Office of George W. Childress, M.D.; Jim Edwardson, Urology Associates of North Texas; Katherine Grigsby; Peggy Hendricks, Austin Ear, Nose and Throat Clinic; Harry Hendrix, Capitol Anesthesiology Association; Margaret Henry and Richard Tallman, Austin Diagnostic Clinic; Paul Herndon, Texas Children's Pediatric Associates; Thomas Johnston, Cardiothoracic and Vascular Surgeons; Anne Kanter, Methodist Healthcare System of San Antonio and Texas Hospital Association; Layton Lang, Dallas Surgical Group; Valery Mueller, Total Reimbursement and V. Mueller, Inc.; Steve Neorr, Medical Clinic of North Texas; Kevin Perryman, Primary Pediatric Medical Association; Tim Pruden, Texas Pulmonary Consultants; David Rogers, Collin-Fannin County Medical Society; Karol Shepherd, Austin Cardiovascular Association; Marjorie Thomas, Office of David Rogers, M.D.; Linda Weinberg, Denton County Medical Association; Debbie Woodard, Texas Health Resources and Texas Hospital Association

Against — Neill Fleishman, Blue Cross and Blue Shield of Texas; Eric Glenn, Humana, Inc.; Greg Hooser, Texas Association of Insurance Officials; Dan Keeling, Pacificare of Texas; Jeff Kloster, Health Insurance Association of America; Ron Luke, Texas Association of Business and Chambers of Commerce; Mike Pollard and Jay Thompson, Texas Association of Life and Health Insurers; Darrell Richey and Anita Schrader, Golden Rule Insurance Co.; William Taylor, M.D., Aetna; Milton Thomas and Rene Underwood, Cigna Healthcare of Texas

On — Dr. Brent King, University Care Plus

BACKGROUND:

Insurance Code, sec. 20A governs the operation of health maintenance organizations (HMOs) in Texas, and sec. 3.70 pertains to non-managed-care health insurance. For purposes of this analysis, the term "insurer" includes both HMOs and non-managed-care health plans, and "provider" includes physicians and other health-care providers. The Insurance 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.

In 1999, the 76th Legislature enacted HB 610 by Janek, which sought to require insurers to pay providers promptly and to standardize regulation of payment by different types of insurers.

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 prescription-benefit claim by the 21st day after the treatment is authorized. By the 45th day after receiving a medical claim from a provider, an insurer must either:

- 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 within 60 days.

DIGEST:

(The author plans to offer a floor substitute. This analysis reflects that substitute.)

HB 1862 as substituted would amend requirements for payment of health-care providers by insurers. The bill would affect activities leading up to the submission of a claim, the receipt and payment of a claim, and activities following payment. It would take effect September 1, 2001, and would apply only to contracts or services administered on or after that date.

Authorization, verification, and coding. HB 1862 would define "preauthorization" as a reliable representation that the insurer would pay the provider for a preauthorized service. This definition would include the terms precertification, certification, recertification, or other similar terms. An insurer would have to furnish a copy of the list of services that required preauthorization within 10 days of a request.

Determination of preauthorization for a service would have to be based on the medical necessity and appropriateness of a service and completed within one calendar day if the patient was in a hospital and within three working days if the patient was not hospitalized. If the proposed service involved inpatient care, the determination would have to specify an approved length of stay in a hospital.

A provider could request verification of eligibility for payment of a specific service for a specific patient. For this purpose, the insurer would have to provide a verification service from 6 a.m. to 6 p.m. CST every day.

Insurers would have to use nationally recognized Correct Procedural Terminology codes and bundling logic and edits. These codes are used to classify health-care services and often are bundled into a single code that designates a set of procedures. An insurer would have to provide a description of coding guidelines within 30 days of a request by a provider. These guidelines would have to be confidential, and providers could be fined $1,000 for misuse. The insurer could change the guidelines with 90 days

notice but could not make changes retroactive. A provider could terminate a contract with an insurer without penalty within 30 days of receiving coding guidelines or changes.

Receipt and payment. HB 1862 would define a "clean claim" as one submitted on the HCFA 1500 form (the federal Medicare claim form for ambulatory services) or the UB-92 form (the Medicare form for institutional services) that contained the appropriate information in the appropriate fields. An insurer could not require additional data unless required in an electronic transaction to comply with federal law. If the provider sent additional information not required by the insurer, the claim still would be considered a clean claim.

Presumed receipt. HB 1862 would remove the provision allowing providers to submit claims by mail with return receipt requested. Instead, the claim would be presumed to be received within three days of the date sent if the provider sent the claim by first-class mail and included a mail log. If the provider submitted a claim electronically, the claim would be presumed to be received if the provider received a confirmation from either the insurer's or the provider's clearinghouse. (Under current law, only confirmation from the insurer's clearinghouse can be used to show receipt.) If the provider faxed the claim, it would be presumed received on the date of the transmission acknowledgment, and if the provider hand delivered the claim, the date on the delivery receipt would confirm receipt.

Prompt payment. A provider would have to submit a clean claim within 95 days or forfeit payment, unless the deadline was extended by contract. The bill would preclude providers from submitting a duplicate claim within 45 days after submitting the original. Prompt-payment provisions would include claims from out-of-network providers and providers of emergency services. Providers could recover both attorney fees and court costs incurred in an action to recover payment. An insurer could not require a provider to use binding arbitration, but could offer dispute-resolution procedures with the provider's consent.

Attachments. An insurer would be limited to a single request for attachments with additional information relating to a claim. The request for attachments would be limited in time to 30 days after the claim was received and in

scope to clinical information. Upon receipt of an attachment from the provider, the insurer would have the greater of 15 days or until the end of the initial 45-day evaluation period to make payment.

If an insurer requested attachments from third parties other than the provider, the insurer would have to notify the provider but could not delay payment. If an error in payment was discovered upon receipt of materials from a third party, the insurer could recover payment from the provider.

TDI would have to adopt rules under which an insurer could identify attachments but could not add requirements for handling attachments.

Coordination of payment. An insurer could require that the provider retain information about other coverage. However, the insurer could not require the provider to coordinate payment for benefits. This provision could not be modified or nullified by contract.

If a provider billed more than one insurer, that provider would have to provide notice of who was billed on the claim to each insurer. Coordination of payment then would be the responsibility of the insurers. This would include initial payment, overpayment, or situations requiring recovery from the provider. The 45-day limit within which insurers would have to take action on a claim would not be extended due to coordination of payment.

Post-payment procedures. HB 1862 would create penalties for not taking appropriate action within 45 days of receipt of a clean claim. An insurer would have to pay the full amount of billed charges plus 15 percent interest. The provider would determine the amount of billed charges, as opposed to the amount of contracted charges, the amount that the insurer otherwise would pay the provider.

The provider would have to provide the insurer with a fee schedule of billed charges within 30 days of signing a contract with the insurer. The provider could change the fee schedule with 90 days notice. Billed charges in effect for the purposes of penalties would be those that were current at the time the claim was submitted.

Recovery. The insurer could recover funds that were overpaid if it notified the provider within 180 days of paying the claim and the provider did not make arrangements for repayment within 45 days. Insurers could deduct overpayments from future payments if the provider did not arrange for an alternative within 45 days.

This bill would specify that it would not affect providers' or insurers' relationships with Medicaid in billing or determining coverage.

HB 1862 would authorize the attorney general to take action and seek remedies against violations of the Unfair Competition and Unfair Practices section of the Insurance Code and the Deceptive Trade Practices section of the Business and Commerce Code.

SUPPORTERS SAY:

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 are counter to prompt payment, leaving providers in similarly dire situations as before HB 610 was enacted. HB 1862 as substituted would close loopholes, clean up areas of confusion in current law, and quickly improve the payment process for providers.

Texas is a national leader in prompt-payment legislation. The state should continue this leadership by approving HB 1862 as substituted. Texas is a large and growing market for insurers, and it is unlikely that any changes proposed by this bill would cause insurers to abandon this lucrative market.

Prompt payment regulations should apply to all insurers. Providers should have one set of expectations for all claims, including the time frame for payment. Exempting certain insurers would be confusing and difficult for providers and would be counter to the goal of uniformity and simplification.

The federal regulations contained in the Employee Retirement Income Security (ERISA) program are concerned with the relationship between insurer and enrollee. This bill would regulate only the relationship between insurer and provider. ERISA covers policies; this bill would cover claims.

Authorization, verification, and coding. Health-care providers should not be expected to render services without assurance that they will be paid. No other industry operates in this manner. Providers often have contact with insurers before rendering a service, then are informed that the service will not be reimbursed. If insurers want providers to check with them before a service is rendered, the insurer's assent should imply that payment is assured. Providers also should be able to verify that a specific service still is covered by calling the insurer to determine verification of coverage before rendering that service.

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. Preauthorization for hospital services should include the length of stay, because repeated calling for preauthorization for patients with conditions that will require multiple days in the hospital wastes everyone's time.

The determination of medical necessity through utilization review should be quick and easy. Given the level of automation used by most insurers, a telephone service for determinations would be appropriate. This would ensure that patients get the care they need within a reasonable time frame.

Insurers and providers must be assured that they are talking about the same thing when they refer to services. Uniform coding descriptions distributed to providers would ensure that all parties could reconcile billing with clinical services provided.

Receipt and payment. Insurers should not be able to delay payment for services indefinitely. Providers bill for services but do not receive payment for a host of technical reasons that are beyond a provider's control. This makes it difficult, if not impossible, for providers to evaluate the health of their business.

Clean claims. A provider may have contracts with many insurers, each requiring different information in a different format. Also, those elements can change at any time. This can lead to significant confusion and require the

provider to dedicate additional resources to billing. The HCFA 1500 and UB-92 forms are sufficient for the federal government to process claims, and they should be sufficient for private insurers. Insurers also could request additional information in the form of an attachment, so a standard form should be sufficient.

Presumed receipt. HB 1862 would establish clear guidelines for how could submit claims and presume receipt. Currently, an insurer can avoid paying a claim by stating that it never was received. Providers can send claims return receipt requested, but some insurers deny that the envelope held the claim or that anyone actually signed for it. Most businesses that send bills presume receipt and require payment within a certain number of days.

Prompt payment. HB 610, enacted last session, sets a deadline for payment of uncontested clean claims of 45 days after receipt. Just as insurers must pay within 45 days, providers should have to submit the claim within a certain time frame. The 45-day deadline for insurers to take action on a clean claim is appropriate because it would allow enough time to determine if the service is covered or not. A "percentage of claims" target would not be feasible because it would require an extensive tracking system.

Providers should have options other than binding arbitration to resolve payment conflicts with insurers. The cost of binding arbitration, up to $1,500 per meeting, discourages physicians from going after smaller costs.

Attachments. Another way that insurers avoid paying claims is by burying the provider in repeated requests for additional information. Given knowledge of the policy, the enrollee's background information, and authority to ask once for additional clinical information, an insurer should be able to make a decision.

Coordination of payment. Insurers, not physicians, should coordinate payment, because this is a function of the insurer's business. Enrollees give permission for the insurer to use any information needed to coordinate payment, so there is no reason why insurers cannot share enrollment information for the purpose of determining primary and secondary policies.

Post-payment procedures. While insurers now are required to 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.

Insurers can recover overpaid funds at any time and usually deduct them from payments for other services. This makes it very difficult for providers to match payments with services. Deducting overpayments from other services should be a last resort, not common practice.

OPPONENTS SAY:

The TDI rules promulgated after enactment of HB 610 in 1999 have been in place for only eight months, not enough time to determine how effective they are. The Legislature should resist making further changes until the current regulations have been in place for at least another year.

Providers are not in a dire situation. The accounts-receivable numbers that they cite as a challenge for their business are inflated because they depend on billed charges, not the contracted charges for services. If providers would account for services according to contracted charges, their accounts receivable would decrease.

The changes put in place by HB 610 have made Texas' regulations the most stringent in the nation. Additional regulations could make the regulatory environment in Texas inhospitable for insurers. The number of insurers in the state continues to decline, and Texas has such a large uninsured population that the state should not discourage insurers from doing business here.

Cost should be a primary concern for legislators. The state already spends billions on health benefits and may spend billions more if the Legislature creates a health insurance plan for teachers and other public school employees. The provisions in HB 1862 would drive up the cost of health insurance for both private and public-sector employers in Texas.

Authorization, verification, and coding. Federal regulations contained in the Employee Retirement Income Security (ERISA) program may bar many of HB 1862'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.

Insurers should not have to pay for a service that is 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 phone in the absence of additional information.

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 of one calendar day for determination is too short, and verification every calendar day is unnecessary. This would require that insurers have agents on staff on weekends, 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.

Coding guidelines are the core of an insurer's competitive advantage. The penalty of $1,000 for misuse of this information would not be sufficient to prevent this highly sensitive material from being distributed. The fines should be at least $10,000 per day per offense.

Receipt and payment. HB 1862 unfairly would punish insurers whose customers' primary concern is affordability. Insurers who write policies for individuals, rather than for employers, depend on providing affordable plans. They do this by limiting and excluding benefits on individual policies and ensuring that only covered services are paid. To reconcile these concerns with claims, these insurers often need more information than a basic claim form provides and must request additional information on attachments.

Clean claims. Most insurers use the HCFA 1500 and UB-92 forms already. Also, they often require that fewer data fields be filled in to constitute a clean claim, focusing only on those that are relevant to that claim. Requiring all elements to be filled out simply would create more work for providers.

Limiting the information that insurers get in a claim would not provide enough information for all insurers for the claim to be determined appropriately. For example, the HCFA 1500 form includes a box for enrollees to check if they have other insurance, but it does not provide for

information about more than one other insurance. HB 1862 would not allow insurers to request this information because requested attachments only could contain clinical information, yet it would require insurers to coordinate benefits.

Presumed receipt. Providers' clearinghouses' confirmations should not be used to verify receipt of a submission. If the clearinghouse were to send the submission to the wrong electronic address, the insurer would be responsible for determining the claim without having received it.

Prompt payment. The 45-day deadline for insurers to take action on a clean claim would be inappropriate for some insurers that rely on keeping costs low by providing policies with many exceptions and limitations. A "percentage of claims" target, under which insurers would take action on (for example) 90 percent of claims within 45 days would be preferable. This would allow the provider to be paid in a timely manner for most claims, but also would allow the insurer to investigate cases that were out of the ordinary. TDI could oversee compliance with this provision.

Insurers should be able to recover the same fees as providers in an action to recover payment. HB 1862 would authorize court costs for providers, but not for insurers.

These regulations should not include out-of-network providers. The regulations are targeted at the contracted relationship between provider and insurer, not at providers with whom an insurer does not have a contract.

Attachments. One attachment request often is insufficient to make a determination on a claim. Also, limiting such requests to clinical information could prevent insurers from determining if an enrollee had other insurance, previous conditions, or other nonclinical information that could have a direct bearing on whether or not the claim was payable.

Attachment information often is used to prevent fraud by ensuring that physicians are not overbilling. Limiting requests to a one time attachment would limit insurers' ability to detect fraud.

Coordination of payment. Insurers should not have to pay an entire claim if they do not owe the entire amount. By sending the same claim to multiple insurers, the provider could be paid multiple times by insurers under pressure of the 45-day deadline. If an insurer overpays, it can take months to recover the payment from the provider.

The entity closest to the enrollee is the provider. Enrollees do not visit their insurers' offices. The provider's office is the most convenient place for the enrollee to provide information about coverage.

Post-payment procedures. The proposed penalty of all billed charges is too high. 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.

Hospitals would find it difficult to share their fee lists, which are much larger and change more quickly than those of other providers.

In current practice, an insurer that overpays simply deducts the overpayment from future payments. HB 1862 would require insurers to wait 45 days before doing this. It would be unfair to make insurers wait 45 days before they could collect.

Limiting recovery to 180 days also would be unfair. Overpayments may be discovered in the course of an annual audit that may not fall within 180 days of the claim being paid. If an insurer found an overpayment, that insurer would have to write off the cost and keep paying the provider for subsequent claims. A longer period for recovery would be more fair.

Limiting the number of days to recover an overpayment also would create a disincentive for providers to help determine if an overpayment occurred. Providers only would have to wait 180 days, and the money would remain theirs, whether or not the payment was made in error. This time-certain provision would cause difficulty in investigations, particularly in cases that involved coordination of payment.

OTHER OPPONENTS SAY:

HB 1862 as substituted should not apply to all insurers. It should exclude individually underwritten, non-employer-based insurance companies, which are not HMOs and do not have the same prompt-payment problems. These insurers' enrollees rely on affordability of coverage, which, in turn, requires exclusions and limitations on coverage. The prompt-payment requirements of HB 1862 would make it impossible for these insurers to determine coverage accurately, which would result in paying for services that are not covered and would drive up costs.

NOTES:

The fiscal note for the committee substitute anticipates no fiscal impact on the state. However, it assumes that TDI would need to hire three additional employees to handle an increase in complaints, given that more providers might contract with insurers (HMOs in particular) because the bill would alleviate some of providers' traditional concerns about managed care. It also assumes that the requirements to provide notice of verification errors would create specific grounds for disagreement between providers and insurers and that the bill would result in increased complaints about noncompliance by HMOs.

A similar bill, SB 1284 by Van de Putte, was considered in a public hearing on April 19 by the Senate Business and Commerce Committee, which has taken no action on the bill.

The floor substitute significantly differs from the bill as filed. Elements in the filed version that are not in the floor substitute include: a list of the elements in a claim form, unlimited number of attachment requests, regulation of utilization review and retrospective review processes, descriptions of coding guidelines, 24-hour determination services, deletion of audit provisions, and 18 percent interest on late payments.

The committee substitute added new provisions and changed some of those listed above, including limiting the number of attachment requests. The floor substitute differs from the bill reported from committee in various ways, including incorporating the HCFA 1500 and UB-92 forms into the definition of a clean claim but not including the data elements. The floor substitute removes regulation of utilization review and retrospective review processes, adds descriptions of coding guidelines, changes 24-hour determination

services to 6 a.m. to 6 p.m. CST, restores audit provisions, and reduces interest on late payments to 15 percent.

Also, CSHB 1862 would provide that the bill's requirements could not be changed by contract, whereas the floor substitute would apply that prohibition only to certain provisions, such as coordination of payment. The floor substitute would provide that coordination of payment would be conducted without the provider. It also would limit the amount of time that a provider would have to submit a claim after rendering a service.