BILL ANALYSIS

Senate Research Center

H.B. 610
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Economic Development
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Engrossed

DIGEST

Currently, Health Maintenance Organizations are not required to compensate physicians for services within a specified period of time. H.B. 610 would regulate payments to providers under certain health benefit plans to ensure prompt payment.

PURPOSE

As proposed, H.B. 610 regulates payments to healthcare providers who provide services under certain health benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the Commissioner of Insurance in SECTIONS 1 and 2 (Section 18B(o), Chapter 20A, Insurance Code and Section 3A(n), Article 3.70-3C, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 20A, Insurance Code (The Texas Health Maintenance Organization Act), by adding Section 18B, as follows:

Sec. 18B. PROMPT PAYMENT OF PHYSICIAN AND PROVIDERS. Defines "clean claim." Authorizes a physician or provider for medical care or health care services under a health care plan to obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim in a certain manner. Provides that a health maintenance organization (HMO) that receives a claim electronically and that confirms receipt of the claim electronically is not required to acknowledge receipt of the claim in writing. Sets forth the required actions of the HMO, to occur not later than the 60th day after the date that the HMO receives a clean claim for a physician or provider. Requires a claim to be within a certain time period, if a prescription benefit claim is electronically adjudicated, and the HMO or its designated agent authorizes treatment. Requires the HMO to pay certain charges within a certain time period, if the HMO acknowledges coverage of an enrollee under the health care plan but intends to audit the physician or provider claim. Requires any additional payment due a physician or provider or any refund due the HMO to be made within a certain time period, following completion of an audit. Provides that a HMO that violates Subsections (c) or (e) of this section is liable to a physician or provider for the full amount of charges submitted on the claim at the contracted rate, plus any penalties imposed under the contract, less any amount previously paid or any charge for a service that is not covered by the health care plan. Authorizes a physician or provider to recover reasonable attorney's fees in an action to recover payment under this section. Provides that in addition to any other penalty or remedy authorized by the Insurance Code or another insurance law of this state, a HMO that violates Subsection (c) or (e) of this section is subject to an administrative penalty under Article 1.10E, Insurance Code. Prohibits an administrative penalty imposed under that article from exceeding $1,000 for each day the claim remains unpaid in violation of Subsection (c) or (e) of this section. Requires the HMO to provide a participating physician or provider with copies of all applicable utilization review policies and claim processing policies or procedures. Authorizes a HMO, by contract with a physician or provider, to add or change the data elements that must be submitted with the physician or provider claim. Requires the HMO to provide written notice of an addition or change to each participating physician or provider, within a certain time period. Provides that this section does not apply to a claim made by an anesthesiologist. Provides that this section does not apply to a capitation payment required to be made to a physician or provider under an agreement to provide medical care or health care services under a health care plan. Provides that this section applies to a person with whom a HMO contracts to obtain the services of physicians and providers to provide health care services to health care plan enrollees. Authorizes the

Commissioner of Insurance (commissioner) to adopt rules as necessary to implement this section.

SECTION 2. Amends Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, by adding Section 3A, as follows:

Sec. 3A. PROMPT PAYMENT OF PREFERRED PROVIDERS. Defines "clean claim." Authorizes a preferred provider for medical care or health care services under a health care plan to obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim in a certain manner. Provides that an insurer that receives a claim electronically and that confirms receipt of the claim electronically is not required to acknowledge receipt of the claim in writing. Sets forth the required actions of the insurer, to occur not later than the 60th day after the date that the insurer receives a clean claim for a preferred provider. Requires a claim to be within a certain time period, if a prescription benefit claim is electronically adjudicated, and the preferred provider or its designated agent authorizes treatment. Requires the insurer to pay certain charges within a certain time period, if the insurer acknowledges coverage of an insured under the health care plan but intends to audit the preferred provider claim. Requires any additional payment due a preferred provider or any refund due the insurer to be made within a certain time period, following completion of an audit. Provides that an insurer that violates Subsections (c) or (e) of this section is liable to a preferred provider for the full amount of charges submitted on the claim at the contracted rate, plus any penalties imposed under the contract, less any amount previously paid or any charge for a service that is not covered by the health insurance policy. Authorizes a preferred provider to recover reasonable attorney's fees in an action to recover payment under this section. Provides that in addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Subsection (c) or (e) of this section is subject to an administrative penalty under Article 1.10E of this code. Prohibits an administrative penalty imposed under that article from exceeding $1,000 for each day the claim remains unpaid in violation of Subsection (c) or (e) of this section. Requires the insurer to provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures. Authorizes an insurer, by contract with a preferred provider, to add or change the data elements that must be submitted with the preferred provider claim. Requires the insurer to provide written notice of an addition or change to each preferred provider, within a certain time period. Provides that this section applies to a person with whom an insurer contracts to obtain the services of preferred providers to provide medical care or health care to insureds under a health insurance policy. Authorizes the commissioner to adopt rules as necessary to implement this section.

SECTION 3. Amends Section 5(c), Article 21.55, Insurance Code, to provide that this article does not apply to a claim governed by Section 3A, Article 3.70-3C, of this code.

SECTION 4. Effective date: September 1, 1999.

SECTION 5. Emergency clause.