BILL ANALYSIS

Senate Research Center
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C.S.H.B. 610
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Economic Development
5/12/1999
Committee Report (Substituted)

DIGEST

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

PURPOSE

As proposed, C.S.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(n), Chapter 20A, Insurance Code and Section 3A(m), 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. Requires a health maintenance organization (HMO) or the contracted clearinghouse of the HMO that receives a claim electronically to acknowledge receipt of the claim by electronic transmission but 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 45th day after the date that the HMO receives a clean claim for a physician or provider. Requires the HMO to pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the claim is received, 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 (d) of this section is liable to a physician or provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, 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, an HMO that violates Subsections (c) or (d) 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 Subsections (c) or (d) 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 an 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 a physician or provider who is a member of the legislature. 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 an HMO contracts to process claims or 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. Requires an insurer or the contracted clearinghouse of an insurer that receives a claim electronically to acknowledge receipt of the claim by electronic transmission but 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 45th day after the date that the insurer receives a clean claim for a preferred provider. 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 (d) of this section is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, 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 Subsections (c) or (d) 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 Subsections (c) or (d) 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 does not apply to a preferred provider who is a member of the legislature. Provides that this section applies to a person with whom an insurer contracts to process claims or to obtain the services of preferred providers to provide medical care or health care to insurers 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. Requires the lieutenant governor and the speaker of the house of representatives to appoint a joint committee of the legislature to make recommendations concerning the adequacy of state laws governing the payment and settlement by HMOs and the enforcement of applicable laws. Requires the interim committee established under this section to report the results of its study together with recommendations adopted by the committee, to the lieutenant governor and the speaker of the house, not later than December 31, 2000.

SECTION 5. Effective date: September 1, 1999.

SECTION 6. Emergency clause.