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## *The Prompt Payment Dispute*

Issues surrounding the payment of physicians and other health-care providers by insurers in Texas have grown more and more contentious in recent years. Physicians say their livelihoods are threatened by insurers' payment practices, and they call for additional regulation to ensure timely payment. Insurers oppose additional regulation without further study of the root causes of prompt-payment issues on both sides.

Texas physicians complain that insurers are slow to pay or refuse to pay for millions of dollars of services the physicians render to insured patients each year. Despite state legislation in 1999 that was intended to accelerate payment to providers, physicians say that insurers have been able to evade legal requirements and delay payment by refusing to accept postal receipt of claims and by denying claims inappropriately. Insurers say they pay almost all claims promptly and that forcing them to pay claims for services not covered, for ineligible enrollees, or that are duplicative would drive up insurance premiums and increase the number of uninsured Texans.

The 77th Legislature in 2001 enacted HB 1862 by Eiland to revise prompt-payment requirements, but Gov. Rick Perry vetoed the bill, citing changes that he said could lead to more lawsuits. However, the governor directed the Texas Department of Insurance (TDI) to be more aggressive in helping to resolve disputes over claims. Since then, TDI has fined 47 insurers a total of \$15 million for prompt-payment violations and has ordered insurers to pay restitution to physicians seeking payment in an amount that ultimately could total tens of million of dollars.

*The 78th Legislature may revisit issues related to the prompt payment of physicians' claims by insurers, which have confronted lawmakers since 1997.*

Lt. Gov. Bill Ratliff established a Senate Special Interim Committee on Prompt Pay of Health Care Providers to evaluate current state law and agency rules and to recommend ways to improve the process of paying health insurance claims. Also, TDI has met four times with the Clean Claims Working Group, created to recommend revisions to the agency's

payment rules. These meetings have sought to resolve some prompt-payment issues, but others are likely to confront the 78th Legislature when it convenes next year.

## Legislative background

The 75th Legislature in 1997 enacted SB 383 by Cain, et al., and SB 385 by Sibley, et al., which require health maintenance organizations (HMOs) and insurance carriers issuing preferred-provider benefit plans (collectively, insurers) to pay a health-care provider for covered services within 45 days after receiving a claim that includes reasonably necessary documentation (Insurance Code, Art. 3.70-3C, sec. 3(m), and Art. 20A.09(j)). Soon after, disputes arose between insurers and providers over what documents were reasonably necessary.

In 1999, the 76th Legislature enacted HB 610 by Janek, et al., which requires prompt payment of “clean” claims, as defined by TDI, and sets penalties for late payments.

The act applies to payments made by HMOs and issuers of preferred-provider benefit plans. An insurer must pay the total amount of a clean claim by the 45th day after receipt or else notify the provider why it will not pay the claim. If only a portion of the claim is in dispute, the insurer must pay the amount not in dispute and must notify the provider of the status of the remainder. An insurer that intends to audit a claim must pay 85 percent of the contracted rate by the 45th day. Failure to make timely payment makes the insurer liable for the full amount of billed charges or for a contracted penalty rate, plus an administrative penalty of up to \$1,000 per day that the claim remains unpaid.

A provider may obtain acknowledgment of receipt of a claim by mailing the claim with return receipt requested. For claims submitted electronically, the insurer must acknowledge receipt electronically. An insurer must give a provider a copy of its policies and procedures for utilization review and claim processing, including required data elements and claim formats. The insurer may change claim elements by notifying the provider at least 60 days before they go into effect.

In May 2000, TDI adopted rules to implement HB 610 (Texas Administrative Code, Title 28, secs. 21.2801-

21.2816). The rules define a clean claim as one submitted with documentation reasonably necessary for the insurer to process the claim. They include a list of elements based on federal claim forms for Medicare. An insurer may request attachments, such as medical records or operative reports, and the amount paid by any other insurer.

**Medical complaints.** A year after TDI adopted these regulations, doctors continued to complain about slow payment or nonpayment by insurers. A survey by the Texas Medical Association reported that 60 percent of Texas physicians had experienced cash-flow problems because of insurers’ failure to pay claims promptly and that physicians’ accounts receivable (unpaid bills) were very high. At the same time, a TDI survey of 52 insurers indicated that almost 99 percent of claims were paid on time. TDI appointed an ombudsman to investigate complaints and warned insurers that the agency might impose sanctions and penalties or even revoke the license of an insurance carrier that did not comply with the prompt-payment rules.

Providers contend that insurers use loopholes to evade the regulations or require physicians to contract away their prompt-payment rights. In many cases, physicians say, an insurer will deny that it has received a claim, no matter how the claim was submitted. Physicians say that they send claims with return receipt requested but that insurers refuse to sign for the claims or deny that the addressee works there. They also report that insurers wait until near the 45th day, then ask for additional information in the form of attachments. In other cases, providers say, an insurer that misses the 45-day payment window will wait as long as possible thereafter to pay the claim, because there is no difference in the penalty for paying on the 46th day or a year later.

Insurers say they sometimes fail to receive claims because a physician’s billing contractor rejects the claim or does not send it. They also maintain that providers are slow to update their accounts-receivable numbers after claims are paid and that the cash-flow problems cited by providers can be due to untimely accounting. Insurers note that they can pay stiff penalties for missing the 45-day window and that their business is most profitable when they pay claims on time.

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*State law requires an insurer to pay a “clean” claim within 45 days of receipt or else notify the health-care provider why the insurer will not pay the claim.*

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Providers also complain that insurers' billing and coding policies make it difficult to know whether providers and insurers are talking about the same things when they discuss certain services. They cite as especially confusing the practices of "bundling," grouping related services under a single procedure code, and "downcoding," replacing one code with another.

As an example of bundling, a patient might make an appointment to see his physician about a cold. While there, the patient might ask the physician to remove a mole also. The physician's office then would issue a bill for an office visit and a procedure, and the insurer might combine or "bundle" the office visit with the procedure and reimburse for a billing code that was less than the two items would have totaled separately. As an example of downcoding, a provider might charge for a complicated office visit, such as a checkup for a patient with the human immunodeficiency virus, and the insurer might change the billing code to reflect an ordinary office visit subject to a lesser charge.

Providers say that bundling can lead to confusion in billing and reimbursement and that not knowing the coding procedures makes it difficult to predict what amount will be reimbursed for a service. They advocate requiring insurers to use uniform billing codes and to distribute all codes and the logic behind bundling. Insurers respond that they use bundling and downcoding to evaluate providers' claims and that these coding changes are necessary to pay correctly what they owe under their contracts with providers. They maintain that providers sometimes willfully overcharge by manipulating coding and that providers can predict their reimbursement by following the American Medical Association's guidelines on coding.

Another area of concern has been prior authorization, requiring a provider to obtain the insurer's authorization before rendering a service. Insurers often require prior authorization for certain procedures, on the grounds that this helps providers and patients determine whether a certain procedure is medically necessary as required by a patient's policy.

Providers complain that some insurers give prior authorization but then refuse to pay the claim on the basis of other information. They say that insurers should have all the information they need to make a decision before a service is rendered and that prior authorization should imply that the service will be reimbursed. Providers also

## Medicaid Prompt-Payment Rules

The state is one of the largest health insurers in Texas through the state-federal Medicaid program for the poor, elderly, and disabled. While some Medicaid beneficiaries are subject to a traditional fee-for-service arrangement, the state also contracts with health maintenance organizations (HMOs) for the Medicaid managed care program.

The Texas Department of Insurance's (TDI) prompt-payment rules do not apply to Medicaid HMOs because federal regulations govern those payments. The contractual agreement between the state and Medicaid HMOs requires that 90 percent of claims be paid or denied within 30 days of receipt. Within an additional 60 days, 99 percent of the claims must be paid or denied. The contract contains TDI's definition of a "clean" claim and penalties for noncompliance, including termination of contract, suspension of new enrollments, monetary damages, and other measures. Medicaid plans are not subject to audits.

note that without a guarantee that insurers will pay, providers and patients cannot make alternate payment arrangements. By the time the insurer rejects the claim, the provider may be forced to negotiate with the patient, whereas the two parties could have established a payment plan during the patient's office visit before the service was rendered. Insurers reply that prior authorization does not mean assent but simply verifies that a proposed service is medically necessary. Prior authorization of medical necessity, they say, is a medical rather than a contractual determination that outside agents often make without knowledge of other policy exclusions. The insurer may deny a claim later because other contract provisions render the claim ineligible for payment.

Insurers say prior authorization cannot guarantee payment because an insurer often does not have enough information to make that determination at the time the provider calls. The intent of prior authorization, they say, is to tell the provider whether or not a service is medically necessary so that the provider can decide whether to proceed. It does not imply a promise to pay, insurers say, because the insurer has not yet determined if the service

is covered. Insurers say they should not be forced to pay until they have all the necessary information.

Insurers maintain that providers have inflated the magnitude of payment problems. They contend that individual insurers typically pay almost all claims within the time frame allowed by law or sooner. They say that they process millions of claims per year and that few claims require additional information before they can be paid. Providers acknowledge that most claims are paid on time, but they say that unpaid claims still represent millions of dollars. They contend that insurers withhold payment on the largest claims for so long that it creates cash-flow problems for individual physicians and hospitals.

**HB 1862 and the aftermath.** HB 1862 by Eiland, enacted by the 77th Legislature but vetoed by Gov. Perry, would have amended requirements for payment of health-care providers by insurers, including activities leading up to the submission of a claim, receipt and payment of a claim, and activities following payment. Among other provisions, the bill would have established presumed receipt for claims sent by mail; defined prior authorization as a reliable representation that an insurer would pay for a service; required an insurer to disclose additional coding information; limited insurers' requests for additional information through attachments; and prohibited an insurer from requiring a provider to use binding arbitration to settle prompt-payment disputes.

Providers said HB 1862 would have addressed their concerns about clean claims, prior authorization, coding, receipt and payment, and post-payment issues. Opponents, however, questioned whether providers' problems were dire enough to warrant new legislation. They contended that providers' high accounts-receivable numbers were inflated because they reflected billed charges, not the contracted charges for services. Opponents also warned that Texas' regulations are among the most stringent in the nation and that additional regulations would make the business environment inhospitable for insurers. Companies that remain in the state, they said, would have to pass along additional costs to their customers, driving up the cost of health insurance for all Texans. The bill's supporters responded that Texas is a large and growing market for insurers and that the changes proposed in HB 1862 would be unlikely to cause insurers to abandon this lucrative market.

Some insurers questioned whether any additional regulation would stand up in court under federal law. They said that regulations for the federal Employee Retirement Income Security Act (ERISA) program would supersede state law and that additional regulation could apply to fewer than half of insurers in Texas.

Gov. Perry's veto message stated that the bill's prohibition of contractual requirements for binding arbitration of disputes would force more cases to go to court, delaying payment further and possibly driving up the cost of health insurance and increasing the number of uninsured Texans. Supporters of the bill said that prohibiting binding arbitration would be unlikely to send a significant number of cases to court because legal costs typically are very high. The governor directed TDI to be more aggressive in assisting physicians and other health-care providers in claims disputes and to strengthen existing prompt-payment rules.

Since the veto, TDI has sought to improve compliance with current law and has mediated disputes between insurers and providers on certain issues. As of July 2002, TDI's efforts had resulted in consent orders requiring 47 HMOs in Texas to pay about \$36 million in restitution to providers and \$15 million in fines for failing to comply with prompt-payment regulations.

Insurers disputed whether TDI could release to the public prompt-payment restitution reports filed by insurers under the consent orders, which the insurers said was confidential, proprietary information. In February, however, the Office of the Attorney General (OAG) determined that the state Public Information Act requires release of this information ([OR 2002-0521](#), February 1, 2002).

In September 2001, Attorney General John Cornyn opened an investigation into physicians' and hospitals' complaints about insurers' payment practices, including prompt payment. These complaints concern bundling services into lower reimbursement codes, downcoding, changing reimbursement rates without proper notification, and retroactive denials for certain hospital stays. The attorney general will seek to determine whether insurers are complying with prompt-payment laws. The ongoing investigation focuses on nine HMOs, representing about 80 percent of the HMO business in Texas.

One company under investigation, PacifiCare of Texas, filed suit in October 2001 challenging the attorney general's authority to conduct such an investigation rather than

cooperating with the state to resolve unpaid claims. In response, the OAG filed suit in February against PacifiCare, saying that the company had failed to monitor the activities of third parties it uses to provide services (called delegated networks) to ensure their compliance with Texas' insurance laws. The OAG claims that PacifiCare's inaction left millions of dollars in claims unpaid and disrupted patient care for its beneficiaries.

## Resolving prompt-payment issues

Some of the issues surrounding HB 1862 have been or are being resolved through other channels. TDI and stakeholders have reached a preliminary agreement about disclosure of claim-processing procedures, although the details remain contentious. Ongoing implementation of the federal law on health insurance portability likely will resolve issues related to claim receipt and attachments. TDI by rule can settle the issue of elements required for a clean claim. Other issues, however, are likely to be the focus of legislative scrutiny in 2003.

**Coding.** Providers have sought access to insurers' billing codes and bundling logic to assure themselves that they are talking about the same services when they bill insurers. Insurers say this information is proprietary to prevent providers from engaging in "creative billing" by using codes that maximize payment but do not reflect accurately the services rendered. In some cases, they say, coding information is protected by confidentiality agreements with software manufacturers.

Following the 2001 legislative session, insurers agreed to make coding information available confidentially by disclosing the type of software and methodology used and the appeals process to be used when a provider disputes payment. They would provide examples of codes and would disclose all information about the coding for individual claims. Providers argue that this type of disclosure is inadequate because they need to see the codes for all services up front rather than individual examples. Insurers say such disclosure would provide enough information to clarify codes for providers within the boundaries of insurers' confidentiality agreements.

Rep. Bob Turner asked the attorney general for an opinion on whether TDI had the authority to make rules requiring insurers to disclose this information. In May, the OAG issued an opinion ([JC-502](#)) determining that TDI has authority to promulgate such rules. Since then, TDI has proposed new rules that would require disclosure of coding and bundling information (*Texas Register*, June 14). One rule would require that a contract between a provider and an insurer contain all necessary information to determine payment according to the terms of the contract. The other proposed rule would make similar information available to providers upon request. Neither rule would require insurers to disclose detailed information on proprietary software, but both would require summary disclosure, a general description of the information.

The disclosure requirements that TDI proposes are likely to displease both providers and payers. Providers say that uniform coding descriptions would help ensure that all parties could reconcile billing with clinical services provided. They support the use of standard codes and edits like those used by the National Correct Coding Initiative (NCCI), established in 1996 by the federal Centers for Medicare and Medicaid Services to ensure proper billing by Medicare carriers. An edit is an automated review of a claim to check for possible double-billing or overbilling by identifying inappropriate codes.

Providers say the NCCI would help prevent inappropriate coding and cut down on bundling and downcoding. For example, an edit might find two codes that represent services that cannot be performed in the same visit to a physician, such as a treatment and follow-up in the same visit. The edit would identify the coding error and flag the claim for further investigation.

Insurers say the NCCI could not be implemented because the commercial market uses codes that the public market does not use. They also say the initiative is not appropriate for the commercial market because an insurer's competitive advantage often rests in the amount the company pays for certain services or in the types of services it covers. For example, an insurer might offer coverage at a lower premium if it can restrict the array of services offered. Instead of including diagnostic tests

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*Some prompt-payment issues are being resolved through non-legislative channels, but other issues are likely to confront lawmakers in 2003.*

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as part of all general checkups, it might restrict those tests to checkups on patients over a certain age. Insurers say they need to use their own codes to achieve this flexibility in benefits packages and to offer competitive premiums.

Providers complain that they are caught between market demands and insurers' quest for competitive advantage. They say that insurers do not want to restrict the services they offer because they want potential customers to perceive that they offer a rich array of benefits, but that insurers try to pay the lowest amount possible for those services, forcing providers to make up the difference. Releasing coding procedures, providers say, would level the playing field for them.

Insurers say it would be unfair to require them to disclose such sensitive information without assurance that providers who misused the information would be fined. They say that their contracts with software makers prevent them from disclosing certain types of information to providers. Even though the proposed rules would require only summary information, insurers might not be able to give providers the depth of information the proposed rules are intended to elicit.

**Claim receipt and attachments.** Providers say that insurers avoid paying for some claims by refusing to acknowledge their receipt in the mail or that they delay payment by asking for additional information through attachments. The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 governs a wide range of insurance issues, including consumer protections and administrative simplification. The act requires the U.S. Department of Health and Human Services (HHS) to establish national standards for electronic health-care transactions, including national numerical identifiers for providers and insurers as well as standard electronic data formats. These ID numbers are intended to resolve the problem of misspelled provider names, wrong addresses, and other clerical problems that can delay processing of claims. The final rule related to establishing the first set of national identifiers will take effect July 30, 2002, and the ID numbers will be phased in over the next 24 to 36 months.

Widespread use of electronic health-care transactions could resolve the problem of presumed receipt of claims, because electronic systems are considered better than mail in minimizing the loss of claims. According to a January 2002 survey by TDI, 73 percent of all claims are filed

electronically. HIPAA directs HHS to create eight standard attachment forms for use in electronic health-care transactions, and efforts are under way to develop them. When those become available and if they are used widely, the problem of attachments should diminish.

**Clean claim elements.** Providers say that some of the elements required for a clean claim create problems for specialty practitioners in certain practice situations. For example, the form asks for the date of current illness, information that a radiologist or other specialist who has no contact with a patient would not know. Insurers have said that TDI could change its rules to make some of the requested information conditional for certain specialists that do not have access to the information.

## Lingering issues

**Prior authorization.** Providers say that if they obtain prior authorization by insurers for medical procedures, they should be able to expect payment. They say that even when a provider calls an insurer to determine whether a patient's insurance policy covers a certain procedure, the provider bears the entire financial risk because the insurer can deny the claim later.

Insurers say that the information they need in order to approve and pay claims is not always available when a provider calls for prior authorization. For example, contractual issues may exist that can be determined only after a claim is filed. A patient may need a service that is medically necessary but that is ineligible for payment because it treats a preexisting condition. Other contractual issues may involve worker's compensation and cosmetic or experimental treatments.

An insurer also may be uncertain about a patient's eligibility for benefits. Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, former employees of a company and their dependents can obtain temporary continuation of health coverage if they choose to do so within 60 days of notification that they are COBRA-eligible. Insurers say that this 60-day window makes it impossible for them to know whether a recipient will opt for this coverage and be eligible to receive a specific treatment, and insurers should not have to bear the financial risk of guaranteeing payment if they are required to leave the COBRA window open for 60 days. If a claim is submitted, the insurer does not want to pay it if the patient is no longer a recipient. Until

60 days have passed, however, the insurer does not know whether that patient will choose to continue coverage under COBRA or not.

A possible solution would be for the insurer to share the risk with the insured's employer, who would pay the insurer for some portion of the premium to continue coverage during the 60-day window. If the insured made a claim during that period, the insurer would pay it. Employers argue, however, that they should not have to pay for health insurance for former employees. Oklahoma has addressed this issue by building the cost of the COBRA risk into the rates that insurers charge. Another possible solution would be for the employer to notify the insurer immediately upon termination. The insurer would deny a claim received after the termination date. If the former employee elected to purchase COBRA coverage, the insurer could pay the claim retroactively.

**Binding arbitration.** Binding arbitration requirements remain an issue in the wake of Gov. Perry's veto of HB 1862. Contracts between providers and insurers often require the parties to use binding arbitration in the event of disputes. Such contracts can preclude providers from hiring attorneys or from contacting their professional societies.

Providers say that arbitration is expensive, up to \$1,500 per meeting, and discourages physicians from pursuing smaller claims. Although providers say they have no interest in taking disputes to court, they want to prevent insurers from requiring binding arbitration as the sole remedy. In its place, they propose voluntary arbitration or more permissive contractual arbitration agreements. Insurers and advocates for limitations on tort liability, however, oppose removing contractual requirements for binding arbitration on the grounds that more disputes would go to court and further clog the state's legal system.

**Penalties.** An insurer that does not comply with prompt-payment rules must pay full billed charges or a contracted penalty rate (Insurance Code, sec. 3.70-3C). Billed charges are the amount a provider would charge any person and are significantly higher than the discounted rate the insurer generally pays.

Providers contend that TDI is not complying with this law because the agency considers the "going rate" when determining billed charges, not the actual billing. Insurers say the law should be changed to remove billed charges from the equation altogether. They say that charges billed by providers are unreasonably high and that insurers can wind up paying amounts in excess of state usury laws if they make a mistake and do not pay in full on time.

**Audits.** An insurer can audit a claim before paying it if the insurer pays 85 percent of the claim within 45 days and completes the audit within 180 days. Insurers say that providers have no incentive to give insurers the information they need to perform accurate audits because providers receive the final 15 percent at the end of the period whether or not they cooperate. Insurers say the law should require providers to provide information requested for audits, and they have suggested penalizing providers for not returning documents in a timely manner.

Providers argue that insurers often ask for information the providers do not have in an attempt to delay payment as long as possible. They say that providers have no interest in delaying payment of the final 15 percent but would rather submit all of the information an insurer needs so that the provider can receive full payment before 180 days have passed.

**ERISA preemption.** Some insurers maintain that federal law preempts Texas from regulating much of the health insurance market. Others counter that prompt payment does not fall under the two types of federal preemptions and can be regulated by states.

The Employee Retirement Income Security Act (ERISA) of 1974 governs employee benefit plans, including health plans. These "ERISA plans" cover about 45 percent of insured Texans. The federal law governs the administration of health plans, including fiduciary standards, requirements for plan descriptions issued to beneficiaries, exclusions for pre-existing conditions, standards for length of stay in maternity hospitals, and other aspects of these plans.

ERISA may preempt state law in two ways. First, in cases where federal law conflicts with state law, federal

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*Some insurers maintain that the federal Employee Retirement Income Security Act preempts Texas from regulating much of the health insurance market.*

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law prevails. Second, ERISA contains a “preemption clause” that supersedes state laws that “relate to” private-sector employee health plans. In the past, the courts have interpreted ERISA preemption very broadly. However, there is an exception in Congress’ authority to regulate ERISA plans, called the “savings clause,” which asserts states’ authority to regulate insurance under the federal McCarran-Ferguson Act of 1945. This means that private-sector employee health plans that are self-insured still fall under ERISA, whereas states can regulate plans that do not bear the primary insurance risk.

Those who maintain that Texas has authority to regulate prompt payment say that because ERISA only pertains to the relationship between insured and insurer and because Texas law relates to the contract between provider and insurer, ERISA would not supersede Texas law. Insurers maintain that ERISA does preempt state law because Congress has the authority to regulate these plans.

— by **Kelli Soika**

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