

The Truth About Texas' Prompt Payment Laws For Healthcare Providers

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The intent of this article is twofold. First, I hope to set the record straight about the legal effect of the so-called “prompt-pay” laws, as are currently found within the Texas Insurance Code. These laws simply do not apply and do not serve the purpose that most health care administrators think they do. Secondly, I will attempt to provide some suggestions as to how hospitals and other entities can protect themselves when contracting with insurance companies and managed care organizations that market and administer various types of health plan products, as well offer some thoughts about how the healthcare provider might proceed with legal action against a payer that is chronically delinquent in its payment practices.

Insurance laws in Texas are currently codified, i.e., they are fairly neatly organized and are found in the Texas Insurance Code. The Texas Insurance Code currently contains three sections, which can be referred to as the “prompt-pay” laws. These three sections are as follows: (1) Article 3.70-3C, Section 3A, entitled *Prompt Payment of Preferred Providers*; (2) Article 20A.18B, entitled *Prompt Payment of Physicians and Providers*, and; (3) Article 21.55, entitled *Prompt Payment of Claims*.

One of the first questions that come to mind when discussing these laws is why there are three different prompt payment provisions within the Texas Insurance Code. That explanation could take up more of the reader’s time than is justified. Let it suffice to say that it was deemed necessary to enact these three different sections of prompt payment provisions to at least attempt to make it clear when the laws were to apply and to what types of insurance policies or health plan products. Let us conduct a brief mini-review of what these three different prompt payment laws have to say. We will then move on to the meat of the matter, which is a frank explanation of why these laws are currently of limited benefit to medical care providers.

Taken in chronological order as they appear within the Texas Insurance Code, the first prompt pay provision is Article 3.70-3C, Section 3A, *Prompt Payment of Preferred Providers*. This section became law in Texas on September 1, 1999 and it states, among other things, that an insurer is to pay a claim submitted by a preferred provider *not later than the 45th day after the date that the insurer receives a **clean claim** from a preferred provider*. On May 23, 2000, the Texas Department of Insurance adopted administrative rules defining what constitutes a “clean claim” for physicians billing on HCFA 1500 forms and hospitals billing on UB92 forms. The new regulations may be found at 25 Texas Register 4543. Therefore, the answer to when one begins counting the 45-day period for payment to be made to a preferred provider has been answered by the Texas Department of Insurance. It should be noted, however, that these new administrative rules are very new and it will likely take some time before insurance companies, managed care organizations and third-party administrators are in compliance. As most healthcare providers know, insurers always have a laundry list of reasons that can be used to delay paying a claim. It will be said again before the conclusion of this article, but providers need to define “clean claim” within their contracts, even if the definition is the same definition found in the new rules of the Texas Department of Insurance.

In light of the new rules adopted by the Texas Department of Insurance defining “clean claim”, it is essential that all patient financial services personnel involved in the claim billing process obtain copies of these new rules to insure that the providers’ billing practices and procedures comply with the new rules. As we move forward and these new rules become incorporated into the procedures of providers and payers, some improvement in the form of standardization of claim processing may come about as a result of the new rules, however, one should certainly not expect disputes regarding provider reimbursement to disappear. For several reasons, some of which we will discuss below, these new rules will not change the process of submitting and paying healthcare claims very much.

Moving on with our review of Article 3.70-3C, Section 3A, it goes on to provide that if the insurer does not pay a claim within 45 days, it is to pay the portion of the claim that is not in dispute and notify the provider in writing as to why the remainder will not be paid, or notify the provider in writing why the claim will not be paid at all. Additionally, this section states that in cases where the insurer acknowledges liability, but wants to conduct an audit of the claim, the insurer is to pay 85% of its contractual liability to the provider within 45 days of receipt of the claim and then conduct its audit. Within 30 days of the audit, the remaining amount due is to be paid to the provider, or a refund made to the insurer, per the results of the audit. The final disposition of any claim is, of course, subject to appeal rights and legal rights of the insured, as well as those of the provider. An insurer that violates this section is liable to the preferred provider for the full amount of the billed charges for a claim, or in the alternative, the agreed contractual penalty.

Article 20A of the Texas Insurance Code is known as the Texas HMO Act. Section 18B, referenced above, was added to the Texas HMO Act and also became law in Texas on September 1, 1999. Article 20A.18B is the prompt payment provision which

applies to HMOs. It contains essentially the same “clean claim” language and virtually the same provisions regarding timeliness of payment as the PPO provisions discussed above. The new section 18B made it clear that HMOs were going to have to comply with Texas’ prompt payment laws. In the past, the Texas Insurance Code was not as clear on the subject. At least we can now discern the Texas legislature’s intent. Unfortunately, we will soon see that much of what the state giveth, the Fed taketh away—and boy are they good at it!

Lastly, and probably of least significance to healthcare providers is Article 21.55 of the Texas Insurance Code. This is the prompt payment provision originally enacted into law in Texas, becoming effective September 1, 1991. True to its roots, it applies to claims that are covered by insurance policies and nothing else. Article 21.55 is the statute that provides for the 18% per annum penalty for late payment. As those of us who work in and with the healthcare industry, we know there are no longer many individuals out there with their own health insurance policies in the form of true indemnity coverage. From the healthcare provider’s perspective, Article 21.55 applies in very limited instances to healthcare claims

So why is it that with having a prompt payment statute on the books since 1991, plus the enactment of our “new and improved” prompt payment statutes applicable to PPO and HMO plans, healthcare providers in Texas still experience significant delay in the payment of such a significant portion of their accounts receivable?

The number one answer was stated above. The state giveth and the Fed taketh away. Setting aside Medicare and Medicaid, most of the commercial business of any healthcare provider, professional or institutional, is going to come through HMO and PPO products. For purposes of this analysis and discussion, one can include the lower-volume products such as POS and EPO. The majority of this commercial business comes from employer-sponsored health plans. Now we are getting down to the crux of the problem—stay with me on this. If the sponsoring employer is a private-sector employer, such as Exxon, IBM, Dairy Queen, or the local automobile dealership, the employee of that company who is also your patient, is considered a beneficiary in an employer-sponsored employee welfare benefit plan and it is governed by *ERISA*. Everyone reading this article probably already knows this, but it bears repeating as a refresher. *ERISA* is the acronym for the Employee Retirement Income Security Act of 1974. In almost all instances where the employee is a beneficiary under such a plan, state mandated benefit laws which govern the plan design, i.e., what benefits the plan provides, as well as state laws which apply to prompt payment of claims, are preempted by federal law, in this case, *ERISA*. This means that for most healthcare providers, most of the commercial payer health plan business for that provider is going to consist of services provided to beneficiaries of health plans governed by *ERISA*, not the Texas Insurance Code. *ERISA* does not have a prompt payment provision. In the real world, *ERISA* applies to virtually all employer-sponsored health care plans, regardless of the funding mechanism. The

exceptions to the application of ERISA are employer-sponsored group health plans of: (1) plans for governmental employees; (2) plans for religious organizations, and; (3) workers compensation insurance programs. The bottom line: the prompt payment laws, by themselves, probably do not apply to a majority of healthcare providers' claims.

The best and only really effective means of counteracting the negative impact effect that ERISA has on commercial HMO and PPO plans is by incorporating appropriate provisions within the provider's contracts with all payers for all types of products and plans. Insurance companies, managed care organizations, healthcare purchasing cooperatives, IPAs—they all want the same thing. They want to be profitable and they want providers to bear as much of the financial risk of servicing their "lives" as possible. These are some of the areas within a managed care agreement where the provider should expect to see evidence of risk-shifting language. Of course, these are also areas where the savvy providers can protect themselves and improve their position and the long-term viability of the contemplated contractual arrangement.

- Make sure the correct entities are the contracting parties;
- Make certain that the agreement may not be unilaterally amended by either party, nor unilaterally assumed by a successor through sale or merger;
- Make certain all procedures and provider manuals are provided in advance of the effective date of the contract and that the provider can administer the utilization management and billing requirements of the agreement, including carve outs;
- Make certain the payer can administer the agreement, including the carve outs;
- Make certain that the reasons for termination with and without cause are specific, i.e., what conduct shall constitute non-performance and/or default;
- Pay special attention to definitions, especially items such as "emergency" and "medically necessary". Use prudent layperson standard for emergency care.
- Make certain that the definitions in the agreement will control over any definitions in certificates or descriptions of coverage provided by the payer or its clients to the members and participants;

- Make certain that the provider may utilize all appeals and grievance processes available to the participants, but without waiving any rights to use subsequent legal remedies;
- Require payer or plan to notify Provider of all legal actions brought against it for any reason;
- Check the payer or plan's filings with the Texas Department of Insurance regarding premium rate setting, as well as its record of complaints and disciplinary actions;
- Make certain billing procedures are set forth in sufficient detail, including a method for determining payer's date of receipt of a claim;
- Limit the time frame that the payer can delay payment based upon the need for information regarding coordination of benefits or pre-existing condition. Insert language to the effect that after, for example, 90 days, if the participant has not provided the necessary information to the payer to adjudicate the claim, it is deemed denied, any "hold harmless" provisions for the benefit of the participants are deemed ineffective due to there being no coverage for the claim...therefore participant may be held financially liable;
- Payer customarily has a right to audit. Provider should always insist on the same rights to go "inside" and audit claims and payments;
- The exact address to send official notices and the method, e.g., certified mail, should be included. We recommend notice to the appropriate person or department in administration and that the agreement also provide that notices be also sent to legal counsel;
- Confidentiality clause should be considered extremely important. It should state with reasonable specificity who is to have access to the agreement and should state clearly that violation of the confidentiality clause is grounds for termination and legal action for damages, regardless of any dispute resolution language agreed to by the parties;
- Payer's right to recoup and effect refunds should be limited in terms of time, e.g., no recouping payments previously made more than 12 months after Provider's receipt of payment. Providers should have a complementary obligation to file claims and initiate administrative appeals in a timely manner, e.g., claims filing within 90 days and appeals initiated within 180 days from receipt of explanation of benefits or remittance advice denying a claim, in whole or in part;

- All products and plans having access to the agreement must be specified. No unilateral addition of plans or payers. No “leasing” of the network without the Provider’s express consent;
- Include an enforceable prompt payment clause with a real penalty. Have one drafted or track 20A.18B of the HMO Act, but **make it a contractual obligation of the payer**;
- Finally, consider carefully whether the Provider should agree to binding arbitration clauses. Surrendering one’s rights to obtain relief in a court of law should not be done hastily. (Sidebar comment: In nearly 10 years of representing hospitals, I have never seen a Payer make a demand for arbitration—only Providers. If you are the Provider and are negotiating a discounted fee for service arrangement, my advice would always be to retain the right to sue. My advice to clients would most likely be to consider arbitration clauses only in contracts where the provider is risk bearing.)

Healthcare is an exciting and dynamic part of all of our lives. It is a noble and rewarding endeavor for all involved, whether as physicians, nurses, administrators, or even attorneys such as myself. More minutia about claims for healthcare services has been provided here than most readers would care to digest. At the same time, we are living and working in a time where healthcare providers are being squeezed and every dollar counts. Charity has its place. So does the concept of payment for valuable services.

That is where the law comes in when necessary. Delinquency in claim payment may be attacked one claim at a time, or on an aggregate claims basis. Both are necessary means of pursuing proper reimbursement, depending upon the facts presented. A provider presented with the situation where a large quantity of claims constituting a significant sum of money is in delinquent status, pursuing legal action against the payer for the aggregate sum of all claims is probably the most advisable method of attacking the problem. In other situations, the provider will be better served by pursuing their claims with the assistance of counsel, but with each claim being handled individually. This is, of course, necessary when claims do not present themselves with like facts and circumstances.

Final thoughts. Don’t penny wise and pound-foolish. Take the time and spend the money to get managed care agreements thoroughly reviewed. Do not focus on the payment rates to the exclusion of the other parts of the agreement. Do not hesitate to use the laws enacted for the benefit of healthcare providers to enforce your contractual and statutory rights. Healthcare providers are expected to provide excellence in medical care to the public 24 hours a day, 365 days a year. There is no reason for healthcare providers to accept anything less than contractual and statutory compliance from managed care organizations, insurers and other payers.

