
An Interstate Comparison of Healthcare Prompt-Pay Laws

THIS PAPER PROVIDES AN OVERVIEW OF TEXAS'S HEALTHCARE
PROMPT-PAY STATUTES AND COMPARES TEXAS'S
STATUTES TO SIMILAR STATUTES IN OTHER STATES.

TEXANS FOR LAWSUIT REFORM FOUNDATION

January 31, 2016

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I. Introduction

All fifty states and the District of Columbia have “prompt-pay” statutes applicable in the healthcare context.¹ Essentially, these prompt-pay statutes require health insurance companies to pay claims submitted by healthcare providers (*e.g.*, physicians and hospitals) within set time limits, or face penalties and other sanctions. These prompt-pay laws vary significantly from state to state – in operation, complexity, and severity – but they share the goal of compelling insurers to promptly and fully pay all legitimate claims.

Texas’s healthcare prompt-pay statutes are among the most punitive in the nation in that they allow substantial penalties when an insurer fails to pay a claim timely, even if by only a single day. Texas law also allows recovery of attorney fees for lawsuits brought by healthcare providers to recover payment for services, which, when coupled with the punitive nature of the statutes, appears to encourage plaintiff lawyers to solicit clients to pursue prompt-pay litigation. For example, notorious lawyer Mikal Watts (currently under criminal indictment in federal court) has been very active in soliciting clients for prompt pay litigation, as have many others.²

This paper provides an overview of Texas’s healthcare prompt-pay statutes and compares these statutes to similar statutes in other states. TLR Foundation is undertaking further research to address the questions of whether Texas’s statutes are excessively punitive to accomplish the prompt payment of legitimate claims and whether Texas’s statutes are encouraging unnecessary litigation.

II. A Brief History of Healthcare Prompt-Pay Laws

Nationally, the impetus behind prompt-pay laws was based in healthcare providers’ unhappiness with the unpredictability and delay associated with getting paid for services provided to privately insured patients.³ Although some insurers⁴ consistently processed claims within 30 days, other insurers might take as long 120 days to pay claims. Providers alleged that these late-paying insurers unfairly profited from the “float” time between submission and payment of claims. Moreover, different insurers often had differing requirements for claim submission, and when a provider’s claim was returned for failure to fully comply with that insurer’s specific requirements, additional delays resulted. This unpredictability in the reimbursement process caused numerous healthcare providers to experience cash flow difficulties and other operational problems.

In seeking to remedy these reimbursement difficulties legislatively, rather than contractually, providers argued that they lacked sufficient bargaining power to negotiate satisfactory claim-processing deadlines due to the fact that most healthcare markets are dominated by only a few major insurers.⁵ Providers also argued that seeking to reform insurer reimbursement practices via litigation was ineffective, as large class action suits were cumbersome and claim-by-claim litigation was cost-prohibitive.⁶

Unsatisfied with their ability to alter insurer payment practices either by contract or through litigation, physicians and hospitals turned to the legislative arena, with great success. In 1998, only 17 states had prompt-pay laws. Five years later, in 2003, that number had grown to 47 states.⁷ Moreover, after initially adopting prompt-pay laws, many states have continued to amend their statutes, further tightening requirements imposed on insurers. Texas similarly expanded and strengthened its own prompt-pay laws in 2003.⁸ As a result, “Texas’s current prompt-pay statute is the most provider-friendly statute in the country, considering the penalties and protections offered.”⁹

III. Overview of Texas’s Healthcare Prompt-Pay Statutes

In Texas, the current prompt-pay statutes stem from various incremental enactments, some of which date back to the early 1990s.¹⁰ However, the most important legislative enactments were 1999’s House Bill 610, and 2003’s Senate Bill 418. Although House Bill 610 (1999) established the prompt-pay framework still utilized in Texas’s statutes, that framework was greatly expanded by Senate Bill 418 (2003). Today, the Texas Prompt Pay Act (“TPPA”) is codified in the Texas Insurance Code as Subchapter J of Chapter 843 (governing health maintenance organizations (HMOs)) and Subchapters C and C-1 of Chapter 1301 (governing preferred provider organizations (PPOs)). And so, while this article refers to a monolithic “act,” the TPPA is in fact comprised of two similar-but-separate statutes, each of which deals with a specific type of insurance plan. Additionally, the TPPA is subject to administrative rules adopted by the Texas Department of Insurance, the majority of which are found in Subchapter T, Chapter 21, Volume 28, of the Texas Administrative Code.

A. How the TPPA Works, In Brief

The TPPA establishes a set of universal “clean claim” formats. All submitted claims are required to comply with these prescribed formats, and the health insurance companies are required to accept claims submitted in the prescribed formats.¹¹ Next, the TPPA established a series of universal deadlines requiring insurance companies to either pay or deny a claim within a fixed time period, starting from the date the claim is submitted in the requisite “clean claim” format.¹² Last, the TPPA enforces pay-or-deny deadlines by establishing a system of graduated penalties, the size of which increases roughly according to the length of delay involved.¹³

B. Entities Subject to the TPPA

A broad range of healthcare “providers” are covered under the TPPA, including physicians, hospitals, chiropractors, registered nurses, optometrists, registered opticians, acupuncturists, pharmacists, and pharmacies.¹⁴ The TPPA’s terms extend to all providers performing services within Texas, regardless of where the billed insurer may be located.

Generally speaking, for the TPPA to apply, the provider must be an “in-network” provider who has contracted with the insurer.¹⁵ The TPPA’s payment deadlines (but not the TPPA’s penalty provisions) extend to out-of-network providers only when the care was rendered under emergency circumstances or at the provider’s request because the services were not reasonably available in-network.¹⁶ Consequently, an insurer has an obligation to pay some out-of-network claims within the statutorily mandated timeframe, but the insurer’s failure to comply with the statutory deadline incurs no penalty.¹⁷

The law applies to health maintenance organizations¹⁸ and preferred provider organizations.¹⁹ The TPPA does not apply to Medicare/Medicaid, worker’s compensation coverage, Tricare and the Texas Children’s Health Insurance Program, or to indemnity policies.²⁰ The TPPA does not appear to apply to employer-sponsored healthcare plans because of the preemptive

effect of the federal Employee Retirement Income Security Act (“ERISA”), or to third-party administrators for “self-funded” health insurance plans. But the applicability of the TPPA to employer-provided plans and third-party administrators has been the subject of litigation and conflicting decisions, a discussion of which is beyond the scope of this paper.²¹

C. Submitting a Claim and the “Clean Claim” Requirement

Under the TPPA, a provider has 95 days to submit a claim to the insurer.²² This 95-day submission deadline is generally calculated from the date healthcare services are rendered.²³ However, for institutional providers such as hospitals, the submission deadline may run from the date of the patient’s discharge.²⁴ Finally, where secondary insurers are involved, the deadline may run from the date the provider receives payment-or-denial notice from the primary insurer.²⁵

A provider who fails to submit his claim within the 95-day deadline forfeits all right to payment, unless the delay was caused by a “catastrophic event that substantially interferes with the normal business operations of the physician or provider.”²⁶ However, the claim-submission deadlines may be extended by contractual agreement between the insurer and provider.²⁷

In initially submitting its claim, the provider is required to indicate what its “billed charges” are for the provider’s services.²⁸

If the provider wishes to take advantage of the TPPA’s penalty provisions, the provider must submit a “clean claim” to the insurer.²⁹ A provider who fails to submit a “clean claim” is excluded from nearly all of the protections offered under TPPA, in that the TPPA’s pay-or-deny deadlines do not begin to run unless and until a “clean claim” has been received by the insurer.³⁰

Under the TPPA, a claim that is electronically filed constitutes a “clean claim” if it satisfies the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).³¹ A claim submitted non-electronically must comply with the Texas-specific standards set out in the Texas Administrative Code.³² The “clean claim” standards are voluminous, but, generally speaking, a “clean claim” is one that contains all information deemed necessary for the insurer to pay or deny that claim, while a “non-clean claim” is one requiring that additional information or documentation be submitted.³³

If a submitted claim fails to qualify as a “clean claim,” the insurer must notify the provider that the claim is not clean within the applicable pay-or-deny deadline.³⁴ If and when the provider receiving this notice re-files a corrected claim that satisfies the TPPA’s “clean claim” requirements, the pay-or-deny deadline then begins running from the date the corrected claim is filed.³⁵ Where claims are submitted in bulk, the insurer is required to promptly process those claims that qualify as “clean claims,” regardless of whether the entirety of the bundled claims meets the “clean claim” standard.³⁶

Prior to the 2003 amendments to the TPPA, each insurer retained the ability to specify the data elements that would constitute a “clean claim” for that insurer.³⁷ Under the current TPPA, however, insurers are not allowed to exceed the universal “clean claim” standards governing both electronic and non-electronic claims, but may – as to electronic claims – contract to require fewer data elements.³⁸

D. Requests for Additional Information

Once a provider has submitted its claim, the insurer is permitted to make a one-time-per-claim request for additional information from the provider, which must be relevant and necessary in assisting the insurer to determine whether that claim is payable.³⁹ To be valid, a written request for additional information must be made within 30 days of an insurer’s receipt of a claim.⁴⁰

If timely made, such requests will toll the applicable pay-or-deny deadline until the provider either supplies the requested information or states that it does not have the information.⁴¹ Upon receiving either response to its request, the insurer must then pay or deny the claim by the later of the claim's original payment deadline or the 15th day after the insurer's receipt of the provider's response.⁴² Note, however, that when the request for additional information is made to a third party, no tolling of the pay-or-deny deadline occurs.⁴³

E. Pay-or-Deny Deadlines

Under the TPPA, once a provider has properly submitted a "clean claim" for reimbursement, the insurer is required – with very few exceptions – to either pay or deny that claim within the applicable statutory deadline as calculated from the date of the insurer's receipt of the claim.⁴⁴ The specific length of the time period for payment depends on two factors: (1) whether the claim is submitted electronically or non-electronically (i.e. on paper), and (2) whether the claim involves pharmacy services.

All properly billed non-pharmacy claims are subject to a pay-or-deny deadline of 30 days for electronically submitted claims, or 45 days for non-electronic submittals.⁴⁵ For pharmacy claims, the applicable electronic/non-electronic deadlines are 18 and 21 days, respectively, after "affirmative adjudication" of such claim.⁴⁶ Insurers and providers are barred from contractually agreeing to modify the statutory deadlines.⁴⁷ Today, nearly all Texas providers submit their claims electronically.

As discussed above⁴⁸, an insurer is allowed a one-time opportunity to temporarily toll the running of the TPPA deadlines by requesting additional information.⁴⁹ Once the pay-or-deny deadlines begin to run, however, the TPPA provides only two exceptions to the application of its penalties for failure to make timely payment. First, an insurer may make a later payment if the failure to pay the claim timely results from a "catastrophic event that substantially interferes with the normal business operations of the insurer."⁵⁰ Second, an insurer is not subject to a penalty if the insurer pays the claim timely, but the claim is underpaid and: (1) the provider does not inform the insurer that the claim is underpaid until more than 270 days after the provider receives payment from the insurer, and (2) the insurer pays the remaining balance within 30 days of receiving the provider's notice of underpayment.⁵¹

It is noteworthy that while the TPPA allows an insurer to deny a claim by the applicable deadline⁵², it does not relieve the insurer of liability for a penalty related to a claim that should not have been denied.⁵³ In other words, an insurer that makes a good faith mistake in denying a claim is nonetheless fully liable under the TPPA's penalty scheme for failing to promptly pay the claim. Furthermore, unlike a substantial number of other states, the TPPA provides no "fraud exception" to its prompt-pay deadlines. Even when an insurer suspects a provider's otherwise "clean claim" is fraudulent, it nonetheless must decide whether to pay-or-deny that claim within the standard deadline.⁵⁴ Consequently, an insurer that denies a claim that ultimately turns out to be valid must pay a penalty under the TPPA, even if the insurer acted in good faith. An insurer that pays a claim that ultimately proves to be fraudulent must attempt to recover that payment within a 180-day period running from the provider's receipt of payment.⁵⁵ In this respect, the TPPA is akin to a strict liability system, in that it focuses on the *existence* of claim-payment delays, and not on the propriety of the actions, causes, or motivations behind the delay.

F. TPPA Penalties and “Billed Charges” v. “Contracted Rates”

As its name implies, the TPPA was intended to encourage timely payment of provider claims, by instituting a system of graduated penalties that are (loosely) keyed to the number of days elapsing between the date a claim is properly submitted and the date the insurer either pays or denies that claim.

The TPPA’s penalty scheme applies exclusively to providers who have contracted to serve as “in-network providers” for insurers operating in Texas.⁵⁶ Under these contracts, providers typically agree to accept from the insurer a negotiated “contracted rate.”⁵⁷ For TPPA purposes, the “contracted rate” includes any portion for which the insured patient assumes responsibility.⁵⁸ The contracted rate often is significantly lower than the provider’s “billed charges,” which are the charges for the provider’s services stated on the claim submitted to the insurer that (at least in theory) represents the fee the provider would customarily charge for the services.⁵⁹ Roughly speaking, the terms “billed charges” and “contracted rate” reflect the difference between the provider’s undiscounted, everyday price for a given procedure (like the regular retail price for a product in a retail store), and the discounted rate the provider has agreed to accept from the insurer as payment for the services provided (like the retailer’s sale price for a product).

There appear to be no specific criteria for determining the amount a provider chooses to use as its “billed charges.” Somewhat unhelpfully, the Texas Department of Insurance (“TDI”) has stated on its website that while it does not regulate the amount a provider can charge for a particular service, any such “billed charge,” if used to calculate a TPPA penalty, must not be “unreasonable.”⁶⁰ The TDI regulations defining the phrase “billed charges” link the term to several Texas statutes prohibiting unreasonable, fraudulent, and ‘two-tiered’ billing practices, but do not specifically mandate that the charges be reasonable.⁶¹

If an insurer fails to take action on a claim within the applicable pay-or-deny period described above, the insurer then becomes subject to statutory penalties which are calculated in a manner unique to Texas. Under the TPPA’s unique “loss-of-discount” penalty scheme, the two relevant factors are the number of days that have elapsed since the payment deadline, and the differential between the provider’s contracted rate and the billed charges.⁶²

An insurer who timely pays a provider’s claim is liable only for the “contracted rate” (the sale price). Should the insurer fail to make payment within the statutory deadline, however, then the insurer owes both the contracted rate plus a penalty based on the difference between the contracted rate (the sale price) and the provider’s undiscounted billed charge (the retail price).⁶³ The following paraphrased examples taken from the Texas Administrative Code demonstrate how the penalty is calculated:⁶⁴

As to claims paid late, but within the first 45 days after the pay-or-deny deadline has passed, the insurer may be penalized the lesser of \$100,000⁶⁵ or 50% of the difference between the “billed charges” and the “contracted rate.”⁶⁶

EXAMPLE: If a provider’s contracted rate is \$10,000 and its billed charges are \$15,000, and the insurer pays the provider’s claim within the first 45 days after the deadline for payment passes, then the insurer is required to pay a \$2,500 penalty (50% of the difference between the discounted and undiscounted rates).

As to claims paid in the period from 46 to 90 days after the pay-or-deny deadline has passed, the insurer may be penalized the lesser of \$200,000 or 100% of the difference between the “billed charges” and the “contracted rate.”⁶⁷

EXAMPLE: If a provider's contracted rate is \$10,000 and its billed charges are \$15,000, and the insurer pays the claim more than 45 days but less than 90 days after the statutory payment deadline passes, then the insurer is required to pay a \$5,000 penalty (100% of the difference between the discounted and undiscounted rates).

As to claims paid in the period more than 91 days after the pay-or-deny deadline has passed, the insurer may be penalized the lesser of \$200,000 or 100% of the difference between the "billed charges" and the "contracted rate"; and the amount owed as a penalty accrues 18% annual interest, from the date upon which the original payment was due.⁶⁸

While TPPA penalties undeniably grow harsher as an insurer's delay in payment grows longer, the correlation is not a precisely calibrated one. Instead of permitting monthly or daily penalty increases, as other states do, the TPPA instead sets up three broad "zones," and within each zone all unpaid claims are treated equally. Under this system, an insurer that pays a claim 44 days after the initial pay-or-deny deadline is penalized no more harshly than an insurer that pays only one day after the deadline, as both offenses lie within a common "zone."

As is obvious from these examples, the greater the disparity between a provider's "billed charges" and "contracted rate," the larger the penalty the provider (and, in some cases, the State of Texas) stands to recover under the TPPA. Conversely, if a provider charges all of its patients a single, common rate, there would be no basis on which to calculate a penalty.⁶⁹ This statutory scheme thus creates an incentive for providers to set their billed charges at the highest defensible rate. Accordingly, concerns have been raised that, in an attempt to maximize the penalties that may be collected through the TPPA penalty system, providers may artificially inflate their "billed charges" to levels bearing no relation to their real-world market value.⁷⁰

As to the question of who receives a penalty paid by an insurer under the TPPA, the answer depends on the type of provider involved. As to a "clean claim" submitted by a non-institutional provider (*i.e.*, a physician), the provider is entitled to any TPPA-required penalty, save for the 18% interest, which is paid to the State of Texas (in lieu of the now-abolished Texas Health Insurance Risk Pool to which the TPPA refers⁷¹).⁷² As to a "clean claim" submitted by an institutional provider (*i.e.*, a hospital), 50% of the total penalty amount (including interest) is awarded to the provider, while the remaining 50% goes to the State.⁷³

The Texas Legislative Budget Board's Fiscal Note accompanying recent proposed TPPA reform legislation⁷⁴ indicated that in 2013, the Texas General Revenue Fund took in \$41 million in penalties paid under the TPPA.⁷⁵ The Fiscal Note also estimated that the 2015 reform legislation – which was proposed but not enacted, and sought to substantially reduce the TPPA's maximum penalty ceilings – would cost the State of Texas \$32.8 million per year, by reducing the size of the penalty recoveries in which the State of Texas shares.⁷⁶

G. Underpayment

When an insurer makes timely partial payment, but fails to pay the entire amount owed, the TPPA penalizes these underpayments through a similar, three-zone system of penalties, with similar ceilings and interest awards.⁷⁷ Underpayment penalties are primarily calculated on the amount left unpaid, rather than directly on the difference between the billed charges and the contracted rate. Nonetheless, within the complex formula that is used to calculate the underpaid amount⁷⁸, the billed charges and contracted rates indirectly affect the penalty owed by the insurer in the underpayment context.⁷⁹

The Texas Department of Insurance supplies the following illustration of the TPPA's application in an underpayment scenario:

EXAMPLE: [A] claim for a contracted rate of \$1,000 and billed charges of \$1,500 is initially underpaid at \$600, with the insured owing \$200 and the HMO or preferred carrier owing a balance of \$200. The HMO or preferred provider carrier pays the \$200 balance on the 30th day after the end of the applicable statutory claims payment period. The amount the HMO or preferred provider carrier initially underpaid, \$200, is 20 percent of the contracted rate. To determine the penalty, the HMO or preferred provider carrier must calculate 20 percent of the billed charges minus the contracted rate, which is \$100. This amount represents the underpaid amount for subsection (c)(1) of this section. Therefore, the HMO or preferred provider carrier must pay, as a penalty, 50 percent of \$100, or \$50.⁸⁰

H. Audit Requirements

Prior to the TPPA's enactment, Texas providers frequently complained of payment delays connected to an insurer's decision to audit the provider's claim.⁸¹ Today, should an insurer desire to audit a particular claim but be unable to complete that audit within the TPPA pay-or-deny deadlines, the insurer must timely pay the claim in full, pending the outcome of the audit.⁸² No audit-related deadline extensions are available under the TPPA, and conducting a good faith audit does not exempt the insurer from paying a penalty if the claim being audited is paid after the pay-or-deny deadline passes.⁸³ Should an insurer choose to pay only the undisputed portion of a claim that is being audited, the insurer's action triggers the underpayment penalties discussed above as to the disputed portion left unpaid.⁸⁴

If payment is being made subject to an ongoing audit, the insurer must notify the provider of that fact, and then complete the audit within 180 days of receiving a "clean claim."⁸⁵ If the completed audit reveals that payment was improper, the insurer may request a refund within 180 days of the provider's receipt of the overpayment, or 30 days after notifying the provider of the audit's completion.⁸⁶

I. Recoupment Deadlines

Under Texas law, once an insurer has paid a provider's claim, if it thereafter discovers that an overpayment has been made, that insurer has 180 days from the provider's receipt of such payment to provide written notice that recovery is sought.⁸⁷ When an insurer seeks recoupment, the provider must be given an opportunity to appeal and the insurer cannot recover its refund until all appeal rights have been exhausted.⁸⁸ However, the recoupment deadlines and restrictions do not apply if the provider is guilty of either fraud or material misrepresentation.⁸⁹

J. Attorney Fees

The TPPA expressly provides that a "provider may recover reasonable attorney's fees and court costs in an action to recover payment."⁹⁰ An insurer is barred from altering this right-of-recovery by contract.⁹¹

K. Administrative Penalties

In addition to individualized penalties that may be paid to a provider or the State of Texas under the TPPA, the TPPA also permits assessment of separate administrative penalties (assessed by the Texas Department of Insurance) against an insurer whose overall rate of compliance with TPPA's pay-or-deny deadlines for "clean claims" falls below 98%.⁹² Compliance is

determined by quarterly reports submitted by the insurers, in which claims are categorized as either institutional or non-institutional.⁹³ Should an insurer fail to meet this 98% compliance threshold, the maximum per-day penalty may not exceed \$1,000 for each claim remaining unpaid in violation of the TPPA.⁹⁴

L. Anti-Retaliation Protections

The TPPA provides that insurers are barred from engaging in any retaliatory action – such as cancellation, refusal to renew, or termination – against a provider who has filed a complaint against an insurer or appealed an insurer’s reimbursement decision.⁹⁵ These retaliation protections are required to be inserted into all contracts between insurers and providers, along with the TPPA’s prompt-payment protections.⁹⁶

M. Verification and Pre-Authorization

Prior to actually performing a given procedure, providers may contact the patient’s insurer to obtain verification that the insurer will pay for the proposed healthcare services.⁹⁷ Under the TPPA, if a provider supplies all required information regarding the proposed procedure, the insurer is required to respond to the verification request “without delay” and inform the provider whether the service will be covered, and specify any amounts for which the patient is responsible.⁹⁸ Insurers are required to make a good faith effort to address all provider requests for verification, and may decline a given request only by offering reasons specific to that request.⁹⁹

Once the insurer has verified that it will pay for the healthcare services, the insurer cannot deny or reduce payment, unless the provider either materially misrepresented the services provided or substantially failed to provide the services.¹⁰⁰ An insurer may decline to provide verification if, at the time of the provider’s request, the insurer cannot adequately determine its liability and the insurer notifies the provider of the specific reason it cannot adequately determine its liability.¹⁰¹

The TPPA also governs situations where insurers choose to require providers to obtain “pre-authorization” for medical procedures.¹⁰² Whereas verification essentially involves two representations (that the proposed procedure is medically necessary and appropriate, and that the insurer will pay for the procedure), pre-authorization determinations are limited to medical necessity only.¹⁰³ Thus, if an insurer chooses to pre-authorize a proposed procedure, the insurer is thereafter barred from denying or reducing coverage based on medical necessity or appropriateness of care, absent fraud on the part of the provider.¹⁰⁴

N. Statutes of Limitations

The specific time limitations governing a provider’s ability to recover penalties under the TPPA depends on whether the insurer entirely fails to reimburse a submitted claim or, instead, pays only a portion of that claim.

The TPPA’s protections extend to any underpaid provider who notifies the insurer within 270 days of receiving the underpayment.¹⁰⁵ If the underpaid provider informs the insurer of the underpayment after this 270-day deadline has passed, and if the insurer pays the claim within 30 days of receiving the belated complaint, then no TPPA penalties apply and the insurer is liable only upon the underpaid amount.¹⁰⁶ The provider’s ability to recover on the underpaid amount (apart from any TPPA-authorized penalties) is subject to the four-year limitation governing an action for breach of contract.¹⁰⁷

Somewhat anomalously, as to claims the insurer entirely fails to pay, the provider appears to have the entire four year limitation period applicable to a debt in which to bring its action against the insurer, including for recovery of both the unpaid claim and any applicable TPPA penalties.

IV. Comparison of Texas's Statutes to Other States' Statutes

A. "Clean Claim" Requirement

The penalty provisions of the TPPA are triggered in Texas and many other states by the provider's submission of a statutorily defined "clean claim." Nineteen of 51 United States jurisdictions, however, have chosen to enact prompt-pay statutes that apply to more claims than just "clean claims."¹⁰⁸ In this regard, the TPPA's scope is somewhat less expansive than the scope of similar statutes in 19 states. For the purposes of productively comparing Texas's statutes to those of other jurisdictions, this article focuses on the treatment of "clean claims" in Texas and other states.

B. Payment Deadlines

In Texas, the pay-or-deny deadline for electronic claims (excluding pharmacy claims) is 30 days.¹⁰⁹ Thirty-one other jurisdictions also have a 30-day pay-or-deny deadline.¹¹⁰ Nine jurisdictions have chosen shorter deadlines of 15, 20, 21, and 25 days, respectively.¹¹¹ The remaining ten American jurisdictions have chosen longer deadlines, of which 45 days is the most popular.¹¹² The nation's longest pay-or-deny deadline is in Arizona, which has an effective 60-day time limit that provides insurers 30 days in which to approve a claim and an additional 30 days in which to pay it.¹¹³

Thus, in respect to pay-or-deny deadlines, the TPPA's 30-day limit (for clean, electronic, non-pharmacy claims) falls within the American mainstream.

C. Exceptions To Payment Deadlines

The TPPA severely limits an insurer's ability to evade compliance with the TPPA's pay-or-deny deadlines, creating a standard akin to strict liability.¹¹⁴ More specifically, once a "clean claim" has been submitted, a Texas insurer's actions are limited to: (i) paying the claim in full, and seeking recoupment if the claim was over-paid or not owed, (ii) sending a one-time request for additional information, which temporarily postpones the pay-or-deny deadline, (iii) sending partial payment with a notice explaining why part of the claim will not be paid, which will trigger a TPPA penalty if the unpaid portion of the claim is owed, (iv) failing to meet the pay-or-deny deadline because of the occurrence of a "catastrophic event," which temporarily excuses compliance with the TPPA deadline, and (v) failing to timely pay the claim altogether, which triggers TPPA penalties.¹¹⁵ An insurer's good faith belief that the claim is not owed or is fraudulent does not allow the insurer to fail to comply with the TPPA's pay-or-deny deadline, nor to escape TPPA penalties.

Other jurisdictions are more lenient than Texas and recognize additional exceptions to an insurer's duty to meet that state's prompt-payment deadline. Over half of American jurisdictions, for example, recognize some form of "fraud exception," either by explicitly providing that the insurer is not required to pay promptly if there is evidence of fraud or misrepresentation, or by excluding potentially fraudulent claims from the statutory definition of "clean claim."¹¹⁶

D. Recoupment Deadlines

Under Texas law, once an insurer has paid a provider's claim, if the insurer thereafter discovers that an error has been made, the insurer has 180 days from the provider's receipt of payment to provide written notice that recovery is sought.¹¹⁷ Among the other 50 jurisdictions, only the District of Columbia, Maryland, and Nebraska employ such short recoupment deadlines.¹¹⁸ New Hampshire allows an eight month recoupment window, and ten other jurisdictions set the limit at one year.¹¹⁹ The remaining 36 jurisdictions have established significantly longer recoupment periods, or set no time limits at all.¹²⁰

Moreover, while Texas does not recognize a fraud exception to its recoupment deadline, more than 20 jurisdictions expressly do. Another 20 states apply no deadlines to any recoupment claim, whether fraud-based or otherwise.¹²¹

E. Provider-Awarded Monetary Sanctions

Texas is truly an outlier amongst the nation's prompt-pay statutes in the size and range of penalties applicable to insurers that violate the TPPA's provisions. In Texas, a failure to promptly pay or deny provider claims can result in three different types of monetary sanctions: "loss-of-discount" penalties, interest on those penalties, and administrative penalties.¹²² Arguably, only Missouri rivals Texas in the magnitude of the penalties that may be imposed on its insurers¹²³; but Texas is completely unmatched in the speed with which substantial penalties accumulate.

In a slight majority of American jurisdictions – 27 of 51 – if an insurer fails to promptly pay a submitted claim, the only penalty is that interest accrues on the unpaid claim.¹²⁴ A significant number of jurisdictions allow the state itself to impose (and to keep) administrative penalties, but only a handful of jurisdictions augment the provider's recovery beyond an award of interest on the unpaid claim.¹²⁵ Because of these differences, most of the prompt-payments statutes in other states are far shorter, and far simpler, than the TPPA. In Wyoming, for example, the applicable prompt-pay statute consists of three short paragraphs.¹²⁶

1. Interest as the Provider-Awarded Penalty

Under the majority of American prompt-payment statutes, the sole penalty mechanism is the accrual of interest on the unpaid claim, most often at an effective annual rate of between 10% and 18%.¹²⁷ Texas is different. While interest is recoverable under the TPPA, Texas law is unique in that: (1) interest does not become available until after "loss-of-discount" penalties have been imposed, and (2) interest accrues on the penalties themselves, and not on the provider's unpaid claim. Additionally, Texas is distinct in that some TPPA-mandated interest is paid to the State of Texas (in lieu of payment to the now-abolished Texas Health Insurance Risk Pool to which the TPPA refers), rather than to the late-paid provider.¹²⁸

Because of the factors discussed above, the interest penalties imposed under Texas law are distinct from those available in other states. Nonetheless, for the sake of rate-comparison, interest accrues at 18% annually when available under the TPPA. Approximately ten other states also set the applicable interest rate at 18%, which is high in today's interest-rate environment. Only a handful of jurisdictions – including the District of Columbia, Kentucky, and Maryland – have established progressive-rate mechanisms, whereby the applicable interest rate can eventually exceed 18%, by allowing that rate to escalate alongside the number of days a claim remains unpaid.¹²⁹ In the District of Columbia and Maryland, for example, claims remaining unpaid for more than 120 days accrue interest at 2.5% per month, for an effective annual rate of 30%.¹³⁰

Other states also have aggressive interest-based penalties. In Utah, for example, for the first 90 days after a claim deadline passes, the insurer is assessed a per-day penalty equivalent to .1% of the unpaid claim. When more than 90 days have elapsed, however, the insurer becomes liable for both the .1% late fee (now at 9% of the claim), plus a second penalty achieved by multiplying: (i) the total amount of the unpaid claim, (ii) the numbers days unpaid beyond 90 days, and (iii) the applicable statutory interest rate.¹³¹ In Missouri, unpaid claims are penalized both by the accrual of interest (at 1% per month), plus an additional penalty of 1% per day.¹³² By way of contrast, Indiana's effective annual rate of interest has floated as low as 2%.¹³³

Furthermore, a number of states' prompt-pay interest rates are pegged to statutory formulas, rather than to a statutorily fixed interest rate.¹³⁴ Consequently, it is possible that during high interest rate periods, these formulas may generate rates above Texas's 18%.

2. Non-interest Provider-Awarded Penalties

Under the vast majority of prompt-pay statutes, the provider's recovery is limited to an award of interest upon the unpaid claim, as discussed above. Only a handful of jurisdictions have joined Texas in allowing the provider – as opposed to the state – to receive any amount in addition to interest on the claim. None are as punitive as Texas. In Colorado, for example, if a claim remains unpaid past 90 days, a one-time penalty of 20% of the claim's total amount is assessed.¹³⁵ In Colorado, the accrual of interest is the first-tier penalty, and an additional penalty is added later if the claim remains unpaid past 90 days. Texas is the opposite.

In Texas, the first layer of penalties imposed on an insurer is a "loss-of-discount" penalty. As noted above, if an insurer has failed to pay a \$10,000 claim within 30 days after the provider submitted the claim (*i.e.*, failed to pay the amount owed within the pay-or-deny deadline), and the provider's undiscounted "billed charges" are \$15,000, then on the 31st day after submission of the claim, the insurer owes \$12,500 (the \$10,000 contracted rate plus 50% of the \$5,000 differential between the contracted rate and the billed charges). If the billed charges are \$25,000 rather than \$15,000, then on the 31st day after submission of the claim, the insurer owes \$17,500 (the \$10,000 contracted rate plus 50% of the \$15,000 differential between the two figures).

The penalty is doubled if the insurer pays the claim more than 75 days after it is submitted. If, on the 76th day after submission (46 days after the pay-or-deny deadline passes), the insurer has not paid a \$10,000 claim, then the total amount owed is \$15,000 (the \$10,000 contracted rate plus 100% of the \$5,000 differential between the contracted rate and the billed charges). If the billed charges are \$25,000 rather than \$15,000, then on the 76th day after submission of the claim, the insurer owes \$25,000 (the \$10,000 contracted rate plus 100% of the \$15,000 differential between the two figures). In the second example, the penalty is more than double the amount of the claim, in only 76 days.

In Texas, unlike any other state, the severity of the penalty depends on the magnitude of the difference between the submitting provider's billed charges and the provider's contracted rate. The greater the difference between the contracted rate and the billed charges, the greater the penalty paid by the insurer. Even a relatively mild difference between the two figures will result in a penalty that is far higher than the most onerous penalty available in any other state.

Furthermore, as noted above, the billed charges are set by providers in their discretion, without any firm statutory limits. Consequently, under Texas law, the amount of penalty an insurer will pay is established not by statute as in other states, but, instead, is within the control of the person who provided services and receives the penalty.

Additionally, the Texas loss-of-discount penalty calculus is frontloaded. Under Texas law, *on the very first day* after the applicable pay-or-deny deadline has passed, the insurer is inescapably obligated to pay what often is a sizeable loss-of-discount penalty. That loss-of-discount penalty then doubles 45 days later. In contrast, 18% interest on a claim – which is a common penalty rate in other states – would in many cases require years to equal the penalty imposed in Texas on a claim that is only one day overdue. Missouri's 1%-per-day penalties would eventually outstrip those available under the TPPA; but in most cases, because of the large difference between contracted rates and billed charges that prevail in Texas, it would likely take a long time for the 1% per day Missouri rate to be more punitive than the penalties imposed in Texas.¹³⁶

F. State Administrative Penalties

Nationwide, administrative prompt-pay penalties roughly break down into two categories: claim-specific or global-compliance. A significant minority of states (not including Texas) allow the imposition of state-collected administrative fines based upon an insurer's handling of specific claims (as opposed to the insurer's cumulative track record in handling of *all* claims within a given time period). States permitting the imposition of these claim-specific fines include Alabama, Arizona, Idaho, Louisiana, Michigan, Missouri, Nebraska, New Mexico, and North Carolina.¹³⁷ Moreover, several of these states – including Louisiana, Nebraska, and New Mexico – expressly provide for significantly increased penalties when the violation is determined to have been intentional or flagrant.¹³⁸

The second category of administrative penalties is the global-compliance variety, as are featured under the TPPA.¹³⁹ As discussed above, the Texas Department of Insurance is permitted to impose administrative penalties when an insurer's overall claims-processing performance falls below statutorily established standards (*i.e.*, on-time processing of 98% of the claims submitted in a given quarter). Once the global threshold has been breached, the per-day amount of the resulting administrative penalty is calculated based on the specific number of untimely claims.¹⁴⁰

A handful of other jurisdictions likewise impose global-compliance targets – including Indiana, Kentucky, Mississippi, Montana, Tennessee and Washington¹⁴¹ – but no other state has fixed their compliance target higher than 95%.¹⁴² Notably, a 95% compliance rate is equivalent to the prompt-pay standard that the federal government has imposed on itself in handling Medicare claims.¹⁴³

Rather than utilizing fixed compliance percentages, numerous other states' prompt-pay laws have provisions granting the enforcing entity more generalized powers to impose administrative penalties when a given insurer is determined to have engaged in an overall pattern of noncompliance. These states include New Hampshire, New Jersey, New York, and Ohio.¹⁴⁴

Finally, Idaho utilizes a hybrid approach, in which it retains discretion to impose administrative penalties for specific acts of noncompliance unless the insurer can show a 95% global-compliance rate in its handling of all claims.¹⁴⁵

G. Attorney Fees

The TPPA explicitly provides for recovery of attorney fees. Among the 51 American jurisdictions, only nine states expressly allow recovery of attorney fees in litigation brought under their prompt-payment-of-claims statutes (Maine, Missouri, Nevada, New Hampshire, Oklahoma, Texas, Virginia, West Virginia, and Wyoming), and New Hampshire limits recovery of attorney fees to those instances when the insurer has acted in bad faith.¹⁴⁶

Conceivably, a provider suing on an unpaid healthcare claim might have other avenues to recover its attorney fees – such as by establishing breach of contract, or fraud – but Texas is one of the few jurisdictions that expressly provides for recovery of attorneys fees by all providers who recover payments owed under the TPPA.¹⁴⁷

H. Explicit Ability to Bring a Private Action

An incidental effect of the TPPA's attorney fees provision (as well as those of the other states discussed above) is that it necessarily grants providers a clear right to bring suit against insurers for prompt-pay violations. According to some commentators, only a minority of states provide clear-cut statutory permission for providers to bring suit for prompt-pay violations.¹⁴⁸ Elsewhere, the right to sue might be found to exist by the courts, but is not explicitly provided in the prompt-pay statute.

In contrast, both Montana and Idaho forbid any private cause of action based on the failure to comply with their prompt-pay deadlines; and Hawaii explicitly grants its Commissioner of Insurance the sole right to pursue remedies and penalties under its prompt-pay act.¹⁴⁹

Finally, North Dakota and South Dakota have enacted healthcare prompt-pay statutes that appear to lack any enforcement mechanism.¹⁵⁰ Nebraska and South Carolina previously employed a similar “honor system” approach, but have recently incorporated penalty provisions.

1. Texas’s Uniqueness

As described in the previous sections, Texas’s prompt-pay statutes are unique in some respects, and outside the mainstream in other respects.

- Texas is one of a handful of states with a graduated penalty structure, whereas other states typically allow steadily accruing interest on the unpaid claim.
- Texas is unique in that, although it utilizes a graduated penalty structure, that structure does not precisely “track” the payment delay, but instead employs three “zones.” Thus, under the TPPA, an insurer that pays-in-full one day after the pay-or-deny deadline is treated no more favorably than an insurer that pays 44 days late.
- Texas’s “front-loaded” penalty system is unique in that no other state allows potentially large penalties in such a short time. Depending on the differential between the “contracted rate” and the “billed charges” claimed by the provider (which can be substantial), Texas is unmatched in the magnitude of penalties that can be generated by a delay of just one day past the pay-or-deny deadline.
- In calculating the amount of provider-awarded penalties, Texas is alone in basing that penalty on the differential between the provider’s discounted and non-discounted rates, the latter of which is not required to have any firm, “real-world” basis. On the other hand, were a provider to charge his insured and non-insured patients a common rate, the TPPA is unique in denying that provider any protection whatsoever.
- Texas also appears to be one of the few jurisdictions in which the state is entitled to a meaningful part of the non-administrative penalties imposed on insurers. In 2013, TPPA payments to the State of Texas exceeded \$41 million.
- Texas is unique in that the interest aspect of a TPPA penalty accrues on the already levied TPPA penalties, and not on the underlying unpaid claim itself.
- Texas imposes the nation’s highest global-compliance rate – 98% – for the timely processing of claims, which it enforces via separate administrative penalties.
- Texas belongs to the minority of states that explicitly permit providers to recover attorneys fees incurred in bringing successful prompt-pay actions.

The most unusual feature of the TPPA is its unique loss-of-discount penalty structure, premised on the differential between the “contracted rate” and the provider’s self-reported “billed charges.” In nearly all other states, prompt-payment penalties are interest-based and calculated by multiplying the amount of the unpaid claim by the period of delay. In Texas, however, loss-of-discount penalties are calculated in a far more complicated manner, with less predictable results.

By way of illustration, let us assume that Texas physicians X, Y, and Z all agree with Insurer to accept \$10,000 for a given procedure, yet the respective claims submitted by them list widely differing “billed charges” reflecting each physician’s undiscounted rate. Physician X,

for example, lists his billed charges as \$10,000, Physician Y lists hers as \$15,000, and Physician Z sets his billed charges at \$20,000. Should Insurer fail to pay all three Physicians until the 46th day after the applicable pay-or-deny deadline, Physician Z would essentially double his money, with a \$10,000 penalty. Physician Y would receive \$5,000, and Physician X would receive \$0, despite the fact that all three providers experienced identical delays while awaiting payment of identically sized claims. As demonstrated by the comparative outcomes for Physicians X and Z, the TPPA's gives providers an incentive to set their "billed charges" as high as possible, all else being equal.

The disparity of outcomes between similarly situated providers appears to lack any rational basis. Providers have argued that the TPPA's front-loaded, rapidly accruing penalty structure provides a "hammer" to compel insurers to speedily process claims and settle disputes.¹⁵¹ The statutes of all other states, on the other hand, appear to reflect the belief that the prompt payment of healthcare claims can be achieved by calculating penalties based on an "unpaid amount times days late" formula, especially when the formula is supported by a sufficient penalty interest rate.

V. Conclusion

The healthcare prompt-pay laws currently in force in Texas are unique in many respects, most particularly in that the TPPA's penalty scheme is rooted in a "loss-of-discount" model, under which the amount of a penalty is governed by the provider's "billed charges." This model can produce anomalous results between similarly situated providers, and, all else being equal, makes it advantageous for providers' billed charges to be as high as possible. Moreover, the TPPA's penalty scheme is uniquely front-loaded in a manner not replicated in any other jurisdiction. This front-loaded scheme can generate significant penalties for payments by insurers that are only a single day late. Furthermore, the TPPA has elements that are akin to strict liability, provides a private right of action, and provides for a mandatory award of attorney fees to a lawyer representing a provider that is successful in litigation brought under the TPPA. Cumulatively, these TPPA provisions appear to be encouraging data-mining, client solicitation efforts, and litigation brought by enterprising attorneys.

Although the prompt-pay statutes in other states are not uniform, most other states rely on an interest-only model that closely correlates the penalty to the tardiness of the insurer's payment. These provider-paid penalties often are coupled with administrative penalties, paid to the state, that are imposed when an insurer fails to pay 95% of its healthcare claims on time.

No matter the scheme, the central impetus behind all prompt-pay statutes is to ensure quick and full payment of providers' legitimate claims. Achieving the goal of prompt and full payment of providers' claims – without causing excessive administrative activity or inviting excessive litigation – should remain the metric by which to analyze the TPPA. ■

ENDNOTES

- 1 Michael Flynn, *The Check Isn't In The Mail*, 10 DEPAUL J. HEALTH CARE L. 397, 403 (2007).
- 2 See, e.g., *Mikal Watts Speaks Out on Legal Battle with Insurance Companies for Prompt Pay*, (Feb. 13, 2013), available at <http://finance.yahoo.com/news/mikal-watts-speaks-legal-battle-140800176.html> (reporting that Watts' law firm "recently formed the 'Prompt Pay Claims Resolution Group' and invested millions of dollars in medical data mining software to identify unpaid and underpaid health insurance claims").
- 3 Hygeia, *Managed Care Compliance Series, Part Two: U.S. Prompt Pay Regulations on Medical Claim Payment – Executive Summary* (2005), available at https://hygeia.net/whitepapers/whitepapers/2005_03_US_Prompt_Pay_Regulations_on_Medica_Claim_Payment_-_Executive_Summary.pdf.
- 4 "Insurer" is the term used consistently in the prompt payment of claims statute applicable to PPOs. See, e.g., TEX. INS. CODE § 1301.102(a) ("A physician or health care provider must submit a claim to an insurer..."). The statute applicable to HMOs typically uses the term "health maintenance organization," although it also sometimes uses "insurer." See, e.g., TEX. INS. CODE § 843.337(a) ("A physician or health care provider must submit a claim to a health maintenance organization..."). In this paper, "insurer" is used as a generic term to refer to the party that is required to pay healthcare provider claims.
- 5 Dave Hansen, *The Failed Promise of Prompt Pay*, (Nov. 5, 2007), available at <http://www.amednews.com/article/20071105/government/311059978/4/>.
- 6 James W. Marks, *Prompt Pay Statutes for Physicians' Billing Claims: An Imperfect Remedy for a Systemic Problem*, 20 J. MED. PRAC. MGMT. 135 (2004).
- 7 Errol J. King, *Prompt-Pay Insurance Laws a Continuing "Hotbed Of Activity"*, FED'N REG. COUNS. J., Vol. 16, Ed. 3, n. 1 (Fall 2005).
- 8 See Act of June 1, 2003, S.B. 418, 78th Leg., R.S., ch. 214, 2003 Tex. Gen. Laws 1016.
- 9 Russell G. Thornton, Michael A. Yanof, *Getting Stiffed No Longer Needs To Be A Cost of Doing Business: Texas Prompt Pay Provisions*, 22 PROC. BAYLOR U. MED. CENTER (2009) at 83.
- 10 See Texas Senate Special Committee on Prompt Payment of Health Care Providers, Interim Report to the 78th Legislature, November 2002, at 1.5-1.8, available at http://www.senate.state.tx.us/75r/Senate/commit/c950/c950_77.htm.
- 11 See Section III.C., *infra*.
- 12 See Section III.E., *infra*.
- 13 See Section III.F., *infra*.
- 14 TEX. INS. CODE §§ 843.002(22), (24), 1301.001(1-a), (6). While the TPPA refers to both "physicians and providers," this article refers to all of these parties as "providers."
- 15 TEX. INS. CODE §§ 843.344, 1301.109.
- 16 TEX. INS. CODE §§ 843.351, 1301.069.
- 17 See "Payment – Penalty Payments" section of TDI Prompt Pay FAQs, at <http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment>.
- 18 TEX. INS. CODE Ch. 843 (chapter entitled "Health Maintenance Organizations"); TEX. INS. CODE § 843.338 (creating pay-or-deny deadline for claims submitted to health maintenance organization by a participating provider); TEX. INS. CODE § 843.342(a) (requiring health maintenance organization to pay penalty to a provider).
- 19 TEX. INS. CODE Ch. 1301 (chapter entitled "Preferred Provider Benefit Plans"); TEX. INS. CODE § 1301.103 (creating pay-or-deny deadline for claims submitted to insurer by preferred provider); TEX. INS. CODE § 1301.137(a) (requiring insurer to pay penalty to a preferred provider).
- 20 See "General Prompt Pay Questions – Prompt Pay and Potential Fraud" section of TDI Prompt Pay FAQs, at <http://www.tdi.texas.gov/hprovider/ppsb418faq.html#general>.
- 21 See, e.g., *Aetna Life Ins. Co. v. Methodist Hosp. of Dallas*, 95 F. Supp. 3d 950 (N.D. Tex. 2015) (Third-party administrator of self-funded health insurance plans brought action against healthcare providers seeking declaratory judgment that TPPA does not apply to self-funded plans, or, if it does, then it is preempted by ERISA); *Health Care Serv. Corp. v. Methodist Hosp. of Dallas*, Case No. 3:13-CV-4946-B (N.D. Tex., Jan. 28, 2015) (same).
- 22 TEX. INS. CODE §§ 843.337(a), 1301.102(a).
- 23 TEX. INS. CODE §§ 843.337(a), 1301.102(a).
- 24 28 TEX. ADMIN. CODE § 21.2806(a) (Tex. Dep't of Ins., Claims Filing Deadline).
- 25 *Id.*
- 26 TEX. INS. CODE §§ 843.337(b), 1301.102(d).
- 27 TEX. INS. CODE §§ 843.337(c), 1301.102(e).
- 28 28 TEX. ADMIN. CODE § 21.2803(b)(1)(BB) (Tex. Dep't of Ins., Elements of a Clean Claim); see also TEX. INS. CODE § 843.342(a)(1), (b)(1) (imposing penalty based on "the difference between the billed charges, as submitted on the claim, and the contracted rate") (emphasis added); TEX. INS. CODE § 1301.137(a)(1), (b)(1) (same); Section III.F., *infra* (discussing "billed charges").

- 29 28 TEX. ADMIN. CODE § 21.2807 (Tex. Dep't of Ins., Effect of Filing a Clean Claim).
- 30 TEX. INS. CODE §§ 843.337(b), 843.338, 1301.102(d), 1301.103.
- 31 28 TEX. ADMIN. CODE § 21.2802(6)(B) (Tex. Dep't of Ins., Definitions); 28 TEX. ADMIN. CODE § 21.2803(e), (f) (Tex. Dep't of Ins., Elements of a Clean Claim).
- 32 See 28 TEX. ADMIN. CODE § 21.2803(b) (Tex. Dep't of Ins., Elements of a Clean Claim).
- 33 TEX. INS. CODE §§ 843.336, 1301.131; 28 TEX. ADMIN. CODE § 21.2803(b) (Tex. Dep't of Ins., Elements of a Clean Claim).
- 34 TEX. INS. CODE §§ 843.338(3), 1301.103(3).
- 35 28 TEX. ADMIN. CODE § 21.2807(a) (Tex. Dep't of Ins., Effect of Filing a Clean Claim).
- 36 TEX. INS. CODE §§ 843.323, 1301.0641.
- 37 See TEX. INS. CODE Article 3.70-3C, § 3A(j) (uncodified) and TEX. INS. CODE § 843.341(b), (c) (codified), both repealed by Act of June 1, 2003, S.B. 418, 78th Leg., R.S., ch. 214, §§ 2, 13, 2003 Tex. Gen. Laws 1016, 1019, 1028.
- 38 TEX. INS. CODE §§ 843.336(f), 1301.131(e), (g).
- 39 TEX. INS. CODE §§ 843.3385(a), (d), 1301.1054(a), (c).
- 40 TEX. INS. CODE §§ 843.3385 (a), 1301.1054(a).
- 41 TEX. INS. CODE §§ 843.338, 843.3385(a), (c), 1301.103, 1301.1054(a), (b).
- 42 TEX. INS. CODE §§ 843.3385 (c), 1301.1054(b).
- 43 TEX. INS. CODE §§ 843.3385(e), 1301.1054(d).
- 44 TEX. INS. CODE §§ 843.338, 1301.103.
- 45 TEX. INS. CODE §§ 843.338, 1301.103.
- 46 TEX. INS. CODE §§ 843.339, 1301.104.
- 47 TEX. INS. CODE §§ 843.353, 1301.107.
- 48 See Section III.D., *infra*.
- 49 TEX. INS. CODE §§ 843.3385, 1301.1054.
- 50 TEX. INS. CODE §§ 843.342(h)(1), 1301.137(h)(1).
- 51 TEX. INS. CODE §§ 843.342(h)(2), 1301.137(h)(2).
- 52 See TEX. INS. CODE §§ 843.338, 1301.103.
- 53 See TEX. INS. CODE §§ 843.342(h), 1301.137(h).
- 54 TEX. INS. CODE §§ 843.3405, 1301.1053.
- 55 TEX. INS. CODE §§ 843.350, 1301.132.
- 56 TEX. INS. CODE §§ 843.344, 1301.109.
- 57 28 TEX. ADMIN. CODE § 21.2802(8) (Tex. Dep't of Ins., Definitions).
- 58 28 TEX. ADMIN. CODE § 21.2815(d) (Tex. Dep't of Ins., Failure to Meet the Statutory Claims Payment Period).
- 59 28 TEX. ADMIN. CODE § 21.2802(3) (Tex. Dep't of Ins., Definitions).
- 60 See "Payment – Billed Charges" section of TDI Prompt Pay FAQs, at <http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment>.
- 61 28 TEX. ADMIN. CODE § 21.2802(3) (Tex. Dep't of Ins., Definitions), citing TEX. HEALTH & SAFETY CODE § 311.0025, TEX. OCC. CODE § 105.002, and TEX. INS. CODE Ch. 552.
- 62 TEX. INS. CODE §§ 843.342, 1301.137.
- 63 TEX. INS. CODE §§ 843.342(a), (b), 1301.137(a), (b).
- 64 See 28 TEX. ADMIN. CODE § 21.2815 (Tex. Dep't of Ins., Failure to Meet the Statutory Claims Payment Period).
- 65 The penalty ceilings (*i.e.* \$100,000 or \$200,000) are calculated per claim, and not per patient, per insurer, or per provider.
- 66 TEX. INS. CODE §§ 843.342(a), 1301.137(a).
- 67 TEX. INS. CODE §§ 843.342(b), 1301.137(b).
- 68 TEX. INS. CODE §§ 843.342(c), 1301.137(c).
- 69 In the Frequently Asked Questions section of its website, the Texas Department of Insurance explains that "[i]f there's no difference between the contracted rate and your billed charges, there's no difference upon which to compute a penalty." See "Payment – Penalty Payments" section of TDI Prompt Pay FAQs, at <http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment>.
- 70 See Texas Senate Special Committee on Prompt Payment of Health Care Providers, Interim Report to the 78th Legislature, November 2002, at 1.20, available at http://www.senate.state.tx.us/75r/Senate/commit/c950/c950_77.htm ("[Carriers] argue that penalties based on billed charges may bear little or no relation to the amount otherwise owed contractually..."); "Payment – Billed Charges" section of TDI Prompt Pay FAQs, at <http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment> (answering "What is considered an unreasonable billed charge?").

- 71 See TEX. INS. CODE Ch. 1506, *repealed by* Act of May 26, 2013, S.B. 1367, 83rd Leg., R.S., ch. 615, § 8, 2013 Tex. Gen. Laws 1640, 1642. The Texas Health Insurance Pool was created by the Texas Legislature to provide health insurance to eligible Texas residents who, due to medical conditions, were unable to obtain coverage from individual commercial insurers. Because the federal Affordable Care Act (“ACA”) provides that insurers cannot deny coverage to a person because of a preexisting condition and requires all Americans who are not covered by a government-sponsored program to purchase private health insurance, the need for the Pool arguably disappeared after the ACA became effective. The Texas Legislature, therefore, abolished the Pool during its 2013 legislative session, and provided that the Pool’s assets would be transferred to the Texas Department of Insurance. See *id.* § 6. The Legislature, however, did not cut-off the payment of prompt-pay penalties by insurers to the Pool. See *id.* Consequently, the State of Texas, in lieu of the Pool, continues to receive prompt-pay penalties from health insurers operating in Texas.
- 72 TEX. INS. CODE §§ 843.342(m), 1301.137(l).
- 73 TEX. INS. CODE §§ 843.342(m), 1301.137(l).
- 74 See Tex. H.B. 1433, 84th Leg., R.S. (2015), available at <http://www.legis.state.tx.us/BillLookup/Text.aspx?LegSess=84R&Bill=HB1433>.
- 75 See Texas Legislative Budget Board Fiscal Note for H.B. 1433, Mar. 17, 2015, available at <http://www.legis.state.tx.us/BillLookup/Text.aspx?LegSess=84R&Bill=HB1433>.
- 76 *Id.*
- 77 TEX. INS. CODE §§ 843.342(d), (e), 1301.137(d), (e).
- 78 See, e.g., TEX. INS. CODE § 843.342(g) (“the underpaid amount is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate”).
- 79 28 TEX. ADMIN. CODE § 21.2815(d) (Tex. Dep’t of Ins., Failure to Meet the Statutory Claims Payment Period).
- 80 *Id.*
- 81 Texas Senate Special Committee on Prompt Payment of Health Care Providers, Interim Report to the 78th Legislature, November 2002, at 1.12, available at http://www.senate.state.tx.us/75r/Senate/commit/c950/c950_77.htm.
- 82 TEX. INS. CODE §§ 843.3405, 1301.1053.
- 83 See TEX. INS. CODE §§ 843.342(h)(1), 1301.137(h)(1) (penalty not imposed only if claim paid late because of a catastrophic event or an underpayment was not noticed until after passage of 270 days).
- 84 See Section III.G., *supra*.
- 85 TEX. INS. CODE §§ 843.340, 1301.105, 1301.1051.
- 86 28 TEX. ADMIN. CODE § 21.2818 (Tex. Dep’t of Ins., Overpayment of Claims).
- 87 TEX. INS. CODE §§ 843.350, 1301.132.
- 88 TEX. INS. CODE §§ 843.350(b), 1301.132(b); 28 TEX. ADMIN. CODE § 21.2818(c) (Tex. Dep’t of Ins., Overpayment of Claims). Although the statutes and rules reference a right for a provider to appeal an insurer’s decision, the right to appeal is a right for the provider to ask the insurer to review its decision, not a right to appeal in court or an appeal to appeal to an administrative agency.
- 89 28 TEX. ADMIN. CODE § 21.2818(f) (Tex. Dep’t of Ins., Overpayment of Claims).
- 90 TEX. INS. CODE §§ 843.343, 1301.108.
- 91 28 TEX. ADMIN. CODE § 21.2817(2) (Tex. Dep’t of Ins., Terms of Contracts).
- 92 TEX. INS. CODE §§ 843.342(k), 1301.137(k).
- 93 28 TEX. ADMIN. CODE § 21.2822 (Tex. Dep’t of Ins., Administrative Penalties).
- 94 TEX. INS. CODE §§ 843.342(k), 1301.137(k).
- 95 TEX. INS. CODE §§ 843.281, 1301.066.
- 96 28 TEX. ADMIN. CODE § 11.901(a)(2) (Tex. Dep’t of Ins., Required Provisions).
- 97 See TEX. INS. CODE §§ 843.347(a), 1301.133(b).
- 98 TEX. INS. CODE §§ 843.347(b), 1301.133(b); see also “Payment – Billed Charges” section of TDI Prompt Pay FAQs, at <http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment> (“the carrier must provide a response to a verification request ‘without delay and as appropriate to the circumstances of the particular request, but not later than five days after the date of receipt of the request for verification.’”).
- 99 TEX. INS. CODE §§ 843.347(d), 1301.133(d).
- 100 TEX. INS. CODE §§ 843.347(g), 1301.133(g).
- 101 TEX. INS. CODE §§ 843.347(f), 1301.133(f).
- 102 TEX. INS. CODE §§ 843.348, 1301.135.
- 103 TEX. INS. CODE §§ 843.348(a), 1301.135(b).
- 104 TEX. INS. CODE §§ 843.348(g), 1301.135(f).
- 105 TEX. INS. CODE §§ 843.342(h)(2), 1301.137(h)(2); 28 TEX. ADMIN. CODE § 21.2815(f) (Tex. Dep’t of Ins., Failure to Meet the Statutory Claims Payment Period).

- 106 TEX. INS. CODE §843.348(h)(2), §1301.137(h)(2).
- 107 See TEX. CIV. PRAC. & REM. CODE § 16.004(a)(3).
- 108 See, *generally*, Appendix A.
- 109 TEX. INS. CODE §§ 843.338, 1301.103. Because the vast majority of healthcare claims nationwide are submitted electronically, this article will compare electronic claim deadlines among the 50 states plus the District of Columbia.
- 110 See, *generally*, Appendix A.
- 111 See *id.*
- 112 See *id.*
- 113 See ARIZ. REV. STAT. ANN. §§ 20-3101 to -3102.
- 114 According to a company advertising for TPPA clients, “the TPPA provides what is almost a strict-liability standard.” See Healthcare Recovery Advisors website at <http://healthcarerecoveryadvisors.com/>.
- 115 See Sections III.D., E., and G., *supra*.
- 116 See, *generally*, Appendix A.
- 117 TEX. INS. CODE §§ 843.350, 1301.132.
- 118 See D.C. CODE ANN. § 31-3133; MD. CODE ANN., INS. § 15-1008; NEB. REV. STAT. ANN. § 44-8004.
- 119 See N.H. REV. STAT. ANN. § 415:6-i.
- 120 See, *generally*, Appendix A.
- 121 See *id.*
- 122 See Sections III.F., *supra*.
- 123 See MO. ANN. STAT. § 376.383.
- 124 See, *generally*, Appendix A.
- 125 See *id.*
- 126 WYO. STAT. ANN. § 26-15-124, *preempted by Moffett v. Halliburton Energy Servs.*, 291 F.3d 1227 (10th Cir. 2002).
- 127 See, *generally*, Appendix A.
- 128 TEX. INS. CODE §§ 843.342(m), 1301.137(l).
- 129 See D.C. CODE ANN. § 31-3132; KY. REV. STAT. ANN. § 304.17A-730; MD. CODE ANN., INS. § 15-1005.
- 130 See D.C. CODE ANN. § 31-3132(c); MD. CODE ANN., INS. § 15-1005(f)(1).
- 131 UTAH CODE § 31A-26-301.6(7).
- 132 MO. REV. STAT. § 376.383(6).
- 133 See IND. CODE ANN. §§ 27-8-5.7-6, 27-13-36.2-4.
- 134 See, *e.g.*, DEL. INS. REG. 1310 §§ 1 § 2301(a); NEV. REV. STAT. § 683A.0879(2).
- 135 COLO. REV. STAT. § 10-16-106.6(5)(b).
- 136 MO. REV. STAT. § 376.383.
- 137 See, *generally*, Appendix A.
- 138 See LA. STAT. ANN. § 22:1860; NEB. REV. STAT. ANN. § 44-8008; N.M. STAT. ANN. § 59A-1-18.
- 139 TEX. INS. CODE §§ 843.342(k), 1301.137(k).
- 140 TEX. INS. CODE §§ 843.342(k), 1301.137(k).
- 141 See IND. CODE ANN. §§ 27-8-5.7-8, 27-13-36.2-6; KY. REV. STAT. ANN. § 304.99-123; MISS. CODE ANN. §§ 83-9-5(8); MONT. CODE ANN. § 33-18-233(2); TENN. CODE ANN. § 56-7-109(c); WASH. REV. CODE ANN. § 48.31B.035.
- 142 See, *generally*, Appendix A.
- 143 42 U.S.C. § 1395u(c)(2).
- 144 See N.H. REV. STAT. ANN. §§ 415:6-h, 415:18-k; N.J. STAT. ANN. § 17B:26-9.1; N.Y. INS. LAW § 3224-a; OHIO REV. CODE ANN. § 3901.3812.
- 145 IDAHO CODE § 41-5606(1), (4).
- 146 ME. REV. STAT. tit. 24-A, § 2436(4); MO. STAT. § 376.383(6); NEV. REV. STAT. § 695C.185(5); N.H. REV. STAT. § 415:6-h(III)(b); OKLA. STAT. tit. 36, § 1219(G); VA. CODE § 38.2-3407.15(E); W. VA. CODE § 33-45-3; WYO. STAT. § 26-15-124(c).
- 147 See, *generally*, Appendix A.
- 148 James W. Marks, *Prompt Pay Statutes for Physicians’ Billing Claims: An Imperfect Remedy for a Systemic Problem*, 20 J. MED. PRAC. MGMT. 135, 137 (2004).
- 149 HAW. REV. STAT. § 431:13-107; IDAHO CODE § 41-5606(5); MONT. CODE § 33-18-232(3).
- 150 See N.D. CENT. CODE ANN. §§ 26.1-36-37.1 to 26.1-36-40; S.D. CODIFIED LAWS §§ 58-12-19 to 58-12-21.
- 151 Angela Morris, *Lawmakers Target Lawyers’ ‘Prompt Pay’ Practice*, TEX. LAW., March 20, 2015.