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TEXAS INSURANCE CODE ARTICLE 3.70-3C AND WORKERS COMPENSATION REQUIREMENTS: POTENTIAL AREAS OF CONFLICT

This document outlines provisions of Article 3.70-3C, Insurance Code, that could be interpreted as inconsistent with workers compensation requirements for regional health care delivery networks, as adopted in HB 2600. The list only includes those provisions that potentially conflict with HB 2600 or appear inconsistent with workers compensation requirements. There may be additional provisions that present policy issues regarding the appropriateness of their application to workers compensation, that are not included here. This list should be considered a partial list and is not necessarily comprehensive.

HB 2600 specifies that Article 3.70-3C should be applied as minimum standards for regional networks except to the extent they are inconsistent:

> **Labor Code Section §408.0221 (as added by HB 2600)**
> (g) The standards adopted for preferred provider networks under Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, apply as minimum standards for regional health care delivery networks created under this section and are adopted by reference in this section except to the extent they are inconsistent with this subtitle. The advisory committee may also recommend additional standards, including standards that require [partial list of standards]:

List of Article 3.70-3C Potential *Conflicting* Provisions.

- **Prompt payment requirements**. Requirements related to timeframes for prompt payment of claims differ under Article 3.70-3C and the Labor Code applicable to workers compensation. It is important to note that the issue of prompt payment is one under review presently, and prompt pay requirements may be subject to change as part of the efforts by the Texas Department of Insurance and others to address this subject.

  In the event of an audit, 3.70-3C requires payment of 85% of the contracted rate by the 45th day after receipt of the claim. Tex. Lab. Code §408.027 mandates payment of 50% of the amount charged by the 45th day after receipt.

  > **Article 3.70-3C:**
  > Section 3(m) An insurer shall comply with Article 21.55 of this code with respect to prompt payment of insureds. A preferred provider contract must include a provision for payment to the physician or health care provider for covered services that are rendered to insureds under the contract **not later than the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim** or, if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer. For purposes of

this subsection, "covered services" means health care services and benefits to which an insured is entitled under the terms of the contract.

See also 28 TAC § 3.3703(a)(11).

Article 3.70-3C:
Section 3A(e) If the insurer acknowledges coverage of an insured under the health insurance policy but **intends to audit the preferred provider claim, the insurer shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date** that the insurer receives the claim from the preferred provider. Following completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:

(1) the preferred provider receives notice of the audit results; or

(2) any appeal rights of the insured are exhausted.

Labor Code § 408.027
(a) An insurance carrier shall pay the fee allowed under Section 413.011 for a service rendered by a health care provider **not later than the 45th day after the date the insurance carrier receives the charge unless the amount of the payment or the entitlement to payment is disputed.**

(b) If an insurance carrier disputes the amount charged by a health care provider and requests an audit of the services rendered, **the insurance carrier shall pay 50 percent of the amount charged by the health care provider not later than the 45th day after the date the insurance carrier receives the statement of charge.**

- **Balanced Billing**. The PPO statute allows physicians and health care providers to bill an "insured" only on a discounted basis if the contract is on a discounted basis. It appears that the "insured" in this article refers to the insured patient. The statute does not specifically prohibit billing the insured and doesn't state under what circumstances insured may be billed.

  This provision may be inconsistent with workers' compensation law, under which balanced billing may be prohibited.

  Article 3.70-3C:
  Section 3(k). A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge.

  See also 28 TAC § 3.3703(a)(10)

List of Article 3.70-3C Potentially *Inconsistent* Provisions.

- **Notice of opportunity to join the network**. Insurers offering a PPO Plan are required by Article 3.70-3C to provide notices, initially and annually thereafter, to all physicians and providers in the geographic area of the opportunity to participate in the network [Sec. 3(c)]. The question arises whether this provision is inconsistent with workers compensation requirements, which limit participation by doctors to only those who have met the requirements for inclusion on the Approved Doctor's List.

  This PPO provision is about giving doctors the opportunity to get on the Approved List so there may be an argument that notice is still required in the workers compensation setting.

  The PPO statute requires notice as follows:

  Article 3.70-3C:
  "(c) Any insurer, when sponsoring a preferred provider benefit plan, shall immediately notify, by publication or in writing to each physician and practitioner, all physicians and practitioners in the geographic area covered by the plan of its intent to offer such a plan and of the opportunity to participate. Such notice and opportunity shall be provided on a yearly basis thereafter to noncontracting physicians and practitioners in the geographic area covered by the plan. The insurer shall on request make available to any physician or health care provider information concerning the application process and qualification requirements for participation as a provider in the plan."

  See also 28 TAC §§ 3.3706(a)(1) to (4) which sets forth specific requirements for notifying physicians, practitioners, institutional providers, and health care providers, of the opportunity to become preferred providers.

  - *Insurer initially sponsoring a preferred provider benefit plan shall notify all physicians and practitioners in the plan service area of its intent to offer the plan and of the opportunity to apply to participate. § 3.3706(a)(1)*
  - *Subsequently, an insurer shall annually notify all non-contracting physicians and practitioners in the plan service area of the opportunity to apply for plan participation. § 3.3706(a)(2)*
  - *An insurer shall, upon request, make available to any physician or provider information concerning the application process and qualification requirements, including the use of economic profiling to admit a provider to the plan. § 3.3706(a)(3)*
  - *All required notifications shall be made by publication or distributed in writing to each physician and practitioner in the same manner. § 3.3706(a)(4)*

The Labor Code requires modification of the registration requirement – that is, the requirement to be on the Approved List – as necessary to ensure that doctors are informed of the regulations. This would argue for modifying the registration requirement in order to comply with requiring notice as required by the PPO statute.

> **Labor Code Sec. 408.023 (as added by HB 2600)**
> " (g) **The commission by rule shall modify registration** and training requirements for doctors who infrequently provide health care, who perform utilization review or peer review functions for insurance carriers, or **who participate in regional networks established under this subchapter**, as necessary to ensure that those doctors are informed of the regulations that affect health care benefit delivery under this subtitle."

- **References to "insureds" and "enrollees."** Certain provisions in the PPO statute raise policy questions with regard to application, as well as questions about inconsistency. Article 3.70-3C refers to "insureds" and "enrollees" frequently, which normally applies to the patient. Such terms could be interpreted as applying to the employer in a workers' compensation setting. In applying Article 3.70-3C to a workers compensation setting, it will be important to determine as a matter of policy whether the rights and responsibilities are appropriately applied to the patient or the employer, as well as whether they are actually inconsistent with workers compensation requirements.

  For example, Article 3.70-3C requires that a list of current providers be given to the insured, ie the patient, at least annually. In a workers compensation setting, that requirement may more appropriately be applied to the employer, since the covered population for workers compensation would not usually be receiving workers compensation care in a given year.

  Another example are Article 3.70-3C's patient notification requirements related to termination and continuity of care. The PPO statute requires notification of termination of a physician or health care provider as follows. The statute requires notice to the "insured" or "enrollee", ie the patient, under certain circumstances. One purpose of this section would appear to be "assuring transition" for purposes of "continuity of treatment" as stated in Section 4(a). Arguably this purpose still applies in a workers compensation setting because the purpose is to make sure the patient continues to get care, and is not necessarily related to the fact that the employer pays for treatment:
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  > **Article 3.70-3C:**
  > Sec. 4. (a) The insurer shall establish reasonable procedures for assuring a transition of insureds to physicians or health care providers and for continuity of treatment. **Insurers shall provide, subject to Section 6(e) of this article, reasonable advance notice to the insured of the impending termination from the plan of a physician or health care provider who is currently treating the insured and in the event of termination of a preferred provider's**

participation in the plan shall make available to the insured a current listing of preferred providers.

See also 28 TAC § 3.3704(a)(4), which states that insureds shall have the right to continuity of care as set forth in Insurance Code Art. 3.70-3C, §4.

Article 3.70-3C:
Section 6(e)(1) If a physician or practitioner is terminated for reasons other than at the preferred provider's request, an insurer shall not notify enrollees of the termination until the effective date of the termination or at such time as a review panel makes a formal recommendation regarding the termination, whichever is later. *See also 28 TAC § 3.3706(g)(1)*

(2) If a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, **the physician or provider shall provide reasonable notice to enrollees under the physician's or provider's care**. The insurer shall provide assistance to the physician or provider in assuring that the notice requirements of this subdivision are met. *See also 28 TAC §3.3703(a)(18),* § 3.3706(g)(2)

(3) If a physician or practitioner is terminated for reasons related to imminent harm, an **insurer may notify enrollees immediately**. *See also 28 TAC* § 3.3706(g)(3)