TEXAS SENATE
SPECIAL COMMITTEE
ON
PROMPT PAYMENT OF
HEALTH CARE PROVIDERS

INTERIM REPORT
TO THE
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TABLE OF CONTENTS

CHARGE #1 . . . . . 1.3

EXECUTIVE SUMMARY 1.3

BACKGROUND 1.5
- Texas Legislative and Regulatory History 1.5
- Additional Regulatory Measures and Legal Action 1.8

OUTSTANDING PROMPT PAYMENT ISSUES 1.9
- Clean Claim Elements 1.9
- Submission of Claims 1.10
- Duplicate Claims Filing 1.11
- Attachments and Additional Information 1.11
- Claims Audits 1.12
- Coding, Bundling and Fee Schedules 1.12
- Standardized Coding and Bundling Guidelines 1.14
- Electronic Claims Transactions 1.14
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) 1.16
- Eligibility Issues - Preauthorization, Precertification and Verification 1.16
- Coordination of Benefits 1.18

PENALTIES AND RESTITUTION 1.18
- Current Law 1.18
- Penalties Restructuring 1.20
- Non-Contract Providers 1.21
- Pharmacy Issues 1.21

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 1.22
- Preemption Provisions 1.23
- State Oversight Limitations 1.23
- Enrollee Identification Cards 1.24

THE MEDICAID MODEL 1.25

RECOMMENDATIONS 1.27

ENDNOTES 1.30

CHARGE ONE:
Prompt Payment of Health Care Providers

CHARGE #1

Evaluate the effectiveness of existing state law and agency rules designed to ensure prompt payment of health insurance claims to providers by insurance companies. The committee should assess the level of industry compliance with current law and the necessity of additional enforcement measures; (and) determine the factors affecting the timeliness of reimbursements and make necessary recommendations to improve the process.

EXECUTIVE SUMMARY

Issues relating to prompt payment of health care providers stem from difficulties experienced by physicians and other health care providers in receiving timely and accurate payment for services. Though concern about prompt payment of claims is not limited to managed care, in many ways the problems are an inherent result of the structure that has become the predominant model for the delivery of health care in Texas and nationwide over the past decade. The introduction of a contractual relationship between provider and insurer, coupled with the employer's role as group heath plan sponsor, has changed the nature of the relationship between those three entities as health care recipients are to a large degree removed from claims submission and payment responsibilities. This has produced a sometimes adversarial relationship between providers and carriers, who otherwise depend on each other to fulfill their functions in order for the managed care model to succeed.

Disagreement over issues relating to payment of claims has grown more pronounced in recent years. Providers claim that their ability to continue serving is heavily compromised by the economic difficulties resulting from payment problems that reflect carrier practices, while carriers point to the cost of administration and adherence to the resulting regulatory environment as a major driver in premium costs and plans' decisions to move their business toward other, less regulated, types of coverage. Employers and, ultimately, patients suffer the consequences through increased health care costs and reduced patient access to care.

Providers contend that insurers routinely fail to pay claims in a timely or accurate manner, and point to "lost" claims, confusing and diverse coding systems, inconsistent and proprietary coding practices such as bundling and downcoding, and plans' denials of payment after prior authorization for procedures as factors resulting in late payment, underpayment, and inappropriate denial of payment. Providers also complain that insurers' failure to disclose coding methods has exacerbated payment problems by making it more difficult for them to ascertain the payment amount owed under the contract.

Insurers claim that they pay nearly all clean claims promptly, and allege that most problems with prompt pay stem from deficient claims filed by providers, failure of providers to provide needed additional information in a timely manner and, in some cases, "creative" billing.

Legislation was passed by the Texas Legislature in 1995, 1997, 1999 and 2001 to address problems relating to managed care and to claims payment issues as they developed. House Bill 1862, 77(R), provided for comprehensive reforms related to prompt payment, but was vetoed due to concerns about provisions that Governor Perry felt would generate more lawsuits.

Lieutenant Governor Bill Ratliff established the Senate Special Committee on Prompt Payment of Health Care Providers in 2001, following the 77th Legislature, to "*evaluate the effectiveness of existing state law and agency rules designed to ensure prompt payment of health insurance claims to providers by insurance companies and Health Maintenance Organizations (HMOs); assess the level of industry compliance with current law and the necessity of additional enforcement measures; and determine the factors affecting the timeliness of reimbursements and make necessary recommendations to improve the process.*"

The committee held six hearings in Austin, Houston, Fort Worth, San Antonio, and the Rio Grande Valley to take both invited and public testimony. It heard extensive testimony on its prompt payment charge from a wide variety of patients, employers, providers including general, specialty practice, and emergency services physicians, hospital and other facilities-based providers, and pharmacy representatives. The committee also heard testimony provided by the Texas Department of Insurance (TDI), Office of the Attorney General (OAG), and the Health and Human Services Commission (HHSC).

Data presented to the committee by TDI indicated signs of improved payment performance by carriers, possibly as a result of previous legislative changes, implementation of rules by TDI, and efforts by the agency to pursue penalties for violations of the law and rules. TDI's ongoing tracking of timely payment performance indicates that reporting companies' payment of clean claims within 45 days has improved from rates averaging close to 96 percent of claims in the first calendar quarter of 2001 to just over 99 percent through the second quarter of 2002. However, performance continues to fluctuate by quarter and by company group. The agency figures represent a percentage of the number of claims paid timely, not the dollar amount represented by claims not paid on time. They also reflect only clean claims, not those that are deemed deficient, and do not indicate the number or dollar value of claims paid both on time and correctly. (A chart illustrating payor performance trends is located in Appendix B.4.)

While insurers and HMOs point to improving success rates, providers report that they have seen little meaningful evidence of improvement as they continue to confront payment difficulties costing millions of dollars annually. Both providers and carriers report significant continued dissatisfaction and frustration with many aspects of current payment requirements, and TDI has identified a number of policy areas in which it cannot take needed regulatory action because it lacks statutory authority to do so. Further, impending changes to federal health insurance regulations require response at the state legislative level. Most important, patients and their employers continue to pay the cost of payment issues through reduced access to affordable and appropriate health care options.

BACKGROUND

Concerns about claims payment are not endemic to the Texas health care market. As of July 2002, 47 states had enacted statutes addressing problems relating to payment of health care claims. Common provisions of these laws include specific time frames for filing and payment of claims; penalty provisions, including interest penalties, for violation of the laws; procedures and standards governing submissions and additional information requests; notification procedures and status of claims processing indicators; limitations on retroactive denials; mandatory compliance reports and audits of carriers; and definitions of "clean claims." Penalties for noncompliance and the time frames within which insurers are required to pay clean claims vary widely. Some states also differentiate between electronic and paper claims submissions, with varying payment requirements based on the type of submission. States' laws also contain provisions relating to provider claims filing responsibilities, including claims filing deadlines, restrictions on the filing of duplicate claims, provisions allowing insurers to conduct retrospective audits and to recoup overpayments, fraud provisions, and, in some cases, allowances for modified terms via contract. (An outline of other states' requirements regarding prompt payment is located in Appendix B.3.)

Texas Legislative and Regulatory History

HMOs are regulated in Texas under the Health Maintenance Organization Act.[1] Insurers which sponsor preferred provider plans are regulated under the Texas Insurance Code (TIC).[2] Prior to 1997, under provisions of the Texas Administrative Code, the Texas Department of Health (TDH) also had regulatory powers over HMOs.[3]

The 74th Legislature (1995) enacted House Bill 2766, the Patient Protection Act, which contained provisions relating to consumer protections, due process and contracting. The bill was vetoed in June 1995 due to concerns relating to the imposition of new regulations, associated costs, and the alleged creation of competitive disadvantages through exemptions contained in the bill.[4] The Governor subsequently directed the Commissioners of Insurance and Health, whose agencies had primary regulatory responsibility at that time, to develop rules to resolve issues addressed in H.B. 2766. The resulting TDI rules addressed a number of issues, including provider due process and financial incentives in provider contracts. TDH repealed rules regulating HMOs, created a new chapter addressing quality of care issues, and provided more standardized complaint procedures.

Legislation developed from interim committee work and enacted by the 75th Legislature (1997) transferred quality of care oversight functions from TDH to TDI and codified certain agency rules within TDI regarding access and quality of care, as well as recommendations of the interim committee for additional consumer protections. The 75th Legislature also enacted Senate Bill 383 and Senate Bill 385. S.B. 383 provided regulations for preferred provider benefit plans offered by health insurers. S.B. 385 amended the TIC to require HMOs to pay physicians and

providers not later than the 45th day after a claim is received with necessary documentation, or within a period specified by a written agreement between the insurer and the provider.[5]

Despite the changes, providers continued to express concerns about claims payment.[6] The beginning of the 45-day statutory claims payment period was frequently delayed because of disagreements with carriers over the documentation reasonably necessary to process the claim and over verification of receipt of claims. Other insurers were required to pay claims within 45 days under Article 21.55 TIC. However, the requirement applied only to first-party claims for benefits paid directly to an insured or beneficiary; it did not apply to third-party payments made by HMOs or insurers or those made to third parties through other contractual arrangements.

In 1999, the 76th Legislature enacted House Bill 610, with provisions requiring prompt payment of "clean" claims by HMOs[7] and issuers of preferred provider benefit plans[8] and adding administrative penalties for late payments. The act requires a carrier to give a provider a copy of its applicable policies and procedures for utilization review and claim processing, including required data elements and claim formats.[9] A carrier may, per contract, add or change the data elements that must be submitted with the claim. The carrier may also change claim elements by notifying the provider at least 60 days before they go into effect. The act also requires prescription benefit claims that are electronically submitted, adjudicated and paid to be paid no later than the 21st day following authorization of treatment.

In May 2000, TDI adopted initial rules implementing H.B. 610.[10] The rules define a clean claim as one submitted by a physician or other provider with required data elements and attachments necessary for processing a claim, any additional elements of which the physician or provider has been properly notified, and notice of the amount paid by the primary plan or other valid coverage. The TDI rules relating to required data elements are based on the federal claim forms used for Medicare.[11] Carriers may add or delete TDI requirements by giving providers sixty days notice prior to the change.[12]

Under the provisions of H.B. 610 and related rules, carriers must pay the total contractual amount of a clean claim no later than the 45th day after receipt or notify the provider, in writing, why they will not pay the claim. If the claim submitted is not clean, the carrier may return the claim with a deficiency notice. If a portion of the claim is in dispute, the carrier must pay the undisputed amount and must notify the provider of the status of the remainder within the specified time period. If a carrier cannot make a claim determination within 45 days, it must notify the provider that it intends to audit the claim and pay 85 percent of the contracted rate not later than the 45th day after the date the claim is received. Following completion of the audit, any additional payment due a provider or refund due the carrier must be made within 30 days after notice of the audit results or any appeals of an enrollee are exhausted, whichever is later.[13] Failure to make timely payment makes the carrier liable for the contract penalty amount. Absent a contract penalty, the carrier must pay billed charges as defined by TDI rule. The carrier may

also be fined an administrative penalty of up to $1,000 per day that the claim remains unpaid. Providers may also recover reasonable attorney's fees in an action to recover payment.[14] A provider may obtain acknowledgment of receipt of a claim by mailing the claim with return receipt requested. Carriers must acknowledge receipt of claims submitted electronically via electronic means.[15]

Notwithstanding the enactment of prompt payment laws and subsequent agency regulations, complaints about slow payment or nonpayment by carriers continued to grow, with TDI reporting that it received over 12,000 complaints between FY 2001 and the present. Providers expressed concerns about carrier billing and coding policies that they believed had a negative impact on communications and timely, accurate claims payment, and about prior authorization.[16] Providers also continued to complain about the additional data element and attachment requirements imposed by carriers. Further, providers characterized the "coordination of benefits" provision requiring providers to identify secondary sources of insurance as one that is "'onerous and costly' to physicians and payers, will slow down claims processing and filing, and thwarts the move toward more efficient electronic claims filing."[17]

According to a 2001 Texas Medical Association (TMA) survey, 60 percent of Texas physicians surveyed experienced cash flow problems due to slow-payment or non-payment of third-party payers, with almost one fifth (19%) reporting cash flow problems substantial enough to require withdrawals from personal funds to pay for practice operations.[18] TMA reported receipt of 5,000 complaints in 2000 related to payment issues, five times the number reported in 1998.[19]

Carriers asserted that the information they require is necessary in order to process claims.[20] The Health Insurance Association of America suggested that more than one-quarter of all claims rejected nationwide did not meet "clean claim" requirements: the claims either contained mistakes or lacked a required data element.[21] Plans have reported similar experience in the Texas market.

The 77th Legislature (2001) passed H.B. 1862 to address the continuing concerns regarding prompt payment of claims. The bill amended requirements for provider payments by carriers including provisions for presumed receipt for claims sent by mail; redefined prior authorization as a reliable representation that an carrier would pay for a service; required carriers to disclose additional coding information; placed limitations on the additional information carriers could request; and prohibited a carrier from requiring providers to use binding arbitration to settle prompt payment disputes.

H.B. 1862 was vetoed due to concerns about the increased cost to the health care and health insurance systems that would result from the bill. The veto proclamation stated that the prohibition against inclusion of an alternative dispute resolution clause in the bill would result in more cases being resolved through litigation, unnecessary payment delays, increased health insurance costs, and increased numbers of uninsured Texans.[22] The proclamation also noted that the 76th Legislature had enacted laws providing for joint negotiation between providers and health plans, that the final rules regulating prompt payment of clean claims had only recently

been adopted, and that the changes had not had sufficient time to "achieve their intended results." The governor, in his veto proclamation, directed TDI "to be more aggressive in assisting physicians and other health care providers in claims disputes" and to "strengthen existing prompt-payment rules." In addition, TDI was directed to continue its provider ombudsman program and establish a mechanism to solicit input from affected parties, including providers and insurers. Since the issuance of the veto proclamation, the Department has levied record fines against health plans for nonpayment or slow payment of claims and has recognized that additional statutory direction is needed for greater enforcement of prompt pay regulations.

Additional Regulatory Measures and Legal Action

In response to the continued growth in the number of complaints relating to payment of claims, TDI established a Provider Ombudsman program in April 2001 to ensure that carriers complied with Texas' laws relating to the prompt payment of clean claims. The ombudsman was given the tasks of educating physicians, providers and insurers; resolving complaints related to prompt payment issues; improving complaint filing processes; analyzing data relating to complaints and recommending enforcement actions.

Since June 2001, TDI has taken additional steps to improve compliance with current law, twice revising and strengthening its prompt payment rules and mediating disputes between carriers and providers on related issues. As of October 2002, TDI's compliance enforcement effort has resulted in consent orders requiring 47 HMOs and insurance companies to pay more than $45 million in restitution to physicians and providers and $14.9 million in fines for failure to comply with prompt payment regulations.[23] Insurers contested TDI's authority to publicly release the consent order restitution reports, leading to a determination rendered by the OAG (OR 2002-0521) in February 2002 that release is required under the Texas Public Information Act.[24] (An updated TDI restitution report is located in Appendix B.5.)

A "Clean Claims Working Group" (hereafter, the "working group") was established at TDI in 2001 to review and recommend additional revisions to the clean claims rules. The working group, comprised of representatives from carriers, providers and associations, held six meetings between November 2001 and August 2002 to discuss ERISA claims, coding and bundling practices, duplicate claim filings, and graduated penalties, among other topics. Based on the group's efforts, TDI staff has made recommendations for rule amendments, suggested legislation to address key issues, and shared research findings with the Senate Special Committee on Prompt Payment of Health Care Providers.

In September 2001, the Attorney General launched an investigation of nine HMOs representing roughly 80% of the HMO business in Texas regarding providers' complaints about the plans' claims payment practices, including bundling, downcoding, changing reimbursement rates without proper notice and retroactive denial of payment.[25] One of the companies, PacifiCare of Texas, filed suit the following month challenging the authority of the Attorney General in regard to the investigation. [26] TDI and the AG joined in a countersuit, with several physicians and other

providers intervening.[27] Trial is currently set for April 2004, but at this time the parties are working toward resolution via mediation.

In addition, a federal suit being contested in U.S. District Court in Miami, Florida involving insurance companies doing business in Texas (and elsewhere) and with plaintiffs that include representatives of Texas providers, was given class action status by the court with a trial date set for May 2003. The plaintiffs in the suit allege fraudulent practices by health plans in relation to claims payment practices.

OUTSTANDING PROMPT PAYMENT ISSUES

Clean Claim Elements

Under current law, a clean claim must contain the data elements set forth in TDI rules, along with any additional, carrier-specific data elements and claim attachments that have been required through proper notice by the carrier. The carrier may require additional elements or attachments either in a provider contract or with 60-day advance notice in the provider manual or by 60-day advance written notice.[28]

Providers have argued that carriers should not be able to require additional elements or claim attachments because it hinders electronic claims filing (attachments are currently submitted on a paper basis, whether via mail, fax, or scanned e-mail) and requires submission of documents that a carrier may not need in order to process claims. They have also expressed concern that repeated requests for additional information slows the payment process. Carriers assert that they only need additional documentation to properly adjudicate certain claims, but unless they can require documentation in advance as a clean claim element, there is no way to assure that it will be received before the processing deadline expires for those claims.

Both providers and carriers agreed that the clean claims rules should be reviewed, particularly those areas that have had an impact on administrative costs. The parties involved in the continuing discussion report agreement that the current process would be improved and simplified if carriers did not have to require additional elements and attachments on all claims in order to assure that they receive information that is needed only for certain claims. Carriers have expressed their support for this change contingent on legislation tolling the clean claim processing deadline pending receipt of requested documents.

At the request of the committee, the TDI working group has extended ongoing deliberations regarding definition of elements of clean claims in an attempt to resolve the issue through agreed rulemaking. While significant progress has been made toward that goal, key issues remain.[29] Among those is the question of which elements are to be considered essential and which will be designated as conditional. To date, the payors have responded to concerns expressed by

providers by acknowledging that some requested information could be made conditional for certain specialty providers who do not have direct contact with patients (and as a result would not have the requested information). However, discussion continues regarding an appropriate definition of the list of providers to whom the allowance would apply.

Submission of Claims

The issue of claims submission and tracking arose both in committee hearings and in TDI working group meetings. A variety of arrangements between contracted third party administrators (TPAs), independent physician associations (IPAs), and carriers adds to the complexity of claims processing and tracking. Providers and payors both expressed concerns regarding proper management of misdirected claims, the filing of secondary claims, submission and confirmation of electronic claims filing, timelines for filing claims and duplicate claims filing.

Physicians and providers have complained that there is no way to know when, or whether, a claim has been received at the office of the carrier or its delegated processor. They say that in some cases carriers may refuse to acknowledge receipt as a means to avoid responsibility for payment. This problem appears to be most prevalent in regard to paper claims and attachments; electronic and faxed claims typically generate automatic confirmation.

In the last adoption of the clean claim rules, TDI attempted to address the problem with the inclusion of a claims mail log system enabling physicians and other providers to create a rebuttable presumption of the date of claims receipt. If the claims mail log system is followed, claims are presumed received on the third business day after the date of mailing. Physicians and providers assert that the mail log system is too burdensome. Providers believe that proof of receipt of a claim should require only the physician's or other provider's assurance it was mailed. They also argue that the rule is ineffective because the carrier need only state that the claims were not received to defeat the presumption. Carriers assert that because they are subject to substantial penalties for late payment, they must have additional documentation to assure that a claim was mailed. Because the claims mail log system is optional, many have opted to forego this process.

Most contracts include a provision requiring a physician or provider to submit a claim within a certain number of days after services have been rendered; however, industry practice varies in regard to the number of days allowed. H.B. 1862 would have required that a physician or provider submit a claim not later than the 95th day after the date the physician or other provider provides the service for which the claim is made, a deadline that appears to be generally accepted among the parties involved. When an enrollee has two carriers and benefits must be coordinated, physicians and other providers have difficulty filing timely claims to the secondary carrier because the claim filing period may expire while the primary carrier processes its claim. This difficulty could be alleviated if the period for filing with a secondary carrier started when a physician or other provider received the primary carrier’s payment.

The current clean claim rules require that carriers properly notify providers of the addresses where claims are to be sent. The rules also require providers to send claims to these addresses in order for the claims to be considered clean. Physicians and other providers have stated that claims that they file to the wrong address should be processed as clean claims, pointing to confusion created by the multiple claims mailing addresses maintained by some larger plans and by the clearinghouses and other affiliated third party vendors involved in the claims process. Carriers state that valuable claims processing time is lost when physicians and providers fail to properly address their claims to the correct processor, and report that many claims received have been addressed to the wrong carrier, not simply the wrong address or affiliate of the correct carrier. They argue that carriers should not be required to notify providers of the correct address and forward misdirected claims while the claims processing timeline continues to run. Actual industry practice varies in that regard.

Duplicate Claims Filing

Carriers complain that many physicians and providers file duplicate claims before the 45-day claim processing period has expired for the initial claim. They report that it is costly to research and process redundant copies of the same claim and that it can delay the processing of the original claim. Some physicians and other providers acknowledge that they file duplicate claims in case the original claim was not received, but cite as reasons the uncertainties surrounding confirmation of receipt of claims and the need to ensure that claims are submitted and received by contractual deadlines.

In June 2002, the Harris County Medical Society sent surveys to 1,800 Harris County physicians and received 217 responses.[30] The survey results indicated a relatively high number of duplicate claims being submitted 30 days or sooner after the filing of an initial claim. H.B. 1862 would have prevented a physician or provider from submitting a duplicate claim before the 46th day after the original claim was submitted. However, currently no statute or regulation prohibits the filing of duplicate claims, and there is no standard for identification of duplicate claims to distinguish them from corrected and resubmitted claims.

Attachments and Additional Information

In addition to charging the insurance commissioner with determination of the contents of a clean claim, current law allows carriers to make changes or require additional elements upon 60 days advance written notice to physicians and providers.[31] Physicians and other providers have alleged that attachments present an obstacle to the use of electronic claims processing because of their inherent "paper" nature. Carriers state that they need attachments to properly adjudicate certain complex claims and note that, unless the attachments are required as a clean claim element, there is no other way to ensure that the physician or provider will furnish the information.

It has been suggested that carriers be allowed to request necessary attachments after a claim is received and that the clean claim processing time period be tolled until the physician or provider furnishes the necessary information. This method would eliminate the submission of attachments that may be unnecessary for the claim at hand and could facilitate electronic filing of these claims. H.B. 1862 would have provided for a thirty-day period in which carriers could make a one-time request for attachment, at which point the 45-day clock would stop momentarily while the request was processed, then resume upon receipt. Discussion on attachments has centered in large part on the implementation of a similar provision.

Claims Audits

An audit is the review of any part of a clean claim for a covered individual which an HMO or insurance company does not pay or deny within 45 calendar days of receipt. An HMO or insurance company must provide written notification of a decision to audit and pay the audited portion at 85 percent of the contracted rate within the 45 calendar days.[32] Any additional payment owed must be made within 30 calendar days of the completion of the audit. Current rules require that an audit be completed within 180 days after receipt of a clean claim.[33]

H.B. 1862 would have required that audits be completed and any additional payment be made not later than the 90th day after receipt of the claim or 45 days after receipt of a requested attachment, whichever is later. Provider and carrier representatives have discussed the audit provisions, and appear to agree that making full initial payment on claims to be audited reduces the administrative burden of trying to calculate and track partial payments. Many plans have indicated that they have already begun to pay 100 percent of claims to be audited in an effort to simplify the process.

In addition, payors have complained that, under current rules provisions, providers have little incentive to provide requested audit information because the remaining 15 percent is due at the end of the audit period, unless the audit produces evidence of an overpayment. Providers have responded that they have no incentive to delay payment by refusing audit information requests with which they can comply, and contend that plans use the audit process as a means to delay payment by requesting information not necessary to determine claims payment or to which the provider does not have direct access. The providers have also requested establishment of a means of distinguishing between regular claims payments and payments representing a claim to be audited through provision of a notice accompanying payment.

Coding, Bundling and Fee Schedules

The generally accepted industry practice for payment of provider claims is for a provider to submit a claim utilizing coding - a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and providers. Current Procedural Terminology (CPT) codes were developed by the American Medical Association and organized

medicine and are the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs. Carriers reimburse the provider according to a fee schedule, a contractual list of amounts to be paid for approved procedures.

Downcoding is a practice whereby CPT codes submitted by a provider are changed unilaterally by an HMO or PPO from codes describing higher levels of service to those describing lower levels of service. Plans contend that downcoding and "bundling," the process of combining multiple service codes into one code describing those services as a single procedure, are necessary tools for accurate characterization of services according to the terms of contracts with providers and essential for the prevention of claims fraud. They report that some providers, intentionally or unintentionally, "upcode" service descriptions or unbundle codes describing services that should be grouped under a single code because they represent elements of a single health care procedure. Providers, however, cite numerous instances where carriers have inappropriately bundled or downcoded, producing reimbursement for fewer procedures or a lower level of service than what was actually provided.

Among the issues discussed in both committee hearings and working group meetings was continued disagreement over the extent to which providers should have access to claims payment policies and procedures, including fee schedules, coding and bundling information. Providers claimed that without access to the payment methodologies employed by insurers, they cannot bill accurately in a manner that conforms to the insurers' coding and bundling logic. They pointed to HB 610's reference to payors reimbursing providers at the contracted rate as being based on an assumption that the contracting parties would be able to determine the contracted rate by reading the contract.

Providers also indicated that they do not oppose bundling per se, but that there is wide variation among payors about how the same services are bundled. Conversely, providers said that with government programs they know what the guidelines are and see them applied consistently. The providers said that use of system edits in electronic claims systems to identify patterns of fraud and abuse is legitimate, but using them as a means of paying less than the contracted amount is not.

Insurers responded by agreeing to provide confidential disclosure of coding and bundling logic software and methods used, but providers argued that such disclosure was inadequate to enable them to bill accurately. TDI questioned whether its current statutory authority permitted the promulgation of rules to require disclosure. In May 2002, in response to a request from Representative Bob Turner, the OAG issued Opinion No. JC-502 determining that TDI does have authority to promulgate such rules.[34] TDI subsequently proposed and adopted new rules that would require disclosure of fee schedules, coding and bundling information and any other information necessary to determine that the physician or other provider is being compensated in accordance with the contract.[35] The rules were adopted on September 24, 2002 and took effect on October 9, 2002.[36] (A summary of the TDI coding, bundling and fee schedule disclosure rules is located in Appendix B.1.)

During discussion on the disclosure of the items covered in the new rules, carriers expressed concern about the impact of disclosure on confidentiality agreements with coding and bundling software vendors, and cited their use of proprietary coding and bundling methods in the prevention of provider billing fraud. In comments regarding the proposed rules, they recommended "adding a provision to allow carriers to include a contractual remedy for inappropriate disclosure of the information," stringent penalties to ensure that providers do not release proprietary fee schedules and coding guidelines, and an express requirement on providers to maintain the information they receive from carriers as confidential.[37]

In response, TDI pointed to the specific provisions already in the Insurance and Penal Codes concerning fraud, as well as to the fact that the new rules do not prohibit a carrier from including additional remedies for inappropriate disclosure in its provider contracts.[38] The new rules also expressly prohibit providers receiving information under the new rules from using or disclosing the information for any purpose other than practice management or billing activities.

Standardized Coding and Bundling Guidelines

Beyond the disclosure requirements of the new agency rules, providers have sought movement toward uniform coding guidelines to ensure that providers and insurers have the ability to understand and correlate each others' coding and bundling methods and rationale used in describing services. Providers have expressed support for the use of uniform bundling logic and edit software, such as those of the National Correct Coding Initiative (NCCI), which were established by the federal Centers for Medicare and Medicaid Services in 1996 for use in regard to Medicare. Insurers, however, point out that no single set of logic and edits has been adopted for use in the commercial market, where several products are available and employed.[39] They also say the NCCI could not adequately serve as a standard in the commercial market because the public market, which provides for a more limited set of services, does not use the same code sets. Finally, they argue that services covered and selection of bundling and edit methods that determine how those services are paid represent a significant part of individual carriers' competitive advantage.

Electronic Claims Transactions

Substantial discussion regarding electronic claims processing in both committee hearings and in working group meetings indicated general agreement that electronic processing can help resolve many prompt payment-related problems by providing transaction immediacy in regard to both claims filing and payment. Texas carriers report that electronically processed clean claims can typically be paid much quicker than their paper counterparts, often within 10 to 14 days. Electronic transactions can also help with issues related to confirmation of receipt of claims and deficient claims due to greater reliability and automatic notification capability, with claims software able to audit electronic claims for mandatory field information as they are filed.

Insurers further indicate that automated electronic claims transactions can substantially reduce administrative processing costs. One committee witness testified that the cost of filing a typical medical claim on paper, including forms, postage, handling, and repeated billings, could be halved by automating the steps electronically. Studies reviewed by the committee reported 35-50 percent reductions in billing and transactions costs by providers using electronic filing and found that medical groups could save up to 37 percent in bad debt and postage by automating transactions.

Parties agreed, however, that electronic transactions will not resolve all payment issues, and reported obstacles to their full implementation. For example, providers have indicated that not all physicians' offices or hospitals currently have access to electronic filing, and that not all available systems are compatible. They also reported that not all plans are equipped to handle electronic claims. A Harris Interactive survey from August 2001 found that only 27 percent of U.S. physicians use their computers to track their billing, and only 17 percent use electronic medical records rather than paper.[40]

However, two recent Texas surveys paint a different picture regarding the use of electronic means to process claims. In early 2002, the Texas Medical Association (TMA) surveyed its member physicians regarding use of electronic claims, with approximately 250 physicians responding.[41] Within a similar timeframe, TDI surveyed 27 HMOs representing 67 percent of Texas' fully insured HMO enrollment and 26 insurers representing 40 percent of Texas' total accident and health insurance premiums regarding their utilization of electronic claim processing[42] (see Appendix B.6.). The surveys found that:

- 90 percent of physicians surveyed file claims electronically for the majority of their claims;
- the vast majority of insurers and HMOs do not require contracted providers to file electronically, but do strongly encourage electronic filing;
- the majority of insurers and HMOs do not provide hardware or software to providers to assist with filing, though some report that they do;
- carriers stated that rural providers are less likely than urban providers to file electronically due to barriers cited that include lack of trained personnel, lack of access to high-speed Internet access, and cost of technology; and
- the most frequent types of assistance cited by physicians surveyed as needed to increase electronic claim filing were software and/or hardware provided at reduced or no cost, and staff training.

All parties involved remind that electronic claims are not infallible. They can be lost in "cyberspace," and there is no guarantee that an electronically submitted claim is necessarily a clean claim because such submissions are still based on human input. For example, information such as patient name, primary insured, identification numbers, and name and number of group must be accurately coded and entered into an electronic claim form or the submission will fail. At the same time, use of electronic transactions holds promise precisely because such errors can be automatically noted and identified on a returned deficient claim, enabling the provider's office to identify and make needed corrections.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Full implementation of the rules related to the federal law on health insurance portability, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in October 2003 is expected to aid in the resolution of many issues related to coding standards, electronic transactions, claims receipt and attachments.[43] The Administrative Simplification Act will require most insurers to implement universal coding, standard formatting and attachment forms for electronic claims.[44] If a provider elects to submit an electronic transaction, the provisions will require the provider to use the standardized coding. Health plans will likewise be required to accept and process the claim using the same coding sets.

While the rules will require use of standardized codes, systems with proper specifications will need to be adopted to transmit codes seamlessly, and state laws and rules will need to be reviewed to ensure compatibility with the new federal standards. The implementation of the new standards will be a complicated process that requires re-programming of computer systems and widespread programmatic changes in the way claims are processed.

Eligibility Issues - Preauthorization, Precertification and Verification

Under current law, the definition of "utilization review" in TIC Art. 21.58A specifically excludes "elective requests for clarification of coverage." If a physician or other provider calls a utilization review agent, HMO or insurance company to ask whether a benefit is covered under an enrollee's health plan, the answer may be that it is a covered benefit, but that the benefit may be subject to eligibility determination, deductibles, benefit maximum limits, pre-existing condition exclusions or waiting periods, and the determination of medical necessity and appropriateness through the utilization review process. Due to the variability resulting from the numerous requirements that may affect payment for the procedure, no guarantee of payment is made at the time of inquiry by the physician or provider.

The definition of "utilization review" references prospective and concurrent review of medical necessity and appropriateness of health care services being provided or proposed to be provided. Prospective review occurs prior to the provision of health care services, and is commonly called "preauthorization" or "precertification" within the industry, though neither term is legally defined. Concurrent review occurs during the process of providing the health care service, generally during an inpatient hospital stay. Since, in current practice, prospective and concurrent review address only the medical necessity and appropriateness of the health care service but not all of the other service variables of eligibility determination, they do not constitute a guarantee of payment. “Precertification” is a term used by indemnity insurers when the enrollee or physician is required to call the plan to notify it of a planned procedure, commonly an inpatient hospital stay. The insurer may or may not perform a medical necessity or appropriateness review at the time of precertification. If it does, the utilization review process has been initiated. If it does not

review medical necessity and appropriateness, precertification is only a notice process. Either way, failure to precertify as required by the insurer may decrease payment for service.

Payors indicate that, though current processes such as preauthorization and precertification may answer initial questions about the service's medical necessity or appropriateness of setting and benefit coverage, the plans do not always have all the other information required in advance of actual provision of the service to determine certainty of payment. For example, they say that they cannot guarantee that a person's eligibility as a plan enrollee has not changed between the time a service is preauthorized and the time it is actually performed as a result of employment status change. A complicating factor is the ability of a plan enrollee to select temporary continued coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), which allows enrollees to make such a decision anytime within a 60-day window after leaving employment.[45] The plans also point out that they cannot confirm that a service has been performed as represented until it has actually been provided and that pre-existing conditions, which apply only in relation to indemnity plans, may be undetermined until a service has been provided.

Such uncertainties notwithstanding, providers have expressed concern that, lacking certainty that preauthorization is at some level a guarantee of payment, they bear full financial risk in carrying out a service because they have no way of knowing if the claim will be approved even if they have carried out the service in good faith.

H.B. 1862 would have defined "preauthorization" to mean a determination by the insurer that the medical care or health care services proposed to be provided to a patient are medically necessary and appropriate. The bill would have required HMOs and insurers to make available upon request by a contracting provider, not later than the 10th working day, a list of health care services that require preauthorization and information concerning the preauthorization process. Further, the bill would have prohibited an HMO or PPO using preauthorization from denying or reducing payment to a provider for preauthorized services on the basis of medical necessity. Additionally, H.B. 1862 would have defined "verification" to mean a reliable representation by an insurer or HMO to a physician or other provider that the insurer or HMO will pay for proposed health care services unless certain eligibility conditions were not met.

Discussions have taken place both in committee hearings and within the working group regarding potential solutions. One suggested approach has been to provide certainty that, since premiums are payable by the month, they should remain good for the entire month, thereby resolving questions about continued eligibility of a enrollee during the month a service has been preauthorized or verified. This approach would require a provider to seek a new preauthorization or verification if the service has not been performed in the month preauthorization or verification was initially obtained. The approach would also place added responsibility on employers to maintain responsibility for coverage until they have provided notice to an insurer or HMO that the enrollee is no longer employed.

Coordination of Benefits

At the request of the committee, the working group has made an extensive effort to reach consensus on issues relating to coordination of benefits, a process that involves determination of responsibility for payment of a health care service in cases where a patient has more than one source of coverage. Such factors include, among others:

- questions about whether the physician or other provider should be required to share knowledge of the existence of another carrier and the name of the carrier, particularly when the physician or provider is filing a claim to that carrier;
- whether a secondary carrier can be required to waive its claim filing deadlines when a provider is waiting until the primary carrier pays its share of the claim before filing with the secondary carrier; and
- whether secondary carriers should be required to ascertain the primary carrier's payment amount only through contact with the primary carrier (who may be exempt from TDI regulation) rather than from the provider who received the payment.

Providers contend that they should not be required to be involved in the coordination of benefits because they may not have all of the information about a patient's coverages. This especially applies in the case of specialty providers who do not need the patient's complete medical record to provide the health care service. Typically, the information concerning a patient's health care coverage is contained in the medical record. Questions also exist regarding the impact of a provider's responsibility to share information with a payor on demand in relation to patient health care information privacy. Payors say that they cannot determine responsibility for payment unless they can examine other coverages, and that if they mistakingly pay for a service they have little recourse for obtaining a refund from another payor. To date, the complexity of the factors involved in coordination of benefits has precluded resolution of the issue, but discussion continues among working group participants.[46]

PENALTIES AND RESTITUTION

Current Law

Current law provides that the penalty for payment of a clean claim is the full amount of billed charges or, if one has been included in the contract, the contracted penalty rate. In addition to any other penalty or remedy, a carrier that fails to comply with this provision is subject to an administrative penalty not to exceed $1000 for each day the claim remains unpaid. The administrative penalty is a fine and is not included in the restitution that must be paid to the provider.

Article 3.70-3C, Section 3A TIC, concerning the prompt payment by insurers of preferred providers who file a "clean claim", and Article 20A.18B, with similar provisions regarding the prompt payment by HMOs of physician and other providers, both require that an insurer or HMO must, no later than the 45th day after the date it received a clean claim:

- pay the total amount of the claim in accordance with the contract between the provider and the insurer;
- pay the portion of the claim that is not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or
- notify the provider in writing why the claim will not be paid.

Subsection (e) requires an insurer or HMO which acknowledges coverage, but intends to audit the claim, to pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date of receipt of the claim. Following completion of the audit, any additional payment due a provider, or any refund due the insurer or HMO, must be made not later than the 30th day after the later of the date that:

- the physician or provider receives notice of the audit results; or
- any appeal rights of the enrollee are exhausted.

Penalties for violation of Subsections (c) and (e) are set out in Subsection (f), which provides that an HMO is liable for the full amount of billed charges submitted on the claim or the amount payable under a contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health care plan.

In addition to these penalties, the Code:

- authorizes, in Subsection (g), a provider to recover reasonable attorney's fees in an action to recover payment under these sections; and
- provides, in Subsection (h), that in addition to any other penalty or remedy authorized by the Code or another insurance law of this state, an insurer or HMO violating Subsection (c) or (e) is subject to an administrative penalty under Article 1.10E of the Code. The administrative penalty imposed under that article may not exceed $1,000 for each day the claim remains unpaid in violation of this article.

In addition, Subsection (d) of both articles provides that if a prescription benefit claim is electronically adjudicated and electronically paid, and the preferred provider or HMO or its designated agent authorizes treatment, the claim must be paid not later than the 21st day after the treatment is authorized. The penalty provisions of Subsections (f) and (h) would not apply to violations of this subsection, because they expressly apply only to violations of Subsections (c) and (e). However, Subsection (g) would apply.

Title 28, Section 21.2815, TAC also sets out penalties for failing to timely pay a clean claim, reiterating those set out in the statutes. This section also clarifies that these penalties do not apply when there is failure to comply with a contracted claims payment period of less than 45

calendar days as provided in Articles 3.70-3C, Section 3(m) or Article 20A.09(j) TIC; under these statutory provisions, an insurer or HMO must pay a physician or provider, if applicable, within the number of calendar days specified by written agreement between the physician or provider and the insurer or HMO.

Penalties Restructuring

Providers testified before the committee that prompt payment penalties comprise the only effective leverage available to compel health plans to pay accurately and in a timely manner. Carriers have expressed concern over the difficulty of complying with prompt payment law and rules 100 percent of the time. According to TDI interpretation of current law, any level of performance under 100 percent subjects the payor to administrative penalties. Payors also point out that, while restitution payments and penalties payable to providers constitute compensation directly to the provider, payment of administrative penalties assessed by TDI go to the state and do not benefit the providers while forcing the payors to raise premiums to offset the costs.

A number of options have been suggested that would alter the current penalties structure. Plans have urged restructuring to allow an "opportunity to cure" incorrectly paid claims and to tie assessed penalties to the degree of violation. One means of accomplishing that goal that was discussed in committee hearings and in working group discussion is the concept of graduated penalties that would increase as the violation increases. An example of that approach would provide for:

- loss of 50 percent of the contractual discount for an unpaid claim from the 46th day to the 90th day, with the payor subject to billed charges thereafter; and
- the ability to reprocess and cure incorrect payments, subject to penalties after 45 days.

Discussions have also included contemplation of a cap for very large penalties. Facilities-based providers have argued against this approach, pointing out the relatively large dollar amount of many of their claims. They have expressed concern that a cap may result in a penalty that is insufficient to deter payors from late or nonpayment. Carriers have reminded that, as the size of a claim increases, so does their potential exposure to much larger billed charges penalties in the event of a late payment. They argue that penalties based on billed charges may bear little or no relation to the amount otherwise owed contractually, and that disproportionately large penalties rapidly drive up their costs and, ultimately, premiums.

Payors have also sought relief from the current "100 percent" compliance level requirement regarding administrative penalties, pointing out improved payment performance rates that now often exceed 98 percent and arguing that no business transaction is mistake-free. Some have proposed that health plans be required to meet either 95 percent of claims dollars or 95 percent of total claims (the Medicare standard) standards regarding administrative penalties, while

continuing to be held to a full compliance standard in regard to penalties and restitution payable directly to the providers. Providers have responded that performance rates cited by payors paint an inaccurate picture because even a relatively small number of mistakes, given the millions of claims filed each year, amounts to tremendous loss of practice revenue.

Payors have also requested reconsideration of the use of billed charges as the basis for penalty calculation, calling for interest-rate based penalties instead. Providers have expressed continued support of the billed charges standard, arguing that any other basis would be harder to administer and would dilute the progress that has been made toward developing penalties substantial enough to provide a meaningful incentive for timely and accurate payment. In all of the discussions on penalties, both payors and providers have expressed concern about implementing any structure that is difficult or cumbersome to calculate and administer.

Non-Contract Providers

On August 27, 2002, Rep. Bob Turner requested an Attorney General's determination as to whether the HMO Act authorizes TDI to enforce its provisions against physicians that are not under contract with an HMO (RQ No. 0597-JC). Basically, the issue involved is whether hospital-based, non-network physicians and providers (such as anesthesiologists and radiologists) that provide services in a network hospital facility are able to balance bill enrollees for amounts over and above the payment the physician receives from the HMO.

TDI filed a brief in response on November 4, 2002 which argued that the HMO Act does not authorize TDI to prohibit physicians from balance billing enrollees in this situation.[47] While TDI reports that it has been able to resolve payment disputes between HMOs and non-contracted physicians by encouraging the parties to reach agreement without the necessity of formal enforcement action, it interprets the Act as allowing TDI to require HMOs to ensure that enrollees are not billed for covered services they receive in network hospitals, since an HMO is responsible to ensure that its enrollees are not balance billed. The opinion request remains pending at this time.

Pharmacy Issues

Pharmacy representatives testified before the committee that problems with prompt payment as it relates to Texas pharmacies, particularly independent pharmacies, differ somewhat from other health care providers.

Most pharmacies are electronically interfaced with insurance companies. Most patients have electronic identification cards issued by the insurers for prescription benefits which allows for

"real time" adjudication of a claim for prescription coverage. The online processing of claims allows the provider to know within minutes the patient's eligibility for coverage, whether the prescribed drug is covered under the prescription plan, and the amount of reimbursement for the drug. Processing of a prescription claim carries with it an implied agreement to pay the contracted amount for the prescription.

Pharmacies report that, as a health care entity based on point-of-sale purchase of inventoried health care products, they must maintain adequate inventories to immediately fill prescriptions and must pay for it prior to receiving reimbursement for dispensing. According to testimony, pharmacies operate on very low net profit margins as a combined result of costs of pharmaceuticals and reimbursement amounts, and often do not have the cash flow to pay for full inventory prior to reimbursement. Those factors combine to make prompt payment essential, with pharmacies relying on payment of electronic claims to avoid payment penalties of their own with pharmaceutical suppliers. Independent pharmacists report this cycle has caused the demise of many of their pharmacies, with one noting that in 1990 there were approximately 5,000 independent pharmacies in Texas, a number that has dropped to 1,900 today.[48]

In general, pharmacy claims fall under the 45-day prompt payment requirement. H.B. 610 addressed the cyclical issue described above by requiring prescription benefit claims electronically adjudicated to be paid no later than 21 days after the claim is authorized. It was reported, however, that to date only two insurers pay claims electronically and are thus subject to the 21-day requirement.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

The federal Employee Retirement Income Security Act of 1974, 29 U.S. Code (ERISA), governs employee benefit plans and preempts state law under certain circumstances.[49] ERISA is designed to prevent abuse and mismanagement of plan assets by plan administrators by setting minimum standards for most voluntarily established pension and health plans in private industry. The statute protects plan participants and beneficiaries by requiring financial disclosure, establishing duties and standards of conduct for plan fiduciaries, and providing "appropriate remedies, sanctions, and ready access to the federal courts." In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws.

Preemption Provisions

Texas health insurance plans that do not fall under ERISA provisions are, in general, subject to state regulations including Texas' prompt pay statutes and regulations, with some exceptions including group plans provided by governments, churches and some school districts. ERISA is regulated by the U.S. Department of Labor (DOL).

Group employer health plans provided through an employer may be fully insured by insurance companies or HMOs, or they may be self-funded by employer contributions and employee premiums. State clean claims regulations apply to fully insured ERISA plans; they do not apply to employer self-funded ERISA plans. If an employer purchases a fully insured health plan, and an insurance company or HMO assumes the risk, all state laws and regulations are applicable, including prompt pay requirements. A self-funded plan is exempt under ERISA from regulation by a state insurance regulator, and thus the prompt pay provisions of the Texas Insurance Code are not enforceable against these plans. Some self-funded ERISA plans are administered by a commercial insurance company or HMO that also holds a license from the state insurance regulator as a third party administrator (TPA). Consumers may erroneously assume that these plans are subject to state regulation because the name of the TPA may appear on the policy or identification card. In fact, these plans are still self-funded and therefore exempt from state regulation.

Although ERISA does contain provisions relating to claims payment procedures, these provisions only address participants' and beneficiaries' rights; not providers' issues or rights. While ERISA's preemption of state laws relating to commercial health plans has historically been interpreted broadly, some federal court cases have upheld a cause of action for misrepresentation regarding a promise to pay made to the provider by the plan, while an action based on the assignment of benefits by the insured to the provider was not upheld. As discussed by the Chief of the Office of the Attorney General's Financial Litigation Division, this may suggest that the state is not necessarily preempted by ERISA from asking about the payment date of a benefit that the self-funded plan has determined it would pay.

State Oversight Limitations

According to information compiled by TDI, there were 6,685,306 enrollees in fully insured private HMOs and group and individual PPOs subject to state prompt pay requirements in the year 2000 (the most recent year for which data is available). This number represents 55 percent of individuals insured under private (non-government) plans. Forty-two percent (5,081,579 individuals) were insured under private non-government plans that are self-funded health plans and not subject to state regulations and prompt pay requirements.[50] (A summary of Texas Insurance Population Characteristics for calendar year 2000 is located in Appendix B.7.)

According to the U.S. Census Bureau, 23.5 percent of the Texas population (4,960,000 Texans) were uninsured in 2001. These individuals are typically billed directly for health care if they are

able to pay, or they receive treatment under a variety of state and local indigent health care programs. Since there is no "plan" or licensee that is subject to insurance regulations, there can be no prompt pay enforcement for payment. On the other hand, payment for services might be subject to prompt pay regulations if the process for reimbursement passes through state sources.

Enrollee Identification Cards

The ability of providers to determine if an enrollee's plan is a self-funded or fully insured ERISA plan was a key topic of discussion before the committee and within the TDI working group. Parties agreed that a standardized method for making this determination would be beneficial and agreed to study the feasibility of incorporating a symbol or identifier on patient identification cards.[51]

Members of the working group agreed in the course of their deliberations that there is a need for a standard way for physicians and providers to determine whether a plan is a self-funded or fully insured ERISA plan (TDI has regulatory authority only in regard to the latter; there is no prompt pay provision in ERISA). Some providers say they ask for such information but do not consistently receive it. The Texas Association of Health Plans (TAHP) indicated that their plans can provide this upon request because the necessary information is in the plans' systems. Carriers report that in some instances difficulties are customer service training issues that can be addressed; many also point to their plan enrollee identification (ID) cards as containing the information. The working group members agreed in principle that a symbol placed on enrollee ID cards is valuable because it allows physicians and providers to make this determination when services are delivered.

ID cards are not required by law or rule, though most plans issue cards to their members, and TDI concluded that it does not currently have statutory authority to require that certain information be contained on such cards. The health plans expressed concern about the cost of changing information already printed on their cards (or the manner in which it is presented: some plans use color-coding, unique ID numbers or other designations, and other unique means to convey information on their cards), and indicated that they consider the use and design of their cards a proprietary matter.[52] While there appears to be general support for including an identifier on the cards, carriers remain concerned about issues related to cost and the proprietary use of their cards, and seek flexibility in regard to the changes required of their current card structures.

THE MEDICAID MODEL

The 74th Legislature (1995) made fundamental changes to the federal-state Medicaid program, moving large portions of the state's Medicaid population into managed care. In 1997, the 75th Legislature made changes to the state's Medicaid managed care program (MMC), including a requirement that Medicaid managed care contracts include procedures for accountability, education and outreach, and prompt payment of claims.[53]

TDH, in conjunction with the claims administrator, developed the Texas Medicaid Administrative System (TMAS) to help administer the MMC program. Under TMAS, the state contracted for the following services: claims administration, encounter processing, managed care enrollment, PCCM network administration, and quality monitoring. In 1996, the state re-examined its needs for managed care support functions, and contracted with four organizations for specialized managed care services.

While providers have expressed dissatisfaction with the Medicaid program, especially in regard to reimbursement levels and administrative complexity, the program has received much more favorable reviews for payment success in relation to other payors.[54] According to committee testimony provided by HHSC Commissioner Don Gilbert, those sentiments may be attributable to several factors including:

- 94.25 percent of all claims submitted in FY 2000 were paid within 30 days;
- Medicaid HMO contractors are required to pay claims within 30 days; and
- Claims that are not paid within 30 days are automatically adjusted 1.5 percent per month with the penalty amount paid directly to the provider.[55]

Other factors include:

- Coordinated provider education efforts;
- Texas' electronic claims submission program, TexMedNet;
- Provider notification of changes in policies in writing and through the agency and contractor websites;
- An interactive submissions system designed to provide nearly immediate responses;
- Claims error identification, correction and re-submission processes designed to increase the number of first-pass clean claims, and an on-line claims status inquiry system;
- 24 hours per day, seven days per week claims submission;
- Adjudication of appeals and resolution of complaints for all Texas Medicaid providers handled by the Medical Appeals and Provider Resolution Division of the State Medicaid Office; and
- Fraud prevention and investigation through the Office of Investigations and Enforcement (OIE) within HHSC.

Although complex, the Medicaid and Medicare programs have clearly defined claims processing standards that all providers are required to use. These programs generally require electronic filing, which enables faster and more accurate processing of claims. On-going efforts are made

to ensure that providers and recipients are educated about the standards and requirements in the programs and are notified about any changes.

While some point to Medicaid/Medicare as a model system regarding claims payment, others point to realities that would make wholesale replication in the commercial market difficult. Among those factors are the limited nature of services provided in comparison to choices available in the commercial market; the cumbersome administrative structure; the state's role in providing related services (see above); and the single-payor structure of the systems. In addition, some point to the clean claims payment success record as no better (if as good) than the current records of plans in the commercial sector. However, elements of the Medicaid program such as predominance of electronic filing, policy notification requirements, and interactive claims processing systems can certainly enhance payment success, and means to create similar process components in the commercial sector deserve careful consideration.

RECOMMENDATIONS

1. Require the Texas Department of Insurance to implement rules defining and standardizing the elements of information that may be required for payment of a clean claim and the forms through which those elements are conveyed; eliminate the ability to add or change data elements or attachments by contract.

2. Establish a clear deadline following the provision of services by a provider by which the provider must submit a claim for payment for those services.

3. Prohibit the filing of duplicate claims by a provider within the 45-day period allowed for the timely processing of a clean claim by a carrier; provide means for providers and carriers to clearly distinguish between duplicate claims and claims resubmitted to correct initial filing errors or provide additional information.

4. Require disclosure by a carrier, at the written request of a provider, of a description of coding and bundling policies and methodologies and fee schedules related to the carrier's contract with the provider in sufficient detail to enable the provider to submit clean claims reflecting those provisions and to determine that the provider is being compensated in accordance with the contract; ensure that providers do not disclose or use such information for any purpose other than practice management or billing activities.

5. Require carriers' and providers' payment processes to use common coding procedures as recognized in federal standardization guidelines.

6. Implement policies that encourage and provide for transition to the full use of electronic claims processing transactions by both providers and carriers; ensure that the Texas Department of Insurance has statutory authority needed for adoption of HIPAA electronic code sets.

7. Clearly define the degree to which and the process and time frames through which carriers may request additional information from providers needed in order to accurately evaluate a claim for payment for services and an enrollee's eligibility for services under the terms of a health coverage plan.

8. Provide for clear notification to a provider by a carrier of intent to audit a claim; require full payment of claims to be audited within the prompt payment period; and establish clear guidelines and time frames for completion of audits.

9. Clarify for plan enrollees, providers and carriers the responsibilities of a carrier that utilizes procedures related to determination of eligibility of a plan enrollee for health care services in regard to disclosure to a provider of services requiring those processes, timely response to provider requests for determinations utilizing those procedures, and payment of a claim based on such determinations.

10. Clarify the responsibilities of employers regarding notification to carriers of employee changes in group plan eligibility status, and carrier responsibility for records maintenance; clarify the impact of employee termination on coverage status; and determine the effective period of procedures used by carriers related to determination of eligibility of a plan enrollee.

11. Require carriers to provide advance notice to providers of material changes to claims payment policies or procedures, methodologies (such as bundling and coding), coding guidelines and fee schedules used in regard to contracts with those providers; and provide for a time period during which a provider may review such a notice and act regarding continuation of a contract based on the changes explained in the notice.

12. Require a provider who submits a claim to more than one carrier to provide written notice of the identity of each carrier with whom the claim was filed to each of those carriers; clarify responsibilities of a provider regarding maintenance of records and provision of information to carriers concerning other health plan coverage held by an enrollee; and clarify the responsibilities of carriers, employers and providers in regard to investigation of coordination of benefits.

13. Establish clear guidelines for the recovery of overpayments by a primary or secondary carrier.

14. Establish effective penalties for failure to comply with prompt payment statutes and rules, based on billed charges, that reflect the degree of violation; establish corresponding provisions for penalties for underpayment and guidelines for the payment of the remaining balance of underpaid claims; clarify that penalties incurred are in addition to the contract amount owed on a claim and are to be paid as incurred; consider restrictions on penalty maximum amounts regarding very large claims; and establish a clear requirement, guidelines and a time frame for provision of notice to a carrier by a provider that an incorrect payment has been received.

15. Clarify the authority of the Office of the Attorney General and the Department of Insurance regarding enforcement of prompt payment statutes and rules in relation to violations regarding requests for additional claims data, efforts to recover overpayments of claims, claims payment time lines and guidelines, repeated failures to pay and repeated underpayment of claims.

16. Continue to monitor complaints filed with the Texas Department of Insurance and resulting state action to enforce prompt payment laws and rules in order to enable evaluation of the effectiveness of statutory provisions in encouraging prompt and accurate payment of claims.

17. Continue to monitor pending Attorney General's opinion requests relating to payment of out-of-network providers, the Attorney General's ongoing investigation of HMOs regarding claims payment practices, related outstanding lawsuits, and the Florida U.S. District Court class action lawsuit in order to assess the impact of outcomes on the state's policies related to claims payment practices.

18. Monitor evolving ERISA case law to assess potential impact on states' regulation of private health plans; and encourage efforts to develop effective means to enable plan enrollees and providers to easily identify the enrollee's type of coverage.

ENDNOTES

1. Texas Health Maintenance Organization Act of 1975; Article 20A.01-20A.36, Texas Insurance Code.

2. Article 3.51-6 and Article 3.70-3, Texas Insurance Code.

3. Title 25, Chapter 119, Texas Administrative Code.

4. Governor George Bush, Veto Proclamation, June 16, 1995.

5. Article 3.70-3C, 3(m), Texas Insurance Code; Article 20A.09 (j), Texas Insurance Code.

6. Complaints received by the TDI prompted then Commissioner of Insurance, Elton Bomer, to issue two separate Commissioner's Bulletins in January and February of 1998 articulating the need for Texas insurers to comply with the Senate Bills 383 and 385. See, Commissioner's Bulletin No. B-0004-98 (January 23, 1998); Commissioner's Bulletin No. B-0007-98 (February 4, 1998).

7. Article 20A, Section 18B (d), Texas Insurance Code.

8. Article 3.70-3C, Texas Insurance Code.

9. Article 20A, Section 18B (i-k), Texas Insurance Code.

10. Title 28, Section 21.2801-21.2820, Texas Administrative Code.

11. HCFA 1500 Form (Medicare claim form for ambulatory services) and UB-92 (Medicare claim form for institutional services).

12. Title 28, Section 21.2804-21.2806, Texas Administrative Code.

13. Article 20A, Sections 18B (c) (1-3) and Section18B (e), Texas Insurance Code.

14. Article 20A, Section 18B (f-h), Texas Insurance Code; Article 1.10E, Texas Insurance Code.

15. Article 20A, Section18B (b), Texas Insurance Code.

16. TDI received a significant number of complaints regarding the practice of some health carriers of notifying providers of "potential" clean claim elements that the carriers "might" require in order to process claims Commissioner Montemayor, in response, sent out a Commissioner's Bulletin, No. B-0012-02, dated April 2, 2002, notifying insurance carriers that this practice was inappropriate and did not comply with the rules governing notice to providers.

17. TMA Clean Claims Action Alert, August 15, 2000.

18. Ibid.

19. Page, Leigh. "Clean claim" rules defang state prompt payment laws, Amednews.com (December 4, 2000).

20. Ibid.

21. Ibid.

22. Governor Rick Perry, Veto Proclamation, June 17, 2001.

23. Texas Department of Insurance Report, TDI April 29, 2002 Prompt Payment Consent Orders (as of July 2002).

24. Attorney General Opinion Request, OR 2002-0521 (February 1, 2002).

25. Office of the Attorney General Press Release dated September 27, 2001.

26. Office of the Attorney General Press Release dated February 11, 2002.

27. Office of the Attorney General Press Release dated February 11, 2002.

28. Article 20A.18B(k) and Article 3.70-3C (3A) (k), Texas Insurance Code; Title 28, Section 3.3703 (a)(20) and Section 11.901 (10)(D), Texas Administrative Code.

29. Minutes, TDI Clean Claims Working Group August 9, 2002.

30. Harris County Medical Society Duplicate Filing of Claims Questionnaire, June 2002.

31. Article 20A.18B(k) and Article 3.70-3C, (3A) (k), Texas Insurance Code

32. Article 20A.18B(e) and Article 3.70-3C (3A) (e)

33. Title 28, Section 21.2809 (b), Texas Administrative Code.

34. Attorney General Opinion No. JC-0502, May 8, 2002.

35. 27 Texas Register 5071, June 14, 2002.

36. Texas Department of Insurance announced adoption of new rules regarding: Physician & Provider Contracts & Arrangements - 11.901; Contracting Provisions Preferred Provider Plans - 3.3703; and HMOs Delegated Entities - 11.2601-11.2612. See: Commissioner Jose Montemayor, News Release: Physician/Provider Fee Disclosure Rules Adopted, September 24, 2002.

37. Letter from Scott & White Health Plan to Texas Department of Insurance General Counsel dated July 15, 2002.

38. Texas Department of Insurance Commissioner Order 020976 and 020977.

39. Letter from Texas Medical Association to Commissioner Jose Montemayor dated July 15, 2002

40. Harris Interactive, Vol. 1, Issue 25 (August 15, 2001).

41. Texas Medical Association Hassle Factor Log, 2002.

42. Texas Department of Insurance Survey Results Report to the Senate Special Committee on Prompt Payment of Health Care Providers, HIPAA Administrative Simplification and Electronic Data Standards, January 2002.

43. Health Insurance Portability and Accountability Act of 1996 (HIPAA), PL 104-191, August 21, 1996.

44. HIPPA, Title II, Subtitle F, Part C (PL 104-191).

45. Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), PL 99-272, April 7, 1986.

46. Possible solutions proposed by the Working Group members included, implementing a 95 day claims filing standard with an extension provision for special circumstances, and a prohibition on submission of duplicate claims until the 46th day after filing an initial claim. They also discussed implementing a web-based claims tracking system that providers can access and requiring a payor who receives a misdirected claim to forward it to the proper payor. See: Minutes, TDI Clean Claims Working Group, May 16, 2002.

47. Letter Brief from Texas Department of Insurance to Office of the Attorney General dated November 4, 2002.

48. Oral testimony by David Haney to the Senate Special Committee on Prompt Payment of Health Care Providers, January 24, 2002.

49. 29 USCA 1144

50. Written testimony by Commissioner Jose Montemayor to the Senate Special Committee on Prompt Payment of Health Care Providers, January 24, 2002.

51. The issue of whether TDI has the authority to require an ERISA identifier on patient identification cards remains unresolved. Some health plans argued that they give providers information to assist in determining whether the plan is self-funded or fully funded because this information is shown in their system. Plans also expressed concerns about the administrative costs associated with changing what is printed on patient ID cards. Some plans use color-coding, unique ID numbers, or other identifiers for this purpose. They include the information in their provider manual. The plans contend that this is a customer service staff training issue that they can address without imposition of a new requirement. It should be noted that some states (e.g. Louisiana) require plans to provide this information. See: Minutes, TDI Clean Claims Working Group, January 17, 2002.

52. Minutes, TDI Clean Claims Working Group November 15, 2001 and January 17, 2002.

53. SB 30, 75th Legislature, Regular Session (1997).

54. *Reforming Medicaid in Texas: Interim Report,* Texas Senate Committee on Health and Human Services, 1994. See also: HB 7, 72nd Legislature, Regular Session (1991); Senate Concurrent Resolution 55, 74th Legislature, Regular Session (1995); SB 10, 74th Legislature, Regular Session (1995); SB 30, 75th

Legislature, Regular Session (1997).

55. Final Report- Medicaid Managed Care Review, HHSC, November 2000.

TABLE OF CONTENTS

CHARGE #2 . . . . . 2.3

EXECUTIVE SUMMARY 2.3

BACKGROUND 2.4

THE IMPACT ON PATIENT ACCESS TO HEALTH CARE 2.5

STATUS OF THE MEDICAL MALPRACTICE INSURANCE MARKET 2.6
- Insurance Premiums & Corporate Losses 2.6
- Severity and Frequency of Claims 2.7
- Profitability 2.8
- Availability of Insurance 2.8
- Insurance Companies Operating in Texas 2.9
- Statutory Status of Medical Malpractice Actions in Texas 2.10

APPROACHES TO RESOLVING THE MEDICAL MALPRACTICE CRISIS 2.11

TORT REFORM 2.11
- Caps on Non-economic Damages 2.11
- Limits on Economic Damages 2.12
- Restrictions on Attorney Contingency Fees 2.12
- Statute of Limitations 2.13
- Periodic Payments 2.13
- Collateral Source Rule 2.14
- Joint and Several Liability 2.14
- Frivolous Lawsuits 2.15
- Charitable Health Care 2.16

ALTERNATIVES TO LITIGATION AND JUDICIAL REFORM 2.16
- Expert Witness Requirements 2.16
- Arbitration 2.17
- Screening Panels 2.17

INSURANCE REFORMS 2.18

PREVENTION AND PATIENT SAFETY 2.18
- Enforcement and Disciplinary Actions 2.18
- Risk Management 2.19

CALIFORNIA'S MEDICAL INJURY COMPENSATION REFORM ACT (MICRA) 2.20

FEDERAL ACTION 2.20

RECOMMENDATIONS 2.22

ENDNOTES 2.24

CHARGE TWO:
The Medical Malpractice Liability System

CHARGE #2

Evaluate the effectiveness of existing state law and agency rules relating to the current medical professional liability system, assess the causes of rising malpractice insurance rates in Texas, including the impact of medical malpractice lawsuits, and their impact on access to health care.

EXECUTIVE SUMMARY

Testimony presented on Charge One to the Senate Special Committee on Prompt Payment of Health Care Providers led to discussion of the impact of rising medical malpractice insurance costs on patient access to health care. The growing evidence that such costs are forcing physicians to curtail or abandon their practices, leaving patients with reduced access, clearly warranted additional formal study of the issue.

As a result, on July 24, 2002, Lieutenant Governor Ratliff added an additional charge to the ongoing work of the Committee. The charge directed the committee to "*evaluate the effectiveness of existing state law and agency rules relating to the current medical professional liability system, assess the causes of rising malpractice insurance rates in Texas, including the impact of medical malpractice lawsuits, and their impact on access to health care.*" Based on that assessment, the Committee was directed to determine the need for corrective action and make recommendations as necessary.

All states rely on the legal system to make determinations of medical negligence and—if found—to hold health providers and facilities financially responsible. Medical malpractice is a tort—a "wrongful act or omission." However, like most states, Texas has special medical liability laws. An injured party must sue to show that a health provider or facility failed to meet the appropriate standard of care and that this negligence caused an injury. Health providers and facilities purchase medical malpractice insurance to pool their risk, and they pay premiums based on the provider or facility's type of medical practice, geographic location, and claim history.

The Committee explored the factors giving rise to the instability in the medical malpractice insurance market which has caused premiums to escalate to the point that many health providers struggle to afford coverage, while others have difficulty finding insurance at any price. In formulating its recommendations, the Committee considered the approaches taken by other states and the federal government which include prevention measures, tort reforms, insurance reforms and other alternatives as means to maintain physician workforces and health facilities, to stabilize the insurance market in Texas and to ensure that patients injured due to negligence receive fair compensation.

BACKGROUND

The medical malpractice liability crisis is not a new phenomenon. In the early 1970s, rising claims and inadequate rates caused a period of crisis in the medical malpractice insurance system and a number of private insurers left the market. The reduced capacity resulted in a lack of adequate insurance coverage. Over the next fifteen years, attempts to reduce the explosion in claim costs appeared to have a positive effect. These efforts included tort reform, increased diagnostic testing, expanded peer review, and increased communication between doctors and patients. However, though the number of claims dropped, the size of claims continued to grow.

The aggressive efforts to reform state laws governing medical liability lawsuits that began in the 1970s resulted in 49 states enacting some sort of reform. (See Appendix C.1.) West Virginia was the only state that failed to enact reforms during this period. The New Hampshire reform act was subsequently struck down as unconstitutional by the state Supreme Court. The Indiana statute, considered the most comprehensive in the nation when it went into effect in 1975, has helped to moderate insurance premiums in that state. California's Medical Injury Compensation Reform Act (MICRA), also enacted in 1975, which caps non-economic damages and modifies the collateral source rule, is also considered a model law.

During this same period, in response to the problem of availability, physicians in many states formed doctor-owned malpractice insurance companies to provide coverage. These companies now write about half of all the medical malpractice insurance in the nation. Although these companies could initially charge much lower rates because they had no claims loss history, during the intervening years they, like the private insurers, have had to pay claims of increasing frequency and size, necessitating higher rates.

While the reasons for the increased incidence of malpractice claims remain difficult to determine with certainty, several possible causes have been suggested. Some have suggested that people became more litigious beginning in the 1970s, and the corresponding media coverage raised public awareness of the medical profession's vulnerability to malpractice suits. Other contributing factors may have been the increased prevalence of managed care, the use of expert testimony in malpractice cases, and the willingness of attorneys to bring malpractice suits. More recent factors contributing to the problem may include the rise in public distrust of the medical profession spurred by publicity about medical errors. The growing resentment of the public toward large for-profit health care firms has also been cited as a possible factor.

Changes in the judicial environment have also contributed to increasing costs. Juries have awarded large settlements and, while many of these awards are subsequently reduced, the final resolution to these cases is less well-publicized. This lack of public awareness may lead to higher claim demands and settlements in future cases.

The increasing sophistication of technology in medical care contributed to the litigious environment during the last three decades. While these advancements improved the quality of care physicians could provide, they also increased the public's expectations of outcomes. By the mid-1970s, claims had increased dramatically and professional liability insurance carriers were

no longer able to predict future losses. As a consequence, many carriers raised premiums to unprecedented levels; others simply left the market.

Across the United States, doctors abandoned high-risk specialties, avoided using high-risk procedures, and increased fees to cover the high cost of professional liability insurance. To protect themselves against the threat of malpractice claims, many physicians began practicing defensive medicine. These actions have resulted in increased costs and reduced availability of health care for many patients.

THE IMPACT ON PATIENT ACCESS TO HEALTH CARE

Patient access to health care has become a pressing concern as maternity wards, trauma centers and rural health clinics have closed or are facing the threat of closure in Arizona, Mississippi, Nevada, Pennsylvania, Texas, Oregon, Washington, and West Virginia. A recent survey from the American College of Obstetricians and Gynecologists (ACOG) suggests that doctors are leaving the practice of obstetrics due to the high costs of delivering high-risk care.

ACOG identified nine states where the liability insurance crisis is threatening the availability of physicians to deliver babies: Florida, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, Washington, and West Virginia. Seven other states — Connecticut, Illinois, Kentucky, Missouri, Ohio, Oregon, and Virginia — were identified as potentially vulnerable. Many physicians are leaving states with high malpractice insurance rates and setting up practice in states that have lower costs for providers.

Decreasing reimbursements from HMOs, combined with high malpractice premiums, have elevated the cost of providing care so high that many doctors claim they can no longer afford to practice. Other doctors believe they pay as high a cost psychologically as monetarily for delivering high-risk care. The ACOG survey shows that as a result of the risk of malpractice, 17.1 percent of OB-GYNs have decreased the amount of high-risk obstetric care they give, 8.9 percent are no longer practicing obstetrics at all, and 6.2 percent are decreasing the number of deliveries they perform.

Physicians in West Virginia have reported a 150 percent increase in their rates over the past year and a half. In Pennsylvania, major medical malpractice insurers are increasing rates from 21 percent to 60.4 percent. In 1999, the average cost to a physician to defend against a claim that was eventually dropped, withdrawn, or dismissed was $13,251; and, only 30 percent of medical malpractice claims result in payment to the plaintiff. When physicians become concerned with meritless claims, many turn to the practice of defensive medicine. Defensive medicine occurs when additional tests and treatments are ordered that are not required, but are utilized to cover all possible claims to medical malpractice.[1] Some doctors are opting to retire early or move to another state. Others have turned to state lawmakers to assist them in developing legislation to control the costs of insurance.

The decline in patient access to care in Texas is alarming. According to the Texas State Board of Medical Examiners, as of January 2002 Texas ranked well below the national average of physicians per capita. Texas has approximately 35,618 physicians practicing in Texas or 152 doctors per 100,000 persons, significantly lower than the national average of 196 per 100,000 persons. The state's physician shortage is most glaring in rural areas where patients requiring any level of health care services are required to travel significant distances due to a complete lack of providers. For example, in Henrietta, Texas, the town's two family physicians have recently stopped providing obstetrical care because of rising insurance rates. Patients now must travel 45 minutes to Wichita Falls, Texas, to receive care. Patient access to care is further accentuated by the fact that rural physicians generally do not have access to advanced medical facilities such as neo-natal intensive care units or to a large pool of colleagues who can share the workload. In addition, rural doctors typically see a high percentage of Medicare and Medicaid patients, so their reimbursement levels are lower than their urban counterparts. These factors magnify the malpractice insurance crisis in rural areas.

STATUS OF THE MEDICAL MALPRACTICE INSURANCE MARKET

When the United States experienced major medical malpractice crises in the mid-1970s and mid-1980s, every state enacted legislation to address the crises, including tort reforms. Medical malpractice insurance remained stable – and highly profitable – for most of the 1990s. Premiums began to rise in 2000, and in 2002, rate increases accelerated at an average of 20 to 25 percent nationally. In some states, the rates have increased between 40 and 80 percent, and even as much as 200 percent for high-risk specialties such as obstetrics, emergency medicine, and surgery. With malpractice claim amounts rising to record levels, physicians and hospitals are struggling to keep pace with increasing premiums. Several medical malpractice insurers have finally yielded to insolvency in response to skyrocketing claims.

Insurance Premiums & Corporate Losses

During most of the 1990s, when the bull stock market and higher interest rates generated higher earning on securities, investment income helped offset underwriting losses for insurers. Low interest rates and volatile financial markets have replaced strong returns in the late 1990s. In addition, insurers were able to keep rates artificially low by using reserves accumulated in earlier years. The current market has been exacerbated by the shortage of reinsurance, insurance for insurers, and large settlements in medical malpractice cases. The drop of investment income generated by the stock and bond markets widens the gap between premium income and claims payouts.[2] (For a chart of state losses, see Appendix C.2.)

The overall insurance market has hardened during the last few years, which means that insurer capacity for new business has lessened while premiums increased. Insurers and reinsurers have begun to reevaluate their risk tolerance, leading to restricted availability and higher costs for reinsurance. Insurance carrier investment income has declined significantly as the stock and

bond markets have weakened. As technology drives up the cost of health care, liability insurance costs rise because successful malpractice claim costs are partially tied to the cost of ongoing medical care or short-term treatment to reverse physical damage. Inflationary costs also affect the value of awards and ultimately, the cost of insurance.

Industry operating costs have also seen a dramatic jump in recent years. Insurers had held rates artificially low to compete with new companies entering the marketplace, using reserves to make up the difference. The industry-wide combined loss ratio in 2001 was a very poor 139 percent.[3] In Texas, the average annual change in pure premiums (the average claim cost per insured physician) was approximately +11 percent over the five-year period from 1997 through 2001. (See Appendix C.3, exhibit A.)

Severity and Frequency of Claims

The frequency of medical malpractice claims and the growing size of jury awards and defense costs have greatly contributed to the rising cost of medical malpractice premiums. Recent national data showed a jump of 43% in the median medical malpractice jury award from 1999 to 2000 -- from $700,000 to $1 million.[4] The report also noted that plaintiffs lost the majority of cases that went to a jury in 2000, although those who were successful received larger awards. More than half of medical malpractice jury awards were for $500,000 or more, from 1994 through 2000, according to the report. After a five-year increase, the settlement median in medical malpractice cases fell 16%, from $592,074 in 1999 to $500,000 in 2000.

A 1999 ACOG survey found that over half (53.9 percent) of claims against Obstetrician-Gynecologists (OB-GYNs) were dropped, dismissed or settled without a payment. Of cases that did proceed to court, OB-GYNs won 7 out of 10 cases closed by a jury or court verdict. Although OB-GYNs continue to lead in the number of claims and indemnity paid, the latest data shows that primary care doctors (e.g. internists, general and family practitioners, and pediatricians) and surgeons have also seen significant increases in claims.

Increasing claims lead to increasing premiums, especially for certain specialties. Nationally, insurance premiums for OB-GYNs have increased steadily over time: the median premium increased 167 percent between 1982 and 1998. The median rate for OB-GYNs increased 19.6 percent in 2002 alone. During that same year, the rate for internists increased 24.6 percent, and for neurosurgeons, 25 percent. The median rate across the board rose 7 percent in 2000, and 12.5 percent in 2001, with increases ranging from 0.3 to 69 percent, according to a survey by Medical Liability Monitor, a newsletter covering the liability insurance industry. Annual premiums range from a low of $12,000 a year in Nebraska, to a high of $208,000 in certain areas of Dade and Broward Counties in Florida.[5]

In Texas, statewide frequency in reported claims is increasing at a rate of 4.6 percent per year, although there are significant differences in claim frequency at the regional level. One regional difference worth noting is the frequency and trend in claim frequency in the lower Rio Grande Valley. The trend in reported claim frequency there is 16 percent. In other words, the number of

claims filed is growing on average at 16 percent per year rate. In addition to having a higher trend in claims, the actual frequency of claims filed in the Lower Rio Grande Valley is significantly higher than the statewide average. Over the five-year period 1997 to 2001, the frequency of reported claims in the Lower Valley was 74 per 100 physicians compared the statewide average of 24 per 100 physicians. (See Appendix C.3, exhibit B.)

Reported claim severity (average size of a claim reported) is increasing statewide at a rate of 6 percent per year. There are also significant regional differences in reported claim severity. The increase in reported claim severity appears to be caused by 4 of the 5 top county regions (Harris - Region 1, Tarrant - Region 2B, Bexar - Region 3 and Travis - Region 4) whose severity trends are from twice as high to four times as high as the statewide average trend. The severity and trend in severity for the Lower Rio Grande Valley was significantly below the statewide average. The average severity for the Valley was $25,600 per reported claim, whereas the average severity statewide was $65,871 per reported claim. (See Appendix C.3, exhibit C.) This data, while inconclusive, shows that the cost of insuring a doctor in Texas has been increasing significantly in recent years.

Also contributing to the problem of increasing claims size are rising health care costs. In the 1990s, managed care helped keep costs low but the savings generated have now been realized. Health care costs have begun rising again and this trend is expected to continue. A small portion of the increase is attributable to rising medical malpractice insurance rate increases. In the past, doctors could pass higher insurance costs to patients, but with managed care contracts it has become more difficult to pass the costs on to patients.

Profitability

Medical malpractice insurance costs are also driven up by the reduced supply of available coverage as insurers exit the medical malpractice business because of the difficulty of making a profit. Medical malpractice insurance in Texas is the least profitable for insurance companies, compared with the other top 15 states, based on the 2000 National Association of Insurance Commissioners (NAIC) Report on *Profitability By Line By State.*[6] For all measures of profitability, including Underwriting Profit and Return on Net Worth, Texas ranks last over the ten year period of 1991 through 2000.

Availability of Insurance

As the cost of claims increased, medical malpractice insurers began to experience solvency problems leading to market instability. The St. Paul Companies, the largest writer of medical malpractice in the United States for some twenty-five years, announced in December 2001 that it was leaving the market because underwriting losses threatened its solvency. In Texas, the number of companies offering medical malpractice insurance coverage has dropped from 17 to 4 since 1999.[7] While some companies have withdrawn from the market completely, others in poor financial condition have been forced to stop selling policies by state regulators.

Insurance Companies Operating in Texas

Due to the different statutory reporting requirements of the companies writing medical malpractice insurance in Texas, the Department of Insurance (TDI) has had difficulty obtaining comprehensive information on the distribution of business. TDI surveyed insurers in April 2002; however, even with a high response rate, only about one third of the market files their rates and forms with the agency. Below are the types of insurers currently writing policies in Texas:
Licensed (Admitted) Insurers — Companies licensed by TDI have Guaranty Fund protection in the event of insolvency. The Commissioner of Insurance must approve policy forms, and rates must be filed with TDI before being used.

Texas Medical Liability Trust (TMLT) — Statewide trust association of self-insured physicians, has no Guaranty Fund protection; and rates and policy forms are not regulated. TMLT is the largest writer in Texas with approximately 10,000 doctors covered.

Risk Purchasing Groups (RPGs) — Group purchasing power is used to obtain malpractice insurance and benefits. Guaranty Fund protection is available to RPGs who buy from licensed insurers. Licensed insurers used in this category are subject to same legislatively mandated provisions as other licensed insurers, but do not have to file forms and rates.

Risk Retention Groups (RRGs) — An insurer that retains and insures the malpractice risk group; has no Guaranty Fund protection, and rates and policy forms are not regulated by TDI.

The Texas Medical Liability Underwriting Association (JUA) — Created in 1975 by the Texas Legislature as a non-profit to provide a "stop-gap" for providers having difficulty finding coverage in the commercial market. Physicians, health care providers, and nursing homes are eligible for coverage by the JUA if they are denied coverage by commercial insurers or would be accepted only at premium rates higher than the JUA's.

The JUA is regulated by TDI and governed by a board comprised representatives from the health care and insurance industries and the general public. About 6,000 Texas physicians have been affected by the departure of eight commercial carriers from the market and the corresponding rate increases imposed by those remaining. The Texas Medical Liability Trust, which covers about one-third of the state's doctors, has increased rates by 119.6 percent since 1999. As commercial rates have gone up, the number of policyholders at the JUA has more than tripled in less than a year.

The JUA board in response to the growing need has also adopted "claims made" policies, which include additional coverage for prior acts. Previously, the JUA only offered "occurrence" policies. The differences between the two major policy types are:

Occurrence policy — covers claims arising from specific events that occur while the policy is in force, regardless of when a claim is filed.

Claims-made policy — provides coverage only if both the event and the filing of the claim occur while the claims-made coverage is in effect.

Statutory Status of Medical Malpractice Actions in Texas

Many issues that the Texas health care industry faces today are the residual effect of past medical liability crises. In the mid-1970s, a similar medical malpractice crisis arose, and the Texas Legislature responded by passing the Medical Liability and Insurance Improvement Act. The Act set the statute of limitations for any action at 2 years, capped recovery on civil health care liability claims at $500,000 and capped non-economic losses at $150,000, both of which to be adjusted for inflation.

Seven years later, the Texas Supreme Court ruled that the absolute two-year statute of limitations for medical malpractice claims set out in Section 10.01 of the Texas Medical Liability and Insurance Improvement Act (Article 4590i of the Texas Civil Statutes) violated the Texas Constitution to the extent that the statute barred a plaintiff from bringing a medical malpractice claim before the injured party had a reasonable opportunity to discover the injury. *See Neagle v. Nelson*, 658 S.W.2d 11 (Tex. 1985). The Court subsequently ruled that the damage caps also violated the "open courts" doctrine. *See Lucas v. United States*, 757 S.W.2d 687, 691 (Tex. 1988).

Over the next several legislative sessions, the Texas Legislature enacted additional tort reform measures. In 1989, the legislature added provisions to the Medical Liability and Insurance Improvement Act which set out the qualifications for expert witnesses in medical malpractice suits,[8] and in 1993, a subchapter was added to the Act that requires a plaintiff to file an expert opinion affidavit within 90 days of filing a claim stating that the health care provider was negligent.[9] In 1995, the legislature limited the amount of and circumstances under which a court may award exemplary damages.[10] Also in 1995, the legislature passed a bill that amended the responsibilities of the claimant and the defendant in health care liability claims; required prejudgment interest in health care liability claims to be awarded in a certain manner; and, established the time at which a period of limitations begins in a suit filed on behalf of a minor.[11]

Recent Texas Supreme Court rulings have limited the application of statutory caps on punitive damages and compensatory damages on constitutional and other grounds. *See Horizon/CMS Healthcare Corporation v. Auld*, 985 S.W.2d 216 (Tex. 2000); and *Columbia Hospital Corporation of Houston v. Moore*, 45 Tex. Sup. J. 957 (Tex. 2002). (For a chronological history of medical malpractice actions in Texas, see Appendix C.5.)

APPROACHES TO RESOLVING THE MEDICAL MALPRACTICE CRISIS

The medical malpractice liability system should be one that is equitable, efficient, and consistently applied. Health care liability is a complex issue with many facets to be addressed by all groups affected — physicians, lawyers, hospitals, insurers, and patients — in order to ensure quality, accessible health care for Texas citizens. State reforms may be categorized as follows: tort reform; alternatives to litigation and federal reform; insurance reforms; and prevention and patient safety.

TORT REFORM

Caps on Non-economic Damages

Non-economic damage awards have increased significantly over the last decade. Non-economic damages, losses attributed to mental anguish or "pain and suffering," are more subjective than economic damages, and thus, are more difficult to quantify from an actuarial basis. As a consequence, the potential for high non-economic damage awards have driven up the cost of professional liability insurance costs. According to the Texas Department of Insurance closed claim data (1999), 66 percent of awards in health care liability cases are attributable to non-economic damages. The average non-economic damage award in 1999 was $1.38 million.[12]

Twenty states have enacted limitations on non-economic damages, with caps ranging from $250,000 to $750,000. Some of the caps are applied per provider and others are applied per claimant. A number of the caps are adjusted annually for inflation. The Nevada legislature recently enacted a $350,000 cap on non-economic damages that is tied to a $1 million/$3 million liability insurance requirement. Legislation was passed in Texas during the 1970s which implemented a cap on non-economic damages, but the Texas Supreme Court declared the limits unconstitutional as written.

Reform proponents that testified before the Committee have proposed caps on non-economic damages ranging from $200,000 to $250,000, with caps not indexed for inflation. Some also support the repeal of the provision that has allowed the legal argument that the Stowers[13] doctrine allows recovery of damages in excess of cap in wrongful death cases.

A state consumer group, however, argues that capping damages is not the way to solve the problem of increasing malpractice premiums. The group holds the position that there is no one-size-fits-all solution and advocates resolving the issue of high premiums through insurance and medical reforms, forcing insurance companies to justify their rates.

Some attorneys argue that insurance companies are "gouging the doctor with excessive premiums in order to recoup the insurers' investment losses." Attorneys argue that medical malpractice cases are the most complex and expensive cases for lawyers to prepare, and they only get paid if they win, establishing a natural disincentive to file cases that lack merit. Lawyers see the issue as one of insurance rather than litigation.

The National Conference of State Legislatures (NCSL), based on its research, states that although caps are not necessarily a guarantee of lower premiums, there is a distinctive correlation between non-economic damage caps and greater market stability which can lead to increased competition between insurers and, thus put downward pressure on rates.

Limits on Economic Damages

Economic damages are more easily quantified and have not contributed significantly to the increase in awards in health care liability cases. An economic damage is categorized as a monetary loss, such as lost wages or payments made toward medical care. The National Center for State Courts reported in 1992 that caps on economic damages had *no impact* on the rate of malpractice litigation.[14] According to Texas Department of Insurance closed claim data (1999), 17.2 percent of awards are attributable to economic damages. Average economic damage award in 1999 was $364,000.

There are six states have enacted limitations on total awards, with caps ranging from $500,000 to $1.5 million. Caps on economic damages have been held unconstitutional in several states, including Texas. The overall cap in Texas has been upheld in wrongful death cases. The Nevada legislature recently enacted a total cap of $50,000 in cases against a physician involving emergency or trauma care, and this cap is tied to an insurance requirement.

Restrictions on Attorney Contingency Fees

Attorneys for plaintiffs in tort cases almost always work on a contingency fee basis, receiving a percentage of the damage award. This arrangement makes it possible for people of all economic levels to bring suit for injuries resulting from negligence. Reformers argue that attorneys' fees are often excessive, take away from the victims compensation, and encourage attorneys to bring frivolous suits. Reform proponents also argue that high contingency fees allow the personal tragedy of a patient that has suffered harm to result in a windfall for the plaintiff's attorneys.

Twenty-five states have statutes or court rules that address attorney contingency fees. Several allow the court to review the fee arrangements of the parties. Others employ a sliding scale that caps attorney fees at a certain percentage on an initial amount of damages, with the fees decreasing as the subsequent amount of the recovery increases. Some states proscribe in statute what percent of an award may go to the parties' attorney.

Statute of Limitations

Reformers support shorter statutes of limitations on medical malpractice claims, which have been enacted in California, Nevada, and Mississippi. California, for example, shortened the statute of limitations for adults to one year from discovery or three years from the date of the alleged injury, and established a special statute of limitations for minors. Proponents state that shortening the statute of limitations for filing claims can reduce claims frequency.

In Texas, the Medical Liability and Insurance Improvement Act set the statute of limitations at an absolute two years. In 1985, the Texas Supreme Court ruled that the absolute two-year statute of limitations for medical malpractice claims violated the Texas Constitution to the extent that the statute barred a plaintiff from bringing a medical malpractice claim before the injured party had a reasonable opportunity to discover the injury. *See Neagle v. Nelson*, 658 S.W.2d 11 (Tex. 1985). Thus, the current statute of limitations is still 2 years, but if a person could not have reasonably discovered their injury in that time period, the statute of limitations becomes a question of fact to be determined on a case by case basis by the court.

Periodic Payments

A plaintiff who suffers bodily injury at the hands of a wrongdoer has traditionally been compensated for both past and future damages through a lump sum judgment, payable at the conclusion of the trial. Those urging tort reform argue that the legislative adoption of a periodic payment procedure would benefit both plaintiffs and defendants. Lump sum awards are often dissipated by unwise expenditures or investments before the injured person actually incurs resulting future medical expenses or earning losses. Periodic payments spread defendants financial burden of paying large awards over time, and thus can help prevent bankruptcy by providers who lose malpractice suits.

Reform advocates in Texas recommends that at the option of either the defendant or claimant, all future damages in excess of $100,000 should be paid by periodic payments rather than by lump-sum. Further, the judgment should specify how and when the periodic payments are made, and periodic payments of future medical, hospital, and custodial care should be paid as incurred and should terminate upon death of recipient.

Thirty-three states have enacted laws allowing payment of future damages by periodic payments. The threshold amount of damages that must be reached in order to request periodic payments ranges from $50,000 to $250,000. In some states, payments for future health care expenses terminate upon death of the claimant, but compensation for loss of future income is not reduced. Many of the state laws give the trial court discretion to determine how future damages are calculated, how and when periodic payments are made, and what level of financial security must be provided by the defendant to assure that the future payments are made. Four jurisdictions have considered the constitutionality of periodic payment provisions. Two have found them constitutional, and two have found them unconstitutional.

Collateral Source Rule

The collateral source rule prevents the trier of fact from considering collateral or other sources of benefits available to a claimant, such as reimbursement for medical costs by an insurance company, when determining damage awards. The National Center for State Courts reported in 1992 that the abolition of collateral source rule *decreases* the rate of litigation.[15]

Modification of the collateral source rule could reduce costs of liability insurance because awards for past or future health care or disability expenses can be reduced to the extent that other resources are available to compensate the claimant for those expenses. There are 30 states that have enacted laws that allow the introduction of evidence of a collateral source of benefits available to the claimant, and many of these state laws require that the award be reduced by the amount of collateral benefits. In some states, there can be no reduction in the award if a right of subrogation exists. The principle of subrogation allows an insurer that has paid a loss under an insurance policy to "step into the shoes" of the insured against a third party with regard to any loss covered by the policy. For example, if an insurance company pays medical claims for an injured person, the insurance company can seek reimbursement from the wrongdoer who caused the injury. Most states allow subrogation by state or federal programs, such as Medicare and Medicaid.

In four states, the state supreme court has found that abolition of the collateral source rule was unconstitutional. As with the cap on non-economic damages, the legal question is whether the restriction on the claimant's recovery (reduction in damages based on collateral benefits) is unreasonable or arbitrary when balanced against the purpose and basis of the statute, which is the reduction in professional liability insurance coverage for health care providers.

Joint and Several Liability

Joint and several liability is intended to protect victims in cases where more than one party has been found liable or responsible for the injuries inflicted. If any party fails to pay its portion of damages, the other parties are held liable for the total damage award. This is designed to ensure that an injured person will receive his or her entire damage award, even if one or more of the responsible parties fails to pay. The counter argument to this rule is that it encourages plaintiffs to sue multiple hospitals or doctors with "deep pockets" or substantial insurance policies.

Although the paying defendant frequently has a right to recover from co-defendants, if the co-defendants are insolvent or immune from suit, this right may be meaningless. Under joint and several liability, any defendant, even if only slightly negligent, may be required to pay the full amount of the award.

In Texas, each defendant is joint and severally liable for the entire amount of the judgement awarded the plaintiff, except that a defendant whose negligence is less than that of the plaintiff is liable to the plaintiff only for that portion of the judgement that represents the percentage of negligence attributable to him. In other words, defendants who are less negligent than the

plaintiff are only severally liable to the defendant, not jointly liable. Only those defendants whose negligence equals or exceeds that of the plaintiff are jointly liable.[16]

Frivolous Lawsuits

The National Center for State Courts reported in 1992 that penalties to punish frivolous lawsuits *decreases* the rate of litigation.[17] An attorney who brings a lawsuit before a court is, by way of signature, swearing that the suit is not frivolous or without merit. It is then left to the judge to determine if a pleading has been signed in violation of any one of the standards prescribed by the Civil Practices and Remedies Code.

Chapter 10 of Civil Practice and Remedies Code provides that an attorney who signs a pleading for the purposes of harassment, unnecessary delay, or needless increase in the cost of litigation, may be sanctioned. The prevailing party may be awarded reasonable expenses and attorney's fees, as well as costs for inconvenience, harassment, and out-of-pocket expenses.

Proponents for medical liability malpractice tort reform support stronger penalties and sanctions for filing frivolous lawsuits. In July 2002, District Judge Ronald M. Yeager granted the motion for sanctions against an attorney of $25,000 per doctor after the attorney signed what the judge determined to be frivolous medical malpractice lawsuits against two doctors for prescribing medications that they had not prescribed.

House Bill 1905 (77R) was crafted to create grounds for a counterclaim against an attorney or individual who filed a malpractice claim in bad faith. The language is almost identical to a statute that the legislature passed in 1977. However that statute provided that it would only go into effect if the State Bar failed to certify that it had disciplinary rules in effect to deter frivolous lawsuits. The State Bar did so a few months later and the law did not take effect.

Requiring that a plaintiff give prior notice of intention to file a lawsuit is another method reform proponents champion for curbing lawsuit abuse. Texas currently requires that plaintiffs give 60-day notice.[18] In California, MICRA requires that no lawsuits for malpractice may be commenced unless the defendant has been given at least 90 days prior notice of the plaintiff's intention to file the lawsuit. A longer notice period, such as 90 days, may encourage parties to settle or employ other alternatives to litigation.

Charitable Health Care

The Texas Charitable Immunity and Liability Act was enacted in 1987 to encourage volunteer services and maximize the resources devoted to delivering these services by reducing the liability exposure and insurance costs of charitable organizations and their employees and volunteers.[19] The Act provides immunity for volunteer health care providers performing non-emergency care for certain charitable organizations. The Act specifically excludes nonprofit hospitals from any liability protection for charitable services.

A volunteer health care provider is an individual who voluntarily provides health care services without compensation or expectation of compensation and who is one of the ten types of health care providers included under the law. A volunteer health care provider who is serving as a direct service volunteer of a charitable organization is immune from civil liability for any act or omission resulting in death, damage, or injury to a patient if the volunteer: (1) is acting in good faith and in the course and scope of the volunteer's duties or functions; (2) commits the act or omission in the course of providing health care services to the patient; (3) provides services within his scope of the license; and (4) has the patient or certain designated legal representatives of the patient sign a written statement that acknowledges both that the volunteer is providing care that is not administered for or in expectation of compensation and the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

Due to the requirements and limitations imposed by the Act, the law has provided limited liability protection to volunteer health care providers. The Act provides no liability protection for hospitals or hospital employees providing charity services.

Several reform advocates propose that volunteer health care providers be immune from civil liability. Another proposal says that a hospital should be subject to limited liability of $500,000 per patient if the patient or legal representative acknowledges that the hospital is providing care without expectation of remuneration and the limitation on liability is in exchange for receiving the charity services.

ALTERNATIVES TO LITIGATION AND JUDICIAL REFORM

Expert Witness Requirements

In an effort to address concerns about frivolous lawsuits against health care providers, the Legislature in 1995 imposed an expert report requirement on claimants in health care liability actions. The expert report was a summary from the claimant’s expert that provided the expert’s opinions as to the applicable standard of care, the manner in which the care rendered by the physician or provider failed to meet the standard, and the causal relationship between the failure and the injury or harm claimed. If the expert report was not filed within a specified period of time, a cost bond also could be required.

Some reformers would like to add to this requirement that the expert witness affidavit be completed by an active Texas licensee. A Texas license holder may be better positioned to provide an opinion in determining whether a malpractice case should go forward. Some say limiting eligibility of expert witnesses to Texans also adds accountability and awareness to the system, as opposed to paying an out-of-state practitioner to sign off on a case that has no bearing on his or her practice. Texas is large and diverse enough that finding a witnesses free of any conflict of interest could be achieved.

Arbitration

Arbitration is permitted in some states, including Texas,[20] and is often a prerequisite to litigation. An arbitration program offers resolution to medical liability that does not involve going to trial. Typically these programs consist of a panel of an attorney, a health care provider, and a lay person. The panel, rather than a judge and a jury, hears the merits of a case and makes a decision on provider fault and patient compensation. The benefits to arbitration are that it takes less time to come to resolution and costs less for both parties to defend. However, arbitration typically results in lower award payments.

In Texas, an arbitration agreement must be signed by an attorney representing the patient. Some reformers point to this requirement as unnecessary and burdensome, and assert that it acts as a disincentive to using arbitration to resolve disputes.

Screening Panels

Mandatory, pre-trial screening panels are intended as a means to increase the effectiveness and efficiency of processing tort claims and to reduce the number of frivolous claims and speed up settlement and payment to those injured parties with legitimate claims. Some states use review or screening panels as a pre-trial screening mechanism, but findings may or may not be submitted as evidence, depending on the state.[21] If the panel's findings are allowed into evidence, the panel members can be called as witnesses at the trial.

Some state courts have found that such panels, as a prerequisite to a jury trial, constitute an impermissible restriction on the right to trial by jury or the open courts provision guaranteed in their state constitution.

Some screening panels, even if found constitutional by the state courts, have subsequently been found to be impractical. Long delays caused by the procedures have effectively denied plaintiffs access to the courts and the statutes have been found unconstitutional as applied.[22]

INSURANCE REFORMS

Insurance reforms designed to increase the availability of malpractice insurance include: patient compensation funds, joint underwriting associations, limits on the ability of companies to cancel policies, and requirements for insurers to report the disposition of claims to insurance regulators. Nine states finance patient compensation funds with an assessment on health care providers. These compensation funds pay portions of especially costly awards that are in excess of the coverage limits of a malpractice insurance policy.

Insurance regulatory agencies can play a larger role by ensuring that premiums are commensurate with loss trends. The Committee heard testimony urging legislators to direct TDI to conduct a formal review of rate structures. Any findings of improper rating practices and unjustified rate increases could be subject to corrective action by the agency. Others suggest that the agency monitor any legislative reforms to insure that they have the intended impact on premiums.

Special state funds and physician mutual insurance companies that now make up 60 percent of the medical malpractice market can also promote the availability of coverage, but they do not necessarily increase the affordability of malpractice insurance.[23]

PREVENTION AND PATIENT SAFETY

Preventing or eliminating conditions that lead to malpractice is another important component in dealing with the problem of increasing insurance costs. Advocates for prevention acknowledge that this requires aggressive action at the state level and by health care providers. Some prevention measures are: increased enforcement and disciplinary actions by state medical boards; risk-management programs; best-practices; tougher licensing requirements; stronger and enforced professional standards; and restrictions on health professionals' work hours.

Enforcement and Disciplinary Actions

Advocates for preventive measures to address medical malpractice lawsuits claim that a properly functioning review board can serve as an alternative to litigation, ensure that injured patients are adequately and quickly compensated, and discipline problem doctors. Physicians and other health care practitioners could be more aggressive in assuring that the members of their profession are adequately trained, supervised, and disciplined when appropriate. This requires more effective monitoring of health care practitioners by state boards of medical examiners. Such boards need appropriate resources to investigate and enforce their authority so that patient complaints and provider disciplinary actions can be pursued and resolved in an effective and timely manner. Without sufficient resources, a board is unable to maintain experienced investigative and legal staff, which negatively impacts patients as well as health care providers.

Reports from the federal General Accounting Office (GAO) have shown that relatively few physicians and other practitioners are disciplined by appropriate professional or state agencies. In September 2002, the *Dallas Morning News* reported that the Texas State Board of Medical Examiners (SBME) had not revoked the license of a single doctor for committing medical errors in the past five years, concluding that a legislative priority should be strengthening the board or creating another supervisory mechanism. The *Dallas Morning News*' investigation revealed that "about $5.2 million statewide, partly derived from doctors' licensing fees, goes to fund the state board. In contrast, California spends $39.3 million to regulate its doctors." The SBME reports that it has made significant improvements in the last year, increasing its rate of investigations opened and closed, licenses suspended, and hearings held. (See Appendix C.4.) The Board continues to make progress in streamlining its licensing and disciplinary processes, and is seeking the help of the Legislature to make further strides.

In 1984, the GAO reported that a health care practitioner licensed in more than one state could have one of those licenses revoked or suspended by a state licensing board, but could relocate to another state and continue to treat patients. Some have proposed denying out-of-state licensees who have lost their license in another state the ability to practice in Texas. In 1987, Congress passed H.R. 1444 and established a period of exclusion from participation in Medicare and some state health care programs for health care practitioners who fall into this category.

Risk Management

The 1987 GAO report, *Medical Malpractice: A Framework for Action,* reports that "state legislatures, where they have not yet done so, should require health care providers to participate in risk management programs as a condition of licensure." Another role for licensing boards can be to provide education and assistance to health care providers to ensure that providers are up-to-date on current technology and best practices. Some preventative programs include early warning systems of adverse patient outcomes, which enable the provider organization to promptly investigate the situation and take appropriate actions to prevent a recurrence and avert a potentially litigious situation. Improved communication with informed consent and counseling can better educate patients about the risks of medical treatments and likely outcomes of medical procedures.

Mandatory medical error reporting programs are in place in 17 states, while five states have voluntary programs. Any written demand for payment which results in a payment being made on behalf of a physician or other licensed health care practitioner must be reported by the insurer to the National Practitioner Data Bank (NPDB). The NPDB is a database in which malpractice data is sealed and thus unavailable to the public. In Massachusetts, all closed medical malpractice claims and suits with physicians named must be reported by the insurer to the Massachusetts Board of Registration in Medicine – even if no payment is made to the plaintiff. In Rhode Island, insurers must report medical malpractice claims or suits to the Rhode Island Board of Medical

Licensure and Discipline within 30 days of their initiation. In Texas, the SBME posts physicians' profiles on its website so that the public may access information about any disciplinary actions taken by the Board and the results of any investigations the Board conducted as a result of malpractice claims.

CALIFORNIA'S MEDICAL INJURY COMPENSATION REFORM ACT (MICRA)

In the mid-1970s, California physicians, faced with increases of more than 300 percent in the cost of professional liability insurance, staged a work slowdown by providing health care only for emergencies. The slowdown brought media and public attention to the problem and resulted in legislative action to resolve the crisis--namely the passage of MICRA. Specifically, MICRA contains the following provisions relating to medical malpractice cases: placed a $250,000 cap on non-economic damages such as compensation for pain and suffering; placed a sliding-scale cap on contingency fees for plaintiff attorneys; allowed for periodic payments rather than a lump sum payment of economic damages in excess of $50,000; shortened the statute of limitations for adults to one year from discovery or three years from the date of the alleged injury, and established a special statute of limitations for minors; allowed for the admission of evidence regarding collateral sources of payment and support and, at the discretion of a jury, the offset of such collateral sources from the damage award; strengthened the disciplinary activities of the Board of Medical Quality Assurance (now the Medical Board of California); required the use of a 90-day notice of intent to sue; and stipulated that contracts for medical services may include provisions for binding arbitration.

Over time, California's reforms have been credited with stabilizing the medical liability environment in that state, making the coverage more affordable than in many other states with large urban populations. Proponents of reforms such as those contained in MICRA assert that medical-malpractice rates rise less than half as much in states with limits on non-economic damage awards as in those that do not.[24] The 1986 GAO report cited the reforms enacted in California as among the most effective in moderating increases in the cost of malpractice insurance and the size of awards.[25]

FEDERAL ACTION

In April 2002, the Help Efficient Accessible, Low-cost Timely Health Care bill (H.R. 4600) was introduced in the U.S. House of Representatives by U.S. Rep. James Greenwood (R-PA). Supporters of the bill say it is intended to restore balance to the medical liability system by imposing a $250,000 cap on non-economic damages, such as pain and suffering, establishing criteria for awarding punitive damages, and eliminating the joint and several liability rule that

allows plaintiffs to recover the total award from an entity only minimally to blame for the accident. It also includes a collateral source provision, establishes periodic payments, and institutes a sliding scale for attorneys' fees. The bill was modeled on California's MICRA legislation.

Federal courts in several jurisdictions and the supreme courts of Pennsylvania and New York have ruled that patients may sue their health care plans for negligence, following a decision by the U.S. Supreme Court in 1995 on the Employee Retirement Income Security Act (ERISA), a federal statute protecting employees. Until the U.S. Supreme Court ruling, courts had generally held that health care plans were covered by ERISA because the services they provided were part of a company's employee benefit plan. But the high court said ERISA was only meant to ensure that benefit plans were administered uniformly, not free to them from the states' general health care regulation. However, industry observers say the ability to sue HMOs will not necessarily reduce awards against doctors and hospitals. Managed care organizations that are being sued are likely to make doctors and hospitals co-defendants.

In June 2000, the Supreme Court upheld the right of states to use independent review boards to make final decisions on the medical treatment that HMOs provide to their members. Most states now allow patients to appeal decisions from HMOs denying coverage for treatment to an independent review board. Forty-two states and the District of Columbia set up review boards in response to consumer complaints regarding denial of treatment by HMOs. The Supreme Court held that ERISA does not preempt the state review boards.

RECOMMENDATIONS

A primary goal of medical liability reform is to decrease the frequency and severity of claims, thus minimizing any adverse affects that medical malpractice claims may have on patient access to quality health care. State legislatures typically respond to medical liability crises with measures that balance the goals of marketplace stability and fair compensation for victims. Toward this effort, the Committee heard from the many stakeholders around the state to identify approaches that would best address the current crisis in Texas. The following are the recommendations of this Committee.

1. Place a $250,000 cap on recovery of non-economic damages.

2. Limit attorney contingency fees.

3. Provide greater certainty about the statute of limitations in health care liability claims in light of the open courts doctrine.

4. Allow periodic payment of future damages.

5. Allow evidence of collateral source payments.

6. Address abusive attorney practices by strengthening penalties for filing frivolous lawsuits, extending the notice required prior to filing a lawsuit, and putting more limits on "ambulance-chasing" advertisements.

7. Expand lawsuit immunity to protect charity and indigent health care providers.

8. Allow the Joint Underwriting Authority to offer temporary malpractice policies to health care providers whose insurance is terminated for economic but not practice-related circumstances.

9. Ensure that the State Board of Medical Examiners ("Board") has adequate resources so that patient complaints and provider disciplinary actions can be pursued and resolved in an effective and timely manner.

10. Strengthen the Board's authority to immediately suspend licenses of licensees who have been convicted of a crime. Clarify what conduct constitutes a "clear and present danger" to patients so that temporary suspensions can be made quickly.

11. Once a license has been temporarily suspended, expedite the informal settlement conference (ISC) process. Contested hearings at the State Office of Administrative Hearings (SOAH) should also receive an expedited hearing.

12. Prohibit any person whose medical license has been revoked in another jurisdiction from practicing in Texas.

13. Direct the Board to develop a program for identifying and remedying doctors at risk of committing medical errors. Focusing on early intervention can help prevent errors from occurring and malpractice cases from being filed.

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10. See Tex. Civ. Prac. & Rem. Code Ann., §41.008.

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