HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 579 Payment of Health Care Claims
SPONSOR(S): Health Innovation Subcommittee, Hager
TIED BILLS: **IDEN./SIM. BILLS:** SB 102

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	15 Y, 0 N, As CS	Tuszynski	Poche
2) Insurance & Banking Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The American Medical Association (AMA) reports that health care providers lose a significant amount of administrative time and revenue due to denied claims. In its most recent National Insurer Report Card, the AMA reported that major insurers deny up to 29 percent of claims. Denials of claims can cost providers thousands of dollars annually.

Claims can be denied both before and after a service or treatment has been provided through a denial of preauthorization requests, denial of claims for payment, or retroactive denial of payment. Claims may be denied for many reasons: incorrect diagnosis code, an incomplete claim submission, a determination that a service is not medically necessary, or insured eligibility issues. For example, an insured may seek a service from a provider prior to that individual's effective date of coverage or after coverage has been terminated.

In the instance of a retroactive denial, the provider may have already verified that the patient was covered, provided services based on that verification, and in some cases already received payment. Retroactive denials can result in the provider or the consumer covering the loss, despite the verified eligibility.

CS/HB 579 amends ss. 627.6131 and 641.3155, F.S., to prohibit a health insurer or health maintenance organization (HMO) from retroactively denying a claim at any time because of insured ineligibility, if the insurer or HMO verified the eligibility of the insured at the time of treatment and provided an authorization number.

The bill has an indeterminate negative fiscal impact on fully-insured HMO plans in the State Group Insurance Plan and no apparent fiscal impact on local government.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Denial of Claims

According to the American Medical Association (AMA), health care providers lose a significant amount of administrative time and revenue due to denied claims. In its most recent National Insurer Report Card, the AMA reports that major insurers deny up to 29 percent of claims.[1] A study by the Medical Group Management Association found the cost to rework and resubmit a denied claim is approximately $25.[2]

Potential Financial Impact of Denials on Providers*

Denied claims per physician per month	44
Rework cost per claim	$25
Rework cost per month	$1,100
Annual rework cost	$13,200

*This example assumes 370 visits per month, one claim line per claim, and a denial rate of 12 percent.

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Insurers and health maintenance organizations (HMOs) may routinely conduct a claims audit to verify the appropriateness and accuracy of the payment of claims. After an audit, if an insurer or HMO determines there is an issue with the claim or eligibility of the insured, it may retroactively deny a claim for a preauthorized service and try to recoup payment from the provider.

In the instance of a retroactive denial, the provider may have already verified that the patient was covered, provided services based on that verification, and in some cases already received payment. Retroactive denials can result in the provider or the consumer covering the loss, despite the verified eligibility.

Exchange Plans and Premium Tax Credits

The federal Patient Protection and Affordable Care Act (PPACA) guarantees access to coverage and mandates certain essential health benefits and other requirements.[4] To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and

[1] Marting, R. *The Cure for Claims Denials*, American Academy of Family Physicians, Family Practice Management, 2015 Mar-Apr;22(2):7-10, available at: http://www.aafp.org/fpm/2015/0300/p7.pdf (last accessed March 23, 2017).
[2] Id.; Graham T., *You might be losing thousands of dollars per month in 'unclean' claims*. MGMA Connex. 2014;14(2):37-38
[3] S. 627.6141, F.S.
[4] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended several provisions of the PPACA, was enacted on March 30, 2010.

moderate-income individuals to purchase qualified health plans (QHPs) on a state or federal exchange.[5] In Florida, 1,588,628 individuals enrolled through the federal exchange received a premium tax credit for plan year 2016.[6]

Under PPACA, insurers and HMOs must provide a grace period of at least three consecutive months before cancelling the policy or contract of a federally subsidized enrollee who is delinquent if the enrollee previously paid 1-month's premium.[7] During the first month of the grace period, the insurer must pay all appropriate claims for services provided. For the second and third months, an insurer may review claims and notify providers that may be affected that an enrollee has lapsed in his or her payment of premiums and there is a possibility the insurer may deny the payment of claims incurred during the second and third months.[8] According to a 2014 survey, 48 percent of providers not participating with any PPACA exchange products cited concerns about financial liability during the grace period as a reason for their decision.[9]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[10] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[11]

Florida's Prompt Payment Laws

Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131 and 641.3155, F.S., respectively.[12] These provisions detail the rights and responsibilities of insurers, HMOs, and providers for the payment of claims. An insurer or HMO has 12 months after payment is made to a provider to make a claim for overpayment against the provider, if the provider is licensed under ch. 458, F.S., (physicians), ch. 459, F.S., (osteopaths), ch. 460, F.S., (chiropractors), ch. 461, F.S., (podiatrists), or ch. 466, F.S., (dentists). For all other types of providers, an insurer or HMO has up to 30 months after such payment to make a claim for overpayment.[13] The statutes provide a process and timeline for providers to pay, deny, or contest the claim. The statutes also prohibit an insurer or HMO from retroactively denying a claim because of the ineligibility of an insured or subscriber more than one year after the date the claim is paid.[14]

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[5] In general, individuals and families may be eligible for the premium tax credit if their household income for the year is at least 100 percent but no more than 400 percent of the federal poverty line for their family size. For residents of one of the 48 contiguous states or Washington, D.C., the following illustrates when household income would be at least 100 percent but no more than 400 percent of the federal poverty line in computing your premium tax credit for 2017:
$12,060 (100%) up to $48,240 (400%) for one individual; $16,240 (100%) up to $64,960 (400%) for a family of two; and $24,600 (100%) up to $98,400 (400%) for a family of four. U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Poverty Guidelines*, available at: https://aspe.hhs.gov/poverty-guidelines (last accessed March 25, 2017).

[6] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016* (Apr. 12, 2016), *available at* https://aspe.hhs.gov/system/files/pdf/198636/MarketplaceRate.pdf (last accessed Mar. 23, 2017).

[7] Example of grace period: Premium is not paid in May. Premium payments are made in June and July, but May remains unpaid, the grace period would end July 31. Coverage would be cancelled retroactively to the last day of May. See https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/ (last accessed Mar. 23, 2017); 45 C.F.R. s. 155.430.

[8] 45 C.F.R. s. 156.270

[9] Tracy Gnadinger, Health Policy Brief: The Ninety-Day Grace Period, (Oct. 16, 2014) *available at:* http://healthaffairs.org/blog/2014/10/17/health-policy-brief-the-ninety-day-grace-period/ (last accessed March 23, 2017).

[10] S. 20.121(3), F.S.

[11] S. 641.21(1), F.S.

[12] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organization, and individual and group contracts that only provide direct payments to dentists.

[13] SS. 627.6131 and 641.3155, F.S., provide exceptions to this time limit in cases relating to fraud.

[14] SS. 627.6131(11) and 641.3155(10), F.S

Grace Periods

The federal regulation governing grace periods for federally subsidized policies or contracts does not affect policies or contracts of individuals who are not enrolled in an exchange QHP or who are enrolled in an exchange QHP and do not receive a subsidy. The grace period for these individual policies or contracts is governed by Florida law,[15] which varies by the duration of the premium payment interval. During the grace period, the policy or contract stays in force, and the insurer or HMO must affirm that an individual is insured, even when the premium payment is late and remains unpaid during the grace period. If the insurer or HMO does not receive the full payment of the premium by the end of the grace period, coverage terminates as of the grace period start date and the insurer or HMO may retroactively deny any claims incurred during the grace period.

Florida's Statewide Medicaid Managed Care Program

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, AHCA oversees the Medicaid program, while the Department of Children and Families (DCF) conducts Medicaid eligibility determinations.[16]

The Statewide Medicaid Managed Care (SMMC) program consists of the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program.[17] AHCA contracts with managed care plans to provide services to eligible recipients. The MMA program covers medical and acute care services for plan enrollees. Most Florida Medicaid recipients who are eligible for the full array of Medicaid benefits are enrolled in an MMA plan. The LTC program covers nursing facility and home and community-based services to eligible adults.

Medicaid managed care plans are responsible for paying claims in accordance with federal and state law and contractual requirements, including s. 641.3155, F.S.,[18] which allows HMOs to deny a claim retroactively because of insured or subscriber ineligibility up to one year after the date of payment of the claim.

The Florida Medicaid Provider General Handbook and Florida Medicaid service-specific coverage policies and handbooks, incorporated by reference in the SMMC contract, require providers to verify each recipient's eligibility each time they provide a service. Although an enrollee may have eligibility on file at the time a service was authorized, the enrollee may have subsequently become ineligible.

Section 409.913(1)(e), F.S., defines "overpayment" to include any amount that is not authorized to be paid by the Medicaid program whether as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. Section 409.907, F.S., prohibits AHCA from demanding repayment from a provider in any instance in which the Medicaid overpayment is attributable to error of DCF in eligibility determination.

Section 1903(d)(2)(C) of the Social Security Act states, "When an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the

[15] SS. 627.608 and 641.31(15), F.S.; The grace period of an individual policy must be a minimum of 7 days for weekly premium; 10 days for a monthly premium; and 31 days for all other periods. The grace period of a HMO contract must be at least 10 days. For group policies, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due. Section 627.6645, F.S.; 45 C.F.R. s. 155.735, provisions relating to the termination of Small Business Health Options Program (SHOP) enrollment or coverage obtained through an exchange.

[16] Department of Children and Families, *Medicaid*, available at: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid (last accessed March 24, 2017).

[17] Part IV of ch. 409, F.S.

[18] S. 409.967(2)(j), F.S.

adjustment in the Federal payment shall be made at the end of the one year period, whether or not recovery was made." This law requires states to return the federal matching portion on overpayments made by the state or the health plan, which could include payments retroactively denied.

Effect of Proposed Language

CS/HB 579 amends ss. 627.6131 and 641.3155, F.S., to prohibit a health insurer or HMO from retroactively denying a claim at any time because of insured ineligibility, if the insurer or HMO verified the insured's eligibility at the time of treatment and provided an authorization number. The prohibition only applies to insurance policies and HMO contracts entered into after January 1, 2018.

The bill provides certainty of payment for insureds and providers who have received authorization numbers from insurers and HMOs. However, the bill prevents insurers and HMOs from pursuing overpayments or payments for non-covered services revealed during a claims audit if the insurer or HMO provided an authorization number. For example, if an insurer authorized treatments X and Y for an eligible insured and the provider provides treatment X, Y, and Z, and treatment Z is not covered by the insurer or HMO, the bill would prevent the insurer from recouping the overpayment for the uncovered service, which may not be discovered until a claims audit is completed.

Medicaid managed care plans are exempt from the prohibition against retroactive denial. The plans will continue to recoup overpayments to adhere to the requirement to repay federal matching funds associated with Medicaid overpayments.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6131, F.S., relating to payment of claims.
Section 2: Amends s. 641.3155, F.S., relating to prompt payment of claims.
Section 3: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill would have a significant negative fiscal impact on the State Group Health Insurance Program's (SGHI) fully insured plans. Initial estimates on impact range from a $0.07 increase per member, per month for the Capital Health Plan (CHP) HMO, to an annual impact of up to $1.4 million for the Florida Health Care Plans (FHCP). SGHI contracts allow for an equitable adjustment to contracts in the middle of a plan-year if a statute or rule creates an impact of $500,000 or more. It does not appear that the bill would have such an impact on CHP or FHCP, but the potential exists for a negative fiscal impact, based on claim history provided by FHCP.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will reduce unanticipated obligations on patients and loss of revenue on providers by eliminating the ability of a health insurer or HMO to recoup or deny the payment of a claim for a previously authorized treatment. This creates financial liability for a health insurer or HMO that provides authorization for an individual who is later deemed ineligible for coverage by preventing recoupment of overpayment due to retroactive denial.

Federal regulations preempt state and local laws relating to claim payment for federally subsidized products purchased on the exchange. This bill would not apply to such claims.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not Applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 27, 2017, the Health Innovation Subcommittee adopted an amendment that restricted application of the bill provisions to insurance policies and HMO contracts entered into or renewed on or after January 1, 2018 and exempted Medicaid managed care plans from the provisions of the bill. The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.