The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Rules

BILL:	SB 162
INTRODUCER:	Senators Steube and Mayfield
SUBJECT:	Payment of Health Care Claims
DATE:	January 31, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Favorable**
2.	Lloyd	Stovall	HP	**Favorable**
3.	Johnson	Phelps	RC	**Favorable**

I. Summary:

SB 162 prohibits health insurers and health maintenance organizations (HMOs) from retroactively denying a claim at any time if the insurer or HMO verified the eligibility of an insured or subscriber at the time of treatment and provided an authorization number. The provisions of the bill apply to policies or contracts issued or renewed on or after January 1, 2019. Medicaid managed care plans are exempt from the provisions of the bill. Currently, a health insurer or HMO may retroactively deny a claim because of an insured's ineligibility up to 1 year after the payment of the claim. Under existing law, the patient is responsible for those claims, which potentially exposes the physician to financial risk if the patient does not pay the claims.

The bill has an estimated negative fiscal impact of $166,347 on the fully-insured HMO plan in the State Group Insurance.

II. Present Situation:

Denial of Health Insurance 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 2013, the AMA estimated that more than $43 billion in savings could have been realized since 2010 if commercial insurers had consistently paid claims correctly.[1]

Coverage for medical services can be denied before or after the service has been provided, through denial of preauthorization requests, through denial of claims for payment, or a retroactive denial of payment. As a condition for coverage of some services, providers or insureds are required to request authorization prior to providing or receiving the service. The full

[1] Amednews.com, *Claims Analysis Shows Doctors the Way to Fight Insurer Denials* (July 15, 2013), http://www.amednews.com/article/20130715/business/130719992/5/ (last visited Jan. 17, 2018).

claim or certain lines of the claim may be denied, such as a surgery with charges for multiple procedures and supplies.

There are many possible reasons for claim denials. Claims may be denied due to an incorrect diagnosis code, incomplete claim submission, or the submission of a duplicate claim. Eligibility issues can cause claims to be denied. For example, a claim may be submitted for a service provided prior to an individual's effective date of coverage or after it has been terminated. Finally, claim denials can occur when a determination is made that the service provided was not covered or it was not medically necessary. Under state and federal laws, denied claims may be appealed.

After an insurer or HMO pays a claim, the insurer or HMO may conduct a claims audit to verify claims were paid appropriately and accurately. Such an audit can be triggered by a variety of reasons. Some of these situations include regulators establishing new billing guidelines; the provider making significant changes to the original bill, such as the diagnosis of the patient; the plan is notified that the enrollee's coverage is terminated due to non-payment of premiums; or the plan is notified that the enrollee has other health insurance coverage. After the audit, an insurer or HMO may retrospectively deny a claim for a preauthorized service and try to recoup the payment from the provider. Reasons for the retroactive denial may include fraud, submission of incomplete or inaccurate information; nonpayment of premiums; exhaustion of benefits; coordination of benefits; or if the individual was not enrolled or eligible for coverage at the time services were rendered. As a result, an insurer or HMO may try to recoup payment from a provider by retroactively denying a previously paid claim.

Group Health Plans Retroactive Termination of Coverage

Retroactive termination of insurance coverage to an earlier date due to an employee's discharge is an increasing problem for some providers and consumers. Some plans may allow an employer to cancel coverage of an employee retroactively more than 90 days post termination. Other plans will accept retroactive terminations for up to the preceding 3 months, if the plan has not paid any claims for the enrollee during that period. If claims have been paid within the previous 60 days, the coverage termination date may be established as of the end of the month in which services were rendered.

When a provider is notified of a retroactive termination, the provider may have already verified that the patient was covered, rendered services in reliance and expectation of payment, and even received payment. Retroactive terminations often result in the provider or the consumer bearing the loss, despite the verified eligibility.

Federal Subsidized Individual Policies or Contracts and Grace Periods

The federal Patient Protection and Affordable Care Act (PPACA)[2] guarantees access to coverage and mandates certain essential health benefits and other requirements. To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and moderate-income individuals to purchase qualified health plans (QHPs) on a state or federal

[2] 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.

exchange.[3] A QHP is a health plan that has been certified by the federal Health Insurance Marketplace, provides essential health benefits, follows established limits on cost sharing (such as deductibles, copayments, and out of pocket maximums), and meets other requirements of the PPACA known as "minimum essential coverage."[4] QHPs can be a health plan bought in the federal Health Insurance Marketplace, but it can also be an individual health plan purchased outside of the marketplace, an employer-based plan, a Medicare Part A or C plan, a Children's Health Insurance Plan (CHIP), and most student health plans.[5]

During the open enrollment period which ended January 31, 2018, 1,588,736 Floridians (or 90 percent of the state's total) who enrolled through the federal exchange received premium tax credits, cost sharing reductions or both.[6] The average premium rate during the 2017 Open Enrollment Period averaged $442 per member per month with advance premium tax credits and cost sharing reductions per person close to $360 per individual leaving a remaining premium responsibility to the enrollee of approximately $84 per month.[7]

Under PPACA, insurers and HMOs must provide a grace period[8] of at least three consecutive months[9] before cancelling the policy or contract of a federally subsidized enrollee who is delinquent if the enrollee previously paid one-month's premium. During the grace period, the insurer must pay all appropriate claims for services provided during the first month of the grace period. For the second and third months, an insurer may pend claims. Issuers must notify providers that may be affected that an enrollee has lapsed in his or her payment of premiums and there is a possibility the issuer may deny the payment of claims incurred during the second and third months.[10]

If the enrollee resolves all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third month would be denied. If coverage is terminated, the termination date is the last day of the first month of the grace period and the insurer may not recoup any payment for claims made during the first

[3] 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 2016: $11,770 (100 percent) up to $47,080 (400 percent) for one individual; $15,930 (100 percent) up to $63,720 (400 percent) for a family of two; and $24,250 (100 percent) up to $97,000 (400 percent) for a family of four. ASPE Research Brief, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace*, (Oct. 24, 2016), https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last viewed Jan. 17, 2018).

[4] U.S. Department of Health and Human Services, Healthcare.gov, *Qualified Health Plan*, https://www.healthcare.gov/glossary/qualified-health-plan/ (last visited Jan. 17, 2018).

[5] U.S. Department of Health and Human Services, Healthcare.gov, *Types of health insurance that count as coverage*, https://www.healthcare.gov/fees/plans-that-count-as-coverage/ (last visited Jan. 17, 2018).

[6] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *2017 Marketplace Open Enrollment Public Use Files – 2017 OEP State-Level Public Use File* (May 11, 2017), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html (last visited Jan. 17, 2018).

[7] Id.

[8] Example of grace period: Premium is not paid in May. Premium payments are made in June and July. 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 viewed Jan. 17, 2018).

[9] 45 C.F.R. s. 155.430.

[10] 45 C.F.R. s. 156.270.

month of the grace period. At the end of the grace period, the provider may seek payment for the medical services the insurer denied for months two and three. Providers note that it will be extremely difficult to obtain direct payment from patients receiving federal subsidies given their low or moderate income.[11] According to a 2014 survey, 48 percent of the providers not participating with any PPACA exchange products cited concerns about assuming financial liability during the grace period as a reason for their decision.[12]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[13] 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 the AHCA.[14]

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.[15] These provisions delineate 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.[16] The law provides a process and timeline for providers to pay, deny, or contest the claim. Further, the law prohibits 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.

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 remains at the duration required under Florida law,[17] which varies

[11] American Hospital Association, *et al*, Letter to Ms. Tavenner, Centers for Medicare and Medicaid Services (Aug. 15, 2013), https://www.aamc.org/download/352602/data/coalitionletteronnonpaymentofpremiums-noncoverageissue.pdf (last visited Jan. 17, 2018).
[12] Tracy Gnadinger, *Health Policy Brief: The Ninety-Day Grace Period*, (Oct. 16, 2014) http://healthaffairs.org/blog/2014/10/17/health-policy-brief-the-ninety-day-grace-period/ (last viewed Jan. 17, 2018).
[13] Section 20.121(3), F.S.
[14] Section 641.21(1), F.S.
[15] 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.
[16] Section 627.6131, F.S., and 641.3155, F.S., provide exceptions to this time limit in cases relating to fraud.
[17] Sections 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, s. 627.6645, F.S., requires that 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

by the duration of the premium payment interval. During the grace period, the policy or contract stays in force, thus the insurer or HMO must affirm that an individual is insured, even when the 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.

Division of State Group Insurance

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with section 125, Internal Revenue Code. To administer the state group health insurance program, DMS contracts with third party administrators for self-insured health plans and insured health maintenance organizations (HMOs), as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

Florida's Statewide Medicaid Managed Care Program

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the Agency for Health Care Administration (AHCA) oversees the Medicaid program. The Department of Children and Families (DCF) conducts Medicaid eligibility determinations.[18] The Statewide Medicaid Managed Care (SMMC) program[19] has two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. The 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 Florida 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. Florida Medicaid managed care plans are required to comply with s. 641.3155, F.S.,[20] which allows HMOs to deny a claim retroactively because of an insured or subscriber ineligibility up to one year after the date of payment of the claim. After paying claims pursuant with the deadlines in s. 641.3155, F.S., an HMO may audit claims to verify payment was appropriate and accurate. As a result, an HMO may try to recoup payment from a provider for claims paid in error. It may do this by reducing payments currently owed the provider, withholding future payments, or otherwise requiring a refund from the provider.

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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. See 45 C.F.R. s. 155.735 for provisions relating to the termination of Small Business Health Options Program (SHOP) enrollment or coverage obtained through an exchange.

[18]The Social Security Administration makes determination for recipients of Supplemental Security Income. See http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid (last viewed Jan. 17, 2018).

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

[20] Section 409.967(2)(j), F.S.

III. Effect of Proposed Changes:

Sections 1 and 2 of the bill amend ss. 627.6131 and 641.3155, F.S., respectively, to prohibit a health insurer or an HMO from retroactively denying a claim because of an insured's ineligibility at any time if the health insurer or HMO verified the eligibility of an insured at the time of treatment and provided an authorization for payment. The provisions of Sections 1 and 2 apply to policies or contracts issued or renewed on or after January 1, 2019. Section 2 provides that the provisions of the bill do not apply to Medicaid managed care plans.

Currently, ss. 627.608, F.S., and 641.31(15), F.S., require individual health insurance policies and all HMO contracts, excluding federally subsidized policies or contracts, to have a grace period of not less than 7 days and up to 31 days. If any required premium is not paid on or before the due date, it may be paid during the following grace period. During the grace period, the contract stays in force. If full payment of the premium is not received by the end of the grace period, coverage terminates as of the grace period start date, and the insurer or HMO will retroactively deny any claims incurred during the grace period. For a group policy, 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. [21]

The bill requires HMOs and insurers to pay claims incurred during the grace period and any other time for policies or contracts that were not eligible for the federal premium tax credit, if the provider verified the insured as eligible at the time of treatment and was provided an authorization number by the insurer or HMO. Currently ss. 627.6131, F.S., and 641.3155, F.S., limit the ability of a HMO or insurer to deny a claim retroactively because of insured ineligibility to one year after the date of payment of the claim.

Section 3 provides this act takes effect July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[21] Section 627.6645, F.S.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Eliminating the ability of a health insurer or HMO to recoup the payment of a claim for an authorized treatment for an individual previously deemed eligible will prevent unanticipated additional financial obligations to a patient and potential unexpected loss of revenues to a provider. This will simultaneously impose additional financial liability on a health insurer or HMO that provides authorization for an individual who is later deemed ineligible for coverage.

Federal regulations govern the grace period and payment of claims of individuals receiving federally subsidized products on the exchange. This bill would not apply to such claims.

The provisions of the bill would not apply to ERISA (Federal Employee Retirement Income Security Act of 1974)[22] self-insured plans. ERISA preempts the regulation of such plans by the state.

C. Government Sector Impact:

DMS/Division of State Group Insurance. According to DMS, Capital Health Plan, the only fully insured plan, would incur an estimated negative fiscal impact of $166,347 on an annual basis. The department's calculation was based on a fiscal impact of $0.23 per member. The bill would not affect the self-funded insurance plans.[23]

Florida's Medicaid Program. Medicaid managed care plans are exempt from the provisions of the bill.

Office of Insurance Regulation. None.[24]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Internally, an insurer may understand an authorization to be a pre-service approval for certain benefits or services, a voluntary pre-certification request, or a pre-admission certification. Not all

[22] 29 U.S.C. 1001 et seq. (1974).
[23] Department of Management Services, *Senate Bill 162 Analysis* (Nov. 13, 2017) (on file with the Senate Committee on Health Policy).
[24] Office of Insurance Regulation, *Senate Bill 162 Analysis* (Sep. 29, 2017) (on file with the Senate Committee on Health Policy).

benefits or procedures require prior authorization. A plan may offer a reference number for the call. An insured, member, or provider may consider this their authorization number.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6131, and 641.3155.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.