HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 217 Payment of Health Care Claims
SPONSOR(S): Health Innovation Subcommittee; Hager
TIED BILLS: **IDEN. /SIM. BILLS:** SB 162

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	10 Y, 2 N, As CS	Grabowski	Crosier
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Health insurers and health care providers often interact with one another prior to the delivery of care for insured patients. An initial interaction often consists of a contact from a provider to the insurer to verify that a patient has active insurance coverage. Once this verification is made, services are provided and claims generated.

If patients seek services for which they are not currently covered, there is no guarantee that a health insurer will pay for those services. For example, a patient may seek a service from a provider prior to that patient's effective date of coverage, after coverage has ended, or during a time in which the patient had not paid the applicable premium, later resulting in termination of coverage. If an insurer later determines that a patient was not eligible for coverage at the time of service delivery, a medical claim may be denied. When a claim is denied at a later date, it is commonly referred to as a retroactive denial.

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

CS/HB 217 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 patient at the time of treatment and provided an authorization number.

The bill has a significant negative fiscal impact on the fully-insured HMO plan in the State Group Insurance Plan. The bill would also have an indeterminate negative fiscal impact on local government.

The bill applies to insurance policies entered into or renewed on or after January 1, 2019.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[1] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of Ch. 641, F.S. to individuals enrolled in the Medicaid program. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[2]

Health Insurance Contracts

All health insurance policies issued in the state of Florida, with the exception of certain self-insured policies[3], must meet certain requirements that are detailed throughout the Florida Insurance Code. Chapter 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for insurance policies issued by HMOs. At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[4]

Responsibilities of insured patients are also reflected in insurance contracts. Contracts set premium payment schedules and require that payments must be made in a timely fashion. In cases where this requirement is not met, a health insurer or HMO may cancel coverage for nonpayment of premiums.[5]

Before cancellation can occur, however, covered patients are protected by grace periods that extend the time frame in which premium payments may be submitted. A grace period is a period of time following the due date of a premium payment in which the insurance policy remains in force, even if the premium payment has not been made. The grace periods for policies or contracts issued in Florida are set in the Insurance Code,[6] and vary based on the premium payment schedule.

Pursuant to ss. 627.608 and 641.31, F.S., insurance policies and health maintenance contracts stay in force during grace periods. 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 deny any medical claims incurred during the grace period. When a claim is denied at a later date, it is referred to as a retroactive denial.

The Insurance Code is silent on whether the insurer or HMO may advise a health care provider that a patient has not paid the applicable premium, and that the policy or health maintenance contract may be terminated in the future, possibly resulting in a retroactive claim denial.

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[1] S. 20.121(3), F.S.
[2] S. 641.21(1), F.S.
[3] The Employee Retirement Security Act of 1974 (ERISA). 29 U.S.C. ch. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.
[4] S. 627.413(1)(d), F.S.
[5] SS. 627.6043(1) and 641.3108 (2), F.S.
[6] 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.

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.[7] These provisions detail the rights and responsibilities of insurers, HMOs, and providers for the payment of medical claims. The statutes provide a process and timeline for providers to pay, deny, or contest the claim, and 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.[8]

Federal Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (PPACA) introduced a set of claims-related requirements for insurers offering plans through the federally-facilitated and state-based insurance exchanges. The Act guarantees access to coverage and mandates certain essential health benefits, among other directives.[9] 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 on a state or federal exchange.[10] In Florida, 1,588,628 individuals enrolled through the federal exchange received a premium tax credit for plan year 2016.[11]

Individual health insurance plans purchased via the exchanges with a federal premium tax credit are not subject to the grace periods in Florida law. Instead, PPACA requires insurers and HMOs to 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.[12] 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 pend claims and then must notify affected providers 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.[13]

[7] 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.
[8] SS. 627.6131(11) and 641.3155(10), F.S
[9] 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.
[10] 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 November 13, 2017).
[11] 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 November 13, 2017).
[12] 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 November 13, 2017); 45 C.F.R. s. 155.430.
[13] 45 C.F.R. s. 156.270

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) and the federal Social Security Administration make determinations regarding Medicaid eligibility.[14]

The Statewide Medicaid Managed Care (SMMC) program consists of the Managed Medical Assistance (MMA) program and the Long-Term Care (LTC) program.[15] 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.,[16] 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 Statewide Medicaid Managed Care (SMMC) contract, require providers to verify each recipient's eligibility each time they provide a service.[17] Although an enrollee may have eligibility on file at the time a service was authorized, the enrollee may have subsequently become ineligible.

Section 1903(d)(2)(C) of the Social Security Act gives states up to one year to recover any overpayments made through the Medicaid program. 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. 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.

Effect of Proposed Changes

HB 217 amends ss. 627.6131 and 641.3155, F.S., the prompt payment laws, to prohibit a health insurer or HMO from retroactively denying a claim at any time based on a patient's eligibility for coverage, for services provided during a patient's premium payment grace period, if the eligibility was confirmed at the time of treatment. This prohibition applies to plans providing individual and group health insurance policies, but does not apply to federally-subsidized plans purchased on the federal health exchange. Medicaid managed care plans are also exempt from the new prohibition.

The bill provides certainty of payment for insureds and providers who have received authorization numbers from insurers and HMOs. If an authorization number is granted and a service provided, but the insurer or HMO later determines that a patient was not eligible, the insurer or HMO must cover the claim. The bill prevents insurers and HMOs from issuing retroactive denials or recouping payments for services provided when a patient's eligibility is rescinded during a later claims audit.

[14] Department of Children and Families, *Medicaid*, available at: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid (last accessed November 14, 2017).
[15] Part IV of ch. 409, F.S.
[16] S. 409.967(2)(j), F.S.
[17] Agency for Health Care Administration. "SMMC Plans – Model Contract". Available at http://www.fdhc.state.fl.us/medicaid/statewide_mc/plans.shtml (last accessed January 28, 2018).

The prohibition on retroactive denial applies to insurance policies and HMO contracts entered into or renewed on or after January 1, 2019.

The bill has an effective date of July 1, 2018.

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, 2018.

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 plan. SGHI estimates the impact will equate to a $0.23 increase per member, per month (PMPM) for the Capital Health Plan (CHP) HMO.[18] This PMPM impact translates to annual costs of $166,347 incurred by CHP.[19] This financial impact may be passed along to the state by way of premium rate adjustment.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   The bill would have an indeterminate negative fiscal impact on local governments. To the extent that the prohibition on retroactive denials increases costs to insurers and HMOs, those costs may be passed on to entities that contract with insurers and HMOs for employee health insurance, including local governments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill would have an indeterminate negative fiscal impact on health insurers and HMOs. The bill creates a financial liability for a health insurer or HMO that provides authorization for services to an individual who is later deemed ineligible for coverage. In such cases, the insurer or HMO will have no mechanism to recoup any payments made to providers.

D. FISCAL COMMENTS:

None.

[18] Department of Management Services. *Agency Bill Analysis for HB 217*. December 14, 2017. On file with staff of the Health Innovation Subcommittee.
[19] E-mail correspondence from Tami Fillyaw, Director of DMS State Group Insurance Program. January 28, 2018.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 30, 2018, the Health Innovation Subcommittee adopted a strike-all amendment that limited the restriction on retroactive claims denials. The amendment prohibits a health insurer or HMO from retroactively denying a claim at any time based on a patient's eligibility for coverage, for services provided during a patient's premium payment grace period, if the eligibility was confirmed at the time of treatment. This prohibition would apply to policies entered into or renewed on or after January 1, 2019, and does not apply to Medicaid managed care plans.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.