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 102

INTRODUCER: Senator Steube

SUBJECT: Payment of Health Care Claims

DATE: April 18, 2017 REVISED:

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

I. Summary:

SB 102 prohibits health insurers and health maintenance organizations (HMOs) from retroactively denying a claim, if at any time, the insurer or HMO verified the eligibility of an insured or subscriber at the time of treatment and provided an authorization number. 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.

II. Present Situation:

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

[1] Amednews.com, *Claims Analysis Shows Doctors the Way to Fight Insurer Denials* (July 15, 2013) (on file with the Senate Committee on Banking and Insurance).

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 new billing guidelines have been established by regulators; the provider has made 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.

Individuals' Exchange Plans and Premium Tax Credits

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] In Florida, 1,588,628 individuals (or 91 percent of the total individuals) enrolled through the federal exchange received premium tax credits for plan year 2016.[4]

Under PPACA, insurers and HMOs must provide a grace period[5] of at least three consecutive months[6] before cancelling the policy or contract of a federally subsidized enrollee who is delinquent if the enrollee previously paid 1-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.[7]

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 month of the grace period. At the end of 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.[8] 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.[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

[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 2015:
$11,880 (100%) up to $46,680 (400%) for one individual; $16,020 (100%) up to $62,920 (400%) for a family of two; and $20,160 (100%) up to $95,400 (400%) for a family of four. ASPE Research Brief, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace,* (Oct. 24, 2016) available at https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last viewed Mar. 9, 2017).

[4] 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/pdf-report/marketplace-premiums-after-shopping-switching-and-premium-tax-credits-2015-2016 (last viewed Mar. 9, 2017).

[5] 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 Mar. 9, 2017).

[6] 45 C.F.R. s. 155.430.

[7] 45 C.F.R. s. 156.270.

[8] American Hospital Association, *et al*, Letter to Ms. Tavenner, Centers for Medicare and Medicaid Services (Aug. 15, 2013) (on file with the Senate Committee on Banking and Insurance).

[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 viewed Mar. 9, 2017).

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

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 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.[13] 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 remain at the length required under Florida law,[14] which varies by the duration of the premium payment interval. During the grace period, the policy or contract stays in force. The policy is in force during the grace period, 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

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

[14] 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, 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.]. *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.

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.[15] The Statewide Medicaid Managed Care (SMMC) program[16] 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.,[17] 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.

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 paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. Section 409.907, F.S., prohibits the AHCA from demanding repayment from a provider in any instance in which the Medicaid overpayment is attributable to error of the DCF in the determination of eligibility of a recipient, which is an insignificant number.[18]

The Insurance Codes does not define the term "eligibility." In the context of the Medicaid program, the term "eligibility" may refer to the recipient's financial eligibility for the Medicaid program (income and general requirements, such as a resident of the state) or clinical eligibility

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[15] See http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid. The Social Security Administration makes determination for recipients of Supplemental Security Income. (last viewed Feb. 17, 2017).

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

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

[18] The Department of Children and Families conducts random sample quality control reviews on all programs for which they determine eligibility. The DCF provided data for calendar year 2016. For the Family Medicaid program, 24,278 reviews conducted; three errors were found for retroactive Medicaid approved but not applied for; and 132 errors were found for retroactive Medicaid requested but not approved when it should have been. For the Medically Needy program, 9,621 reviews were conducted; four errors were found for retroactive Medicaid approved but not applied for and 19 errors were found for retroactive Medicaid requested but not approved when it should have been. Email from the Department of Children and Families (Feb. 20, 2017) (on file with Senate Banking and Insurance Committee).

(e.g., whether the service is medically necessary). An individual can be deemed ineligible retroactively if the individual provided inaccurate or incomplete information during the application or renewal process, failed to report a change, or DCF made an error when determining eligibility.[19]

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 render a service. A managed care plan may issue prior authorization for services, ranging from a single event to months of service. When a prior authorization is tied to multiple dates of service, the provider must be responsible for re-verifying the recipient's eligibility at the time each service is delivered, as the managed care plan is not involved in, and will not know, the individualized schedule for delivery of the service. Furthermore, when an authorization spans multiple dates of service, an enrollee's eligibility for service may change from one month to the next. An authorization may be granted on a date when eligibility is confirmed, but the enrollee may become ineligible in a subsequent month. Although an enrollee may have eligibility on file at the time the service was authorized, the enrollee may have become ineligible on the date of service for additional reasons (e.g., enrollee has become deceased or moved to a setting in which Medicaid payment is prohibited).

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 adjustment in the Federal payment shall be made at the end of the one year period, whether or not recovery was made."

Federal regulation[20] implementing this requirement distinguishes between discovery of an overpayment attributable to fraud or abuse as compared with other overpayment situations. While in most situations, discovery of an overpayment is deemed to occur when any state official first notifies a provider in writing of an overpayment and specifies an overpayment amount, the regulations[21] provide that [a]n overpayment that results from fraud is discovered on the date of the final written notice of the state's overpayment determination that a Medicaid agency official or other state official sends to the provider. Florida Medicaid managed care plans are contractually required to comply with both of the above provisions. Because of recoupment of overpayments, states are required to return the federal matching portion on recoveries made by the state or the health plan.

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

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[19] Memorandum from Department of Children and Families (Jananuary 25, 2017) (on file with the Senate Committee on Banking and Insurance). Examples of changes affecting eligibility include pregnancy, birth of child, receipt of new or increased earnings, termination of employment, changes in living arrangement, and address.
[20] 42 C.F.R. s. 433.316.
[21] 42 C.F.R. s. 433.304 and 42 C.F.R. s. 433.316(d).

at any time if the health insurer or HMO had previously verified the eligibility of an insured at the time of treatment and provided an authorization for payment.

Sections 627.608, F.S., and 641.31(15), F.S., require individual health insurance policies and all health maintenance contracts, excluding federally subsidized plans, 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. [22]

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. The bill would require 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.

Section 3 provides this act takes effect July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[22] Section 627.6645, F.S.

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.

C. Government Sector Impact:

Division of State Group Insurance. According to DMS, the two fully insured plans (Capital Health Plan and Florida Health Care Plans), would be impacted by the bill. The initial estimated impact ranges from seven cents (+.07) per member, per month, to a yearly impact of up to $1.4 million. The financial impact of the bill may be shifted to the state by way of a rate adjustment to offset associated losses.[23]

Florida's Medicaid Program. According to the AHCA, the bill would prevent Florida Medicaid managed care plans from recouping overpayments from their providers if they had previously verified eligibility and provided an authorization number. The State of Florida is responsible for submitting to the federal government the federal share of any overpayments recovered by the state or a health plan. To ensure Florida Medicaid managed care plans can continue to seek return of payment from a provider because of audit findings and meet the state's obligation to return federal matching funds, the bill may require clarification of the Florida Medicaid managed care plans' ability to recoup overpayments in the case of inappropriate payments.[24]

This bill would result in an indeterminate fiscal impact to Florida Medicaid. Florida Medicaid payments to managed care plans could potentially increase due to managed care plans not being able to demand or recoup overpayments from their providers for retroactive denials.[25]

VI. Technical Deficiencies:

None.

[23] Department of Management Services, *Senate Bill 102 Fiscal Analysis* (Dec. 28, 2016) (on file with the Senate Committee on Banking and Insurance).
[24] Agency for Health Care Administration, *Senate Bill 102 Fiscal Analysis* (Dec. 9, 2016) (on file with the Senate Committee on Banking and Insurance).
[25] *Id.*

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 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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.