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DATE: April 16, 1998

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE STANDARDS AND REGULATORY REFORM
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/HB 1843

RELATING TO: Medicaid/HMOs/Claims

SPONSOR(S): Committee on Health Care Standards and Regulatory Reform, Representative Effman and Representative Brooks

COMPANION BILL(S): CS/SB 1584(s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE STANDARDS AND REGULATORY REFORM YEAS 8 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

CS/HB 1843 requires a health maintenance organization (HMO) to reimburse all claims or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO. If the claim or a portion of a claim is contested by the HMO, the HMO is required to formally notify the contract provider within 35 days after receipt of the claim by the HMO. Such notification must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Upon receipt of the additional information requested from the contract provider, the HMO must pay or deny the contested claim or portion of the contested claim within 45 days after receipt of the information.

An insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

The bill creates section 641.3155, F.S.

There is no fiscal impact on state and local government, or the private sector in general.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

Section 627.662, F.S., requires group health insurers to reimburse all claims or any portion of any claim from the insured or insured's assignees, for payment under a group health insurance policy, within 45 days after receipt of the claim by the health insurer. If the claim or a portion of the claim is contested by the health insurer, the insured or the insured's assignees must be notified within 45 days after receipt of the claim by the health insurer. Upon receipt of the additional information requested from the insured or the insured's assignees must pay or deny the contested claim or portion of the contested claim within 60 days. An insurer must pay or deny any claim no later than 120 days after receiving the claim.

Presently, s. 641.3903(5)(c), F.S., provides that it is an unfair or deceptive act for an HMO to fail to affirm or deny coverage of claims upon written request of the subscriber within a reasonable time not to exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the HMO. The Department of Insurance, under the provisions of Rule 4-191.066, F.A.C., requires an HMO to pay within 30 days after receipt of all valid (clean) claims from subscribers or providers, except as provided below:

> Each HMO is required to pay all valid and undisputed (clean) claims within 30 days of receipt by the HMO of the claim from the provider, except as otherwise authorized by Medicare and Medicaid regulations. If additional information is needed, the HMO is required to request the additional information in writing within 30 days of receipt of the claim and must maintain that request in the claim file. If additional information is requested, the HMO must affirm and pay any valid claim within 30 days of receipt of the additional information.
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> Each HMO must pay all valid (clean) claims for emergency services within 30 days from receipt of the claim unless additional information is requested to evaluate the claim. Each HMO must affirm and pay any valid claim within 30 days of receipt of the additional information, or deny coverage of the claim within the same 30-day period. If the claim is denied, the HMO must provide written justification for the denial to both the subscriber, including the right to appeal, and to any provider involved.

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and counties. The federal government, through laws and regulations, has established extensive requirements for the Medicaid Program.

The federal Balanced Budget Act of 1997 revised the payment provisions under 42 U.S.C.s.1396a, entitled Social Security - Grants to States for Medical Assistance Programs, to require a Medicaid HMO receiving payments under a state medical assistance program to provide for claims payment procedures which 1) ensure that 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through

shared health facilities are paid within 30 days of the date of such receipt of such claims and that 99 percent of such claims are paid within 90 days of the date of the receipt of such claims; and 2) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.

The Agency for Health Care Administration is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss.409.901 through 409.920, F.S. Pursuant to s. 409.907, F.S., the agency contracts with each provider through a voluntary agreement in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program. The agency is authorized to adopt, and include in the provider agreement, other requirements and stipulations on either party as the agency finds necessary to properly and efficiently administer the Medicaid program.

The current Medicaid HMO contract requires that a contractor provider's claim (if properly documented) must be paid within 35 calendar days of receipt. The contract authorizes AHCA to impose the following sanctions against a Medicaid HMO if it determines that the HMO has violated any provision of the contract: (1) suspension of the plan's acceptance of applications for Medicaid enrollment; (2) suspension or revocation of payments to the plan for Medicaid recipients enrolled during the sanction period; (3) suspension of all marketing activities to Medicaid recipients; (4) imposition of fines, up to $2,500 per violation (not to exceed an aggregate amount of $10,000); (5) termination of the contract; or (6) nonrenewal of the contract.

In response to concerns regarding the timeliness of processing and payment of claims, AHCA recently audited claims provided by some hospital contract providers. As a result of the audit, AHCA determined that many hospital claims were denied as a result of a hospital not obtaining authorization, the patient being ineligible, and other reasons.

Currently, the 1997-98 Medicaid Prepaid Health Plan Contract, Attachment I.D.14, requires Medicaid HMOs to pay claims to providers of goods and services within 35 days. The HMO may agree to the payment of all claims, deny the claim, or make a request for additional information within 35 days from the receipt of the claim by the HMO. The HMO actively agrees to these conditions at the point they sign a contract with the Agency for Health Care Administration (agency) for the provision of Medicaid services on a capitated basis.

In August of 1997, agency staff met with Representative Effman, Senator Campbell (sponsor of the similar Senate Bill), and approximately 90 representatives of the hospital industry concerning prompt payment issues. During the meeting, it became clear that hospitals were frustrated with HMOs across all lines of business (commercial, Medicare, and Medicaid). As a follow-up to the August meeting, the agency met with HMO representatives in an attempt to understand their perspective regarding prompt payment issues. The HMO representatives identified "upcoding" of procedure codes, billing for non-emergency services, and "unbundling" of services as their primary prompt payment problems.

In November of 1997, the agency and the Department of Insurance (DOI) created a prompt payment task force for all interested stakeholders to explore the problems

associated with the prompt payment issues. Subsequent meetings have been held, during which the task force identified five major problems: authorization of services related to emergency rooms, access to emergency room services, medical records documentation, timeliness of payment, and balanced billing by providers.

Recently, the task force has begun to identify best practices in the five areas listed above. It is their hope that these best practices may be used to form the basis of a three-industry agreement. At a March, 1998 meeting, the three industries decided that they wanted industry-specific issues to be addressed by each industry. The agency is compiling the issues, which will be sent to each industry for comment. The answers returned will form the basis of the three-industry agreement.

The agency continues to monitor the Medicaid HMO contractors for compliance with the agency requirement that all claims be paid within 35 days of submission.

B. EFFECT OF PROPOSED CHANGES:

Section 641.3155, F.S., is created, relating to provider contracts and payment of claims, to require a health maintenance organization (HMO) to reimburse all claims or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO. If the claim or a portion of a claim is contested by the HMO, the HMO is required to formally notify the contract provider within 35 days after receipt of the claim by the HMO. Such notification must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Upon receipt of the additional information requested from the contract provider, the HMO must pay or deny the contested claim or portion of the contested claim within 45 days after receipt of the information.

An insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. <u>Lower Taxes:</u>

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Yes.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Section 409.912, F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1. Creates s. 541.3155, F.S., relating to provider contracts and payment of claims, to require a health maintenance organization (HMO) to reimburse all claims or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO. If the claim or a portion of a claim is contested by the HMO, the HMO is required to formally notify the contract provider within 35 days after receipt of the claim by the HMO. Such notification must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Upon receipt of the additional information

requested from the contract provider, the HMO must pay or deny the contested claim or portion of the contested claim within 45 days after receipt of the information.

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Section 2. Provides for an effective date of October 1 of the year in which enacted.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

It is anticipated that there would be a fiscal impact on the HMOs.

2. Direct Private Sector Benefits:

None.

3. Effects on Competition, Private Enterprise and Employment Markets:

None.

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

The 10 percent interest penalty, coupled with the statutorily required 35-day turnaround (or 120 days total resolution time) for the payment or denial of a contract provider's claim may force an HMO to resolve the payment or denial of a claim in a timely manner. Also, if an HMO violates the provisions of the statute, the Department of Insurance may determine that the HMO is not operating in compliance with part I of chapter 641, F.S., and impose such administrative penalties authorized by ss. 641.23 and 641.25, F.S., which authorizes fines of up to $2,500 for each nonwillful violation and up to $20,000 for each willful violation.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The differences between the original bill and the Committee Substitute are as follows:

-HMO's are required to reimburse all claims or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO;

-If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Upon receipt of the additional information requested from the contract provider, the HMO must pay or deny the contested claim or portion of the contested claim within 45 days after receipt of the information;

-An insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered; and

-Overdue payment of a claim bears simple interest at the rate of 10 percent annually.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE STANDARDS AND REGULATORY REFORM:

Prepared by:	Legislative Research Director:
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