HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 1335 Payment of Health Insurance Claims
SPONSOR(S): Health & Human Services Committee, Healthcare Regulation Subcommittee, Rudman
TIED BILLS: **IDEN./SIM. BILLS:** SB 1160

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	15 Y, 0 N, As CS	Poche	McElroy
2) Health & Human Services Committee	19 Y, 0 N, As CS	Poche	Calamas

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 provider contact to the insurer to verify that a patient has active insurance coverage. Once this verification is made, services are provided and a claim is generated.

If patients seek services when 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, the resulting 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/CS/HB 1335 amends ss. 627.6131 and 641.3155, F.S., 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 rendered during an applicable grace period if the insurer or HMO verified the patient's eligibility and provided an authorization number. The bill establishes one exception – a health insurer or HMO may retroactively deny a claim within one year of payment if the provider was convicted of insurance fraud under s. 817.24, F.S. The 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. The bill requires information regarding the patient's grace period status to be readily available at the time that authorization is given to the provider.

The bill also permits an insurer or HMO to recoup payment of an improperly adjudicated claim if the provider was given accurate information regarding the patient's grace period status at the time of authorization. To perfect the recoupment, the insurer or HMO must request the return payment within 30 days of the expiration of the patient's grace period.

The bill does not have a fiscal impact on state or local government.

The bill applies to insurance policies entered into or renewed on or after January 1, 2024.

The bill provides an effective date of July 1, 2023.

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 contracts issued by HMOs. At a minimum, insurance policies and contracts 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 policies contracts. Contracts and policies 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 premium.[5]

Premium Non-Payment and Grace Periods

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.[7] For example, if the premium is paid monthly, the grace period is 10 days.

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.

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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.
[7] 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 an 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.

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.

Florida Prompt Payment Laws

Florida 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.[8] 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.[9]

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.[10] 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.[11]

Premium Non-Payment and Grace Periods

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 one 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. The insurer must then must notify affected providers that an enrollee has lapsed in payment of premiums and there is a possibility the insurer may deny the payment of claims incurred during the second and third months.[13]

The federal regulation governing grace periods for nonpayment of premium for federally subsidized policies or contracts does not affect policies or contracts of individuals who are not enrolled in an exchange qualified health plan (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.

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[8] 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.

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

[10] 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.

[11] 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 2023:
$14,580 (100%) up to $58,320 (400%) for one individual; $19,720 (100%) up to $78,880 (400%) for a family of two; and $30,000 (100%) up to $120,000 (400%) for a family of four. The American Rescue Plan Act of 2021 and the Inflation Reduction Act of 2022 impact these premium tax credits through 2026. U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, Poverty Guidelines, available at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (last viewed on March 21, 2023).

[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 viewed on March 21, 2023); 45 C.F.R. s. 155.430.

[13] 45 C.F.R. s. 156.270.

Florida 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.

State Medicaid regulations and contracts 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.

False and Fraudulent Insurance Claims

Health care fraud often causes tens of billions of dollars in losses each year. Fraud can also lead to increased health insurance premiums. Health care fraud can be committed by medical providers, patients, and others who intentionally deceive the health care system to receive unlawful benefits or payments. Common types of health care fraud committed by providers include:

- Double billing – submitting multiple claims for the service
- Phantom billing – billing for a service or supplies that the patient never received.
- Unbundling – submitting multiple bills for the same service.
- Upcoding – billing for a more expensive service than the patient actually received.

Florida law has a robust insurance fraud statute in s. 817.234, F.S. Under that section, a person commits insurance fraud if he or she, with the intent to injure, defraud, or deceive any insurer:

- Makes or causes any written or oral statement as part of, or in support of, a claim for payment or other benefit under an insurance policy or an HMO contract, knowing that such

[14] Department of Children and Families, Medicaid Redetermination, available at https://www.mflfamilies.com/Medicaid (last viewed on March 21, 2023).
[15] Part IV of ch. 409, F.S.
[16] S. 409.967(2)(j), F.S.
[17] Agency for Health Care Administration, 2018-2023 Health and Dental Plan Model Contracts, available at https://ahca.myflorida.com/medicaid/plans_FY18-23.shtml (last viewed on March 21, 2023)(AHCA is currently procuring all SMMC plans; some of the links for SMMC information from 2018-2023 have been disabled while the procurement is ongoing).

statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;
- Makes any written or oral statement that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit under an insurance policy or an HMO contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;
- Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a health maintenance organization subscriber or provider contract;
- Knowingly conceals information concerning any fact material to such application; or
- Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer a claim for payment or other benefit under a personal injury protection insurance policy if the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400.

Current law defines what constitutes insurance fraud in the health care industry – any licensed physician, osteopathic physician, chiropractic physician, or other practitioner who knowingly and willfully assists, conspires with, or urges any insured party to fraudulently violate any of the insurance fraud provisions under s. 817.234, F.S., or part XI of chapter 627 , or any person who, due to such assistance, conspiracy, or urging by said physician, osteopathic physician, chiropractic physician, or practitioner, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud. The same punishments apply to these instances of insurance fraud.

In the event that a physician, osteopathic physician, chiropractic physician, or practitioner is adjudicated guilty of a violation of this section, the Board of Medicine, the Board of Osteopathic Medicine, the Board of Chiropractic Medicine, or other appropriate licensing authority must hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against said physician, osteopathic physician, chiropractic physician, or practitioner.

If the value of any property involved in the insurance fraud under s. 817.234, F.S.,

- Is less than $20,000, the offender commits a third-degree felony , punishable by a term of imprisonment not exceeding 5 years and a fine up to $5,000.
- Is $20,000 or more, but less than $100,000, the offender commits a second-degree felony , punishable by a term of imprisonment not exceeding 15 years and a fine up to $10,000.
- Is $100,000 or more, the offender commits a first-degree felony , punishable by a term of imprisonment not exceeding 30 years and a fine up to $10,000.

In addition, if the offending person is found to be a habitual felony offender, the court may sentence him or her as follows:

- In the case of a life felony or a first-degree felony, for life.
- In the case of a second-degree felony, for a term not exceeding 30 years.
- In the case of a third-degree felony, for a term not exceeding 10 years.

Effect of Proposed Changes

CS/CS/HB 1335 amends ss. 627.6131 and 641.3155, F.S., both 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 rendered during an applicable grace period if the insurer or HMO verified the patient's eligibility and provided an authorization number. The bill provides one exception to the prohibition on retroactive denial – a health insurer or HMO may retroactively deny a claim within one

year of payment if the provider seeking payment was convicted of insurance fraud under s. 817.234, F.S.

The 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. The bill requires information regarding the patient's grace period status to be readily available at the time that authorization is given to the provider.

The bill permits an insurer or HMO to recoup payment of an improperly adjudicated claim if the provider was given accurate information regarding the patient's grace period status at the time of authorization. To perfect the recoupment, the insurer or HMO must request the return payment within 30 days of the expiration of the patient's grace period.

The bill may result in fewer instances of payments claw backed by insurers and HMOs related to services provided during a grace period, reducing administrative costs incurred by insurers, HMOs, and providers associated with receiving, researching, and challenging such requests for returned payments. Also, the bill provides a mechanism for insurers and HMOs to recoup payments on improperly adjudicated claims, if the insurer or HMO provide accurate information on the patient's status and makes the request for recoupment within a time certain. This provision allows insurers and HMOs to be paid back for truly mistaken claim payments surrounding services rendered during a patient's grace period.

The prohibition on retroactive denial applies to insurance policies and HMO contracts entered into or renewed on or after January 1, 2024. The bill also exempts Medicaid managed care plans from prohibition on retroactive denial of claims.

The bill has an effective date of July 1, 2023.

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, 2023.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill provides a mechanism for health insurers and HMOs to recoup payment for an improperly adjudicated claim if the provider was given accurate information regarding the patient's grace period status and the recoupment request is made within 30 days of the end of the patient's grace period.

D. FISCAL COMMENTS:

None.

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 any 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:

The bill establishes an exception to the blanket ban on retroactively denying a claim based on insured eligibility – a retroactive claim denial may be issued within 1 year of the date of payment of the claim if the provider was convicted of insurance fraud under s. 817.234, F.S. As drafted, the exception is unclear regarding when the conviction must occur or whether the conviction is related in any way to the previously paid claim. As drafted, if a provider was or is convicted of insurance fraud at any point in his or her career, the insurer could use that information to take advantage of a 1-year statute of limitations from date of payment to retroactively deny a claim.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 28, 2023, the Healthcare Regulation Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment exempted Medicaid managed care plans under chapter 409, F.S., from the prohibition on retroactive denials of claims established in the bill.

On April 17, 2023, the Health and Human Services Committee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- Prohibited retroactive denial of a claim by a health insurer or HMO for services rendered during a grace period if the insurer or HMO verified the patient's coverage eligibility and provided an authorization number.

- Required information regarding whether the patient is in a grace period to be readily available at the time authorization is provided.
- Permitted a health insurer or HMO to recoup payment for an improperly adjudicated claim if the provider was given accurate information regarding the insured's grace period and the recoupment request is made within 30 days of the end of the grace period.

The bill was reported favorably as amended. The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.