HCS HB 1498 -- PAYMENT OF HEALTH INSURANCE CLAIMS

SPONSOR: Cooper (Jones, 89)

COMMITTEE ACTION: Voted "do pass" by the Committee on Health Care Policy by a vote of 10 to 0.

This substitute changes the laws regarding the requirements for the payment of health insurance claims. In its main provisions, the substitute:

(1) Requires health insurance carriers, including third-party contractors, to send an electronic acknowledgment of the date of receipt within 48 hours after an electronically filed health care claim is received;

(2) Increases the length of time, from within 10 working days to within 30 processing days, that a health insurance carrier or a third-party contractor has to send an electronic or facsimile notice of the status of a health care claim that notifies the claimant whether the filed claim has any reason which will prevent timely payment or if more information is required. If the claim is properly filed, the carrier must pay or deny the claim;

(3) Requires a health carrier to notify the health care provider, electronically or by fax, within 10 processing days, instead of the current 15 days, upon receiving the requested additional information from the health care provider to pay the claim or make a final request for additional information. If the health care provider submits the additional information, the health carrier must pay or deny the claim within five processing days, instead of the current 15 days, of receiving the additional information;

(4) Adds a penalty equal to 1% of the total claim amount per day on unpaid claims if a carrier has not paid a claimant within 45 processing days of receiving the claim;

(5) Increases the amount at which a carrier can combine interest and payments on unpaid claims from $5 to $100. Claims that were properly denied prior to the forty-fifth processing day will not be subject to interest or penalties;

(6) Repeals the current penalty imposed on carriers that do not take required action within the 40 processing days;

(7) Specifies that a claim for which a carrier has not communicated a specific reason for the denial of payment cannot be considered denied; and

(8) Changes the requirements a carrier must follow when requesting and acknowledging receipt of additional information that is necessary to process all of a claim.

The substitute becomes effective January 1, 2011.

FISCAL NOTE: Estimated Income on General Revenue Fund of Unknown less than $30,579 in FY 2011, Unknown less than $36,710 in FY 2012, and Unknown less than $36,710 in FY 2013. No impact on Other State Funds in FY 2011, FY 2012, and FY 2013.

PROPONENTS: Supporters say that the bill removes a loop hole that allows health insurance claims to be suspended for a period of time before a decision is made by the health carrier to pay or deny the claim. The bill requires a claim to be paid or denied and removes the ability to suspend it. Payment must be made promptly to the health care provider or the provider is notified why the claim cannot be paid. Currently, the lack of prompt payment is a problem which ultimately ends up costing consumers more money. Practitioners are spending too much money to ensure payment, and those costs ultimately are passed on to the consumer. Providers' administrative costs have increased due to the necessity to have staff follow up with insurers for payment. These costs are passed on to consumers through insurance premium rates. Providers on average wait three times as long for payment as compared to other businesses. The bill has penalties to encourage insurers to pay on time. Medicare pays claims within 21 days on average; however, current law allows a carrier to indefinitely suspend a claim unlike states that have a prompt pay act. Currently, only two-thirds of claims are processed by carriers within 60 days. The healthcare system works on a "serve now, pay later" basis. Government claims are paid faster than claims from insurers. Prompt pay laws need to be revised so that patients are protected from rising costs. Government intervention is necessary to make changes that cannot be handled through mediation between providers and insurers. The patient-responsible portion of a claim is the last to be billed and the last to be paid. It is also the least likely to be paid. A patient needs to know his or her responsible portion in a timely fashion. By delaying the decision on a claim, the entire billing process is delayed placing the provider at greater financial risk.

Testifying for the bill were Representative Jones (89); Karen Pickett; John Marshall; Andrew Schwartzkopf; Nancy Glass; Jeanne Blumm; Leesa Apfelbaum; St. Luke Health System; Kaye Jarrell; Missouri Ambulance Association; Missouri Academy of Family Physicians; Missouri Association of Osteopathic Physicians and Surgeons; Missouri State Medical Association; Missouri Nurses Association; Missouri Ambulatory Surgery Center Association;

Washington University; Missouri Dental Association; Missouri ER Physicians; BJC Health Care System; Missouri Hospital Association; and Department of Insurance, Financial Institutions and Professional Registration.

OPPONENTS: Those who oppose the bill say that health carriers are given incentives to pay bills for product pricing and medical management through claims processing. However, because there is no definition of a clean claim, a claim will go to suspended status. Having a clean claim definition forgoes the need for a suspended status. The Department of Insurance, Financial Institutions and Professional Registration made three recommendations, and the bill addresses these recommendations. However, the recommendations do not include a change to the penalties. Insurers are subject to market conduct standards. Paying claims is extremely complex, and insurers have to be stewards of the consumers premium rates.

Testifying against the bill were America's Health Insurance Plans; Missouri Insurance Coalition; Coventry Health Care; Blue Cross Blue Shield of Kansas City; and Anthem Blue Cross Blue Shield of Missouri.