HB 1063

Department of Legislative Services

Maryland General Assembly
2011 Session

FISCAL AND POLICY NOTE

House Bill 1063 (Delegate Donoghue)
Health and Government Operations

Health Insurance - Health Care Providers - Payment of Claims for Reimbursement by Carriers

This bill requires all carriers that issue or deliver health insurance in the State, or that receive, process, adjudicate, pay, or deny claims for reimbursement of health care services provided in Maryland, to abide by Maryland law regarding (1) prompt payment of provider claims for reimbursement; (2) retroactive denial of provider claims; and (3) denial of reimbursement for preauthorized or approved health care services. The bill also requires Maryland carriers to pay a provider according to these provisions if the provider is licensed, certified, or otherwise authorized to provide care in the jurisdiction in which a health care service is rendered.

Fiscal Summary

State Effect: Potential minimal increase in general fund revenues from the imposition of fines. Any additional enforcement can be handled within existing budgeted resources of the Maryland Insurance Administration (MIA). No impact on the State Employee and Retiree Health and Welfare Benefits Program.

Local Effect: None.

Small Business Effect: Minimal. Small business physician practices may benefit from more prompt payment of claims and a reduction in denials of reimbursement under the bill.

Analysis

Current Law:

Prompt Payment of Provider Claims for Reimbursement: A "clean claim" is a properly submitted claim for reimbursement. A carrier must permit a provider 180 days from the date a covered service is rendered to submit a claim. Within 30 days of receipt, a carrier must pay the claim or send a notice of receipt with the status of the claim. If a carrier denies a claim, it must permit a provider at least 90 working days to appeal. If a carrier erroneously denies a claim and the provider notifies the carrier within one year, the carrier must reprocess the claim. If a carrier disputes a portion of a claim, it must provide payment for any undisputed portion within 30 days of receipt of the claim. A carrier that does not pay clean claims must pay interest on the amount of the claim that remains unpaid 30 days after the claim is received. Interest must be paid at a monthly rate of:

- 1.5% from the thirty-first through sixtieth day;
- 2.0% from the sixty-first through one hundred-twentieth day; and
- 2.5% after the one hundred-twentieth day.

A carrier in violation of these requirements is subject to a fine of up to $500 per violation and additional penalties for frequent violations that indicate a general business practice.

Retroactive Denial of Provider Claims: For purposes of retroactive denial of provider claims, a health care provider is a person or entity licensed, certified, or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services. In most cases, a carrier may only retroactively deny reimbursement for services within six months after the date that the carrier paid the provider. Claims for services subject to coordination of benefits with another carrier, Medicaid, or Medicare may be denied for up to 18 months. If a carrier retroactively denies reimbursement as a result of coordination of benefits, the provider has at least six months from the date of denial to submit a claim to the carrier, Medicaid, or Medicare. A carrier may retroactively deny reimbursement *at any time* if information submitted was fraudulent or improperly coded or if the claim was duplicative. If a carrier retroactively denies reimbursement, the carrier must specify in writing the basis for the denial.

Denial of Reimbursement for Preauthorized or Approved Health Care Services: A carrier (or the carrier's private review agent) may not deny reimbursement to a health care provider for a preauthorized or approved health care service unless the information submitted to the carrier was fraudulent or intentionally misrepresentative, critical information requested by the carrier was omitted, the approved course of treatment was

not substantially followed, or information was available to the provider at the time of service indicating that the patient was not covered by the carrier on the date the service was delivered. Payment for preauthorized or approved covered services must be made to health care providers under the prompt payment and retroactive denial of provider claims requirements.

Background: Under current law, if a Maryland health care provider treats an individual whose health insurance is out-of-state (either because the individual is visiting the State or the individual's insurance is based in another state), reimbursement for that health care service is not subject to Maryland law. Therefore, depending on the health insurance laws in the state in which the carrier is regulated, payment may not be received as promptly as it would be under Maryland law, the claim may be retroactively denied according to different requirements, or payment for a preauthorized or approved service may be denied under different requirements. MIA currently receives complaints from providers about these issues but cannot take any action.

The bill requires carriers to follow Maryland law when paying claims for health care services rendered in Maryland and subjects the payment of such claims to the Insurance Commissioner's enforcement authority. Furthermore, under the bill's altered definitions of provider, the bill would require out-of-state providers in any jurisdiction who treat patients with health insurance from a Maryland carrier to be reimbursed according to Maryland law.

BlueCard is a national program offered through the Blue Cross Blue Shield Association that enables members of one company to obtain health care services while traveling or living in another company's service area. The program links participating health care providers with the independent Blue Cross Blue Shield companies across the country and worldwide through a single electronic network for claims processing and reimbursement. Beginning in March 2011, if a BlueCard holder under an insured policy sees an in-network health care provider in Maryland and the provider's clean claim for reimbursement is not paid within the required 30 days, CareFirst will pay the interest required on that claim under current law.

Additional Information

Prior Introductions: None.

Cross File: SB 561 (Senator Pugh) - Finance.

Information Source(s): CareFirst BlueCross BlueShield, Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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